



CONCEPTUAL, METHODOLOGICAL AND POLICY ISSUES  
IN PATIENT SATISFACTION RESEARCH

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ABSTRACT

This thesis is concerned with current debates as to the value of patient satisfaction research. The thesis reports two surveys by means of which the scope of patient satisfaction research is considered. Conceptual and methodological problems in this field of research and alternative theories of the social process whereby patients evaluate health care are reviewed.

The two surveys are presented in terms of an introduction to the particular field of medicine involved, the methods of enquiry used, survey responses and discussion of results. The first survey is of patients attending outpatient neurological clinics presenting with headache. This study was conducted with intensive interviews, one before the neurological consultation and a second at home, one month later. The problems of making sense of patients' accounts in terms of 'expectations' and 'satisfaction' are outlined. Instead different perceptions of the value of clinic visits are related to four different concerns felt by patients in relation to their headaches, concerns for reassurance, explanation, prevention and symptomatic treatment.

The second survey is of patient satisfaction with outpatient care in a department of genito-urinary medicine. This survey was conducted with two questionnaires: one completed whilst patients waited in the clinic for their

consultation, and a second which was mailed to patients one month later. Survey results are used to examine an interactionist model of patient satisfaction developed by Ben Sira. The data is examined by various methods to suggest limitations of and modifications to the original model.

#### Abstract

Finally the thesis assesses the contribution of the two surveys to an understanding of how patients evaluate medical care. Alternative models of patient satisfaction are reexamined. It is argued that some perspectives have too restricted a view of patients' abilities. The implications of the two surveys are reviewed in terms of the different interests researchers may have in surveying patients' views.

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CHAPTER 1 CONCEPTUAL, METHODOLOGICAL AND POLICY ISSUES IN  
PATIENT SATISFACTION

Introduction and outline of main arguments

The patient or potential patient, for whose benefit health services are ultimately provided, has been, according to many analyses, the unseen and silent actor in the arena of health policy. Whether one examines health care as a myriad of individual decisions between health professionals and their patients, or as a system of resources allocated to populations, it is widely observed that the provider's voice has been louder and more influential than that of the recipient of health care. In modern society generally it has become almost an aphorism to observe how neglected is the consumer of goods and services compared with the interests of the occupations and institutions that produce the goods and services. The emergence of social movements such as consumerism reflect such neglect. Disregard for the recipient's interests and perspective may have specific and particularly damaging consequences in the field of modern health care. This view has been accepted to some extent and at many different levels and in a variety of different ways, modern health care systems have attempted to become more attentive to the patients whom they treat and the populations whom they

serve. In this context patient satisfaction has emerged as a term with many referents: as an issue to which health services must pay more attention; as an object of enquiry in the monitoring of services; and as a concept or field of concepts in the explanation of patients' behaviour in the social sciences. This thesis attempts to examine the concept of patient satisfaction in terms of conceptual, methodological and policy problems that arise in examining the views of patients about their health care.

The investigation of peoples' views, opinions and reactions to the health care systems which they use, pay for or simply live with, is undertaken for a variety of different purposes, as shall be argued later in this chapter. A particular health authority may be embarking on major decisions about its maternity or rheumatological services to a population and conclude that one crucial item of information is the views of current or recent users of those services. At another level a government may be concerned about the value or popularity of health services compared with other parts of its welfare provision or compared with hypothetical alternative methods of funding or providing health care. At yet another level a clinician may be concerned with the reasons why some patients do not return for treatment, do not comply with advice received or show less than expected improvements from treatment. In each case consideration may be given to the question of the level of satisfaction individuals express about their treatment.



Although patients' views about their health care are increasingly sought, there is no consensus about the value of such information. The aim of this thesis is to provide some assessment of the value and scope of inquiring into patient satisfaction. The thesis identifies alternative uses for information about patient satisfaction. Alternative models of patient satisfaction are also delineated. The importance of such models is that they present different perspectives of the process whereby patients judge their health care, and alternative views of the scope of patient satisfaction. Two studies of patients' views are presented and used to assess the value of patient satisfaction research more generally. The first study examines patients' views with regard to a neurological clinic. The data are used to examine the more ambitious view of the scope of patient satisfaction research, which is that it is a crucial component of health service evaluation. In this view, patients are central sources of information about the benefits of health care. At the same time the neurological clinic study is used to examine one particular model of the process whereby patients evaluate their health care. This model focuses upon the importance to patients' of having their expectations of the doctor's role satisfied when they consult the doctor. The results of the study are used to argue that this is too narrow and misleading a view of the way in which patients evaluate their medical treatment.

The second study of patient satisfaction examines patients' responses to attendance at a sexually transmitted

diseases clinic. The purpose of this second study is to examine one of the few, major theoretical models of patient satisfaction, developed by Ben Sira. The importance of this model is that it identifies a far more narrowly delimited role for patient satisfaction. Patients are only able to observe a narrow range of aspects of their health care such as the niceness and humaneness of their doctor. As this model presents patients as unable to judge the medical content of their treatment, the implications of the model are that patient satisfaction has a much more circumscribed function in providing feedback about matters such as the 'art of care', and is of very limited value in more ambitious attempts to evaluate overall outcomes and benefits of health care.

The thesis is organised in the following way. This first chapter sets out to examine some of the difficulties that surround the concept of patient satisfaction and its use in survey research. Firstly attention is drawn to the diverse range of uses to which the concept has been put. One of the purposes of the thesis is to consider the value of patient satisfaction research to such diverse interests and potential users. This chapter goes on to argue that, despite the increasing number of patient satisfaction surveys, there remains widespread scepticism as to the value of such data. Such scepticism is based on a number of conceptual and methodological problems considered to be inherent in patient satisfaction surveys. These problems are reviewed.

Some of the problems thought to inhere in patient satisfaction surveys derive from assumptions as to how patients actually judge or evaluate the quality of their health care. According to some evidence, for example, patients rely on a very narrow and limited range of experience and evidence in forming their views of their medical care. To the extent that such assumptions are accurate, patient satisfaction could only play a modest role in evaluating the quality of health services, compared with, for example conventional indices of morbidity. The process whereby patients evaluate their health care, and form judgements of satisfaction or dissatisfaction is therefore a central focus of the thesis and of the two empirical studies of patient satisfaction which are reported. A number of different models or assumptions of how patients evaluate health care can be distinguished in the social scientific literature. This chapter reviews some of the distinctive features of three different approaches, which focus in turn upon cognitive beliefs, role expectations and emotional needs. Each of the approaches, most clearly in the case of the model developed by Ben Sira, share the widespread tendency to regard patients' judgements as being based on very limited observations and criteria.

Chapters 2, 3 and 4 report the first of two surveys of patient satisfaction - a study by intensive interview of patients attending neurological outpatient clinics for headache. By focusing upon patients presenting with a single symptom - headache, it is possible to give more



attention to the range of meanings for patients of their symptoms. In particular the study examines the relationship between patient satisfaction and the diverse concerns held by patients in relation to their presenting symptoms. The focus upon patients' concerns emerges from attempting to identify patients' expectations with regard to the neurological clinic.

Chapter 2 examines existing evidence of the ways in which headache, normally a problem that is self treated, may come to be presented to medical specialists. Evidence that social-psychological factors may play a role in illness behaviour in relation to headache is examined. The methods of the study are then described, together with the basic social, demographic and medical characteristics of the study sample.

In chapter 3, the results of interviews carried out before patients consulted the neurologist are reported. This pre consultation interview was used to identify the expectations patients held of their clinic visit. Role expectations are identified in chapter 1 as a common concept employed in social survey research to make sense of the process whereby patients evaluate health care. Expectations in this study are found to be tentative, fluid and emergent. Nevertheless it is possible to identify a small range of different concerns experienced by patients in relation to their presenting symptoms. Four different concerns are important and are described in the chapter: concerns for reassurance, explanation, prevention and

symptomatic relief.

In chapter 4 satisfaction with the neurological clinic visit is reported. Patients' comments indicate that a wider range of aspects of their consultation enter into their evaluations than is allowed for by Ben Sira's conceptual framework. A number of reservations and qualifications to their negative comments by patients support the view that patients do not readily express critical attitudes. Nevertheless a range from positive to negative views are clearly identified as they judge the overall value or appropriateness to their problem of the clinic visit. Such judgements of outcome are neglected in much patient satisfaction research. However in this study it is possible to relate varying types of judgement of the value of the clinic to the different concerns identified in the previous chapter. There is considerable variation in the extent to which different concerns are associated with subsequent satisfaction. It is argued that this approach provides important insights into the strengths and limitations of neurological management of headache.

In chapters 5,6,7 and 8 the second of the two studies is reported - a survey by questionnaire of patient satisfaction with attendance at a sexually transmitted diseases clinic. The results of this survey are used to examine one of the most extensively researched, elaborate and influential conceptual frameworks for patient satisfaction, that developed by Ben Sira. He traces his model of patient satisfaction from social interactionist

theory. Its most distinctive characteristic is an emphasis upon the importance of patients' emotional and affective needs as influences upon their degree of satisfaction with health care. Patients, according to this approach, are much more reliant upon cues from doctors' affective behaviour (such as showing interest in the patient) compared with more technical, instrumental aspects of his behaviour, in evaluating the quality of their medical care. Thus satisfaction with affective aspects of health care is held to be of prime causal importance in relation to other judgements of satisfaction. Whilst Ben Sira's work represents the most thoughtful examination to date of the processes involved in patients' evaluations of their health care, it is argued that the kind of general population survey data used by Ben Sira is not the most appropriate for examining his model. Data derived from patients actually attending a medical service for health care provide a more appropriate means of examining Ben Sira's conceptual framework.

Chapter 5 delineates Ben Sira's model of patient satisfaction. It is argued that there are considerable problems of sampling, concepts and method in the surveys he has carried out to develop the model. Chapter 6 introduces the questionnaire-based survey of patient satisfaction carried out in a London sexually transmitted diseases (STD) clinic. In the chapter are described the characteristics of such clinics and of the medical work carried out there. The methods of the survey are described together with the social, demographic and medical characteristics of the

survey sample. In chapter 7, the satisfaction scores of patients attending the STD clinic are reported. The data are first examined by means of the same process of 'specification' of relationships between variables that Ben Sira used to develop a theoretical model. It is argued that there is little support for this causal model in the pattern of correlations so produced. Furthermore a fuller examination of different possible four variable causal models does not provide any support for the central postulate of Ben Sira's theory which assigns causal primacy to affective judgements in determining patient satisfaction.

In chapter 8, data from the STD clinic survey are used to examine further the influence of affective factors such as psychological distress and illness concerns upon patient satisfaction. Various aspects of psychological distress measured at the time of clinic attendance are found to be associated with subsequent levels of satisfaction, whether examined in terms of simple bivariate relationships or from multiple regression analysis.

The results of the survey are used to reassess the role of affective factors emphasised in Ben Sira's conceptual framework. It is argued that Ben Sira's model, by underlining the role of emotional and affective factors in patient satisfaction, serves as an invaluable counterbalance to the cognitive emphases of other perspectives. On the other hand no basis can be found for

the overwhelming emphasis upon affective factors in his approach. It is concluded that the approach associated with Ben Sira has been valuable both in that it has brought the subject of patient satisfaction within the scope of sociological inquiry, and specifically because it introduced consideration of affective factors into social research on illness experience. On the other hand it has been important critically to re-examine Ben Sira's thesis precisely because, as a result of the relentless emphasis upon the view that patients depend on affective cues to evaluate their health care, the patient's potential role as a source of information about the quality of health services becomes too narrowly confined to matters such as the friendliness and 'niceness' of health care workers, to the neglect of other issues such as the outcomes of health care.

In chapter 9 the results of the two surveys are reviewed in relation to the process whereby patients judge their health care. Patients make more complex judgements than are allowed for in Ben Sira's model. They make direct inferences about the appropriateness and value of medical interventions, rather than relying on cues from the affective behaviour of doctors. Thus patients may be said to make judgements of the outcomes of care, in addition to and independently of judgements of the processes of care. The different conceptual frameworks available in the social sciences are again reviewed in the light of the two surveys reported in this thesis. The primary limitations of the cognitive anthropological approach are that cognitive



explanations may be quite secondary concerns to patients and that the degree of compatibility or distance between patients' and medical cognitive concepts are far less important influences upon satisfaction compared with divergence between the concerns and agenda of the two parties. In the neurology study, the group whose concepts of headache are most compatible with those of medical science in viewing their symptoms as a complex multifactorial and discrete disorder prove to be the most dissatisfied with their medical treatment.

The role expectations approach also has important limitations in terms of making sense of the neurological study. Role expectations are less stable and fixed in reality and tacit assumptions about the way in which the specialist should behave only prove to be an important source of dissatisfaction when other more profound goals and concerns are frustrated or disappointed.

The chapter also assesses the model in which emotional needs and affective factors play the dominant role in influencing satisfaction. Neither study provides either qualitative or quantitative evidence to support the view that affective criteria are causally prior influences upon satisfaction. Furthermore specific findings contradict the theory. In the STD clinic study, instrumental judgements are as strongly and consistently related as are affective judgements to satisfaction with outcomes of the clinic visit. In the neurology clinic study patients with no emotional anxiety about their symptoms - those seeking

preventive interventions for migraine - regard the close personal interest of the doctor - his affective behaviour - as especially important.

Finally observations are made regarding the different possible uses of patient satisfaction research. There are serious limitations in the value of the conventional attitudinal survey most frequently used by health authorities to monitor the services for which they are responsible. More carefully targetted and more intensive surveys need to be explored as means of obtaining useful information from patients about the quality of services. For clinicians, both conventional questionnaire based surveys and more intensive interview based studies provide valuable insights into aspects of the art of care and provide further support for and specification of the philosophy of 'patient - centered care'. Finally it is suggested that the role of patient satisfaction needs to be more fully explored alongside other survey - type instruments such as health status and quality of life instruments that are playing a growing role in the evaluation of health care in health services research. One of the greatest barriers to the extension of patient satisfaction into evaluation research is the assumption that patients can only usefully comment upon a narrow range of issues, especially with regard to the affective aspects of care. Evidence from this thesis indicates that broader issues such as the value and appropriateness of medical treatment could also be more extensively investigated by social scientific methods.

Thus the thesis is primarily concerned to investigate the process whereby patients form judgements of their health care. This is an essential first step towards a broader examination of the value of patient satisfaction research. Before embarking upon this assessment of the concept of patient satisfaction, it needs to be made clear that the formal investigation of patients' views, by survey questionnaire, interview or whatever has developed within a wider context of changes in modern health care systems. An understanding of the changing health policy context is ultimately essential to an evaluation of the potential value of patient satisfaction research. In particular, it is important to appreciate the diversity of developments that have led to interest in the subject. Health services research, like much social policy and applied social research, is intimately implicated in the specific political issues of its environment. The most obvious aspect of recent social change in which to search for reasons why the patient's views have so recently and so widely become an object of concern and of enquiry is in the development of 'consumerism' in medical care. The emergence of patient satisfaction research is often seen as a direct reflection of the development of consumerism. In this sense concern about the consumer's views has increased because the consumer has demanded more attention from the politician, administrator, manager and doctor who have hitherto determined health policy. The concept of the consumer needs particularly close examination because of its frequent use in the field of patient satisfaction



research. It is argued here that the origins of patient satisfaction research cannot simply be traced back to consumerist pressures and that, particularly in Britain, other interests have primarily fostered this particular field of inquiry.

#### The Consumer in the modern welfare state

Advanced modern democracies, whilst creating formal arrangements for popular involvement, may at the same time foster in the individual a sense of remoteness from the influence that reduces participation (Kornhauser, 1959; Etzioni Halevy, 1981). At the heart of modern western societies are welfare systems whose scale, bureaucratisation and specialisation, according to many observers (Glennerster, 1983; Hadley and Hatch, 1981; Mishra, 1981), have created problems of alienation and disaffection amongst those whom they are supposed to serve. Publically provided welfare services may be particularly liable to become unresponsive to consumers' needs and preferences (Weale, 1985). In all western societies modern technological medicine is a central element of welfare provision. Analysts and critics see such medical care as particularly susceptible to alienating effects in its clients whether through the impersonal nature of highly technological procedures essential to the practice of modern medicine (Berliner, 1984), through methods of professional training that systematically depersonalise medicine and result in reductionist models of illness (Osherson and AmaraSingham, 1981) or through the buildings

and institutions that tend towards impersonal care of patients by virtue of their scale and social organisation (Duff and Hollingshead,1968). Above all, the professional dominance of health care has been seen directly to contribute to the passivity of the patient and to the neglect of his or her concerns (Freidson,1970).

The recipient of medical care has always therefore been viewed as playing a particularly passive and dependent role vis a vis the providers of health care. However in the latter half of the sixties and early seventies, the language and ideology of consumerism began to infiltrate health policy discussions in the USA (Bashshur,1967; Hochbaum,1969). The trends were diverse. On the one hand the assertion of patients' legal rights became more common (Curran,1974). Also patients were encouraged, in new forms of health care such as Neighbourhood Health Centres, to participate more in the planning and management of facilities. More broadly and ideologically, interest groups such as the womens' movement and the ethnic minorities began to assert a claim to more influence over the content of medical practice (Ehrenreich,1978) and the very value of professionally dominated medical care began to be questioned more widely (Illich,1975). Taylor (1984) views the growing volume of criticisms of medicine as a social institution during this period as a reflection of a 'participation revolution'. Starr summarises many of the trends in American critiques of medicine in the mid 1970s as follows:

'The left wing advocates of health rights saw a common thread linking national insurance, community

participation on the boards of health centers and hospitals, and individual patient rights to take part in their own treatment and to treat themselves. The issue was basically professional dominance, and their aim was to increase the power of consumers.' (Starr, 1982:392)

In this context it was plausible for Reeder to view 'consumerism as a force for changing the professional-client relationship' (Reeder,1972:407).

Reeder viewed the very change in terminology in this area to be significant:

'The mere use of the term "consumers" to replace "clients" initiates a different perspective. ...the switching of labels tends to change the fabric of the social relationships between practitioners in the health delivery system and their clients.....in consumer - provider relationships, caveat emptor implies that the consumer has considerably more bargaining power than formerly. (Reeder,1972:409)

Growing interest in patient satisfaction as an issue was seen by Reeder as the clearest sign of all of a fundamental shift in power and influence between providers and recipients of health care:

'Finally, consumerism manifests itself most prominently in terms of the expression of satisfaction and dissatisfaction with that system in its varying forms....The increasing number of published papers concerned with client satisfaction or dissatisfaction with health care is an indicator of the growth of interest in this type of research. The importance of such studies is not in the intrinsic data presented but in their sounding a prelude to something far more fundamental - citizen participation in health care. (Reeder,1972:410)

Reeder was not alone in viewing increased interest in patient satisfaction as a reflection of more pervasive trends towards 'consumerism' in wider society (Locker and Dunt,1978:283; Gray,1980:72). According to Lebow (1982:244) concern with patient satisfaction must be related to 'the movement to a more consumer-oriented

society'. For Martin (1986) consumers have a right to have their evaluations of health services taken into consideration. The common thread in such views is to see current levels of interest in patient satisfaction primarily as representing a shift of emphasis in health care systems towards more patient focused care and patient participation in the process of care and away from more professionally dominated provision. The new level of priority given to patients' views and opinions thus both reflects and amplifies the recognition that such views had hitherto been seriously overlooked.

This analysis of patient satisfaction as a focus of policy interest that reflects the rise of consumerism as a social movement however, may be deficient or require qualification for a number of reasons. In the first place, in America, where the liberal critiques of medicine summarized above had been most vociferous, the late 1970s were a period of disenchantment with both professional dominance and with government welfare intervention. Starr describes this period as one of 'the liberal impasse' (Starr, 1982:411) out of which emerged a new force in health policy, threatening to alter radically the social relations of medicine - the corporate medical enterprise. The recent rise of large scale business interests in medicine documented by Iglehart (1982), Salmon (1984) and Derber (1984) is a phenomenon outside of the scope of this thesis. However Starr makes a prediction of immediate relevance: 'The corporate health services industry will also represent a powerful new force resisting public accountability and

participation' (Starr,1982:448). For Salmon (1984), the rise of the 'medical industrial complex' will mean a more pervasive sacrificing of the interests of consumers to those of corporate profits. It is difficult to speculate on such predictions. What is clear however is that the vision of consumerism as a secular transfer of power and voice from health care providers to patients requires re-examination. Whilst both earlier liberal critiques and current sociological analyses of the rise of the corporate medical business, agree in a diagnosis of declining professional dominance, they differ in their views of the prospects for consumers that might result. Yet there is no apparent diminution of interest in patient satisfaction in this new policy climate. One critical feature of corporate medicine according to Starr is closer vertical control and integration in which medical and economic information is used more closely to monitor service performance. It is not implausible that patients' attitudes may be a central item of information in that vertical control. As I shall argue elsewhere in this thesis, the issues that emerge as most salient in conventional patient surveys are precisely those aspects of health care - accessibility, interpersonal aspects of care, catering facilities - that a more powerful corporate sector might wish to monitor and adjust according to consumer response. Thus some aspects of consumer interests may be furthered in this way, at the same time as 'corporate rationalization' increasingly dominates the health care system as a whole (Pollitt,1982; Alford,1975). However the liberal critiques of medicine were also concerned with the



lack of consumer voice in relation to the quality and content of medical care and with the escalation of economic costs to the consumer which appeared to produce few medical benefits. Patient satisfaction surveys may still be a major tool of corporate control in this new policy climate. But attention to the consumer by attitude surveys may serve mainly to perpetuate the status quo with regard to the core medical activities of the system since patients in such surveys are rarely critical of this aspect of their care. Consumerism in the US may therefore paradoxically produce results which reproduce an expensive health care system which does not optimally serve the interests of the American population (Pollitt,1982).

It is difficult therefore to relate continued interest in patient satisfaction as an issue in any simple fashion to liberal and consumerist trends in the United States. The liberal critiques of medicine in the 1970s were clearly favourable to patient satisfaction research; yet such policy interests have not declined in the very different climate of the 1980s. It may be that the concept of consumerism in American health care has very little explanatory force, because it has been used by analysts to cover such disparate phenomena as participation in planning and management, involvement in clinical treatment decisions, feminist critiques of medical patriarchy and so on. Concern with patient satisfaction is compatible with a variety of different policy contexts.

### Health care 'consumerism' in Britain

In Britain, consumerism in health care and concern with patient satisfaction are more recent policy issues and have different origins and consequences. It is tempting to see, as some analysts have (Johnson, 1977, Taylor, 1984), the foundation of the Community Health Councils in 1974 as marking the delayed expression in Britain compared to the USA of popular demands for participation in health policy. However closer examination of CHCs indicates some of the ambiguities of 'consumerism' in the British context. When the NHS was founded, lay persons were included alongside professionals as members of the newly created Regional Hospital Boards and Hospital Management Committees, but the role of such lay persons was unclear. Klein (1983:96) notes that the Ely inquiry into abuse in a hospital for the mentally handicapped drew many people to conclude that lay members of the authority had become too concerned with managerial functions and staff interests and had lost sight of a distinct role as 'watchdogs' protecting the interests of the consumer. Reform of this function of the layman in the NHS sprang from broader desires to reform and clarify management generally. Thus according to Klein, the CHCs at least in part owed their origins, not to popular consumerism but to politicians' and civil servants' enthusiasm for managerialism that dominated health policy in this period: 'Paradoxically it was the doctrine of managerial efficiency which led to the institutionalisation

of the voice of the consumer in the shape of Community Health Councils' (Klein,1983:96). A further function of CHCs, built in by virtue of the number of members drawn from local voluntary groups, was that they provided, at local level a voice to particularly deprived client groups in the NHS such as the mentally ill and the elderly. Whilst given the function of representing local consumers' views, CHCs were '...a good example of the paternalistic rationalisers deliberately loading the dice' (Klein,1983:96) in favour of minority groups instead of broader constituencies of consumers. Klein goes further in casting doubts on the concept of consumerism as a social movement in Britain. The period of the 1970s undoubtedly saw the growth in number and level of public participation of a range of patients' interest groups. Such groups represented specific categories of patient such as MIND acting on behalf of the mentally handicapped and mentally ill, and the British Migraine Association to encourage research and treatment for migraine sufferers. Thus pressure groups to act for patients with particular problems proliferated. Yet, according to Klein, these developments should not be seen as evidence of widespread involvement in health as an issue:

'The growth of special interest groups and lobbies should not be interpreted as evidence of a general desire for public involvement in the health care policy arena. For the main characteristics of these groups and lobbies were that they were organised around very specific issues and were run by middle class activists. Their strength lay precisely in the fact that they were unrepresentative of NHS consumers or citizens at large; that they were exceptionally articulate in putting forward the case for particular interests.' (Klein,1983:117)

Thus the view that patient satisfaction has become



an issue in Britain as a result of consumerism is also deficient. Innovations such as CHCs appear to reflect as much the initiatives of central political paternalism. Patients do not actively complain about the NHS although it may be that official complaints procedures discourage some complainants (Stacey, 1974). Stacey (1976) more generally questions the value of the concept of consumer. The concept was introduced into policy discussions for ideological purposes, she argues, to reduce the deferential associations of the term 'patient'. However 'consumer' undervalues the importance of the patient as active participant in producing his or her health. Whether the concept demeans the status of patient would seem a matter of opinion. Whatever the case, Stacey's view suggests that the term may have more rhetorical than analytical value. A more serious problem with the concept is that it implies a persistent and enduring interest in an issue whereas, with health problems particularly, most people prefer not to think about such matters most of the time, and when illness occurs to make the issue salient, the individual is least able to act like a consumer (Ham, 1977). Thus, whilst in both Britain and the USA the period in which patient satisfaction has become a matter of policy concern has coincided with changing ideologies relating to the user of health services, it would be wrong to link the two too closely as reflecting expressed social pressures for public participation. Instead the continued interest in health services with patient satisfaction as an issue is more readily explained in terms of other parties' interests in the field of health care.

Other parties with interests in patient satisfaction:

Health authorities

Interest in patient satisfaction has arisen less as a result of consumer pressure, it may be argued, and more as a result of the needs of health authorities that provide health care. As third parties such as governments, corporate businesses and insurance companies increasingly take over the funding and running of health services, their needs for information as to the users' views of services increase. In Britain, the bodies mainly concerned are primarily the Regional and District health authorities, although higher levels of the NHS such as the DHSS or Parliament, because of their statutory responsibilities, may take an interest in examining patients' views about health care provision. A distinctive feature of recent years has been the increased pressure from Parliamentary Committees such as the Social Services Committee and the Public Accounts Committee demanding that the NHS be more accountable in terms of 'value for money' and quality of care provided to the public (Klein, 1982b). The responsibilities of public bodies such as the NHS increasingly extend beyond the provision of services to include regular monitoring of the quality of services and the demonstration by means of evidence that such monitoring occurs. Demands are increasingly made for the NHS to be more openly accountable in terms of progress made towards the achievement of objectives (Day and Klein, 1985; Day and Klein, 1986). The range of information available to health

authorities about their services is enormous, but is almost entirely information about the volume and inputs of services - numbers of beds, lengths of patient stay, number of x-rays performed - and provides no information about the outcomes of services - the resulting benefits to patients of the use of services (Klein,1982a). Even the recently introduced Performance Indicators (Pollitt,1985) intended to enhance health authorities' intelligence focus almost exclusively upon such inputs. This weakness is largely because of the immense technical problems in measuring and evaluating outcomes (Long,1985). It is extremely difficult to isolate the extent to which levels of health can be attributed to health care interventions rather than to other factors. Academic commentators on the NHS have nevertheless argued that this lack of data on outcomes urgently needs to be remedied and that patients' views need to be incorporated into health authorities monitoring of services, as one crucial component of outcomes (Doll,1973; Maxwell,1984). Surveys of patient satisfaction offer the possibility of feedback to an authority of the end results of the services it provides at least in terms of lay individuals' judgements of outcomes (Pollitt,1985; 1987).

However the level of practical involvement in this area appeared to be modest until the Griffiths report (NHS Management Inquiry,1983). The main recommendations of this report have been largely implemented and have led to the introduction of the general manager in the NHS. The report also strongly attacked the lack of interest in and sensitivity to consumers' views in the NHS. Invidious

contrasts were made between the business world and the NHS: 'Businessmen have a keen sense of how well they are looking after their customers. Whether the NHS is meeting the needs of the patient, and the community, and can prove that it is doing so, is open to question' (Quoted in Day and Klein, 1983: 1814). Thus in addition to stronger managerial control, the report advocates market research to elicit: 'the experience and perceptions of patients and the community' (Quoted in Day and Klein, 1983: 1815). Health authorities have responded to this challenge, and have even been criticised for over-enthusiasm in this respect. Thus Shaw writes that in the wake of the Griffiths Report: 'The subsequent stampede of districts to label a senior officer as personally accountable for testing patient satisfaction is in danger of being seen as synonymous with quality of care' (Shaw, 1986: 110). Districts in particular appear to be very active in carrying out such consumer surveys whether as key components of general district quality control measures (Fisher, 1986), or as more limited evaluations of specific services such as district physiotherapy departments (Gittins and Williams, 1986). It is important to note that the Management Inquiry was led by Roy Griffiths, the Managing Director of Sainsburys and has been seen (Butler and Vaile, 1984: 182) as assuming that management and organisational problems in the NHS were very similar to those of industry. Information about consumer satisfaction may play a central part in private sector business decision making, and for some observers it is surprising that this has not been the case for the NHS. Halpern, for example, in reporting a 4% decline in

satisfaction with the NHS expressed in two opinion polls between 1985 and 1986 observes:

'Four per cent might not seem a great deal but if the boss of a large store or an airline got the the same returns for his or her organisation some searching questions would soon be asked.' (Halpern, 1986:654)

Decision making in the NHS compared to private business is infinitely more complex and less responsive to such pressures. The Griffiths report's accusations of NHS insensitivity to the consumer must be understood as an attempt to change or simply overlook such structural differences between the two types of organisation. For some this assumption of common problems and common solutions is an 'heroic oversimplification' (Day and Klein,1983). Certainly there are difficulties which will be confronted by efforts to place consumers' views to the fore. Professionals are reluctant to accept criteria of evaluation that are not professionally derived (Freidson, 1970, Wilding,1982). Consumers' views in particular may not be viewed as legitimate data (Kelman,1976; Kisch and Reeder,1969). Thus it is not yet clear how helpful health authorities will find consumer information as a means of changing practices. Health professionals often contrast survey data with 'hard' 'scientific' or 'technical' data, by professionals in a way that discredits the survey as a basis for action. Thus Marsh and Kaim Caudle make the following observations about patient satisfaction surveys in relation to primary care:

'Evaluation must be based on technical data and technical understanding...the patient as a layman is



not well placed to participate in this process...The findings of such surveys should not be considered as an evaluation of the quality of primary health care but should be viewed as part of the trend to make the care more patient - orientated. They should provide useful indicators for the desirability of certain types of change but not conclusive arguments for changing all procedures and conduct which cause dissatisfaction.' (Marsh and Kaim Caudle,1976:139)

Stocking (1985) provides evidence to indicate how slow and unresponsive many authorities have been in permitting patients in hospitals to be wakened at a later hour in the morning. Early wakening time was the aspect of NHS hospitals which provoked the most dissatisfaction amongst former patients' in the Royal Commission's investigation of patient satisfaction with the NHS (OPCS,1978). It has been repeatedly investigated by CHCs at local level, yet it is an aspect of hospital practice remarkably slow to be changed. Such examples indicate how very modest may be the impact of consumer surveys in the health service.

#### Health service researchers

Districts have begun to make appointments such as 'consumer relations officers' as a result of the Griffiths Report (Young,1985). Nevertheless the limited resources available to health authorities have tended to make the development of systematic health services research problematic in Britain. More research is conducted by academic departments on DHSS and MRC grants than by health authorities (Warren,1983). For various reasons, health services research is therefore underdeveloped in this country compared to the USA and poorly integrated into



policy and planning (Butler and Boddy,1983). In particular the case has been made that the evaluation of medical treatments is underfunded, and the patients' experiences and views of treatments unexamined (CSS,1982; Maxwell,1984).

Such views have to be understood in relation to current 'state of the art' discussions of health services evaluation research. Doll (1973) argued that the evaluation of complex health care systems such as the NHS requires three types of information. Firstly and most obviously there is a need for information about medical outcomes. Cochrane (1972) has convincingly shown that the medical benefits of much modern medicine remain unexamined and the methods whereby such evaluations are carried out are time consuming and complex. Techniques such as randomised controlled trials also pose enormous ethical difficulties. The second requirement for the effective evaluation of health services identified by Doll is information about economic efficiency. Given the universal experience of resource constraints in health care, increasing attention has to be given to such techniques as cost effectiveness and cost benefit analyses to facilitate more rational choices between treatments. Since Doll wrote his discussion, health economics has burgeoned as a discipline (Culyer,1976; Drummond,1980). The third kind of information Doll identified as essential concerns the social acceptability of health care. Doll argued that public satisfaction with the NHS was an important issue which was not reliably reflected

through mechanisms such as Parliament and lay representation on governing health boards. He also expressed scepticism about the capacities of the then new CHCs to reflect the users' views. He concluded by advocating 'a medical equivalent of market research' (Doll,1973:733).

Doll was effectively advocating a multidimensional approach to the evaluation of health care in which medical, economic and social aspects were considered simultaneously. Since then, especially in the USA, the conceptual, theoretical and methodological issues involved in such evaluation have progressed further. In particular Donabedian (1980) has developed a sophisticated framework for evaluating the quality of health care one aspect of which is the evaluation of outcomes. In discussing evaluation he concludes that patient satisfaction is 'a legitimate component of quality assessment. Information about it should be obtained as carefully and assiduously as we now seek professional judgements' (Donabedian,1983:220).

Such research is undoubtedly expensive and time consuming and therefore beyond the means of health authorities within current NHS budget constraints. In practice, therefore, very little authoritative evaluation research is conducted which matches the comprehensive standards commended by Donabedian. In particular few studies are conducted in which patient-focused assessments such as satisfaction with care find a place alongside more conventional medical measures of outcome (CSS,1982). An

example in Britain is a study by Adler et al. (1978). They were concerned with the issue of reducing lengths of stay in hospital following routine surgery. A randomized controlled trial was set up with some patients being discharged earlier than normal for hernia and varicose veins. In addition to such outcome measures as the rate of complications following discharge, the team also assessed the degree of satisfaction of both patients and their families.

Such studies are 'state of the art' investigations, the results of which are scientifically evaluated and disseminated. The ambition of such health services research is to have more than local impact. Such investigations set out to provide definitive evaluations of aspects of services rather than the information gathering and monitoring functions which health authorities take on. The rigorous use of patient satisfaction as an outcome measure in such research is more commonly practiced in the USA than in Britain. For example, in the debate about the merits of pre-paid insurance forms of general practice as a substitute for more conventional fee for service, patient satisfaction has been put to use as a potentially important outcome measure (Ross et al., 1981; Tessler and Mechanic, 1975). However it may still be said that patient satisfaction is not yet a well sufficiently established concept to be extensively used in 'state of the art' health services research. There is some considerable distance between the sophisticated approaches advocated by writers such as Donabedian and the reality of health services

research. It nevertheless remains the case that the subject is strongly advocated by some as a way of more systematically evaluating health services (Donabedian, 1983; Long et al., 1985; Pollitt, 1985).

#### Public opinion pollsters

There is another quite separate realm in which the concept of patient satisfaction is frequently invoked - the assessment of public opinion in relation to the welfare state as an institution. The monitoring of social attitudes is a growing area of enquiry (Jowell and Airey, 1984). A particular focus of interest, in welfare states such Britain, is the assessment of public opinion with regard to the popularity and acceptability of the state's provision of services and also with regard to the very principle of public compared with private provision of services (Taylor Gooby, 1985a). As a large component of welfare provision, the NHS has been the subject of repeated opinion surveys. In the main such work is less concerned with the monitoring of quality for which health authorities have statutory responsibilities, than with more fundamental questions regarding the legitimacy of public forms of welfare provision. There is also interest in such work in the extent of social variation in views about public welfare.

Such studies suggest that the majority of people support the principle of funding of the NHS (Bosanquet, 1984:84), although other evidence indicates that

a majority of people would personally choose private over public care if the costs were equal (Taylor Gooby,1985a:40) and that only a minority of respondents wish the provision of private health care to be limited (Harrison and Gretton,1985). Harrison and Gretton summarise the evidence of the British Social Attitudes Survey (Jowell and Airey,1984) as indicating that :

'The NHS commands widespread support among all sections of the population.....a good deal of that support comes from a general desire to see more health spending, rather than from any strong approval of public provision' (Harrison and Gretton,1985:47).

Opinion surveys have always tended to find high levels of satisfaction with the NHS as an institution (Klein,1982). A recent survey commissioned by the National Association of Health Authorities and conducted by Marplan (Halpern, 1986) found 87% of respondents satisfied with hospital treatment in the NHS and 88% satisfied with family doctor treatment. The British Social Attitudes Survey (Jowell and Airey, 1984) found that 25% of respondents described themselves as dissatisfied with the NHS. There were no differences in dissatisfaction between respondents of different social classes but those with higher incomes were more likely to express dissatisfaction. Taylor Gooby's survey (1985a) also found dissatisfaction with the NHS to be associated with membership of private health insurance schemes.

Taylor Gooby (1985b) concludes from the survey evidence that, overall, the NHS commands a higher level of popularity than most other institutions of the British welfare state and that people are willing to pay more in



their taxes to support it. There are diverse explanations for variations in public support for institutions such as the NHS between different social groups. This issue is beyond the scope of the current thesis and the interests of social theorists concerned with the legitimacy of public institutions such as the NHS are not discussed in detail. However public opinion research does make clear that the NHS as an institution receives widespread support. This attitudinal support is a key factor that needs to be borne in mind in the other uses of patient satisfaction surveys which are the focus of this thesis. It may in practice be difficult to separate out attitudinal aspects of support for a principle or institution from more specific evaluations of the services provided.

### Clinicians

In recent years there has been a remarkable growth and convergence of interest amongst some branches of clinical medicine and the applied social sciences in research into what may be called the patient's point of view (Armstrong, 1984; Engel, 1977). One common focus of such research has been to examine patients' views and reactions to their consultations with health professionals with the goal of using such information to improve the quality of personal care provided (Pendleton and Hasler, 1983). Perhaps the single most important effect of research into patient satisfaction has been as a means of altering the 'art of care' or interpersonal aspects of the provision of medical treatment.

Two aspects of this applied social and behavioural research are of particular importance in the development of interest in patient satisfaction. On the one hand dissatisfaction has been identified as a predictor of patient behaviour thought not to be in the interests of the patient such as 'failure' to comply with medical advice or to reattend for further treatment. On the other hand patient dissatisfaction has been widely used to indicate aspects of health professional behaviour within the consultation that may hinder the good practice of medicine such as poor communication or failure to provide reassurance. These clinical applications of patient satisfaction research may be briefly reviewed.

Patients who are dissatisfied with their treatment may be less likely to continue using the health care facility. Thus studies by Larsen et al. (1979) and by Kline et al., (1974) both found a moderate correlation between dissatisfaction and premature termination of use of psychotherapy. A study by Roghmann et al. (1979) examined the use of ambulatory health care of a sample of mothers in Rochester, New York receiving welfare. They found that their assessment of satisfaction increased the explained variance in clinic visits by a modest 10% compared with predictions from demographic variables alone. A similar study by Thomas and Penchansky (1984) found no zero order correlations between satisfaction and use of health services but did find positive correlations within more specific sub groups of the sample. However, partly for

methodological reasons, such as the measurement and time order of variables, the research on satisfaction and use of services is usually inconclusive (Gray,1980).

Somewhat more support is found for the proposition that satisfaction is positively associated with compliance with medical advice. Kinsey et al.,(1975) followed up for interview patients who had attended a general practice. They found that patients' reported compliance with advice was significantly positively related to their satisfaction score. Similarly Blumhagen (1982) found a modest positive association between satisfaction and compliance with treatment amongst a group of hypertensive patients. Other studies provide support for the importance of satisfaction in influencing compliance (Becker et al.,1972) although in some studies there is no association between the two variables (Hulka et al.,1976).

Many of these studies are cross sectional and therefore less convincing than the locus classicus of such research - the American series of studies of mothers attending paediatric clinics in Los Angeles (Korsch, Gozzi and Francis,1968; Francis Korsch and Morris,1969). This study related many aspects of mothers' reactions to specific experiences tape recorded in their consultations with the paediatrician. A finding of particular importance was that mothers who rated themselves as satisfied with their consultations were three times more likely to comply with the paediatrician's advice than those who were dissatisfied (53% vs. 17% complied). Once again however

not all studies have found the same positive association (Wartman et al., 1983).

Patients' views also provide important information about those aspects of health care that may be summarised as 'the art of care'. By this phrase is meant the variety of non technical aspects of treating patients such as showing interest, giving sufficient time to the patient, and giving adequate explanations. There is something approaching a consensus in the view that patients are most concerned about and more likely to express dissatisfaction in relation to the interpersonal aspects of their treatment than with anything else. Thus Kelman observes that:

'Recipients of care are more concerned or dissatisfied with the manner and means of the processes of health care delivery, the way in which they are regarded and dealt with by health care personnel,..... than with the outcome of care or the competencies of the health care personnel providing care.' (Kelman,1976:436)

Another American observer concludes that: 'The American public is generally more satisfied with the technical aspect of medical treatment than with the interpersonal component' (Pope,1978:293). A summary of research on patients' views in Britain concurs:

'Patients seldom criticize their doctor's clinical judgement or their technical competence. A not inconsiderable minority will complain about the difficulty of consulting their doctor as soon as they would like. Even more will confess that their general practitioner is not so warm or friendly as they would like or that they have difficulty in telling him all they feel he should know about them and their condition.' (Jefferys 1977:188)

Such conclusions are generally based on attitudinal

surveys. Thus in Hulka et al.'s study (1975), 14% of patients expressed dissatisfaction about aspects of their doctor's personal style and manner, twice the size of the proportion who were critical of the doctor's technical skills. In Cartwright and Anderson's study (1979) of patients' views of General Practice in England, 23% of patients were critical of the explanations they received from their doctor; only one other issue - the doctor's waiting room - provoked more dissatisfaction. Other community surveys (Patrick et al., 1983) of patients' views emphasize the importance of problems of communication as a main source of patient dissatisfaction.

However, the most interesting and more cogent research in this field has involved examining patients' responses to specific medical consultations in circumstances where independent information about the consultations was also available. The Los Angeles study of paediatric clinics cited above in connection with compliance is an excellent example (Korsch et al., 1968; Francis et al., 1969). The study is so frequently cited because of its methodological sophistication. The investigators were able to tape record and analyse in detail some 800 consultations and examine specific aspects of the consultations in relation to subsequent levels of satisfaction amongst the mothers whom they subsequently questioned. The tape recordings revealed many possible shortcomings in paediatricians' approaches to communication. Doctors frequently used jargon, failed to provide any diagnostic or prognostic information and often



did not discuss the main worries and concerns of the mothers. One quarter of the mothers subsequently expressed dissatisfaction with the consultation. If the doctor engaged in friendly talk with the mother during the consultation, mothers were significantly more likely to be satisfied with the consultation. If the mother had a chance to express her concerns during the consultation, and such concerns were acknowledged or registered by the doctor, the sense of being understood led mothers to be more satisfied subsequently. Most important of all, as mentioned earlier, mothers who were dissatisfied were significantly less likely to comply. Thus this study was able to identify an important set of links from specific gaps in the doctors' approach to communication through patients' reactions, ultimately to the level of compliance with treatment. This approach to the investigation of consultations is also used in Stiles et al.'s (1979) study of 19 doctors providing general medical care. The consultations were tape recorded and analysed and patients' level of satisfaction assessed by subsequent questionnaire. They identified a style of interviewing used in some consultations which facilitated patients in telling their history fully and in their own terms. This mode of interviewing was significantly and positively associated with patient satisfaction. A similarly designed study of consultations and patient satisfaction in Family Medicine in Canada came to conclusions that resemble those of Stiles and colleagues: 'a positive outcome depends on physician behaviour which is facilitating rather than dominating' (Stewart, 1984:76).

Further studies underline the importance of other aspects of the doctor's interpersonal behaviour and communication skills (Dimatteo et al., 1980; Weinberger et al., 1981; Ley, 1982). One of the most important developments in thinking about health care in recent years, especially in primary care, has been the advocacy of 'patient centered' as against 'doctor centered' forms of medical practice - a rhetorical short hand for a wide variety of changes in practice which encourage the patient to be a more important actor in the consultation and encourage the doctor to facilitate the more open expression of problems, rather than the limited reporting of medical symptoms (Byrne and Long, 1976; Tuckett et al., 1985; Kurella, 1979; Good and Good et al., 1982). Physicians such as Lazare and colleagues go so far as to advocate a 'customer approach to medicine' in which the consultation is seen as 'a process of negotiation between the clinician and the patient, taking the patient's request as the starting point' (Lazare et al., 1975:553). The research evidence reviewed above suggests that assessments of patient satisfaction have played an important part in supporting such philosophical shifts in certain branches of medicine. A distinctive and important thrust in patient satisfaction research bears upon issues within clinical practice, and primarily addresses the concerns of a clinical audience.

### Unresolved problems with patient satisfaction surveys

Thus the investigation of patient satisfaction has been conducted with a variety of different purposes and concerns. Despite the increased use of patient surveys, there remain widespread reservations about the ultimate value of the information gained from such inquiries. In the most extreme form it may be felt that patients can provide no really useful views about the health services that they receive. More commonly the view is expressed that whilst the patient's views should be obtained, they are only likely to prove valuable with regard to very specific aspects of health services that the patient is competent to appreciate and judge. Scepticism may also derive from doubts about the methodological robustness of the survey as a means of obtaining information. To the extent that such sceptical views prevail, clearly the scope and application of patient satisfaction research will ultimately remain modest. This section attempts to draw together some of the main methodological problems that have emerged that ever threaten to undermine confidence in the value of further research.

### Problems arising from patients' limited technical competence

Perhaps the single most important reservation or limitation felt to exist in patient satisfaction research

is that patients are not very knowledgeable about technical medical matters. Earlier in the chapter Marsh and Kaim Caudle (1976) were cited as expressing reservations of this nature about the value of patients' views. They state quite succinctly that: 'patients are unable to judge the quality of the service they receive' (Marsh and Kaim Caudle, 1976:138). Such profound reservations with regard to patients' abilities to assess medical care are commonly expressed (Ben Sira, 1976: 3; Parker, 1976: 194; Scheirer, 1978:66). Thus it is frequently observed (Locker and Dunt, 1978:290; Van Den Heuvel, 1980:425) that the perception of the consumer as unable to assess technical aspects of the quality of care is the main reason for the limited role of the consumer in health service evaluation and decision making. Kelman expresses the problem in this way:

'...although the traditional and the more 'enlightened' provider perspectives on quality care and its assessment may differ with respect to the importance or relevance of the consumer as a data source, neither viewpoint provides opportunity for the consumer to participate in the definition of quality, that is, in specifying the criteria of health care quality... To justify this exclusion or constraint on the grounds of ignorance or incompetence is essentially an ideological denial of legitimacy.' (Kelman, 1976:434.)

One result of the prevalence of this view is that the serious investigation of such aspects of patients' views is often not undertaken precisely because it is assumed in advance that nothing of value can be learned. One of the clearest expressions of this is the Royal Commission's decisions about which aspects of patients' views to investigate in its own major study:

'It was decided not to ask patients about their satisfaction with their actual treatment and with the

standard of medical care they had received for two reasons: firstly there was no objective standard against which to set their answers and secondly it was felt that the patient's own views on his treatment would not be a sound basis on which to make recommendations for changes or improvements' (OPCS,1978:5).

As Gray observes (1980:65), potentially there is a self fulfilling prophesy involved if investigators persistently neglect attitudes or views on the basis they are unsound or unreliable.

The basis for neglecting patients' views with regard to the technical and medical aspects of their care is essentially that of the patient's ignorance. Much medical and behavioural scientific research in areas such as communication and the doctor patient relationship used to be based on similar premises (e.g. Samora et al.,1961). Research was designed above all to underline the importance for the clinician to simplify technical medical matters for patients because of their limited capacity to understand technical terms. Failure to simplify technical medical concepts risked creating problems in the doctor's relations with the patient. More recently however it has been suggested (McKinlay,1975) that the stereotype of the ignorant patient is one used by health professionals to justify avoiding extended discussion in consultations. Because patients cannot understand, there is no need for extensive explanation. Moreover the resulting lack of discussion within the consultation provides further confirmatory evidence of the stereotype. More recent evidence of patients' medical knowledge (Segall and Roberts,1980) suggests higher levels of comprehension



amongst patients than was indicated in earlier research. Equally important, doctors who were asked to estimate the patient's comprehension of medical terms often seriously underestimated the patient. It would seem, therefore, that at the very least empirical evidence is needed to examine the extent of patients' ability to provide useful information with regard to more technical medical aspects of their treatment. In the same way patient satisfaction research needs to consider just how knowledgeable patients are, rather than assume a priori major limitations. More generally it might be argued that a distinction needs to be made between level of technical knowledge on the one hand and ability to comment on the the application of such knowledge to one's problems. To anticipate some of the arguments arising from the neurological clinic study, patients may not share the hospital specialist's technical understanding of medicine, but they may make extensive comments upon the application of that knowledge to their problems, in terms of, for example, the value of treatment.

Problems arising from patients' inability to discriminate between different aspects of care

Related to the view that the patient has limited ability to understand medical care, is a second widely held assumption about patients that is often seen to render patient satisfaction research problematic. In summary the problem in this case is that patients are said to be unable to discriminate between different aspects of their treatment. In the 'weaker' version of this claimed

limitation of patient satisfaction surveys, it is held that patients may distinguish between a variety of different features of what happens to them in the course of their medical treatment, but nevertheless develop a single global judgement or attitude by the time their attitudes can be formally elicited (Larsen et al., 1979). In the 'stronger' version (e.g. Ben Sira, 1976), it is maintained that even at the time of experiencing and observing their medical treatment, patients' perceptions and views are limited to specific aspects of that experience, and that judgements, for example of the technical quality of their care tend to be determined by judgements of a quite different issue - the humane and interpersonal skills of the health professional. Perceptions of this latter aspect of treatment are the only aspect of health care the patient is capable of judging and therefore, even at the time of treatment, tend to be the basis of judgements that patients make about quite different issues such as how good is the quality of medical treatment they receive from the doctor.

The 'strong' version of this view has been developed by Ben Sira to a sophisticated level such that an ambitious theory has been elaborated to explain the factors that determine patient satisfaction. This theory, in summary, holds that patients' overall judgements of the value of their medical treatment are determined by their prior judgements of satisfaction with the doctor's affective behaviour'. By 'affective behaviour' Ben Sira refers to actions of the doctor such as showing interest and treating the patient as an individual. Because the

layperson is unable to appreciate or understand the medical aspects of treatment received from a doctor, he or she is heavily reliant on other cues and other evidence in deciding how worthwhile is the health care that is received. The theory is an important one for two reasons. Not only does it provide a specific set of predictions with regard to the range of factors that influence patient satisfaction. More generally the theory provides strong support for the broad thrust of medical philosophy that would place enormous emphasis on the importance of interpersonal aspects of health care, for example, in the education of future health professionals. This particular theory is examined in detail in chapters 5,6, 7 and 8 so that detailed discussion of Ben Sira's theory is not undertaken at this point. However the general basis of the claim that patients do not form distinctive attitudes in relation to the various different aspects of their treatment needs some consideration. Lebow expresses the problem in this way:

'halo judgements severely limit the value of [patient] assessment, restricting the use of consumer satisfaction data to the reporting of general satisfaction with services. In the presence of halo judgements, analyses designed to assess attitudes toward specific parts of the care process become impossible.' (Lebow, 1982:248)

In referring to halo effects, Lebow points to a widely observed phenomenon in the social psychology of interpersonal perception, whereby, when judging other people, observers' global evaluative judgements of a positive or negative nature tend to affect their reactions on all other dimensions. If a person is liked, favourable characteristics are attributed to the person on other

dimensions of judgement (Cook,1971). According to this theory therefore global judgements of whether a doctor is liked or not may strongly affect other dimensions on which a patient is invited to comment, such as the perceived value of the doctor's medical treatment.

Halo effects are not easy to identify other than through experimental effects in the laboratory. They are particularly difficult to demonstrate in attitudinal surveys such as those used to investigate patient satisfaction. One particular problem is that respondents' attitudes in the field of health care tend to be very heavily positively skewed. Most patients report positive results on most dimensions of a patient satisfaction survey. It is therefore difficult to examine the question as to whether judgements on particular dimensions are the source of halo effects. Nevertheless observations such as the above quotation by Lebow do reflect widespread assumptions that patients' answers in surveys may reflect very global attitudes of a positive or negative kind to their health care.

One way in which this question has been addressed has been by means of factor analytic studies to identify distinct dimensions in patients' responses to attitudinal questionnaires. Factor analysis sets out to discover which variables in a data set form coherent subgroups that are relatively independent of one another. Such a technique can be used on the items of satisfaction questionnaires to identify the independent dimensions of the instrument,

which may be assumed to reflect in turn the dimensions of underlying attitudes. Ware and Snyder (1975) conducted a survey of respondents' views about their health care in a sample of Illinois households. Responses to questions about eighty different aspects of care were obtained. Factor analysis identified four distinct dimensions to patients' views:

- (1) The doctor's conduct
- (2) Availability of care
- (3) Continuity and convenience
- (4) Financial accessibility

To the extent that such dimensions are valid, they are evidence to support the view that responses to patient satisfaction questionnaires are not solely or largely determined by halo effects. Judgements of the doctor's conduct do not so extensively determine judgements of the availability of care from the doctor that the latter cannot be distinguished. However, most importantly, Ware and Snyder found that the first factor - the doctor's conduct - was comprised both of items about the technical quality of medical care and items about the humane and interpersonal aspects of the doctor's care. They conclude that:

'The finding that measures of patient attitudes toward the quality of care received from doctors (thoroughness, preventive measures, information giving and the like) have basically the same factor content as measures of doctor humaneness (consideration and support) suggests that consumers of medical care



services may have one general attitude toward their doctors. In other words the distinction between the 'caring' and 'curing' aspects of physician behaviour which often appears in the literature is not supported by the results.' (Ware and Snyder, 1975: 778)

The thesis propounded by Ben Sira is that, using Ware and Snyder's terms, patients' judgements of the quality of a doctor's care are considerably influenced by judgements of that doctor's 'humaneness'. Ware and Snyder's evidence is further support for this view. At present, whereas some studies support the view that there are strong halo effects in patient satisfaction research (Lebow, 1975), other investigations (Tesler, 1975) find distinct dimensions. Penchansky and Thomas (1981) used factor analysis to examine a survey of attitudes to health services in Rochester, New York and argued that they were able to demonstrate as many as five different dimensions of attitudes to access in the survey! Factor analysis has been subjected to considerable criticism as a means of identifying underlying patterns in data (Hirschi and Selvin, 1973; Tabachnick and Fidell, 1983), particularly as there are so many choices of procedure and so many resulting solutions to any particular data set. It may not, therefore, provide a very clear means of determining the extent to which patients form distinct judgements of different aspects of their health care. Thus, especially with regard to the issue raised in Ware and Snyder's work, using such techniques it is still unresolved whether patients distinguish between so called 'curing' and

'caring' aspects of medical treatment in their evaluations. As a result, the clinical relevance of patient satisfaction research for medical training continues to be particularly strongly contested by those with differing views as to the importance of behavioural skills for doctors ( Cousins, 1985; Mathews, 1986). More robust as a means of determining the independence of different dimensions of patients' attitudes are studies in which measures of some external referent are available as, for example in the studies on validity (referred to in the next section) where different dimensions of patients' judgements can be related to measures of different dimensions of the health care that they have experienced. One can for example investigate whether attitudes regarding the interpersonal aspects of a consultation correlate more with an observer's independent measure of the interpersonal features of the consultation or with measures of the technical medical aspects. Such an approach also involves addressing the wider question of the validity of patient satisfaction surveys.

#### Problems of the reliability and validity of questionnaires

Reliability is more simple to address as an issue compared with validity. However very few studies examine or report on the reliability of measures used to assess patient satisfaction. Hulka and colleagues (1975) provide an example in their study of attitudes to medical care. Attitudes to different aspects of care were obtained by Likert format items and scales were produced to assess three distinct components of care: (1) the technical

competence of the physician, (2) the personal qualities of the physician and (3) the accessibility of care. Reliability was examined by split half technique and produced correlations of 0.75, 0.86 and 0.68 respectively. Other studies using this method have produced satisfactory reliability figures (e.g. Woodward et al., 1978). The context in which attitudes are elicited has received occasional attention in studies. Thus Raphael (1969) found somewhat higher rates of critical comment by patients when interviewed in their last day or two still in hospital compared with a matched sample interviewed at home after discharge. There is little systematic evidence however of the effect of location of interview on patients' views in surveys (French, 1981). The reliability over time of measures has been examined even less frequently. The study of mothers' views of paediatric care discussed earlier (Korsch et al., 1968) found satisfactory levels of stability in respondents' views. However there are considerable difficulties inherent in examining reliability over time as patients' attitudes and judgements may actually change.

The few efforts to examine different aspects of reliability are nevertheless quite encouraging. However the more complex issue is validity, that is the extent to which instruments accurately reflect patients' views. One broad issue, referred to by Lebow (1974) as 'reactivity' and by Jackson and Messic (1967) as 'social desirability', is the possibility of patients altering the report of their views in accordance with their perceptions of the

consequences of reporting. In particular, respondents may wish to present their doctor or the hospital they have attended in a positive way, as they consider who will read the survey and what the consequences of the survey are. The detection of social desirability effects is not easy. There is an undoubted uniformity of positive satisfaction found in most patient satisfaction surveys which may be due to widespread reluctance to criticize socially valued institutions. More direct evidence of social desirability may be found in comments made by patients and observations by investigators. Thus Cohen (1971) describes how the mothers of retarded children found it difficult to express critical comments about the services they received. One reason cited for this reluctance was a widespread view that such services were a favour, rather than a benefit to which they were entitled. The following observation of the experience of an investigator administering a patient satisfaction survey is revealing; in sections of interviews which invited patients to think of possible improvements to their treatment, she detected 'a perceptible frosting of the atmosphere' (French, 1981: 28).

Such observations underline the likelihood that 'social desirability' may influence responses. A more complex point is raised by the view that many findings of positive satisfaction reflect lack of awareness of alternatives. This problem clearly overlaps with the more general point about consumer ignorance raised above. Shaw (1976), for example, argues that the inbuilt conservatism of the majority of clients of welfare services, which

results in tendencies not to criticize, arises from 'the fact that clients are unlikely to be acquainted with the range of alternatives open to them' (Shaw,1976; 32). As Feldman expresses the point: 'It may be that people's satisfaction with their present care simply reflects their ignorance of what might be achieved' (Feldman,1966:88). It is difficult to determine whether such considerations are about the validity of measures or whether they concern factors that may influence underlying levels of satisfaction with health services. It is in practice difficult to separate out the two levels. At present there is little basic empirical evidence as to whether the extent or range of prior experience of services influences levels of satisfaction.

One promising approach to the question of the validity of satisfaction instruments is to examine patients' responses in relation to aspects of the quality of care that can be measured independently - in other words to examine what Lebow refers to as 'the external validity' of patient satisfaction measures (Lebow,1974: 333), but which may more accurately be considered in terms of construct validity, i.e. 'how well the measure conforms with theoretical expectations' (de Vaus,1986:48). Some very simple examples of such validation are to be found. Penchansky and Thomas (1981) found that patients with longer travel times to their doctor were more dissatisfied with the accessibility of care. If one theoretically predicts that the greater the difficulties of access (including increased travel time) to a health service, the



greater will be the level of patient dissatisfaction, then the measure used by Penchansky and Thomas has some construct validity. More ambitious and more complex in terms of validity are studies such as the one carried out by Ross et al., (1981) which independently assessed aspects of the quality of paediatricians' 'psychosocial care' as reflected in observations of consultations and interviews by the researchers with the paediatricians and showed significant correlations between their scores of quality of care and the patient satisfaction measures. Again if one theoretically predicts that the better the quality of psychosocial care, the more positive should be patients' reactions in terms of satisfaction, then a degree of construct validity is obtained for the measures. Other studies cited above in relation to clinical applications of patient satisfaction research, have produced similar construct validation of satisfaction scores. Stiles et al., (1979) found associations between communication styles of physicians as assessed from tape recordings and satisfaction. Dimatteo et al. (1980) assessed a sample of doctors' empathic skills by measuring their ability to interpret non verbal cues in a film designed specifically for the study. Patients attending the doctors' clinics were asked to complete a patient satisfaction questionnaire. Satisfaction with doctors' 'art of care', but not with the technical quality of care correlated significantly with the doctors' scores for empathic skills. Weinberger et al. (1981) showed that patient satisfaction scores were associated with independent assessments of doctors' demonstration of social interest in the patient in

the consultation.

While the validation of instruments has received attention, especially with regard to patient satisfaction with the 'art of care', less progress has been made with regard to other aspects of patients' views such as in relation to more technical or medical aspects of care. As was argued earlier, studies such as DiMatteo and colleagues' also begin to address the question of whether patients form independent judgements of the different dimensions of their care. In particular their study provides some support for the view that patients do distinguish interpersonal and more technical medical aspects of their consultations with health professionals.

Under the rubric of validity there also needs to be considered a very real practical problem in relation to measurement, namely that most surveys do not produce useful variability. Whether for reasons of social desirability or because of other constraints on answers, patients normally judge most health care facilities in very positive terms. This very uniformity of response may make evaluation technically difficult. Furthermore as Lebow observes 'The lack of variability in patient evaluation also makes the validity of such measurement questionable' (Lebow, 1974:335). As important as the scientific issue of validity is the question such lack of variability inevitably raises as to whether there is any practical utility in carrying out an investigation which may not produce any meaningful variability of response.

### Problems arising from the effects of expectations

The purpose of obtaining patients' views is most frequently to identify aspects of the provision of health care that require attention or change. However variation in survey responses is explained by patient characteristics more often than by health service - characteristics. Social and demographic variables often produce the only significant associations in a patient satisfaction survey.

Thus it has been found that younger patients in particular are more likely than older patients to express dissatisfaction (Kurella,1979; Gray,1980; Fox and Storms, 1981; Jefferys and Sachs, 1983; Carmel,1985; Treadway,1983). In some studies less educated respondents express higher levels of satisfaction than do the highly educated ( Pope,1978; Roghmann et al.,1979; Linn and Greenfield,1982). In the USA, race sometimes exerts a significant influence with blacks ( Hulka et al., 1975) and other minorities (Ciarlo and Reihman, 1977) more frequently expressing dissatisfaction. Less frequently social class has been shown to have an influence upon satisfaction (Pope,1978; Jefferys and Sachs,1983). In a few studies males are more dissatisfied with health care than are females (Hulka et al., 1975; Fox and Storms,1981). However with the possible exception of age, it must be noted that social variables do not relate in a consistent way with satisfaction scores. Some studies find few or no significant influences of social or demographic variables

upon satisfaction (Korsch et al., 1968; Larsen et al., 1979; Breslau and Mortimer, 1981).

The importance of demographic variables relative to other influences upon satisfaction makes it clear that satisfaction surveys cannot be used directly as evaluations of services without some account being taken of the social variation amongst responders. For the most part the influence of such variables remains unexamined in surveys or at best, analysts follow the traditions of 'facesheet sociology' in which interesting interpretations are inserted by 'supplying a meaningful dimension of analysis from the outside' (Marsh, 1982:103). Fox and Storms (1981) argue for a theory of the different orientations of different social groups that result in differing levels of satisfaction. As Pope expresses it: 'Satisfaction of course must be considered relative to expectations... people's expectations may differ according to their varying sociodemographic and socioeconomic characteristics' (1978:292). To the extent that social and demographic variables do exert any stable influence upon levels of satisfaction with a particular service or health care facility, it raises the possibility that survey results reflect attitudinal dispositions within the sample surveyed rather than evaluative judgements of their health care. Once again this poses questions of practical utility since the sponsors of investigations are most likely to have conducted the survey to obtain useful information about services.

### Conceptual issues in patient satisfaction research

The problems identified above derive in part from measurement difficulties and in part from conceptual sources. It is in principle possible to conceive of ways in which the dimensionality and factor structure and construct validity of measures of patient satisfaction could be further examined. As Lebow argues in relation to patient satisfaction: 'validation problems can be viewed as being in large part correctable... the validation argument, although a serious criticism, does not appear to be sufficient to dismiss the consumer's view' (Lebow, 1982:253). Other problems can also be regarded as having a large empirical component: for example the question of the extent to which levels of knowledge and amount of prior experience of health services influence levels of satisfaction. However there remains a more conceptual dimension to many of the problems thought to be inherent in patient satisfaction research. In different ways each of the problems discussed above derive from fundamental uncertainties that persist with regard to how patients perceive, judge and evaluate their health care. The meaning of results from satisfaction surveys is generally invoked from assumptions outside of the survey and the meaning to respondents of their answers and the reasons for their answers remain hidden. Tacit concepts about, for example, how patients approach the evaluation of their medical treatment can have important consequences. As has already been illustrated, patients may be considered as incapable of contributing useful information on



particular aspects of their care. Alternatively, levels of satisfaction may be attributed in large part to social differences in expectations rather than to significant aspect of the service on which they give their views.

Thus it may be argued that whilst in large part the problems outlined above are essentially due to problems of measurement, it is also important to acknowledge the possibility that the field of patient satisfaction has remained underdeveloped at the level of examining alternative conceptual approaches to patient satisfaction (Calnan, 1987:166). Alternative frameworks posit fundamentally different views of what matters to the patient when seeking medical help and of how the patient evaluates health care received. They ultimately offer potential solutions to the difficulties and problems in patient satisfaction research outlined above. It is somewhat surprising therefore that more effort has not gone into examining their respective advantages. Three alternative conceptual frameworks are distinguished here. Much of the rest of the thesis is concerned with examining the extent to which any of the alternatives find support from the empirical data gathered in two patient satisfaction surveys.

#### The cognitive / anthropological explanation.

Especially in the United States, social scientists have stepped boldly into the health policy field to bridge the postulated chasm between the patient and the technology

of medicine. In particular social anthropologists have conceived of much of modern medicine's problems as essentially cognitive and cultural - as a failure on the part of medicine to understand the beliefs and interpretations patients bring with their health problems. Kleinman and colleagues explicitly state the claims of clinically applied anthropology:

'Major health care problems such as patient dissatisfaction, inequity of access to care, and spiralling costs are no longer amenable to traditional biomedical solutions. Concepts derived from anthropological and cross cultural research may provide an alternative framework for identifying issues that require resolution' (1978:251).

The clinical examples cited in this article and elsewhere (Kleinman, 1979) focus upon the explanatory concepts patients have for their symptoms and health problems and the often wide divergence between such concepts and those held by medicine. A central concept in this anthropological work is that of the Explanatory Model (EM), which in summary refers to the various beliefs patients may hold in relation to illness. Essentially the greater the divergence between patients' and practitioners' explanatory models, the greater the likelihood of problems occurring. In the following quotation the relevance to patient satisfaction is made explicit: 'Health care outcomes (compliance, satisfaction, etc.) are directly related to the degree of cognitive disparity between patient and practitioner EMs' (Kleinman, 1979:114). This approach to interpersonal aspects of medicine and communication skills has proved particularly fruitful in serving to underline the importance of the patient's view point in health care. To date however, the importance of

cognitive beliefs in explaining patient satisfaction has rarely been put to the test.

#### The importance of role expectations

A second approach to satisfaction emphasises less the cognitive beliefs that patients hold in relation to health and illness and more the influence that role expectations have in shaping their views of health care encounters. Thus Mechanic argues that patients: 'have an image of the physician's role and the way it should be performed.' In terms of this image, 'the patient attempts to evaluate the professional qualifications and capabilities of the doctor' (Mechanic, 1978:407). Larsen and Rootman (1976) examined the relevance of such role expectations in patient satisfaction in Canadian primary care. In a postal questionnaire they found that whether a doctor conformed to a patient's role expectations, in for example giving explanations or having up to date equipment was positively associated with satisfaction. Segall and Burnett (1980) take further the idea that patient satisfaction is determined by 'perceived physician conformity to patient behavioural expectations' (Segall and Burnett, 1980:272). In all such analyses, the emphasis is upon the criteria whereby patients judge and evaluate professionals. Patients rely on general and stable expectations of the doctor's role, departure from which is predicted to lead to dissatisfaction. There are fundamental ambiguities in the use of the concept of expectations in social research in this field (Stimson and

Webb,1975:27) which have never been clearly addressed. To take one difficulty, it is often not clear whether expectations refer to patients' appraisals and predictions of what is likely to happen or their hopes and aspirations - what they would ideally like to happen. The problems of using the concept of expectations as a means of making sense of patient satisfaction are particularly examined in the first of the two studies reported in this thesis.

#### The importance of emotional needs

A very different approach is provided by the work of Ben Sira. He has built upon the evidence that patients' particularly emphasise interpersonal and 'caring' aspects of their medical treatment, and has developed a uniquely elaborate theory of patient satisfaction in which 'affective' factors in the doctor patient relationship are the prime influence on satisfaction. Emotional or affective factors play three crucial roles in the model. Firstly Ben Sira emphasises the fact that illness is normally accompanied by emotional distress. This results, according to this view, in emotional needs that patients bring to doctors because of the anxiety resulting from their illness. Secondly affective factors are involved in the consultation itself because the doctor's interpersonal skills are important in addressing such emotional needs. Thirdly and most important, the model postulates that the patient is strongly reliant on perceptions of such 'affective' skills in judging whether the doctor has provided satisfactory treatment. This model is the central

focus of the second study of patient satisfaction reported in chapters 6,7 and 8. However at this point it may simply be noted how distinctive the theory is in that distress and anxiety are made explicit components of the theory, whereas other approaches emphasise more cognitive aspects of help seeking and responses to treatment.

Common ground to all three approaches is the attempt to understand the process whereby patients evaluate their health care. One of the major limitations of almost all survey research in this field is a lack of interest in the fundamental question of what factors enter into patients' evaluations of the treatment they receive. This is the deficiency that Davis and Horobin identify in criticizing survey research for representing a picture of the patient that is 'frozen, temporally fixed and devoid of any sense of cognitive emergence' (Davis and Horobin, 1977:13). However if survey research may be faulted on these grounds, qualitative and ethnographic research on patient satisfaction has neither been prolific nor necessarily instructive with regard to the subject. Key concepts such as 'expectations' (Lipton and Svarstad, 1974; Stimson and Webb, 1975) and 'satisfaction' (Stimson and Webb, 1975) prove to be such elusive concepts in qualitative research into patients' evaluations of health care, that fundamental reservations are expressed as to the value of seeking to summarise patients' views in such terms. Stimson and Webb sum up their reservations about the concept of satisfaction: 'To sum up and label in this way distorts reality and misses the continual process of



ordering and evaluation which goes on' (Stimson and Webb, 1975:77). They go on to quote a conclusion by Mauksch with evident approval: 'Studies of patient satisfaction have been acknowledged as being largely useless' (Mauksch, 1972:26).

Studies such as Stimson and Webb's have been important contributions in that they have underlined the complexities of patients' evaluations of their health care. Yet they risk 'throwing out the baby with the bath water'. They conclude not merely that the concept of satisfaction is complex but also that it is unstable, thereby jeopardising the possibilities of patient centered evaluations of health care. It is the argument of this thesis that such conclusions are premature. The complexities of patients' views revealed through close ethnographic work do not necessarily undermine the overall goal of obtaining systematic information that may be of relevance to health policy in the broadest sense.

It is apparent that there are still deficiencies in basic social scientific knowledge regarding the processes behind patients' evaluations of health care. Locker and Dunt (1978) conclude their overview of this subject thus:

'Research is needed to clarify the process whereby consumers arrive at assessments of the services they receive. While expressions of satisfaction and dissatisfaction are the end product of such a process, we know little as yet of the procedures, criteria and standards consumers employ.... Research needs to go beyond the identification of socio demographic and institutional variables associated with satisfaction. Studies are required which explore these issues in depth.' (Locker and Dunt, 1978:291)

Earlier they define the gaps in our understanding more explicitly; little is known of: 'the process by means of which respondents decide whether they are satisfied or dissatisfied. On what are expressions of satisfaction and dissatisfaction based? ... little attention has been directed towards developing a well defined sociopsychological theory of satisfaction' (Locker and Dunt, 1978:288).

Such arguments for more basic research into the processes involved in patients evaluations are echoed by others. Segall and Burnett declare the need for an 'explanation of the process of patient evaluation of physician role performance' (Segall and Burnett, 1978:278). Lebow advocates research 'to elucidate the social psychological processes involved in consumer satisfaction' (Lebow, 1982:256). Other authors (Kelman, 1976; Fox and Storms, 1981; Leventhal et al., 1984) underline the need for such work. Central to any social scientific investigation of patient satisfaction therefore must be an examination of the process of patient evaluation of care.

### Summary

Arguments for the importance of 'consumer' research on responses to the welfare state have recently grown in volume (Pollitt, 1985; Smith, 1986; Weale, 1986). Given the policy context outlined in this chapter it is inconceivable that interest in the consumer will diminish, whether or not the social scientist engages in the issue. This chapter

has argued that the steady growth in interest in patient satisfaction research has taken place in a complex policy environment in which ideas of consumerism considerably oversimplify the issues. Although a cultural movement of consumerism might be detected in sections of American society, other interests and other purposes have been at least as important in accounting for sustained concern with patient satisfaction.

Health authorities have actively pursued the concerns defined by central government in making patient satisfaction a greater priority, at least at the level of appointing 'consumer relations officers' and other possibly symbolic acts. Yet there can seldom have been such a widely shared policy goal with such crucial ambiguities: different actors refer to different things in discussing the issues; the social survey literature points to a variety of major methodological limitations in the measurement of satisfaction, and the more academic literature has contributed a variety of different models or theories of the processes underlying patients' judgements of their health care. Advocates of more patient focused health care, research and evaluation must accept that serious reservations about the value of patients' views have not been assuaged. The legitimacy of patient opinion in the health policy field is not yet established.

The social sciences, which might have been expected to be more actively engaged in the scrutiny of public opinion surveys, have often simply despaired of the value

of concepts such as patient satisfaction. At the very least there is a challenge to identify the processes whereby patients form their judgements of services such as health care. The remainder of this thesis attempts to examine in one kind of medical setting - the outpatient clinic - the processes involved in patients' judgements and thereby to contribute to an evaluation of patient satisfaction as a useful object of social enquiry.

How extensive and how useful is the patient's capacity to provide views about his or her health care? The next three chapters describe a study of patients attending a neurological outpatient clinic for headaches. The focus of the neurology clinic study is upon patients' experience of the clinic in terms of satisfaction and the results of the study are examined in the light of the overall focus of this thesis. Of central interest, therefore, is the question of how valuable patients' views of the neurological clinic would prove. Patients' views were sought for this study both before and after their clinic visit, by means of relatively unstructured, open interviews rather than by the survey questionnaire more conventionally used in patient satisfaction research. The purpose of adopting this approach was to encourage patients to evaluate their health care as much as possible in their own terms. A central aim of this study was to gain insights from patients' own accounts of the process whereby consumers arrive at judgements of the services they receive (Locker and Dunt, 1978: 290).

In chapter 4, the view of Simson and Webb (1975)

CHAPTER 2. AN INTRODUCTION TO A STUDY OF PATIENTS  
PRESENTING HEADACHES TO NEUROLOGICAL CLINICS

This thesis is concerned with the scope of patient satisfaction research. How extensive and how useful is the patient's capacity to provide views about his or her health care? The next three chapters describe a study of patients attending a neurological outpatient clinic for headache. The focus of the neurology clinic study is upon patients' responses to the clinic in terms of satisfaction and the results of the study are examined in the light of the overall focus of this thesis. Of central interest, therefore, is the question of how valuable patients' views of the neurological clinic would prove. Patients' views were sought for this study both before and after their clinic visit, by means of relatively unstructured interviews rather than by the survey questionnaire more conventionally used in patient satisfaction research. The purpose of adopting this approach was to encourage patients to evaluate their health care as much as possible in their own terms. A central aim of this study was to gain insights from patients' own accounts of 'the process whereby consumers arrive at judgements of the services they receive' (Locker and Dunt, 1978:290).

In chapter 1, the view of Stimson and Webb (1975)



was cited that summing up patients' views in terms of 'satisfaction' is a distortion and oversimplification of a more complex and fluid process whereby patients evaluate their health care. The use of predetermined fixed categories such as 'satisfaction' oversimplifies patients' judgements according to this line of criticism. Stimson and Webb believe, on the basis of the qualitative research they carried out in general practice, that it is ultimately not worthwhile summarizing patients' views in such terms. Similar difficulties are reported by them in operationalising the concept of 'expectations'. A related problem is that fixed choice questionnaires do not allow patients to express the basis or rationale for their judgements of satisfaction or dissatisfaction. A more open ended approach to data collection might enable respondents both to use more natural or more appropriate categories of response and also to describe the basis or rationale for judgements - to express the 'procedures, criteria and standards' that lead to 'the end product' of satisfaction (Locker and Dunt, 1978:291). Thus a more open ended style of collecting data might be more successful at meeting the criticisms of, amongst others, Locker and Dunt (1978) and Martin (1986), who hold that tightly structured questionnaires do not allow respondents to voice their views properly and hence inhibit full participation by consumers in the process of evaluation. According to such critiques the scope for patient satisfaction research is circumscribed by the limited methods with which views are sought.

Most studies of patient satisfaction are based on patients presenting with a diverse range of health problems. This is hard to avoid where, as is usually the case, the aim of the study is to investigate patients' views of health care facilities (such as general practice) which have diverse responsibilities. A disadvantage of such studies, however is that it is difficult to devise methods that examine in any kind of systematic fashion patients' perceptions of their problems and their needs in relation to problems. It is difficult to question about perceptions in detail when a diverse range of health problems are involved. As a result, studies of patient satisfaction with most general health care facilities are only able to examine in a fairly superficial way the relationship between patients' satisfaction with care and their perceptions of need. General questions have to be devised in most studies that allow patients with widely differing problems to respond.

The purpose of the study of neurological clinics reported here was to examine the experiences of patients presenting with headache. As all patients had a single symptom - headache - in common, it was possible to examine this aspect of their experience of attending the clinic in some detail. It was possible to examine in particular the ways in which headache had become a problem and the kinds of help for headache which the patient hoped for as a result of attending the clinic. The relatively narrow range of medical problems in this study may make it possible to focus more clearly upon the influences that

social psychological factors have upon satisfaction.

The study is reported in the following way. This chapter begins with a discussion of existing evidence of the processes whereby headaches may initially become a medical problem for some sufferers. Then the specific sample of patients referred to specialists is described and the methodology of the study outlined.

Chapter 3 then examines the expectations of the patients in the sample. It is argued that patients' expectations in this context are extremely tentative and hesitant and that, in order to understand the different reactions to clinics, attention needs to be given to the varying concerns and illness careers of patients with headache presenting in the clinic. Chapter 4 then directly examines patients' accounts of their subsequent reactions to clinics, and attempts to explain the variation in such responses by means of the different initial concerns that patients have in attending the clinic.

#### Illness behaviour and headaches

In order to examine and understand the experiences of patients presenting to hospital clinics with headache, it is essential to examine the process whereby a symptom that is extremely common can become of sufficient concern to require medical treatment. This section examines that process. In particular evidence is sought for social factors that may influence the process of responding to

symptoms of headache.

With regard to a wide range of different medical disorders research has uncovered a consistent pattern which has become known as the 'symptom iceberg' (Hannay,1979). The term graphically conveys the point that for many medical conditions, only a minority of episodes or symptoms of illness result in a medical consultation. The evidence that many patients, with such diverse problems as rheumatoid arthritis, diabetes and bronchitis do not consult their doctor, has stimulated enquiry into what has become known as 'illness behaviour'. Mechanic defines the term thus:

'By illness behaviour we mean the way in which symptoms are perceived, evaluated and acted upon by a person who recognises some pain, discomfort, or other signs of organic malfunction.' (Mechanic, 1968:117)

This concept is of importance in understanding responses to a symptom such as headache because, for the majority of people, the experience of headache is either ignored, tolerated or self medicated. Wadsworth et al. (1971) examined the health status of 2153 individuals in the community in South London. Only 5% reported no symptoms in the 14 day period covered in the survey. Twenty one per cent of the sample reported a headache and a further 5% reported a severe headache during the relevant period. Seventeen per cent of respondents reported a migraine and 46% stated that they normally suffered from migraine but had not had episodes in the 14 day period. The relationship between migrainous episodes and headache was not examined in this study. Reports of headaches fell with

increasing age and were more common amongst women. An important aspect of the study is the pattern of behaviour found in the sample. Only one quarter of those reporting headaches had consulted a doctor for a diagnosis of their problem, and, paradoxically, the proportion amongst those reporting a severe headache who had had their problem medically diagnosed was even lower (15%). Approximately half of both the headache and severe headache sufferers had taken a medication for their symptoms. This medication was more often a lay medication than a medical prescription. Again, unexpectedly, lay medication outweighed medical prescription by eight to one for severe headaches and four to one with other headaches. The most common medication was an analgesic and the symptom of headache was one which was more likely than other symptoms to result in a lay medication. A similar picture of headache is provided by Dunnell and Cartwright (1972) who surveyed the reported health and drug consumption of a sample of 1412 adults in Britain. Headache was the most common symptom reported. The symptom was less frequently reported by older patients. It was, after a 'temperature', the symptom most often resulting in medication (83% of episodes).

In Wadsworth et al's study, persons complaining of headaches were significantly more likely to have gone to a doctor if they were retired, housewives or unemployed. Only 11% of employed persons had consulted a doctor about headaches. Social class was not significantly associated with consultation and the authors observe that background social and demographic variables explained only 5% of the



variance in consulting. It is however not uncommon in studies of illness behaviour in other areas for such background variables to explain little of the variance in behaviour (Tuckett,1976).

Other studies underline the problems of understanding illness behaviour in relation to headache. Banks et al. (1975) asked a random sample of women to complete health diaries in which every symptom experienced was recorded. The investigators also noted all their general practice consultations over a year. The 'symptom iceberg' was again striking. Thirty seven symptom episodes occurred in the sample for every one patient-initiated consultation. Headache was the most common symptom in the sample, reported twice as often as the next most common symptom - 'change in energy'. After 'change in energy' however it was the symptom least likely to result in a consultation; the ratio of consultations to symptom episodes was 1:184 compared with a ratio of 1:456 for 'change in energy' and 1:29 for abdominal pain. The investigators report elsewhere (Beresford et al.,1977) upon the role that social and psychological factors played in influencing consultation rates in this sample of women. Background demographic factors were not significantly related to utilisation, although it was found that those who were more attached to their local community and those with more housing amenities such as a kitchen or bathroom were less likely to consult. Instead this study emphasises the process of evaluating symptoms as being important in deciding to consult a doctor. Some decision about the

threat of symptoms or the benefits of medical consulting must be involved to explain wide variations in ratios of use, for example, between headache and disturbance of gastric function.

Thus for the vast majority of people, either the threat or discomfort of headache is minimal or the benefits of medical consultation are normally perceived as low. Evidence that expectations of therapy are modest amongst chronic headache sufferers who seek medical care is reviewed later in the chapter. However there is some evidence of higher expectations of medical effectiveness to be found in Dunnell and Cartwright's survey in which 29% of respondents felt doctors could cure frequent headaches and a further 58% felt that doctors could at least 'help' with the condition. The sample expressed much less optimism about medicine's efficacy with regard to a variety of health problems including rheumatism, arthritis, bad colds, skin cancer and depression. Fifty seven per cent of patients also felt that, if they suffered a headache more than once a week for a month, they would consult a doctor. These answers indicate a considerable level of reliance upon and faith in medicine at least in hypothetical terms. This does not however appear to be translated into consulting behaviour.

It is clear that most episodes of headache do not give rise to medical consultations. It is possible that social factors may be involved in the process whereby headaches do lead to medical consultations in a small

minority of instances, although simple, background, demographic variables are unlikely to be the primary source of such explanations. One concept that is often cited to link social factors and illness behaviour and that has obvious potential relevance to the problem of headache is 'somatisation'. This term refers to the tendency to express emotional distress and discomfort in terms of somatic symptoms. In its strongest form, the concept assumes the presence of psychological mechanisms whereby stress and distress are translated into physical symptoms through 'failure' accurately to identify emotions. Thus Katon, Kleinman and Rosen refer to 'the selective perception and focus by the patient' (1982:127) that leads from affective distress to somatisation. It has often been suggested that somatisation and 'psychogenic pain' are both more commonly experienced by people with less education or lower socio economic position (Merskey,1965; Barsky and Klerman 1983; Katon, Kleinman and Rosen,1982; Kleinman,1979). In view of the psychological mechanisms implicated in headache this theory is of great potential importance in understanding social differences in relation to headache. The research evidence on which basis it has been maintained that lower social class individuals are more likely to somatize emotional distress is small and mainly derived from the examination of social differences in the presenting symptoms of patients attending psychiatric clinics (Hollingshead and Redlich,1958). From such evidence various theories have been proposed that explain the manifestation of psychological distress in terms of somatic symptoms such as headache amongst working

class or less educated patients. Somatisation is seen as occurring because of a relative lack of medical sophistication or of psychological insight amongst such groups. However patient groups such as psychiatric referrals are unrepresentative of the social distribution of emotional distress in the community generally (Fitzpatrick, 1983) and do not represent a sound basis for examining the full range of headache symptoms in particular. Only an investigation of headache and somatisation in the community can properly test such theories.

The social distribution of headache has long been a subject of speculation. It has commonly been assumed that migraine in particular is associated with higher intelligence and more professional occupational background. One epidemiological study that supports this view is the investigation by Crisp and colleagues (1977) of a Cotswold market town. The two year prevalence of migraine was found to be higher in Social Class 1 and 2 compared with Social Class 3,4 and 5, amongst both males and females. However this result is based on a small number of cases of migraine altogether. The evidence from Wadsworth's study, cited above is that there were no significant differences between social groups in headache symptoms of any kind. The most thorough evidence of the social distribution of migraine is the Pontypridd epidemiological investigation by Waters (1971). No evidence of a difference in rates of migraine between social classes was found. However they did find that, whilst in Social Class 1 and 2 81% of migraine

sufferers had consulted their doctor about the problem, this proportion fell to 62% in Social Class 3, 4 and 5. This pattern of consulting may be responsible for the prevailing view that migraine is more common in higher social groups. This pattern of differences between social groups also occurs amongst migraine patients referred to neurological clinics, where it is found that middle class patients are over-represented compared with working class patients (Fitzpatrick and Hopkins, 1981a). Many of the speculative links between migraine and intelligence are likely to have arisen from clinical impressions formed from such unrepresentative patients.

Thus the Pontypridd survey suggests that it is middle class patients who are more likely to seek medical help for some headache problems. This still does not address the heart of the 'somatisation' thesis which is that emotional affect is more likely to be expressed in somatic terms or psychogenic functional pain is more likely to be presented amongst working class compared with middle class patients. An interesting study that bears on this issue is that of Larson and Marcer (1984). They examined a series of 500 patients referred to a pain relief clinic. The sample was examined by social class in relation to pain, anxiety and depression. There were no differences between social groups before treatment. All social groups showed some improvement in scores after treatment but the degree of improvement increased with falling social class. There were no treatment differences between groups that could account for the differences in extent of improvement.



Thus, contrary to conventional thinking, it was patients from Social Classes 1 and 2 who were more likely to respond unfavourably to pain treatment. The authors conclude that:

'The persistent myth maligning the lower social classes with a higher perception of pain and neuroticism may have arisen because of failure in communication between the clinician and patients of dissimilar socioeconomic class.' (Larson and Marcer, 1984 :885)

The authors go on to cite further evidence that failures of communication may be principally responsible for the view of working class tendencies to somatise. They speculate that 'in lower social groups "pain" is preferred as a complaint rather than more esoteric terms such as "stress".' This would indicate that greater care is needed in taking histories of symptoms such as headache, since failure to establish the true meaning of a patient's complaints can easily result in erroneous management.

Thus it is difficult to find support for the view that the process of somatisation has a social class distribution. The view that symptoms such as headache become distressing medical problems for lower social class individuals through a process of somatisation would require more complex evidence than is currently available. The argument that somatisation is related to social class involves somewhat demeaning assumptions about the lack of insight and naivety of working class or less educated individuals. Such views are not empirically substantiated. The view that social differences in illness behaviour for symptoms such as headache arise out of different vocabularies and ways of expressing problems involves

fewer assumptions about psychological mechanisms or implications of psychological naivety. This view is a more social or cultural version of the psychological model of somatisation. However the idea that social classes differ in their vocabularies of pain and distress has received only occasional attention. One study (Bart, 1969) compared a sample of women who entered a neurological service but who were discharged with psychiatric diagnoses, with another sample of women who directly entered psychiatric services. The former sample were found to be less educated, more rural and of lower socio economic status. She suggests that working class patients more often lacked a developed vocabulary of emotions and were thus less able to communicate their problems with doctors, as a result of which they were inappropriately managed as having a physical problem, by being initially referred to neurologists. However the evidence in the study is of patterns of referral only and patients' vocabularies were never directly assessed. The differences between the two samples could have been due to different patterns of referral by doctors or different standards amongst referring doctors, rather than social class differences amongst patients in their ways of describing symptoms.

The direct investigation of patients' illness beliefs has more recently become of increasing importance in understanding the outcomes of health care. The evidence of such research points to the wide diffusion in society of 'stress' and related psychological mechanisms of disease, which would run counter to Bart's thesis. Thus Blaxter

(1983) asked a sample of middle aged women of semi skilled and unskilled manual social backgrounds to discuss in detail the illnesses that had occurred in their families. The interviews were analysed and explanations for illness episodes categorised. Although less commonly invoked than 'infection' or 'heredity' as a way of explaining family illnesses, 'stress' and 'worry' were nevertheless commonly mentioned. In particular she notes that: 'Stress was especially blamed for headaches and migraine, of course, and in this context the women appeared to have adopted the word 'tension' presumably learned from the doctors or perhaps from advertising' (1983:64). Such evidence again indicates the problems that may occur in studies of illness behaviour such as Bart's (1969) in which implicit theories of social differences are drawn upon to make sense of observed differences in behaviour between social groups, without more detailed and direct examination actors' perceptions and meanings.

Another study (Pill and Stott,1982) which also set out to investigate the illness beliefs of working class respondents produced similar evidence to that of Blaxter. 'Stress' was the fourth most commonly invoked form of explanation amongst their sample of women. Furthermore the study concluded that intra class variation was important in understanding differences in health beliefs. Such careful studies do not support simplistic notions of a somatising tendency amongst working class patients of a kind that might result in resistance to psychological interpretation. They suggest the limitations of relying

upon social and demographic variables to explain illness behaviour.

Distinctive patterns of pain behaviour have also been sought in particular ethnic groups (Zola,1973). However more careful studies have suggested that early work neglected the enormous amount of intra-cultural variation in behaviour ( Weisenberg,1975; Lipton and Marbach,1984). Similarly arguments that somatisation is important in Chinese culture (Kleinman,1980) have been challenged (Cheung,1981). There are problems in seeking characteristic ethnic patterns of response to pain. Just as with research on other social and demographic variables in illness behaviour research, often background variables explain none or little of the variance in the relevant behaviour. Furthermore, even where significant relationships are found between background characteristics and behaviour, the meaning of the relationship needs further examination.

Thus illness behaviour research indicates the need for caution in assuming that there are characteristic meanings that can be attributed to the presentation of headache by particular social groups. In order to understand those patients who seek specialist attention for their headache, it is unlikely that simple social factors such as social class background will prove sufficient for understanding the needs and expectations of help brought to the clinic or the responses in terms of satisfaction after attendance at the clinic. Mechanic's concept of illness

behaviour and the evidence reviewed above of responses to symptoms such as non specific pain and headache, enjoin much closer examination of individuals' anxieties, perceptions and expectations than can be assessed from background social characteristics.

#### Specialist referral for headache

All of the patients included in this study attended the hospital clinic because they were referred there by their general practitioner. Thus a full understanding of the needs of the patients in the sample would require considering the role of the general practitioner and his or her expectations of the specialist clinic. It is unusual for the general practitioner to refer a patient with headaches to the neurologist for specialist consultation. Most aspects of the management of headache in primary care do not require specialist support, and the most frequent forms of treatment are simple prescriptions and advice (Phizacklea and Wilkins,1978; Ambulatory Sentinel Practice Network,1987). The main reason for a general practitioner to seek specialist help is to obtain support for his or her own diagnosis in cases where symptoms presented are atypical or indicative of a possibly more serious disease. As Grove and colleagues observe: 'Hospital referral is usually made with the purpose both of confirming the diagnosis and reinforcing the reassurance which forms the mainstay of management' (Grove et al.,1980:195). In other words the main purpose of such a referral is to support or assist the general practitioner's diagnosis rather than



contribute to the active treatment of the patient's headache. Nightingale (1976), reviewing the role of the general practitioner in the field of migraine, argues that neurological referral is indicated where there is 'a measure of doubt' about the possibility of a serious intracranial lesion such as a haemorrhage rather than a more benign diagnosis. However it is unusual for more serious disorders to be presented to general practitioners with headache as the primary symptom (Nightingale, 1976; Phizacklea and Wilkins, 1978; Jerrett, 1979).

More recently, specialist clinics have developed to treat acute episodes of migraine and to foster research into the specific disorder of migraine. 'In addition to offering treatment of the acute attack, these and other clinics provide consultation facilities for general practitioner referrals, so that all sorts of treatment methods are tried and many trials undertaken' (Clifford Rose and Gawel, 1979:91). Thus in recent years neurologists have come to play a more general role in the management of headache disorders, by treatment as well as by offering expert differential diagnosis. Where such clinics are available locally, the general practitioner may make increased use of specialist advice.

However Grove and colleagues observe of the specialist referral for headache that 'There is little evidence to indicate whether this is a worthwhile exercise or not' (Grove et al., 1980:195). In the general practice management of other problematic patients such as those with

psychiatric illnesses, studies have suggested that neither patient nor doctor has clear goals and that expectations of the specialist may be quite low. Kaeser and Cooper go so far as to compare the referral to a primitive healing ritual: 'Seen in this light specialist referral may fulfil a social purpose independent of its bearing on rational treatment' (Kaeser and Cooper, 1971:324).

#### Background and Methods of investigation

The immediate background to the study of neurological patients reported here is the application to the DHSS for a research grant by Dr. Anthony Hopkins, consultant neurologist, St. Bartholomew's Hospital, London, for funds to investigate the expectations of patients with headache referred to neurological clinics (Hopkins, 1974). The argument outlined in the proposal was that neurologists have fewer problems in reaching management decisions for patients with clearly defined disorders with a basis in organic disease compared with patients with non-specific symptoms, of which headache is the best example. With patients presenting with headache, 'the consultant does not know what the patient expects of him' (Hopkins, 1974:1). The purpose of the proposal was 'to analyse these expectations through sociological techniques' on the basis that 'if expectations are recognised they can more easily be satisfied; treatment will then be more effective and more economical' (Hopkins, 1974:1). Some specific questions that the project was to address were detailed in the proposal. 'Does the patient expect to see the consultant?

What parts of the body does the patient expect to be examined? Does the patient expect to have a blood test, a skull x-ray, an EEG?' (Hopkins, 1974:8-9). Although the proposal was not framed in these terms, it might be said that the assumption behind the proposal was that patients hold 'role expectations' (see chapter 1) in relation to the hospital visit. They hope for or expect specific actions from the doctor. If these expectations are met, the patient will be satisfied.

The proposal also included the investigation of the referring general practitioner's expectations of the specialist. However when the project began, a pilot interview with a number of general practitioners identified a number of problems in eliciting their expectations. It proved unavoidable that some considerable time elapsed between when the G.P. wrote his referral letter and when an interview could be conducted. In this period, much of the detailed reasoning behind the decision to refer was forgotten by the G.P.. Often accounts were of a highly general nature, where, for example, the G.P. indicated that he simply wanted some assistance in the management of the patient. In other cases, the impression was gained that retrospective accounts of the decision to refer were influenced by 'reconstructed logic'. As a result it was decided not to collect a full series of G.P. interviews and to concentrate in the study upon patients' expectations.

Thus the present author, on taking up the DHSS-funded post of research officer, at the Department of

Neurological Sciences, St. Bartholomews' Hospital, undertook to design, carry out and analyse a study by interview of the expectations of a specialist consultation held by patients referred to neurologists for headache. At the beginning of the study the problem of patient satisfaction was not seen as a focus of investigation. However, as experience was gained of interviewing patients, it became increasingly clear that patients varied in response to their hospital consultations and that the concept of satisfaction needed to be examined in relation to such variation.

The aim of the study was to investigate referrals to a wide range of different hospitals - teaching and non teaching hospitals; hospitals in and outside of London. It was initially decided, therefore, to approach all of the 42 neurologists who held consultant contracts in either North East or North West Thames Regional Health Authorities. Only a small number of participating consultants were essential for the study to be feasible and ultimately 18 consultants agreed to participate. The study sample of consultants held posts in a wide range of hospitals, including non-teaching hospitals outside of London such as The Lister Hospital, Stevenage and Queen Alexandra Hospital, Harlow; non teaching hospitals in outer London such as Chase Farm Hospital, Enfield and London teaching hospitals such as Charing Cross and Middlesex Hospital.

The criteria for inclusion in the study were any patient who (1) was a new referral for headache as a

predominant symptom rather than a 'follow up', (2) was aged 16 years or over, and (3) was not suspected, after investigation, of having a serious space occupying lesion (i.e. a tumour).

To obtain suitable patients, the clerical staff of eleven hospitals were regularly contacted. They inspected referral letters for patients who met the first two of our three criteria and informed us of the appointment times of suitable patients. An interviewer then attended the appropriate clinic on the day and time of the patient's appointment and asked the patient to participate in a brief interview before seeing the hospital doctor. Only 4 out of 115 patients, thus approached, did not agree to participate. No information was collected about non-participants. After this brief initial interview, patients then saw the hospital doctor. Patients were then contacted to arrange a further research interview, three to four weeks later or a similar period after any follow up visit that was necessary for the management of their headaches. This second interview was conducted in the patient's home.

Initially 111 patients who met the first two criteria for inclusion in the study were contacted and briefly interviewed before their hospital consultation. Two patients were excluded from further investigation because their neurological investigation had resulted in suspicion of a space-occupying lesion, although further investigations did not confirm the clinician's suspicions.



Thus 109 patients were interviewed before seeing the consultant. Of this group 102 patients were subsequently contacted, of whom seven were unwilling to participate in a further interview. Thus the second (main) interview, conducted at home after the hospital visit, was completed with 95 (87%) of the original 109 patients. The patients who were not interviewed on the second occasion did not differ from those successfully interviewed in terms of any information that was available, on gender, age or pattern of symptoms and diagnosis. Sixty eight per cent of the sample were obtained from the neurological clinics of London teaching hospitals and 32% were obtained from London general hospitals or from hospitals outside of London. As a result, the geographical spread of patients' homes was considerable. In addition to the patients living in parts of Central and Greater London there were others living as far away as in Stevenage and Hitchin in North West Thames R.H.A. and in Southend in North East Thames R.H.A..

### Interviews

The first interview took place at hospital before the patient saw the doctor. Standardised data were collected with regard to the patient's presenting headaches in terms of the location, typical duration, frequency and character of pain, associated symptoms such as photophobia and nausea. In addition, patients were asked for any views they had about the nature and causes of their headaches and

particular concerns or worries they had in relation to their symptoms. Finally patients were asked about their expectations of the hospital visit to the neurologist.

The second interview, at home after the hospital visit, lasted much longer (typically one and a half hours). In this interview a more detailed account was obtained of the impact that headaches had upon the patient's life in terms of disability. Information was obtained on the history of the patient's headaches. The patient's perceptions of the nature and quality of prior medical and non medical treatment of symptoms was obtained. As full an account as possible was obtained of the circumstances surrounding the decision by the general practitioner to refer the patient to the hospital. In particular detailed information was obtained on the state of symptoms, the advice and perceived views of other people in the individual's social network and the relevant general practice consultation. This section focused on a three month period prior to the time that the decision to refer was taken by the general practitioner. The last main section of the interview covered the visit to the neurologist. Patients were asked to give as detailed a description as possible of the visit(s) to the neurologist, their reactions to the visit and the perceived benefits of the referral. As patients were rarely seen longer than three to four weeks after the visit, it was not expected that many patients' symptoms could have changed, and in most cases a longer period of time would have been necessary for the changes in a chronic recurrent problem to be reasonably assessed by patients.

Thus detailed accounts of symptom change were not obtained at this point. It seemed that our assumptions were accurate in that patients had not generally expected dramatic changes at this point. This coincides with the primary objective of interviewing at a time so close to the hospital visit, namely to obtain patients' evaluations of the referral itself, as far as possible uninfluenced by changes in symptoms that would conceivably influence such evaluations.

The second interview was also used to obtain a standardised history of recent psychiatric symptoms by using the Present State Examination (PSE), an instrument developed by Wing and colleagues (1974). Assistance in the use of this clinical type interview was provided by Dr. Elaine Murphy, a psychiatrist then working at Bedford College, Social Research Unit, who discussed methods of eliciting and rating symptoms in the headache sample and provided anchoring examples of tape recorded cases used in training for the PSE to enable some judgements to be made of the degree of psychiatric morbidity present.

Both interviews were 'non schedule standardised' interviews (Richardson et al., 1965; Brown and Rutter, 1966) and were tape recorded. Essentially two kinds of information were to be obtained from patients. On the one hand the study was concerned with 'objective' information such as the number of headaches patients had experienced or the frequency of their contact with doctors. On the other hand certain focal aspects of the study were concerned with

feelings or 'subjective' aspects of patients' experiences, for example worries and fears in relation to their symptoms or feelings of disappointment or satisfaction with their hospital visit. Brown and Rutter make a useful distinction between two kinds of subjective material:

(1) Self reports of feelings ('I get terribly on edge when he's around')

(2) Actual expressions of positive or negative feeling, considering the words used, tone of voice, gesture, facial expression and the like. (Brown and Rutter, 1966:3).

Both sources of 'subjective' material were used in this study. However, especially in the sections of the interview in which patients described their experiences at the hospital, the second source - the direct expression of feelings through tone of voice or other forms of 'non verbal leakage' of emotion (Ekman and Friesen, 1969) - proved particularly important. A critical, hostile or dissatisfied tone or indeed a warm and positive tone were often important indicators of the views of patients about their referrals where direct questions about their views would produce more neutral attitudinal material. As shall be shown in the results, the need to express gratitude and appreciation for medical care received, appears strong. As a result, direct questions about satisfaction may produce blandly neutral while apparently positive replies. On the other hand, patients may elsewhere in the course of describing their consultations spontaneously express more strongly positive or negative feelings.

Thus for both 'objective' and 'subjective' material the emphasis in the interviews was upon encouraging patients to describe their experiences in detail. The advantage of the non schedule standardised interview is that the interviewer has an agenda of issues to cover but is not constrained by specifically worded questionnaires and wherever possible facilitates the respondent to describe things in his or her own terms. The principles of such interviewing, such as the demonstration of interest to facilitate detailed reporting and the use of neutral probes ('How do you feel about this?'), were, as far as possible, followed.

Much of the material gathered by the interviews could be coded up fairly directly. However some central variables such as 'satisfaction' required the development of rating scales and of anchoring descriptions for the different values or points of such scales. Given that such scales are so pivotal to the study, their description is left until the appropriate point in the text where the concept is introduced.

The interview schedules were developed by the author over a nine month period in which different forms of questioning were tried out on patients from St. Bartholomews Hospital and from the Lister Hospital, Stevenage who attended neurological clinics and were willing to participate. When the interview schedules were completed, the second interviewer (O.H-W) also conducted training interviews which were tape recorded and



subsequently discussed with the author. In the development phase, in addition to discussing in an exploratory way patients' experiences at the two clinics cited, a series of thirty patients were interviewed at The Princess Margaret Clinic for Migraine in order to produce the final study interviews. Unexpectedly, one patient attending the clinic spontaneously volunteered to ask some friends to gather at her home for the benefit of the author to discuss the problems of migraine that they shared in common. Seven women met and for some two hours spontaneously discussed the topic. They had happily agreed to have their discussions tape recorded and the resulting material provided a further source of information from which to develop the research interviews. The author also sat in on the neurological clinics of several different neurological consultants to observe the typical pattern of such consultations, in order to develop appropriate questions or probes to facilitate patients' reporting of their encounters. In addition a period of two weeks was spent in a health centre in Ashford, Middlesex, as a guest of a senior partner, Dr. Adams. This was an opportunity to observe the consulting styles of six different general practitioners and to discuss informally hypothetical questions in relation to how general practitioners manage chronic headache sufferers, and the circumstances under which specialist advice is sought. Thus a variety of sources were used to inform the development of interviews.

### The sample

The majority of the sample of patients interviewed at hospital about their expectations (69%) were women. The sample was quite young (mean age=37). The majority of the sample (70%) were married. Data was collected and coded in terms of the 36 category Hope - Goldthorpe Occupational scale (Goldthorpe and Hope,1974). The sevenfold schema of class positions which is based on the scale (Goldthorpe and Llewellyn,1977) was then used. One further transformation was made for the purposes of some analyses: a three fold distinction was employed (Goldthorpe and Payne,1986) between service class (1,2) intermediate class (3,4,5) and working class (6,7). The resulting distribution of the sample was as follows: service class - 39%; intermediate class - 31% and working class 30%.

Diagnostic information from the neurologist was available for all but one of the 109 patients interviewed before seeing their consultation with the specialist. Fifty four per cent of patients were diagnosed as having migraine. The next most common diagnostic category was tension headache, diagnosed in 32% of patients. Six per cent of patients were diagnosed as having a combination of migraine and tension headache. Finally, 8% of patients fall into a miscellaneous category of diagnoses, for example, migrainous neuralgia and 'post influenza headache'. Other studies of patients attending clinics for headache (Friedman et al., 1954; Diehr et al.,1981) indicate that the vast majority of such patients receive

one of the two diagnoses of tension headache and migraine. It may be noted that the diagnosis of migraine as defined by the Ad Hoc Committee on Classification of Headaches (1962) requires the presence together of unilateral (one sided) distribution of headache, aura (disturbances of vision and other similar 'warnings' or prodromal preheadache phenomena) and nausea or sickness. Only 21 of the 58 patients diagnosed by the neurologists as having migraine met this criterion. Seventeen of the migraine patients had only one or in some instances none of the classical symptoms. However the definition and diagnosis of migraine in other than classic typical cases is problematic and it has been suggested recently that the conventional distinction between migraine and tension headache is open to challenge (Ziegler et al. 1972) and indeed this range of headache phenomena may be best explained as a continuum in relation to a single underlying disorder (Raskin and Appenzeller, 1980), in which the symptomatic variation is primarily a reflection of the severity of episodes (Kaganov et al., 1981). Thus, as discriminant function analyses of larger samples of headache sufferers in neurological clinics have failed to confirm the conventional diagnostic categories of neurology (Drummond and Lance, 1984), it is not surprising that many patients in this sample received diagnoses that depart from strict classificatory principles.

Information was also gathered about the severity of patients' headaches in terms of the frequency and typical length of patients' episodes. These two characteristics in

particular permit comparison with other samples and in Table 1 and Table 2 the headache clinic sample is compared with the severity of headaches reported by headache sufferers in a community sample (Waters,1973). It is clear that the referred clinic sample reports more frequent and longer lasting headaches than are typically experienced in the community sample. Forty per cent of the clinic sample report headaches that occur twice a week or more frequently, whereas only 15% of the community sample report such frequent episodes. Similarly 30% of the clinic sample report headaches that typically last one day or longer, whereas only 12% of respondents report such long lasting headaches. It is also noticeable that many patients in the clinic sample report headaches which are not particularly frequent or long lasting when compared to the community sample. The sample is quite heterogeneous in this respect.

The clinic sample of headache sufferers may also be compared with another, larger series of patients with migraine and tension headache attending a neurological clinic. Selby and Lance (1960) report on 500 cases in their clinic and find that two thirds of their sample report headaches four times a month or less frequently which is very similar to the proportion (60%) in this study. The typical length of patients' headache episodes can be more directly compared between the two series of patients. Selby and Lance report the following distribution of patients' duration of headaches (with the distribution of the current sample in brackets for

comparison):

- (1) Less than 4 hours - 27% (29%)
- (2) 4 to 24 hours - 40% (40%)
- (3) More than 24 hours - 33% (30%)

Thus on both dimensions in which comparisons can be made, the two samples are quite similar.

The number of years of headache suffering of this sample is compared with a series of 100 neurological patients with headache reported by Packard (1979) in Table 3. It is again apparent that the two samples are very similar in the distribution of respondents. A significant minority of both groups of patients have suffered from their headaches for less than one year. On the other hand a minority of patients, of similar size in both samples have suffered from their headaches for more than twenty years. Thus with regard to evidence of the frequency and typical duration of headache episodes and the number of years patients have suffered headaches, patients in this study are quite similar to those reported in other surveys of neurological clinics.

The results of the PSE interview were coded in two ways. Firstly patients were grouped according to the number of symptoms positively scored in the PSE. Wing et al., (1978) indicate that a score of 11 or more is found in 92% of psychiatric patient samples but in only 13% of a general population sample. It can thus be used as a cut off score for an operational definition of 'caseness'.



Another lower cut off point was also used of 6 or more positive scored items. This produced three bands of scores: (1) 0 - 5 (2) 6 - 10 and (3) 11 or more symptoms. The second use of the PSE information was to make ratings of the severity of psychiatric symptoms on the basis of the interview as a whole, in the light of anchoring case examples provided by Dr. Murphy. Again three bands of ratings were used to classify patients: (1) Normal (2) Mild and (3) Moderate to Severe. The two approaches produced similar results, as can be seen in Table 4. Indeed of the 95 patients with whom the PSE was conducted, 80 were placed in the same relative position on both instruments. For this study, the main focus is less the question of 'caseness' in relation to patients and more the extent to which the presence of some significant psychological distress influences satisfaction. For subsequent analyses which consider that question, 'Normal' patients are compared with a combined group of 'Mild' and 'Moderate to Severe' patients - henceforth termed 'patients with significant psychiatric symptoms'.

### Summary

Although patients often seek general practitioners' help for their headaches, the majority of episodes are managed by the sufferers themselves. It is particularly unusual for further, specialist help to be sought. The indications for such referrals are by no means clear although neurologists are increasingly providing specialist advice in, for example, the management of migraine. A

review of evidence relating to illness behaviour and headache suggested that, whilst social factors such as social class may play a role in influencing patterns of illness behaviour in response to migraine, such background factors alone are insufficient to explain the patterns of demand for medical treatment. This chapter has introduced a study which was concerned to examine further the nature of patients' perceptions of their problems and reasons for consulting a specialist. Subsequent chapters report patients' views especially in relation to the concept of patient satisfaction. An interview based investigation, it is suggested, may particularly provide evidence of the ways in which patients themselves evaluate health care. The next chapter describes patients' reports of their expectations of the specialist referral. This study was undertaken on the assumption that such expectations may be important influences upon subsequent levels of satisfaction. As indicated in chapter 1, role expectations have often been seen as prime influences upon patients' satisfaction.

CHAPTER 3. THE EXPECTATIONS AND CONCERNS OF PATIENTS  
ATTENDING NEUROLOGICAL CLINICS FOR HEADACHE

One basic assumption behind much patient satisfaction research is that the patient's level of satisfaction is determined by the extent to which the doctor or health professional fulfils the patient's prior expectations of what should happen. Thus, for example, Lipton and Svarstad refer in their study of paediatric clinics to 'the widely held hypothesis that the nature and outcome of professional - client interaction depends upon the fulfilment of lay expectations of what should happen during the course of evaluation and treatment' (Lipton and Svarstad, 1974:157).

In the search for understanding of the processes whereby patients evaluate their medical treatment, the importance of expectations is stressed in many discussions, although the empirical research to explore the significance of the concept was until recently poor. Larsen and Rootman refer in their study of primary care to 'a basic assumption that a patient's overall satisfaction with medical services is influenced by the degree to which a physician's role performance lives up to the patient's expectations' (Larsen and Rootman, 1976:29). They go on to observe, however, that 'while this proposition is plausible on the

basis of both practice and theory, it has not been tested systematically' (Larsen and Rootman, 1976:29).

One of the few attempts to explore directly the relationships between patients' expectations prior to a consultation, on the one hand, and subsequent levels of satisfaction on the other hand, is the study by Stimson and Webb (1975) of general practice consultations. Patients were interviewed before their consultations to elicit expectations and after leaving the surgery to assess satisfaction. The relationship between the two sets of information is not directly discussed by Stimson and Webb. However they sound this cautionary note:

' "Expectation" seems to be a concept which like so many others used in describing social aspects of medicine..is extremely difficult to examine analytically.' (Stimson and Webb,1975:27)

The same basic approach was adopted in this study as was used by Stimson and Webb in that patients were interviewed at hospital before seeing the specialist and again some three to four weeks after their hospital visit. In the first interview general, non directive questions about expectations were asked of patients but were then followed up by more specific questions about particular treatments and other items that might be expected by the patient.

#### The expression of expectations

The single most striking impression of the pre consultation-interviews with the patients attending the

clinics is the hesitant and non committal nature of patients' replies. Patients appeared not to hold very firm or definite expectations of their hospital visit. Patients often began their answers with a disclaimer such as 'I honestly didn't know. I was quite muddled.' Sometimes such answers were even more emphatic: 'I haven't got a clue what they are going to do or say or anything.' Another commonly used phrase in response to questioning was to say that the hospital visit had been approached 'with an open mind.' This repeated and uniform emphasis upon uncertainty does not mean however that patients had given the hospital visit no prior thought. The patient quoted above as saying that she 'honestly didn't know' can be quoted in full to convey more clearly the nature of patients' replies.

Interviewer . 'When you were coming up here to the hospital, what did you expect would happen?'

Patient. 'I imagined it was going to be something like allergy tests. I didn't quite know quite how you were going to go about it, though.'

Int. 'How about a physical examination?'

Pat. 'I honestly didn't know, I was quite muddled. I imagined something on my head or something like that - to find out what's going on there -that's all. I didn't see how... I couldn't understand..I feel a tiny bit nervous.'

Int. 'What kinds of questions did you imagine?'

Pat. 'I didn't really know. We only discussed the fact that you might ask about dietary habits, that's all.'

Int. 'About personality?'

Pat. 'Well I would think it could be relevant, if one was a stressful person or not but I would have thought most people who come here are.'

Int. 'How about tests?'

Pat. 'I was quite suprised about the urine test. I didn't think about blood tests, no. Are they going to be necessary?'



Int. 'How about x-rays?'

Pat. 'No. I really did say all that I thought to you.'

Int. 'What sorts of things did you expect they will tell you?'

Pat. 'Precious little actually. I can't see what there is to tell me. Maybe he might say 'don't eat chocolate ' or 'don't eat something like very fatty food'. But I can't imagine what he would say.'

Int. 'Might he recommend things you should avoid?'

Pat. 'Ah, maybe just say "try not to get worked up". I would imagine for some people, it would be a good idea to give mild tranquillizers. I suppose it makes sense if you're getting headaches because you're getting stressed.'

The tentative tone of voice with which much of this was said cannot be conveyed. However this section of the interview illustrates several very common themes in most of the sample's answers. Above all the quotation does convey the unfamiliar, even uncomfortable nature of the line of questioning as a whole for patients. Clearly, to be asked about one's expectations and hopes of a consultation is an unfamiliar experience in a hospital and for many patients this was more than a surprise. Such reactions did not arise out of the anxieties of consulting for a possibly serious health problem since patients consulting for more mundane reasons such as dietary advice appeared equally surprised by the task of expressing their feelings in this way.

Thus the task of expressing expectations was a novel one. Also evident in the quoted section of interview is the fact that a neurological consultation is an unfamiliar experience on which the respondent is unlikely to have definite views. Thus the patient resorts to

guesses or imagination to reply to the questions. Such guesses, far from being expressions of firmly held views, appear partly to reflect spontaneous efforts to satisfy the interviewer. Only 44% of patients knew that the specialist they were about to consult was a neurologist. In very few cases did the general practitioner explain in any detail the nature of the specialist consultation the patient should expect. As a result the patients fell back upon imagination to piece together an answer. Occasionally a friend or relative had consulted a specialist for similar reasons and patients expressed more concrete expectations as a result. The following statement is unusual because the patient actually made specific preparations for the hospital visit as a result of such advice:

'I thought they would put wires on my head. They did that to my son-in-law some years ago when he was having fainting spells. He told me to wash my hair and not to put anything on it like lotions.'

Although tentative, patients did therefore formulate expectations of the consultation. These expectations arose from two sources. Past experience of doctors' behaviour generally provided some broad guidelines for the hospital visit. The problem of headaches provides the patient with further cues as to the likely course of the consultation:

'You don't know quite what will happen. I'll see a doctor who'll ask me questions. I thought I might have an x-ray, blood tests possibly. I don't know. I presume he'll ask about the types of headaches, worry, diet.'

Another patient summarised his expectations succinctly:

'Possibly questions about work, how that might affect

me; questions about eating, drinking, a quick examination and out.'

In this patient's brief statement is conveyed the likely sequence of history taking and examination which is a familiar part of most consultations. This quotation also illustrates the second source of patients' guesses about their hospital visit - that is the specific issues likely to arise in the case of a presenting problem of headache. Two themes were far more frequently cited than any other in this respect. They may be summarised as the themes of 'diet' and 'stress'. The theme of 'stress' in patients' replies is a broad one and covers both internal psychological responses and environmental demands on the individual:

'I am a worrying type of person. When I get very worried, I get a headache in the neck. But unless they're unconscious, I haven't got anything to worry about. We've got our own home, my husband's okay.'

Stimson and Webb (1975:28) distinguish between three different types of expectations that patients may express: background, interaction and action expectations. Background expectations are '..largely implicit expectations about what usually happens when you see a doctor' (Stimson and Webb,1975:28). Such expectations are rarely expressed or considered unless something unexpected happens that bring them to the fore. Garfinkel's (1967) social experiments at disrupting the taken for granted rules of social behaviour are good illustrations of the ways in which background expectations are most dramatically elicited. Otherwise they are the implicit assumptions of 'how things are' which are difficult to bring to the

surface. The replies to questioning in this study mainly focused upon the other two types of expectations, although sometimes the unease with which such answers were given resembled the reactions of Garfinkel's victims. The examples Stimson and Webb give of interaction and action expectations suggest that they did not find it easy to distinguish clearly the two concepts; for example, prescribing is cited as an example of both kinds of expectations.

Interaction and action expectations generally focus upon the typical actions doctors perform in the management of problems such as taking a history, prescribing and referring to colleagues. However there is another analytical type of expectation, not discussed by Stimson and Webb, but of presumed importance to the patient, which may be referred to in terms of 'outcome expectations'. Patients may have a sense of the likely results of the doctor's actions on their symptoms. Such views may be expected to vary in degrees of optimism or belief in the efficacy of the doctor. This dimension of patients' experience comes close to the mechanism frequently invoked to explain placebo effects - optimism or faith with regards to a favourable outcome being viewed as a psychological mechanism enhancing the patient's chances of experiencing more favourable outcomes (Frank, 1968). This sense of expectation has received more attention in research in psychiatry where it is postulated that 'patients entering psychotherapy have varying degrees of belief in its efficacy and this belief or set of expectations may be an

important determinant of the results of therapy' (Goldstein,1962:12). However the evidence for such effects is quite equivocal (Krause,1967). Non specific benefits of therapy may be produced by characteristics of the therapist rather than by initial expectations of the patient (Wilkins,1973). This dimension of expectations is raised because patients themselves, if pressed to express their expectations of the specialist referral would occasionally refer to the question of outcomes. With regard to outcome expectations, the interviews again mainly revealed patients as cautious in their answers, rarely committing themselves to over optimistic statements of the possible results of the hospital visit. Sometimes patients would actually express quite pessimistic outcome expectations as in the case of the following statement by a patient who above all wished to identify the specific factors that provoked his headaches: 'I don't think he can tell me the causes of my headaches. He's a clever man if he can!'

Sometimes the modest nature of such outcome expectations appears to arise from hearing of other individuals' experiences:

Int. 'What did you hope would be the result of seeing the specialist?'

Pat. 'My mother's been [to the clinic]. She said basically some questions and some kind of test is all they did with her. I didn't expect them to do anything about it.'

Most frequently patients wished to indicate that they did not expect complete cures of the specialist. This was perceived as being unrealistic. Even patients whose initial answers suggested a high degree of optimism in



relation to the specialist's efficacy would modify their answers to more sensible and reasonable dimensions:

Int. 'What ways do you think the doctor will especially help you?'

Pat. 'Hopefully a cure. Not something like a miracle cure but the assistance to avoid - perhaps to track down triggers for migraine - as much as possible to avoid them. Perhaps I'll never be able to get rid of it completely. But much reduce the suffering.'

One of the most revealing aspects of the interviews with patients before seeing the specialist is the way in which respondents so frequently used the interview itself as a source of cues about the hospital visit and as a way of clarifying their expectations. The following is an extract from an interview, beginning with some specific items from the interviewer:

Int. 'Did you think there would be a physical examination?'

Pat. 'Yes I thought there would be a short physical.'

Int. 'How about tests?'

Pat. 'I didn't particularly give it too much thought, but now you mention it, I would't be suprised if they...'

Int. 'What kinds of questions might they ask?'

Pat. 'After reading the pamphlet, I obviously thought: "what triggered it, what the headaches were like." '

Int. 'How about questions about work?'

Pat. 'No I didn't. I suppose thinking about it now, I suppose it would be a cause for it. It's not a particularly stressful life in the post office though.'

Int. 'How about questions on personality?'

Pat. 'I didn't think my mental state would have too much bearing on it.'

Int. 'How about tests, x-rays?'

Pat. 'Mmm..yes.. that.. it could be something that's

not been discovered before.'

Int. 'Did you think they might tell you the cause of your headaches?'

Pat. 'Yes, I thought after a period of time, I thought judging from the leaflet, with a little help from myself, with a lot of information, the doctors might eventually be able to pin it down - to say: "This will cause migraine headache and try to avoid doing certain things and eating certain things." '

On at least two occasions the patient makes it quite clear that the interview itself is helping him to clarify his thoughts in terms of expectations, with phrases such as 'but now you mention it' and 'I suppose thinking about it now'. Both the expectations cited in relation to these phrases clearly emerged as a result of the interviewer's suggestion. On a third occasion, the thoughtful pondering in relation to a question about tests also indicated that the respondent was clarifying his ideas rather than reporting strongly felt needs. Finally on several occasions he refers to a pamphlet that he had seen in the waiting room whilst awaiting his appointment which, only minutes prior to the interview, had put certain other ideas into his head. It must again be remembered that for all patients this was their first neurological consultation for headache, so that all had quite hazy views of what to expect. Nevertheless the observations of McHugh (1968) remind us that in all social interaction individuals' sense of their own and of others' roles is emergent - that is, dependent on continuous search for patterns. Current interaction is also used as a primary source of evidence that the individual has understood underlying patterns. The use by many patients of the interview as a cue to the consultation with the specialist is a particularly clear

instance of individuals' constantly emergent sense of pattern in interaction - the process McHugh terms 'elaboration'. Both Stimson and Webb (1975) and Heath (1975) describe the continuous search for such cues amongst patients in general practice waiting rooms. The less the patient's prior experience with a particular general practitioner or certainty about the nature of his or her presenting problem, the greater the likelihood that such elaboration is necessary (Stimson and Webb, 1975:32). In the case of this sample anticipating a neurological consultation, the research interview became a crucial source of cues.

Thus to draw together this discussion, patients in this study were encouraged to say as much as possible about their expectations of the consultation on the assumption from the social scientific literature that such statements would provide valuable sources of explanations of subsequent reactions. As Locker and Dunt tentatively suggest: 'it does seem reasonable to suggest that expressions of satisfaction are the end product of a process of evaluation in which expectations figure to some extent' (Locker and Dunt, 1978:289). However despite every effort to facilitate such views, patients generally found the task unsettling and answers to questions were often uncertain and hesitant. Moreover this style of interviewing revealed a process of elaboration of expectations that might well not have emerged if more structured methods of questioning had been used in which the processes behind answers were more hidden. Thus, in

addition to the hesitant expression patients gave to answers, must be added a further note of caution in assigning importance to statements made by patients in this aspect of the pre-consultation interviews.

To anticipate the results of the follow up interview with patients after they had seen the specialist, patients more clearly expressed and identified their expectations after the event. Thus one very clear reaction from a patient after her hospital visit is described in the following terms:

'It was a bit of a let down - a complete waste of time. I suppose I had expected some sort of tests, what sort I don't really know. All he did was to look in my eyes. He just asked me what the headaches were like and about the pills and just said: "You have definitely got migraine, carry on taking the pills." I was quite shocked.'

Another patient whose reactions to the clinic were less extreme explains:

'Reactions to the clinic? I don't know. I think everything happened that I was expecting to happen. I was suprised by the intensity of the examination. So intense, so thorough. I wasn't expecting anything like that.'

In both cases it is apparent that the actual experiences of the clinic compel the patient to reassess what was expected beforehand. The same phenomenon was observed by Stimson and Webb amongst general practice patients as they responded to their consultations afterwards. They note that: 'It is sometimes through reappraisal and evaluation after the event that the person begins to formulate ideas of what he was really expecting and what he felt would have been appropriate for the doctor

to do' (Stimson and Webb,1975:73).

It may be thought that the tentative nature of views expressed by patients before their consultations are peculiar to this sample. Other studies however suggest that, with regard to specialist medical treatment, patients in different medical settings have similarly uncertain expectations. Thus especially in psychiatry, patients are unclear of the role of the specialist. Humphrey observed some quite wildly unrealistic expectations in a few of the patients in his study of psychiatric outpatients but otherwise noted that 'expectations were modest and ill-defined' (Humphrey,1968:252). Similarly Skuse concluded in a different psychiatric outpatient study that 'Three quarters had no clear idea of what help might be offered them at the clinic, usually because they had no idea what psychiatrists did' (Skuse,1975:470). Lipton and Svarstad (1974) conducted a study of a specialist multidisciplinary paediatric clinic in which the focus of the investigation was parents' expectations and the methods used enabled detailed recording of responses as in this study. Again the main conclusions of the study are that parents were uncertain about their expectations and had few specific views. Indeed the authors conclude that many patients: 'were reluctant to state their expectations because they felt they lacked the authority or legitimate right to do so...some patients did not consider it sensible or even possible to express their opinions about desired treatment until after the evaluation process was completed and a firm diagnosis was reached' (Lipton and



Svarstad,1974:164). The authors also concluded that it was misguided to view, as others had done, expectations as static and unchanging. Their results indicated that parents' expectations clarified as they went through the diagnostic and treatment procedures of the clinic.

Thus specific action or interaction expectations were not a salient aspect of pre-consultation interviews and answers often resembled the 'guesses' that Lipton and Svarstad (1974:162) noted. However two kinds of 'background' expectations did emerge from interviews that seemed to be a part of many patients' implicit assumptions about the hospital visit. Firstly patients felt that they were going to see an expert in the kinds of problems they suffered. He would have more knowledge and experience of the management of headaches. One patient summarised her feelings about having to wait for her hospital appointment thus: 'I didn't mind waiting that long because I felt, at last I'm going to see someone who knows something.'

A second assumption that appeared to be part of patients' tacit expectations of the hospital visit was that the specialist would have somewhat more time to listen to and evaluate the patient's problem. Thus the patient quoted earlier indicates a hope that the doctor may give the headaches careful consideration:

'..Yes I thought after a period of time...with a little help from myself - a lot of information - doctors might eventually be able to pin it down to saying 'this will cause migraine headache...'

For many patients this hope that the doctor would

give their headaches careful attention was tempered by the belief that headaches were not a particularly serious problem and could not therefore reasonably occupy the doctor's attention for too long.

The expectations of patients with headaches were so frequently expressed in tentative terms in the interviews that no attempt was made to transform this aspect of the interviews into more quantitative information. One other investigation however, has been conducted into patients' expectations with regard the specialist management of headache. Packard (1979) asked 100 patients attending a clinic for headache to complete a fixed choice questionnaire regarding their expectations of the clinic. This format of data collection inevitably induces patients into making firm selections of response in a way that an interview may not. The most commonly selected item in this sample was the expectation of an explanation for their headaches. Next most frequently selected was 'pain relief'. It is of interest that the doctor was also asked to estimate those items that patients would cite as expectations. The doctors reversed the importance of the two items, believing patients to be more concerned about pain relief than explanations. However more important from the point of view of the current discussion is the finding that only 31% reported that they expected total relief of their headaches from the clinic. The majority expected only 'some' relief. Moreover many of the 31 patients who said that they expected total relief from their clinic visit, did not cite pain relief as their most important

expectation, but rather emphasised explanation. Packard viewed this as evidence that pain relief was not consistently seen as a likely goal by many of those who cited it in one section of the questionnaire. Whatever the case his interpretation of results overall is consistent with the interview data presented here in that he views patients in headache clinics as having very modest expectations. Moreover patients who had suffered their headaches for ten years or more had particularly modest hopes of the clinic with regard to pain relief. This view of headache sufferers as having low expectations of treatment has been taken up in the specialist medical literature on headache. An editorial of the journal *Headache* (Edmeads, 1984) went so far as to say that headache sufferers had 'negative expectations' in the sense that they expected virtually no benefits from medication or medical treatment. The editorial then speculates that 'negative expectations' may be a possible explanation for the modest benefits typically achieved by medical treatments in this area. Placebo effects, it is argued, depend partially upon the mechanism of patients' expectancy of benefits. Thus one reason why chronic headache sufferers do not respond to any form of medication is that they have 'fixed and unyielding expectatons that they cannot be helped' (Edmeads, 1984: 343). Whether or not such speculation is sound, it is clear that such clinical impressions of the modest nature of patients' expectations is consistent with the views of patients obtained from our initial interviews.

### The concerns of patients

Thus the apparently simple proposition - that patients' satisfaction is influenced by the extent to which their treatment matches prior expectations - proves to be more difficult to examine in practice. Some investigators (Reader, et al., 1957) have been led to conclude that patients indeed have few expectations and prefer passively to leave everything in the hands of the doctor. Others (for example Locker and Dunt, 1978:289) support the view that this may particularly be the case with forms of medical care that are unfamiliar to the patient. Locker and Dunt go on to argue that, given that patients may form their expectations on the basis of past experience, it is important to distinguish between on the one hand such expectations which may be considerably modified by actual experience, and on the other hand patient defined 'need': 'Research on consumer opinion could be extended to include data on the perception of need and how far consumers expect services to meet these needs' (Locker and Dunt, 1978:289). In other words patients' views of their health problems and of their needs in relation to problems may be a firmer basis than their expectations for the purpose of understanding subsequent levels of satisfaction.

As Cooper succinctly expresses it: "Needs" are those demands which in the opinion of the doctor require medical attention' (Cooper, 1975:20). In other words, the concept of need has normally been confined to professionally defined and accepted medical problems. It

is less clear how the patient may contribute to the definition of needs. Thus although patient - based perceptions of need are frequently cited in conceptual discussions as distinct and important components in health care systems (for example, Long,1985), less attention has been given to their empirical investigation. The patients investigated in this study presented quite homogeneous problems in one sense - from a medical point of view all the patients' symptoms could be simply be described as 'functional headaches'. On the other hand the patients' extended descriptions of their symptoms indicated that headaches could prove to be a health problem in a number of different ways and could give rise to varying concerns on the part of patients.

As has been shown, patients were rarely able to say in so many words precisely what their expectations of the clinic were. To be able to do so would have required a clearer understanding of the range of professional contributions appropriate to the treatment of headache than most patients possessed. On the other hand patients did noticeably differ in the ways they experienced headaches as a problem. The concept of 'concern' is here used to try to capture some of the different experiences of headache and associated goals in seeking treatment. The term 'goal' itself is avoided because it carries the same rigidly cognitive associations as 'expectations'. In other words 'goals' would imply clearly defined 'wants' that the patient may describe in precise terms. 'Concern' as a concept comes closer to the emotional and cognitive



aspects of help seeking in which anxiety and uncertainty may be a salient experience. In focusing upon how patients described their headaches and how they hoped for help, a finite number of themes emerged and for almost all patients a major concern could be identified that most represented his or her experience of headaches and sense of need for help. Four different concerns in particular were commonly found in patients' descriptions of their headaches and reasons for going to a doctor:

- (1) a concern for reassurance,
- (2) a concern for explanation,
- (3) a concern for prevention and
- (4) a concern for symptomatic relief.

It must be underlined that the focus of this study was on the role of expectations in influencing satisfaction. It is argued here that a conceptual shift to 'concerns' provides a clearer means of describing and delineating the main goals of attending the clinic described by sample. However patients were not asked in a specific question to identify their major concern and the concepts have a proximate relationship to patients' motivations. Whilst clear in some patients, the concerns of others had to be more directly inferred from the pattern of patients' accounts. Each of the four major concerns needs to be examined in detail.

### Concern for reassurance

Patients in this first group were considered to be distressed, worried and anxious about their headaches primarily because they were concerned that symptoms were possibly not those of 'normal' headaches but presaged a more serious illness. A majority of patients in the sample indicated some occasional worry or thought about serious disease, and in 49 patients a concern for reassurance appear to be the main focus of the patient and the dominant reason for seeking help.

Neurologists are aware that many patients presenting in their clinics with headache are afraid that they may have some serious intracranial disease such as a brain tumour or an impending cerebral haemorrhage. Worries of this kind arose in the sample for a number of different reasons, but nearly always involved a period in which the patient evaluated his or her symptoms to decide whether they were ordinary headaches or a symptom of more serious pathology. Most commonly the pattern of headaches changed either in terms of their frequency, severity or duration. This change of pattern led patients to doubt the 'ordinary' nature of the problem. Thus one patient explained a history of headaches that commenced when she began using the contraceptive pill. She understood her general practitioner as having diagnosed the headaches as migraine associated with her periods. However the duration and severity of episodes deteriorated and a friend advised her that migraines only lasted three days. Thus the patient, by

the time she was attending the clinic, had begun to think of more serious possibilities such as a brain tumour and hoped that the specialist would confirm her original understanding that the headaches were only migraine. In a few cases a single alarming episode proved so unusual and frightening that friends or family insisted that the patient go to the doctor. The pattern of symptoms led some patients to be very frightened and alarmed. Patients described themselves as 'panicked' 'scared' and 'terrified' by their symptoms. Although only 49 patients were rated as having this concern for reassurance, altogether 65 out of 95 patients appeared quite significantly worried or frightened by their headaches.

Eighteen of the 65 patients with some significant fear about serious organic disease cited someone personally known who developed a brain tumour or haemorrhage. Thus a 24 year old teacher complained of shooting pains that lasted a few seconds. He acknowledged the possibility that his symptoms might be due to tension but when asked about his worries in relation to the symptoms, he spontaneously mentioned that the mother of a friend of his had similar kinds of sharp stabbing head pains to his own and was discovered to have a brain tumour. This had occurred just three months prior to the patient's referral to the neurological clinic.

In many cases where the patient knew someone personally who had developed a serious organic disorder, initial reactions by other people to that person's symptoms

had mainly consisted of normalisation of the problem. Other people explained the individual's symptoms in terms of 'ordinary' headaches. This added to the anxiety of patients in the study who were particularly afraid that doctors would also normalise their symptoms and not specifically consider and exclude other serious possibilities. A 34 year old mother of three children who worked as a kitchen assistant in a school presented with a 7 month history of headaches described as pressure at the back of the head which usually lasted about three weeks. This was sometimes associated with a momentary sensation of something 'tingling' going through her head, making her feel giddy. Again, when asked about worries in relation to the headaches she spontaneously mentioned several other people's health problems with which she identified and which caused her to worry about her own symptoms.

' Before I went to the doctor, my mother-in-law was telling me about a little girl. She was not feeling well, all lethargic. The mother kept saying: "she's not well because she's run down." Poor child had a tumour on the brain and was dangerously ill in hospital.'

She went on to describe how her father had had a door fall on his head but had refused to go to the doctor. He died of a brain tumour. Both episodes signified to the patient how misleading it can be to neglect or trivialise symptoms. In both cases by opting for a 'normal' explanation for symptoms, the sufferer had neglected a life threatening problem. She was well aware that these two episodes made her 'tend to look on the black side of everything'. After her father's problem, she found that every newspaper that she picked up seemed to be referring to brain tumours and

strokes. This patient's perceptions are important for another reason. Her father's tumour was of particular concern to her since she felt there might be a familial tendency towards such problems. It would appear from other research investigating lay beliefs about disease that heredity is a much more common explanation for disease than is accepted in medical science. Individuals frequently resort to heredity to explain the occurrence of illness in the family (Blaxter, 1983) and evaluate their own vulnerability to particular disorders differently if there is a 'family history' (Morgan et al., 1985). One way in which some patients had become particularly alarmed and threatened by their headaches was where the patient had a close family member whose headaches or related symptoms developed into a serious disease such as a brain tumour or haemorrhage. This was the case with six out of 65 patients with such fears in this sample. Mechanic (1972) suggests a widespread and normal process is involved when patients become alarmed by their own ambiguous symptoms such as headaches in conjunction with cues from seeing other individuals' illnesses. He argues that processes of social comparison occur. The greater the perceived similarity between self and the person with a serious disorder, the greater the likelihood that the example will increase the individual's sense of threat or vulnerability to the same disease. This likelihood of threat from symptoms is increased by emotional arousal and when more normal explanations for symptoms are exhausted.

Altogether, 24 out of 95 (25%) patients mentioned



fear of a brain tumour. A further three patients expressed the focus of their fear in terms of 'cancer', and ten patients were concerned by fears of a brain haemorrhage or 'blood clot'. Thus altogether 37 (39%) of the sample had worries of a specific disease. A further 28 patients were worried about possible serious illness but expressed this concern in non specific terms. The proportion of patients in Packard's (1979) questionnaire based study who admitted to being worried about a brain tumour in relation to their headaches was 26%. Packard did not investigate fears of other serious diseases, and his results cannot be used as an estimate of the total proportion of clinic patients who have serious fears and worries in relation to their headaches. A wider range of factors were considered in this study compared with Packard's direct question, in order to gain some estimate of fears and worries about serious disease. In addition to mention of specific organic disease, indication of 'relief' from our questioning about the subject, evidence that worry about serious disease was disruptive to the person's life and involved thoughts that could not be controlled or evidence of discussing such worries with others were all factors taken into account to assess this concern. It has been noted that patients are often 'reluctant to volunteer suspicions to a clinician, fearing that he or she will be viewed as ignorant or unsophisticated' (Barsky, 1981:494). The solution suggested by Barsky and adopted in this investigation was, where necessary, to facilitate discussion by pointing out that 'many people say they have worries about what may be wrong with them'. This appeared

to uncover quite extensive fears in the sample.

Such fears may sometimes arise out of misunderstandings of previous medical explanations. For example, a 71 year old woman, had suffered migrainous headaches for almost 40 years. She had been free of episodes for several years but then experienced a particularly severe throbbing headache with scotoma (temporary loss of vision) whilst on a bus. The episode frightened her because she was unable to remember names of familiar people for several hours afterwards. She became terrified of having a stroke, something that she had seen happen to several friends. Moreover her GP's explanation had added to her anxiety:

'My one fear was that the blood had not moved over my brain. My doctor had told me that a migraine is blood held on one side of the head. And then when the blood is released, it gives you pain on the other side. So I thought "is the blood becoming static over my head and not passing over?"'

Certain factors were correlated with worry about serious organic disease. Patients having headaches more often than twice a week were more often worried than those whose headaches were less frequent (Chi Square=6.14; d.f.=1;  $P<0.05$ ). Women were more likely to be worried than men (Chi Square=4.04; d.f.=1;  $P<0.05$ ). Those with a subsequent diagnosis of tension headache compared with other diagnoses, and those with headaches for less than two years compared with patients with longer histories were both more likely to be worried but differences were not statistically significant.

The relationship between psychiatric morbidity and fear about serious disease was also considered. Those rated as suffering from having significant psychiatric symptoms according to the Present State Examination (PSE) were more likely to be afraid of serious illness (Chi Square=4.65; d.f.=1;  $P>0.05$ ). However, the majority (57%) of those were rated as significantly worried by organic disease were not identified by the PSE as psychiatrically distressed. This further supports the view that the many of the patients' fears arose out of a normal reaction to a combination of unusual circumstances - that is symptoms that changed in nature in alarming or unusual ways sometimes in association with social evidence to the patient of the dangers of apparently innocent symptoms. There appeared to be few patients whose worries could be regarded as hypochondriacal, in the sense of a 'psychiatric syndrome composed of "functional" somatic symptoms, fear of disease, bodily preoccupation and the persistent pursuit of medical care' (Barsky and Klerman, 1983:273). If that term is taken to refer to 'an unrealistic interpretation of one's bodily sensations as abnormal, leading to the fear and belief that one has a serious disease' (Barsky and Klerman, 1983:284), then very few of the patients in the sample would appear to warrant this label. The pattern of fears in this clinic lends support to the view (Appleby, 1987) that distressing fears about disease cannot be explained solely in terms of underlying disorders of affect such as depression and may constitute a distinct clinical problem. It may be observed that disease worries have been shown to be extremely common in such diverse

medical settings as STD clinics and cardiology clinics (Mayou,1976) yet, as Mayou argues, little is known about the origins or prognosis of such fears. In the second study reported in this thesis an effort is made to measure the amount and nature of fears about disease present in an STD clinic. Fears and concerns of this nature are found to be common. Again it is argued from the evidence of the STD clinic study that such distressing concerns cannot be reduced to underlying primary affective disorders in the way that some writers have suggested (Kenyon,1964).

#### A concern for explanation

Most patients who wanted to know what their symptoms were due to were frightened of more serious illnesses as described above. A small number of patients (six), who might easily have been characterised in terms of a concern for reassurance are distinguished here because they did not appear over concerned about possibilities of more serious diseases, but instead simply wanted an explanation for symptoms which they accepted as 'normal headaches'. The need for an explanation is important in most individuals' experience of illness and many patients in this sample who either wanted reassurance, symptomatic treatment or a more basic preventive intervention by the specialist also wanted an explanation for their symptoms. These patients are distinguished only because an explanation appears to be the sole reason for seeking help.

A case that illustrates this concern is that of a twenty two year old single woman studying law at college. She presented complaining of pressure at the back of the head. These episodes normally lasted a day and were often accompanied by feelings of sickness. She had had the headaches for some 3 months and, at the time she was referred, she was suffering episodes most of the time. She had attended her GP on at least 15 occasions in this three month period in search of an explanation for her symptoms and described her concern thus:

'He [the GP] was putting it down to my childhood, not being able to talk to my parents - all that kind of thing. It sounded quite coherent. I'm not sure that I agreed with him, but he made out quite a good case that that was what it was. I was never satisfied. He said that it was tension that manifested itself in headaches. What I couldn't see was why it should suddenly manifest itself when I was 22 - living away from home and not under those pressures any more. Also why should it come out at a time when I'm feeling happy in myself? I was very pleased that he should try to get to the bottom of it and not try to palm me off with more pills. I'm still left with the question of why the headaches occurred in the first place. It would be sheer intellectual laziness on my part to dismiss it as physical illness that will be probably get better. I think there's probably something behind it. I've had to think about my self, my home because of the headaches.'

At the time of interview, just before seeing the consultant, she displayed no anxiety at all about more sinister serious possibilities and underlined rather the puzzlement that had led to her repeated visits to her GP:

'I can see good arguments for saying it would be caused by pressure. I haven't closed my mind to that. But I find it very hard to see why at this moment it should come out in this way.'

Thus those with a concern for explanation largely sought an answer to what might be thought of as an intellectual question. There is no doubt that the law



student felt pain and distress during headache episodes and would have preferred that this did not happen. However the dominant concern conveyed by her and by others was a need for explanations rather than a cure.

#### Concern for prevention

The distinctive feature of the 24 patients with a concern for prevention is primarily a negative characteristic - they did not want further symptomatic treatment. They wished somehow to tackle the underlying problem that created or caused regular headaches. It is in this sense that they had a preventive orientation to headaches. They wished to take actions that would prevent or at least reduce the occurrence of their headaches. Not all the patients could say very clearly how this might be achieved; often the patient had little more than a vague hope that the specialist because of his expertise would approach the treatment of headaches in a more fundamental way than the symptomatic management of the GP. In some cases preventive medication was still considered appropriate provided it was specific to their symptoms and not mere palliative treatment. For other patients no medication would have been acceptable and more 'primary prevention' was essential. Specific environmental, dietary or psychosocial factors would need to be evaluated by the specialist. Others were less clear. This more general expectancy is summarised in the following statement by a

patient: 'I'm here to find out what you can do to find out what causes migraine so that you can stop it before it happens.'

Another patient summarises equally general expectations: 'I don't know whether migraine is something you've just got to live with. I didn't expect a cure - but something - why it starts up... why we get them.'

As both of these quotations suggest and as will be shown shortly, this concern was particularly associated with patients with migraine. Macintyre and Oldman (1977) discuss migraine as frequently involving a series of discrete phases or stages in a 'career' of suffering. They describe one typical 'career' in which the patient passes through an initial 'anomic' phase often during childhood, in which headaches are inexplicable and unpredictable. The patient then passes through an 'identificatory' stage in which, often after exhaustive investigation, the diagnosis of migraine is made and in some cases confirmed by a specialist. At this point the sufferer may over a number of years pass from seeking ameliorative, symptomatic treatment to a point at which he or she seeks more personal and preventive treatment. The patient or others trying to help the patient may seek a personal interpretation of the significance of their disorder. Macintyre as a migraine sufferer herself, describes how at this stage, whilst at university, she received numerous interpretations of her migraine from her GP. She describes how her doctor:

'..variously informed me that my migraine resulted from my not having a boyfriend, sublimating my desire

for children, for postgraduate studies, and having over - strong internalised guilt and achievement - strivings. When I became depressed lest all these analyses were true, the migraine was attributed to depressive tendencies.' (McIntyre and Oldman, 1977:62)

Partly because of the unsatisfactory nature and contradictions of such personal interpretations the patient may move on to another career stage of seeking more physical prophylactic treatment if he or she continues to suffer regular episodes. At this stage the patient seeks medications or other medical treatments that may reduce the frequency of episodes.

Thus long term migraine sufferers will often reach a point at which, once the diagnosis is definitely established, they seek preventive treatment, either in terms of personal interpretation of their disorder or in terms of preventive medication. Macintyre and Oldman point out that the time it may take patients to pass through prior stages of a 'migraine career' to reach this point may vary enormously. Patients with an onset of migrainous symptoms during childhood may immediately be identified as having the disorder if a parent is a migraine sufferer and straightaway propelled into the ameliorative treatment seeking stage. Other sufferers may not be diagnosed as migraine sufferers until many years later, if at all.

Of the 58 patients in the study who were diagnosed by the neurologist as having migraine only 23 had a very definite and clear view of their problem as being migraine. Others had considered the possibility of this diagnosis but were still unsure about it. This group of 23 patients had

very fixed, definite views that in most cases had been long established. Above all, this group was striking in that the diagnosis of migraine was one in terms of which all other ideas about their symptoms of headache were organised and described to the interviewer, whereas other patients, who received the same diagnosis from the neurologist did not regularly use the term to describe, organise or make sense of their experiences. More than half (14) of the 24 patients with a preventive concern came from this group of patients with strong views of their problem as migraine. Some of these patients with a very definite definition of their symptoms as migraine also had other clear ideas about, for example, the causes or triggers of their episodes. Macintyre and Oldman introduce a very useful concept to further the understanding of the long term migraine sufferer; they refer to the patient as 'expert'. Many patients develop quite elaborate understanding of their own migraines; they may be sensitive to the triggers or circumstances that provoke their attacks and develop complex patterns of coping with episodes to alleviate pain or reduce their duration. The patient will develop quite clear views, for example, of the benefits or side effects of different medications and of the most appropriate and helpful ways of taking medication. This understanding is personal and practical and emerges from the necessity of coping with a lifetime of suffering migraines. The importance of their concept of 'expert' is that it refers to experiential rather than theoretical knowledge; in other words personal observation of experiential evidence becomes the basis of knowledge rather than purely intellectually

gained evidence. The advice of other fellow sufferers may be of importance. In some cases this personal awareness and understanding is supplemented by assimilating available medical knowledge and research about the disorder. Migraine is a relatively safe and unthreatening disorder and therefore often discussed in the media. Patients may also join the Migraine Association which disseminates information on current thinking on the disorder. The concept of the patient as 'expert' is also important because traditionally the patient has been conceived as passive, lacking sophisticated knowledge of his or her disorder and dependent upon the medical profession for information. The expectations of treatment may be different and the scope for conflict between patient and doctor greater, it is suggested by Freidson (1970), where patients do develop such specialized expertise of their own.

One of the main developments in migraine research in recent years has been the investigation of the disorder as an allergic reaction, especially in response to certain foods (Egger et al., 1983; Monro et al., 1984). Enthusiasm for food allergic explanations for ill health in medicine are not universally shared and some commentators cast doubt on the validity of much of the work in this field (Pearson, 1986). Nevertheless it has undoubtedly passed into popular thinking in relation to migraine and, as observed earlier in the discussion of patients' expectations, one of the few commonly cited expectations of the clinic was that the possible role of diet would be discussed with the



specialist. With patients who had clearer views of their problem and looked to the clinic to consider the reasons for their headaches, clearly diet was a particularly important issue, especially for many of the group with more definite views of their symptoms.

However not all of the patients who fell into the group as having a definite view of their headaches as migraine, had definite goals or expectations of the specialist. Thus a 28 year old school teacher had her first attacks at the age of 14. Her mother, who also suffered from migraine, immediately identified them as migraine. She reported a history of various treatments received from her GP, ranging from analgesics through psychotropic drugs to migraine specific treatments. She described this process as 'trial and error'. She had attended her general practice 5 times in the year before seeing the specialist. She described the events leading to the referral as follows:

'It had got to a "Keep taking the tablets" situation with the GP. I'd been through a bad patch. In four days I'd had three migraines. I thought that was the time to see if there was anything else. The GP gave out the idea: "Why don't you try a clinic?" I thought: "What have I got to lose, if anybody knows what treatments are out at the moment, obviously you're the people in touch with it." '

She then added: 'I dont expect them to be able to do anything about it.' Thus in this typical case, the patient had no specific expectations of the clinic except that her understanding of the clinic as having specialist expertise led to a tentative hope that a more recent or different medication might be suggested.

Other patients in this group did look to the specialist for a more fundamental intervention than a prescription. A 33 year old housewife married to a policeman described a history of migraines beginning at the age of 12. Again it is noticeable how early in this history that the diagnosis was established. She suffered visual disturbances in her first attack which were so alarming that she was taken home from school and taken to the family doctor. He immediately diagnosed the headaches as migraine. Since then she had taken Migril for episodes and never visited the doctor otherwise in relation to migraine. She explains the specialist referral as due to other individuals' pressures on her:

'I had four attacks. My husband said "I think you ought to go to the doctor about it." I said: "There's nothing they can do." He said "Well there's no harm in going." Its something I'm so used to having and I've always known there is no cure. I've always just gone to the doctor to get a prescription for more tablets. He never asked me anything about the migraine - why I ever had them. I had spoken to a friend I used to work with who had been to the clinic. She said that they ask you a lot of questions and try to find out whether its certain foods that appear to trigger it off.'

Her account reveals slightly more ambitious expectations of the specialist's role than previous patients. She went on to explain that she thought the specialist would ask about her social background in order to evaluate the possible role of stress. It is important that her expectations that the causes of migraine might be explained appeared to derive from someone else's account of a referral. Her own account illustrates another common pattern in this and in other samples of patients' illness

behaviour. She had to be convinced to visit the doctor by her husband and also by a friend's encouragement. The majority of the sample (79%) described themselves as having spoken to someone else who recommended going to the doctor for the symptoms. Suchman (1964) and Scambler et al. (1981) describe similar proportions of patients consulting a doctor with symptoms as having first consulted another lay person for advice about action. Zola (1973) found that one of the most important factors influencing the decision to consult for long standing symptoms is the advice or pressure of friends or family, a phenomenon he refers to as 'sanctioning'.

Patients with migraine who looked to the doctor for more than symptomatic treatment still conceived of the possibilities of medical action in fairly narrow terms. They hoped either for more preventive medication or for some increased understanding of the personal causes of their migraine, such as diet or psychological factors. Only one patient in the sample cited a specific alternative therapy. This exception was a woman who had heard that a particular specialist offered acupuncture for migraine. She had heard favourable accounts of acupuncture for migraine in Canada. Despite evidence for its efficacy in chronic headaches (Loh et al., 1984), acupuncture is still regarded as a 'fringe' treatment in medicine and is seldom offered as a treatment for headaches. That only one patient should cite it in our investigation is at least evidence of the ability of the medical profession to shape public expectations. The extent to which such treatment

expectations are met by non medical practitioners in Britain is unknown. In Canada, 8% of a large sample of migraine sufferers reported experience of acupuncture (Parnell and Cooperstock, 1979). The absence of any mention of other methods of treatment in our sample such as psychotherapy, biofeedback or hypnosis is significant in that it underlines the accurate public perception of the narrow range of conventional treatment available in this area.

Although the discussion has constantly treated patients' expectations in this field as modest, it must nevertheless be significant that in 38% of cases the patient played an active role in asking for a referral to the specialist suggesting at least some positive expectations of a helpful outcome on their part. Moreover the group who were more likely to take such initiative were the patients who clearly defined their disorder as migraine

#### Concern for symptomatic relief

It has already been indicated that symptomatic relief is a major concern of many patients attending the neurologist, although the expectations of relief are not particularly high or unrealistic. Only 15 patients were rated as having this as their major concern as so many patients sought symptomatic relief through more fundamental interventions from the specialist. In terms of Macintyre and Oldman's schema of a headache 'career', a concern for

symptomatic relief may arise at any stage in the experience of chronic headaches. Patients with a recent onset or deterioration of headaches may seek symptomatic relief. Equally patients with long histories of suffering headaches may decide that there is little they can personally do to alter their life style or diet to change the pattern of their headaches and may return again to seeking medication that at least relieves the severity of episodes.

A quite clear statement of concerns is provided by the following respondent. A 21 year old typist married to a welder described throbbing pains that lasted for several hours and which were usually associated with feelings of nausea and 'everything going misty' in her right eye. Her headaches occurred about once a week. She did not define them as migraine but rather linked them to periods of extreme difficulties in her marriage. She volunteered that she had also in the recent past taken an overdose of tranquillizers because of her marital problems. She was unsure about the extent to which these difficulties provided a complete explanation of her symptoms. Her G.P.'s treatment of the problem had been confined to symptomatic treatment with analgesics such as paracetamol. He had explained to her that her headaches were 'tension'. She described her last visit to the GP when he referred her to the neurologist as follows:

'They were getting so bad. I wanted him to give me something stronger. I said to him: "The headaches are getting worse. The Panadol only help for a while. Surely there must be something you can do." I didn't mean him to send me to a specialist. I'd passed out on two occasions, I told him. I only really wanted some tablets. I was a bit suprised. I only really wanted some tablets - not to be sent to a specialist.'



When interviewed after her hospital visit, this theme of obtaining medication for her headaches still predominated in her thinking about the referral. She explained: 'I was a bit - not exactly disappointed - but I at least thought they'd give me something for them.'

Very few patients appeared to expect dramatic results from medication. Rather it was a question of 'trying something different'. One reason for the modest expectations of drug treatment amongst patients must be their prior experience with medication. Patients were asked to describe all medications taken for headache in the 3 month period prior to being referred to the specialist. The assessments patients made with regard to the different major categories of treatment are indicated in Table 5. The numbers in the sample are too small to regard these as useful assessments of the real benefits of different categories of medication. It also should be kept in mind that these assessments of medication were made by a group of patients, the majority of whom appeared in the sample because their headaches were deteriorating to such a point that they consulted a doctor. However they do provide firm evidence that patients' previous experience of medication had not been impressive. Only a small minority of patients found any kind of medication very helpful and in the case of non prescription analgesics and psychotropic drugs the majority reported no benefits.

The assessments of recent medication by the sample

of patients referred to the neurologist are not dissimilar to those obtained by Parnell and Cooperstock's (1979) investigation of 15,000 migraine sufferers in Canada. Their sample is of migraine sufferers who had made enquiries to the Migraine Foundation. They found that, whilst non prescription pain killers were the most commonly used medication in the sample (84% indicated use at some time), they were rated fairly poorly by the sample. Only 4% rated the effects of non prescription pain killers as 'excellent', and 28% rated the effects as 'fair'. Psychotropic drugs were also rated poorly: 12% rated their effects as 'excellent' and 37% as 'fair'. Prescribed pain killers were rated more positively: as 'excellent' by 23% and as 'fair' by 47%. The assessment of migraine - specific drugs varied enormously. Thus injections were quite highly rated, described as 'excellent' by 58%, whereas oral ergotamine was rated as 'excellent' by only 12% of respondents. Both studies are based on samples of respondents who are in some way motivated to seek help for their headaches and their responses may therefore reflect sufferers who are less responsive to drug therapy. Nevertheless the concept of Edmeads introduced earlier, that patients with chronic headache may present to the neurologist with 'negative expectations' seems to be only a slight exaggeration of many patients' views with regard to the general efficacy of medication for headache. Instead of referring to medications that might 'cure' their headaches, patients instead spoke of a desire to try something 'new' or 'different'. The specialist was perceived as a potential source of more 'up to date'

medications, rather than of 'miracle cures'. Thus with regards to relief by medication, this sample appears not at all dissimilar to Packard's description of the headache clinic attenders he investigated, as having quite modest expectations.

It must be said as a cautionary note that the inference of major concerns in patients' interviews is not always easy and indeed there is a danger of oversimplifying the complexities of patients' continuous search for solutions to their problems. For example not all patients who appeared mainly to want symptomatic relief described their motivations in such clear terms as the patient cited above. Some patients described a situation where their headaches had become such a problem that they wanted 'to get something done', although experience had led them not to expect that powerful treatments might be available. Nevertheless particularly painful or distressing episodes prompted the need for some action. To some extent it is misleading to regard such patients' responses as being captured by a single and focused concern. Nevertheless in drawing together the argument of this chapter it is important to restate some of the conceptual limitations of this field of enquiry out of which the resort to 'concerns' emerged. One common theme in discussions of patient satisfaction is that prior expectations are crucial determinants. There are ambiguities in the concept of expectations, especially in that goals and hopes on the one hand are conflated with predictions and probabilities on the other hand. However it would appear, at least with

regard to the patients studied in the neurological clinic, that, especially with health care services of which the patient has no prior experience, expectations appear modest and unclear. Equally patients do not formulate clearly defined goals and objectives in terms of which hospital services are then evaluated. Illness involves inchoate and fluid emotions and thoughts that many concepts such as 'expectations' do not easily capture. The latter concept implies an ability to settle on specific solutions that the uncertainties of illness make unlikely. In comparing and contrasting patients' accounts four different dominant patterns of symptoms, responses to symptoms and motivations were detected. The term 'concern' is used to convey the shifting discomforts, distress, worries and thoughts experienced in response to symptoms. These different concerns convey important elements of the patient's perspective against which subsequent levels of satisfaction are examined in the next chapter.

### The neurological consultation

The neurologist - although essential in the following analysis of the project setting and their impact - thus has a central role in the diagnosis of disorders such as epilepsy and multiple sclerosis. The neurologist is also a diagnostician in the case of chronic progressive conditions, the primary function of the neurologist, especially where there

#### CHAPTER 4. PATIENT SATISFACTION WITH NEUROLOGICAL CLINICS

In this chapter patients' reactions and responses to their visit to the neurological clinic are examined. Patients views were often difficult to label in terms of 'satisfaction' and 'dissatisfaction', and some reasons for this difficulty are discussed. Responses in terms of perceived benefits of the clinic visit were however clearly discernible in interviews with patients. In this sense reactions were varied, including very strongly favourable and critical views of the value of attending the clinic. This diversity of responses is examined in relation to the different concerns patients had in attending the clinic. Before embarking on a discussion of patient satisfaction the consultations and the treatments that patients received from the specialist will be described.

##### The neurological consultation

The neurologist's particular expertise is in identifying lesions of the nervous system and their causes. Thus the neurologist plays an important role in the diagnosis of disorders such as epilepsy and multiple sclerosis. The neurologist is above all a diagnostician. In the case of patients presenting with headache, the primary function of the neurologist, especially where there



is any uncertainty about cause, is to exclude the possibility of a serious structural lesion such as a brain tumour or cerebral haemorrhage. It is generally recognised that an important aspect of the neurologist's role is the communication of reassurance. Thus Grove et al., (1980:195) observe in relation to an audit of referrals to neurologist for headache that: 'Hospital referral is usually made with the purpose both of confirming the diagnosis and reinforcing the reassurance which forms the mainstay of management.' The next most important task for the neurologist is to provide further diagnostic expertise in advising on the most probable mechanism responsible for the patient's headaches - most frequently either muscle contraction, vascular or migrainous neuralgia. Finally the specialist may advise the general practitioner and the patient about the most appropriate form of treatment for the symptoms. It is rare for such treatment advice to be anything other than a medication.

It has been said that the main task - differential diagnosis - can normally be carried out on the basis of a clinical history (Mathews,1975). The information relevant to this differential diagnosis consists mainly of the history of the patient's headaches - their precise location, character of pain, accompanying symptoms. Information on only a modest number of signs and symptoms is sufficient to provide differential diagnosis in most cases (Diehr, et al.,1981). As a result the neurologist rarely has to explore very much of the patient's social, psychological, dietary or family history to make the

diagnostic decisions.

The clinical history is generally sufficient to reach a diagnosis. Neurologists often conduct a physical examination in addition although it is unusual for this to reveal anything (Hopkins,1988:66). Investigative tests may be undertaken, such as a skull x-ray or electroencephalograph. Such tests do not often make a difference to the neurologist's decisions (Bull and Zilkha,1968) and rarely detect abnormalities responsible for headache that history and physical examination failed to reveal (Larsen et al., 1980). Mathews (1975:8) view of such tests is that: 'The almost inevitably normal result will be reassuring to the patient and just occasionally clinical judgement can be wrong.' This view of the reassurance value of investigations was one frequently cited to the investigator by neurologists in the sample. Forty three per cent of the study sample were sent for investigative tests; most frequently a simple skull radiograph. Characteristics of the patients' presenting problems were less apparently important influences upon whether patients were investigated than other factors. Thus junior doctors more frequently investigated patients than did consultants (48% and 38% of cases respectively). Moreover consultants, if they did instigate investigations, tended to choose a skull x-ray alone whereas junior doctors asked for multiple investigations. In this case it may be the doctor's degree of diagnostic confidence that determines whether a patient is investigated. This is the suggested reason in other studies in which such differences

have been found (Royal College of Radiologists, 1980). Another source of variation is less easy to explain. The proportion of patients with headache investigated with tests in the two clinics where they were most used was 82% and 80%, the proportion in the two clinics where they were least used was 0% and 7%. One possible explanation for this difference is that the rate of initiation of tests become established hospital or clinic routines (Evans, 1980).

Seventy of the 93 patients ( 75%) for whom treatment information is available received medication from the hospital specialist. For those patients diagnosed as having migraine, prophylactic medications such as clonidine, or ergotamine were most frequently prescribed; for patients diagnosed as suffering muscle contraction headaches, psychotropic medication was the most common prescription. Usually the treatments were recommended to the GP, although in some cases the specialist would directly prescribe and assess the patient's progress in a follow up consultation. The only other reason that a patient might be asked to attend the clinic on a second occasion was if the specialist wished to communicate the results of investigations to the patient directly. Otherwise the patient was only required to attend the hospital on one occasion.

The direct observation of a number of different neurologists' clinics and the above details of investigations and treatments both suggest that in broad

terms neurologists' consulting styles and approaches to the management of headache were similar. Most emphasis was placed on the careful eliciting of symptoms, except in those consultations where the general practitioner's letter made it quite clear that migraine was a well established diagnosis and that the advice sought was solely with regard to medication. As has been observed in other outpatient medical contexts (Bloor, 1976; 1977), hospital specialists may vary in point of detail with regard to the specific 'search procedures' whereby they obtain a history, but tend to share in common a style of history taking - for example, asking a series of specific closed questions rather than eliciting patients' views by more open ended questions - that has the effect of controlling communication and discouraging patient participation. In this case, there appeared to be few occasions where the neurologist felt it helpful to encourage more open discussion of the patient's concerns or detailed personal biography. Such information would not contribute to the main agenda as perceived by the neurologist.

#### The focus of patients' responses to the clinic visit

Patients were not treated significantly differently from each other: the neurologist's agenda and approach to management varied very little. It may therefore seem surprising that patients' reactions varied quite considerably. At one extreme a patient enthusiastically concluded: 'I must say I was very impressed. I don't know whether I was very lucky. I felt at last something was

getting done.'

Another patient however reacted in quite the opposite way: 'I was disappointed and annoyed - a waste of time.'

Between these two extremes of positive and negative reactions to the clinic were observations - less easy to illustrate - of a more neutral nature, indicating no strong feelings in any direction.

Elsewhere in this thesis (chapter 1 and chapters 5-8) the argument is discussed that patients attend to and judge only a narrow range of affective, interpersonal aspects of doctors' behaviour in consultations in evaluating their medical consultations. Observations of affective behaviour are seen as a substitute for other more technical, instrumental aspects of health care that the patient is unable to discern or evaluate. In some discussions of patient satisfaction, it is argued that patients tend to make global undifferentiated judgements of their consultations, in which interpersonal aspects are primary considerations. This view of the process whereby patients' respond to medical consultations needs to be set against the comments made by the patients in this study when asked for their views on their hospital visit. A consideration of some of the sample's negative comments towards their consultations reveals a quite different picture.



Certainly some patients did focus in their comments upon interpersonal aspects of the doctor's care. Thus the following patient makes his views about the neurologist quite clear:

'I wasn't very happy with the doctor's manner. She seemed to have less time. I felt like I'm an ordinary migraine sufferer - nothing special and I'm holding other people up. I'm there under false pretences. She was probably thorough. I felt I was just another example of this particular phenomenon. Nothing special. There was no emotional feedback at all. She was asking me questions and writing it all down.'

This patient was clearly unhappy with the interpersonal aspects of his consultation and, to adapt Ben Sira's distinction, did not feel that he had been treated as a person rather than a case. In fact the main focus of his criticism is a strong sense of being labelled as a 'case' of migraine. This patient's observation is an interesting one however, because he does distinguish between the apparently unsatisfactory manner of the consultant and her technical approach to his problem. He concedes that 'she was probably thorough'. Moreover, elsewhere in the interview, he also admitted to being pleased that the investigations she had initiated had been reassuring and had adequately excluded the possibility of serious organic lesions. Thus whilst focusing very critically on the interpersonal aspects of care, the respondent did distinguish and evaluate in quite different terms more instrumental aspects of the consultation.

A second type of critical comment by patients focused upon the way in which the doctor took the patient's medical history. This may be illustrated by a

61 year old woman who was attending the clinic because she had been taking a particular drug for migraine (Deseril) prophylactically for some 12 years, had recently received treatment for a cardiovascular problem and had become worried because she understood that the drug was contraindicated in such circumstances. She had asked her G.P. for 'a second opinion'. Of the neurologist she says:

'He asked me a few questions.. very little. I was rather suprised that he didn't ask me a lot more. He didn't go into reasons, what brought them on. I was suprised that he asked so few questions. He simply said " Keep on the Deseril, and take these [ different tablets]." The interview was very quick really..... He seemed a bright little man, he gave me confidence.'

Again it is apparent how differentiated and complex are the patient's evaluative responses to the consultation. She felt that the consultation was quite successful in terms of her main concern. The doctor considered the question of whether she could safely continue with the prophylactic medication. However there were aspects of his approach to her case that did surprise and disappoint her - particularly the limited background history the specialist took before taking his decisions. Equally striking from the quotation is that, just as with the previous patient, different aspects of the consultation may receive quite distinct evaluations. Whilst she emphatically remarks upon the poor medical history, she is equally clear in another view that the neurologist was 'bright' and gave her 'confidence'. Such evaluations do not appear consistent with a process of patient satisfaction emerging from global and affectively biased judgements.

A third focus of criticism was lack of, or

inappropriate investigations . Thus a middle aged woman presented to the neurologist with two types of problem, a persistent ache in the back of her neck which she felt frequently provoked episodes of a second, different type of pain which she defined as migraine - a more distinct episode involving sickness. She had become worried, not by the migraines, but by the significance of the neck pain and had mentioned fear of cancer in her interview before seeing the doctor. Afterwards, her responses to the consultation comprise a similarly mixed and complex set of judgements as the previous two examples:

'He went through my whole history.. you have to think! I wasn't prepared for it. I didn't expect an examination! He said it was muscular pain. Nothing wrong. I would have been happier with an x-ray of my neck. I had one before. I was a bit disappointed.'

Thus whilst clearly positively impressed and surprised by the detail of this doctor's history taking, possibly because of very specific concerns about physical aspects of her neck, she was critical and disappointed in relation to another aspect of the neurologist's instrumental approach - the nature of his technical investigations.

A fourth area of critical reaction in some patients is that of the treatment given by the specialist . The only treatment received by patients in this sample was medication. Some of the critical reactions were based on the patient's feeling that they had received the wrong medication from the specialist. As one patient explained: The thing I wasn't happy about was the prescribing of Dixarit. I've had them so many times before. They only

work for a limited period. I think he could have prescribed something else.'

In other cases, the patient's criticism is based on the fact that the specialist prescribed medication rather than adopting alternative approaches to the management of the patient's problem. The following quotation exemplifies this view:

'He was not very interested. I said to him: "Don't you think, if it's caused by tension, a radical change of life style is the answer and not tablets." He said: "Well yes". He supposed so but he couldn't offer any suggestions whatsoever. I can't understand the health service attitude to medication. Why supply someone with tablets when you can get nearer the solution. If it's stress, perhaps they could investigate ways in which I could stop stress building up.'

The fifth type of critical comment expressed by patient in the sample related to explanations received from the specialist. The following quotation illustrates this theme:

'If I'm honest I didn't get anywhere. There's lots of questions I'd like to ask now but they didn't appear. I wanted to face him and say: "Is it migraine? If it is, what in my case, do you think is the reason for it happening? Is it likely to get worse? Have I got to be a permanent pill taker? Unless you raise a question and drag it out of them, you don't seem to get it. I was disappointed.'

Most of the patients who were disappointed in this respect focused upon the lack of explanations received as to the nature of their headaches, their causation and the implications for the future that chronic headaches entailed. By contrast hardly any criticism was expressed of excessive use of complex medical terminology and failure to provide comprehensible explanations. In the main, criticisms arose because the doctor did not elaborate upon

his basic diagnosis.

Thus to summarise, by focusing on patients' negative reactions to the clinic, enough examples have been cited to indicate that patients attended to and evaluated a wide range of different aspects of their treatment. Far from being restricted to a narrow range of interpersonal aspects of the doctor's behaviour, patients commented upon a diverse range of technical aspects of treatment. Far from relying upon affective behaviour, patients often quite sharply distinguished between observations about the manner of the doctor that they had seen and the nature of the treatment they had received. In the second study reported in this thesis, Ben Sira's model of patient satisfaction is more systematically tested by means of data on patient satisfaction with an STD clinic. For the present, the qualitative data presented here suggest that patients' own accounts of the grounds for their dissatisfaction indicate that a wide range of different aspects of the consultation enter into judgements of the value of treatment.

#### The qualification of judgements

Many of the comments cited above reveal quite strongly felt disappointments. However patients frequently made it quite clear that they did not wish such reactions to be thought of as expressions of 'dissatisfaction'. Patients did not wish to be thought of as adopting critical attitudes in relation to their medical care and wished to make known to the interviewer the difficulties of judging



medical treatment in such simplistic evaluative terms. In the course of interviews it was possible to discern a number of different qualifications or reservations expressed whereby patients distanced themselves from simple expressions of dissatisfaction.

One qualification sometimes used by patients was to follow up critical observations with remarks that emphasised how difficult it was to interpret what had happened to them in the clinic. Thus for example one patient was quite shocked at how few questions the doctor had felt it necessary to ask before deciding upon his diagnosis and treatment. However in the midst of criticizing the doctor for this apparent lack of thoroughness she added various qualifications:

'Whether he didn't ask me questions because what I was rambling on about was making enough sense. Whether he was making out of what I was saying things which led him to understand the kind of person I was. I was suprised. He wasn't very thorough.'

Thus the patient appears genuinely uncertain as to whether impressions of apparently limited questioning by the doctor may in reality be quite misleading. Another patient conveys this same puzzlement:

'The questions were all laid down and obviously stereotyped. He just rattled through them. This is the problem with doctors. You start your story and immediately they come in with their questions and are writing their prescriptions. One isn't able to tell one's story but one assumes the doctor knows what's relevant and half the information I could be giving... I could be prattling on, and not giving anything worth knowing. So perhaps it wouldn't be fair to criticize.'

Patients are confused and uncertain in such circumstances as to what view to take of their treatment.

One way in which such uncertainties particularly led patients to qualify criticisms was to consider many of the frustrations of their hospital visit as at least partly of their own making. Thus many patients commented critically about the 'rushed' and inflexible pace of the clinic, which gave rise to a sense of not having one's problem fully and carefully considered by the doctor. However respondents also attributed this sense of being rushed to their own nervousness. As one patient reflected: 'I didn't get enough time to explain. I don't know whether it was me getting anxious.' Another patient illustrates in detail and in even more extreme form the qualifications that may surround critical comment:

'You get the feeling that he was very busy and rushed and when you get out you think of all the things you could have said. I was aware that they're in a rush, a lot of people to see. It's not their fault that I'm aware of this. Someone else might come along and not care less. So I suppose its me, not them - your own reactions to their situation.'

Thus one source of qualifications stems essentially from doubts about what happened in the clinic and the reasons behind disappointments. A second common qualification to critical comments arose, not from uncertainties as to what happened, but from a sense of understanding and sympathy for the shortcomings of clinic and hospital organisation. For many patients, hospitals are unavoidably and inevitably places in which problems will occur. Because hospitals deal with large numbers of people with demanding and difficult problems, they inevitably are to be experienced as rushed and without time for the individual. One patient complained of the brisk and rushed nature of the doctor's history taking:

'Quick fire questions. But one has become accustomed to that at any hospital. Sheer time and the people you've got to see. I couldn't see how he could ask the questions so quickly, be ready with the next one and write down some form of answer. It amazed me, albeit he must be doing it everyday. I don't think now one can expect the old bed side manner, the way it used to be.'

Another patient explained succinctly: 'I was not ultimately disappointed. I think I've got to realise that other people are waiting, time is short'.

Behind such comments is a sense that a reasonable person has to understand (and therefore forgive) how medicine has to operate. Related to this qualification to criticisms was a third frequently expressed qualification. One must not be unreasonable in the sense of 'expecting too much', being 'selfish' or inconsiderate of others. Thus patients emphasised to the interviewer how aware they had been that other patients were also waiting to see the doctor:

'He was a very busy man. He made me so I couldn't think straight. You know there're other people outside. I know they can't help it. I sympathise.'

Some patients appeared to be acutely conscious of the pressure of other patients even as they answered the doctor:

'They fire questions at you and there's no way you can keep up. You get annoyed. It puts pressure on you. But there's a lot of other patients besides me, so I need to keep my wits about me, answer the questions and let someone else have a go.'

Partly patients felt that other people in the waiting room had more serious problems than their own and therefore deserved more time. Thus: 'I felt also that he

didn't have a lot of time, that he had patients with more serious things. I was quite trivial by comparison.' Partly patients seemed simply to feel concerned not to be thoughtless or unreasonable by expressing criticism of their treatment. A patient explained: 'I don't want to be critical of it. You've got to understand how these people work.'

These examples indicate that patients appeared frequently to become involved in a number of different considerations in reaching a judgement of the care that they received. Such considerations included interpreting what actually happened in the clinic and the reasons for what happened; decisions about what might be reasonable to expect from health care; evaluations of their own 'worthiness' for treatment compared with other patients and also considerations of self presentation in the research interview as a reasonable and thoughtful person. Locker and Dunt remind us that '...we know little of the 'procedures, criteria and standards consumers employ' (Locker and Dunt, 1978:291) in reaching a position of being satisfied or dissatisfied with health care. The evidence of patients' self reports in this section has suggested that innumerable judgements of both an empirical and evaluative nature enter into such evaluations. The quotations cited above indicate a complex process of 'reflexive monitoring' (Giddens, 1976) in patients that normally remains hidden in questionnaire surveys. At the very least this evidence of reflexive monitoring casts doubt on simplistic notions of 'satisfaction' and

'dissatisfaction' as summary representations of patients' attitudes. In particular patients appear themselves to be reluctant to summarize their views in these terms. One must assume that similar processes precede and interfere with the responses patients give in any survey of satisfaction.

#### The classification of patients' responses to treatment and communication

Thus patients themselves were reluctant to be thought of in simple terms such as 'dissatisfied', and in many cases expressed such qualifications that the use of the terms 'satisfaction' and 'dissatisfaction', as Stimson and Webb suggest, 'distorts reality and misses the continual process of ordering and evaluation' (Stimson and Webb, 1975:77). However, although it was difficult to label patients' views in terms of attitudinal dispositions to their treatment, at another level it remained apparent that patients did vary with regard to the extent they viewed their referral to the neurologist in primarily positive, neutral or negative terms. However, whilst the concept of satisfaction has largely been used in the sense of 'favourable' or 'unfavourable' attitudes towards something such as medical treatment, the way in which patients appeared most obviously to vary was in terms of whether the referral was perceived as beneficial and helpful on the one hand or as disappointing and unhelpful on the other hand. In other words it appeared easier and more close to patients' responses to ask how helpful or successful



patients had found their hospital visit. Above all it was in terms of the degree of value of the visit that many patients tended to express the most unqualified and emotional positive or negative views. On the one hand a patient said with a strongly emotional tone of voice: 'A total waste of everybody's time.' She goes on to explain with a strong sense of disappointment: 'Literally all that happened was that I got a prescription out of it which I could have got from my doctor.'

Most importantly the patient herself then goes on to make a crucial distinction which also informs this discussion:

'It's not that he wasn't sympathetic or he wasn't any good. I mean you always find this. It's a total blank wall. You have migraine and that's it. We won't do anything for you but we'll give you something to relieve the situation.'

The patient explains quite clearly that she is not reporting an attitude towards the doctor or the clinic, and moreover appears as if she would report herself as 'satisfied' in such attitudinal terms. The strongly negative evaluation of the clinic is because the visit proved worthless and unhelpful in terms of the patients' goals and concerns.

At the opposite extreme were patients who described their response to the clinics in very positive terms such as: 'I don't know whether I was very lucky. I felt at last something was getting done.'

This patient proceeded to describe how she had felt

for many years that she had suffered headaches without ever being taken seriously or having them properly investigated. Seeing the specialist, regardless of any difference it might make to the course of the headaches, was experienced as a relief and as real progress.

Many patients therefore conveyed in the course of the post-hospital interview a sense of the visit having been either a success and worthwhile or, to adopt several patients' phrase, 'a waste of time.' Another group of patients described their hospital visit in predominantly neutral terms. Neither in emotional tone, nor in evaluative terms did such patients give a sense of having made up their minds about the clinic visit. It is in relation to this group of patients that Stimson and Webb's strictures about labelling patients as 'satisfied' or 'dissatisfied' most particularly applies. Their accounts of their hospital visit are expressed in mostly neutral terms. They describe themselves as 'satisfied' with the visit but without the enthusiasm or positive sense of benefits gained of the group of patients who describe the visit as positively successful.

The next step in this analysis of the process of responding to and evaluating the neurological clinic is to see whether positive or negative evaluations of the success or failure of the visit are associated with other known characteristics of the patients. For this purpose patients had to be placed into equivalence classes. Observer ratings were used, based on the principles described above.

Patients were placed into a 'successful' (positively satisfied) response category where positive evidence of perceived benefits was provided in the interviews and patients described the hospital visit in positive emotional terms. Conversely patients were classified as falling into a 'disappointed' (dissatisfied) category where evidence of negative evaluations of the clinic and negative tone of voice predominated in the interviews. It seemed most parsimonious to classify remaining patients as 'neutral' where there was no compelling evidence of any strongly felt reaction. So far as possible two scales were used because in some instances patients differed in views between two issues; whether they viewed the clinic visit as successful in terms of treatment and whether they viewed the clinic visit as successful in terms of communication, that is in terms of learning more about their headaches. Such reactions will continue to be discussed in terms of 'satisfaction' although sufficient has been said to indicate that mostly patients' reactions were evaluations of benefits rather than attitudinal responses. Responses in terms of the two scales are discussed in turn.

#### The value of treatment

It must be emphasized at the outset that the interview which is used in making this rating was conducted only three to four weeks after the initial hospital visit. In other words, for most patients it would have been difficult to judge whether the pattern of recurrent episodic headaches had changed in the brief period between

the hospital visit and the research interview. Thus in most cases patients were making judgements on the appropriateness or potential value of medical treatment rather than the impact treatment appeared to have on the course of symptoms over time.

A 27 year old woman, a housewife married to an Insurance Broker, is an example of a patient who viewed the treatment she received at the hospital as successful. She had presented with headaches described as a dull pain over one eye spreading to the right side of her head. She sometimes experienced 'silver sparkles at the edge of the right eye' during these episodes. She had suffered occasional severe headaches since childhood but had recently suffered almost constant headaches for five weeks prior to the GP's decision to refer her to the specialist. Both she, and her GP in his referral letter, described another woman in the practice who had had similar symptoms which had proved to be due to a cerebral tumour. This incident had clearly made an impression on the patient.

After the hospital visit her reactions were very clear:

'I was amazingly impressed. He was very thorough, very sympathetic, and made me feel very important. He examined me - which I never expected... .. I'm absolutely sure that if there had been anything there he would have found it. .. I had just a headache and a lady sitting next to me in the waiting room had Multiple Sclerosis. I thought - poor chap - he really hasn't got time to sit around and think about my headaches.. I was suprised to be told what he thought the problem was. He said it was a type of migraine because I was a woman unsuited to the pill.'

By contrast the following is an example of a

patient very disappointed by his treatment in the clinic. He was a 38 year old electrician who presented at the clinic with a dull pain in the forehead which lasted typically for half a day and was usually accompanied by 'different colours that appear in front of the eye'. His headaches had begun one year before the referral and had been diagnosed and treated by his GP as migraine. The patient had gone to see his GP several times as different medications failed to help. The patient was not at all anxious about his headaches and had been surprised by the GP's suggestion that he see a specialist. His response to the clinic was one of disappointment:

'All he did was to shine a light in my eyes and look at them. He said: "You've definitely got migraine. Carry on taking the pills." That was it! I don't think I'd have chosen him as my G.P. He didn't seem too sure of himself. He said: "I was going to ask you something but I can't remember what it was now." He did explain to me the cause of migraine - something to do with blood vessels in the head. But as far as telling me about cures, he didn't mention it at all.'

#### The value of communication

A typically favourable response to communication with the neurologist is the case of a 44 year old woman who worked part time as a domestic help. She presented with a dull pain all over her head, together with a 'feeling of a swirling in the head', and a slight feeling of dizziness that sometimes accompanied the headaches. Her symptoms had only begun 3 months prior to referral. They were associated with her monthly periods. She became concerned however when they persisted for two weeks beyond the end of her period. Before seeing the neurologist, she admitted suspecting that her symptoms might be 'the change of life'



but her doctor's decision to refer had alarmed her into thinking of more sinister possibilities. After the clinic visit she spoke very warmly of her consultation:

'He examined me and put it down to my age, overweight and the fact that I don't breath properly. He sent me along to the rehabilitation place to learn to breath properly and I was to lose weight. I now know that there is nothing wrong. Now we know what causes the giddiness. Obviously it was lack of oxygen. I came out feeling so happy that there wasn't anything wrong. He just confirmed what I had thought in the beginning.'

Quite different are the reactions of a 19 year old single woman who worked as a shop assistant. She presented with sharp pains on the top of her head which she described as occasionally so severe that she fainted. The episodes lasted a day each and had been occurring twice a week for four months prior to referral. She described herself as only mildly worried by the symptoms when interviewed before seeing the neurologist, her worries mainly arising because other people had suggested to her that the symptoms might be due to anaemia or a brain tumour. These are her reactions to the communication aspects of the clinic visit:

'He said I was physically okay and that the headaches would go as soon as they came but he would do an EEG to make sure. I was quite shocked - annoyed. My God! All he is saying is that they will go as soon as they came. How long do I have to wait? An absolute waste of time. There were students there. Quite embarassing, with everybody staring. I would have said: "What are the causes of headaches like this?" Instead I just sat there embarassed. He explained more to the students than to me. I got the impression he thought: "Let's get this over and done with." He didn't ask me whether there was anything I wanted to ask. I was suprised he let me walk out without knowing anything. He just said: "There doesn't seem to be anything seriously wrong. They'll probably go the same way they came." I could have worked that out for myself. They could have explained why they test feet movement and reflexes. I was not at all reassured by the visit itself.'

Patients attending the clinics could be classified in terms of three broadly differing responses to their clinic visit: (1) a positive view that the visit had been beneficial and helpful (2) a negative, disappointed view that the visit had been unsuccessful and (3) a more neutral view of the clinic which might be classified as 'satisfied' in the sense that no disappointed critical reactions were expressed but is here placed in an intermediate 'neutral' category of response. A fourth reaction was observed in a small number of patients (7 patients in relation to treatment and 2 patients in relation to communication), comprising a predominantly negative critical view on most aspects of the visit to the hospital, but some feelings also of positive satisfaction. This response for the purposes of analysis here has been combined with the purely negative responses. Patients' views were categorized with regards to two central aspects of the clinic visit - in relation to medical treatment and information and explanation ('communication') and the results shown in Table 6. Patients were rated separately on the two scales of treatment and communication. As can be seen from Table 7, 59 (62%) patients responded the same way to both aspects of their hospital visit. The remaining patients (38%) were rated as responding in different terms to the two dimensions of their hospital visit.

#### Statistical associations with patients' responses

A number of variables were examined which it was thought might explain the different responses to treatment

and communication from the clinic. There was no indication that responses on either scale were associated with age, sex, social class, or educational level. Next, those aspects of patient management that could be measured were considered in relation to the two scales. None of the following variables were significantly related to patients' responses: whether or not the patient attended a teaching hospital, whether the patient was seen by a consultant or by a doctor in training, seeing any particular doctor, whether or not a follow up visit was arranged and whether or not the patient received investigative tests. There are many other aspects of patient management which may well have influenced patients' views but which could not be measured, particularly with regard to aspects of communication within the consultation.

However some patient characteristics were significantly associated with responses. Firstly in relation to views of the value of treatment, a comparison of the 27 patients who received a diagnosis of muscle contraction (tension headache) from the neurologist with 53 patients who were diagnosed as having migraine showed that migraine patients were more likely to be dissatisfied with their medical treatment (Chi square 4.06; d.f.=1;  $P < 0.05$ ). Also, when patients with a history of headaches of longer than one year's duration (63 patients) were compared with patients with shorter histories (32), those with longer histories of headache suffering were found to be more

dissatisfied with medical treatment (Chi Square 6.35; d.f.=1;  $P < 0.05$ ). The 24 patients whose major concern was for preventive intervention, when compared to the rest of the sample were found to be more likely to be dissatisfied with treatment (Chi Square 6.77; d.f.=1;  $P < 0.01$ ). The group of 23 patients who in the pre-hospital consultation interview were rated as defining their problem clearly in terms of migraine were much more likely to be dissatisfied with their medical treatment than the rest of the sample (Chi Square 16.68; d.f.=1;  $P < 0.001$ ). Patients with no significant PSE symptoms (60) were compared with patients with significant psychiatric symptoms (35). The latter group of patients were also more likely to be dissatisfied (Chi Square 6.40; d.f.=1;  $P < 0.02$ ).

Finally, it was noted earlier that, in the interviews conducted before the clinic consultation, 65 patients were to some extent anxious about their headaches in terms of possible serious illness. In the follow up interview these patients were again asked about such worries in relation to their headaches. Twenty five of this group of patients ( 38%) expressed some remaining worry or concern, although in many cases the worries appeared less severe than before seeing the specialist. Those patients who expressed some continuing worry about serious illness in relation to their headaches were much more likely to be dissatisfied with their medical treatment compared with those who were reassured ( Chi Square 8.47; d.f.=1;  $P < 0.005$ ).

Similar patient characteristics were also significantly associated with the patients' evaluations of communication. Patients with a history of headache of more than one year's duration were more likely than those with shorter histories to be dissatisfied with communication (Chi Square 4.45; d.f.=1;  $P<0.05$ ). The patients who clearly defined their problem in terms of migraine were also more likely to be dissatisfied (Chi Square 4.92; d.f.=1;  $P<0.05$ ). Patients with significant psychiatric symptoms were more likely to be dissatisfied (Chi Square 4.78; d.f.=1;  $P<0.05$ ). Finally those who still reported some worry about serious illness were also more likely to be dissatisfied with communication from the specialist (Chi Square 8.26; d.f.=1;  $P<0.005$ ).

From these results it appears that three main variables are independently influencing the two satisfaction scales: (1) whether or not patients viewed themselves clearly as migraine sufferers ('the patient's definition of the problem') (2) whether the patient had significant psychiatric symptoms and (3) whether the patient felt reassured about serious illness as a result of the hospital visit. The numbers in the sample are small for examining multivariate influences; however it is suggested that the relationships between these three variables and the two satisfaction ratings reflect three important and separate underlying processes. The relationship between the three variables and satisfaction is examined by looking at relationships with regard to the scale of satisfaction with treatment. An examination of



the three variables in relation to satisfaction to communication would show similar independence for the three variables as is shown for the treatment scale.

Firstly there is a group of variables that were shown above to be related to satisfaction with treatment which also are quite evidently related to each other. These variables are: diagnosis (migraine versus tension headache), chronicity (whether or not the patient had suffered headaches for longer than a year), concern for preventive intervention, and the patient's definition of the problem (whether the patient clearly defined their headaches as migraine). Chronicity is associated with the patient's definition of the problem in that patients' with headache histories longer than one year are more likely to define their headaches as migraine (Chi Square 14.50; d.f.=1;  $P < 0.001$ ). Chronicity is associated with diagnosis in that patients with headache histories longer than one year are more likely to be diagnosed as migraine rather than tension headache (Chi Square 24.44; d.f.=1;  $P < 0.0001$ ). The concern for a preventive intervention is more commonly reported by patients who define their problem in terms of migraine (Chi Square=20.38; d.f.=1;  $P < 0.0001$ ). Finally and predictably, patients with migraine are more likely to define their problem as such (Chi Square 15.81; d.f.=1;  $P < 0.001$ ).

These four variables in fact reflect overlapping aspects of the experience of migraine. However in relation to satisfaction, the important variable of the four is the

patient's definition of the problem (whether or not the patient clearly defined their headaches as migraine). If patients who did or did not define their headaches as migraine are considered as two separate groups then chronicity does not have a strong independent influence on satisfaction with treatment. All patients who defined their headaches as migraine had suffered headaches more than a year; so chronicity cannot be examined in this group. Amongst those who did not define their headaches as migraine however, chronicity is not significantly related to satisfaction with treatment. On the other hand, if patients with more than one year's history are considered, there is a significant independent effect of patient's definition upon satisfaction with treatment (Chi Square 11.97; d.f.=1;  $P < 0.001$ ). Again, there is no independent association between concern for preventive intervention and satisfaction if the sample is dichotomised by the patient's definition.

The patient's definition of headaches as migraine is then one important influence upon satisfaction with treatment. It has the strongest association with satisfaction of the three variables considered here. It is unrelated to either of the two other main variables that appear to influence satisfaction - psychiatric symptoms and reassurance. Thus there are no significant zero order associations between the patient's definition, psychiatric symptoms and reassurance. Moreover if, for example, the sample is examined in terms of sub-groups formed from the variable of significant psychiatric symptoms, it is

apparent that the patient's definition of the problem has an important independent influence upon satisfaction with treatment (Table 8).

The two other variables - psychiatric symptoms and reassurance - may be examined in the same way. As already indicated there are no zero order relationships between psychiatric symptoms, reassurance and patient's definition that are significant. Moreover if, for example, sub groups of patients are taken with regard to whether the patient defines headaches as migraine or not, it is apparent from Table 9 that psychiatric symptoms have an influence on satisfaction at least amongst the majority of patients who do not clearly define their symptoms as migraine. Finally the influence of reassurance upon satisfaction can be examined in different sub groups formed of whether or not significant psychiatric symptoms are present. Only the 65 patients who were initially rated as anxious before their neurological consultation, are included in this analysis of reassurance (Table 10). It is apparent that reassurance is significantly associated with satisfaction regardless of the patient's psychiatric state.

#### The interpretation of associations:

##### the migraine sufferer

One particular cluster of variables were very strongly associated with the likelihood of expressing

dissatisfied and disappointed reactions to the clinic visit. Patients with chronic headache histories, especially if they were diagnosed as migraine were more often dissatisfied. Amongst chronic migraine sufferers, the group who were rated as having a very clear definition of their headaches as migraine were particularly likely to be dissatisfied. The reactions and views of this group, which showed the most dissatisfaction in the sample, require particularly close attention.

Above all else this group of migraine sufferers were disappointed because seeing a specialist proved to be no different from consulting their general practitioner, most particularly in that the consultation proved to be rushed and did not permit a careful consideration of their headaches by the specialist. As one migraine sufferer summarised the hospital visit:

'I wasn't very impressed really, a complete waste of time. Very disillusioned. She went through me like a conveyor belt. The idea of seeing a specialist is that they've got some time to see you, explain various points. The questions were very quick. Answering the questions was like a game of table tennis.'

This perception of being rushed was very commonly reported by this group. It had a number of disappointing consequences. Firstly it meant that the doctor did not appear to take a full history of what to the patient was usually a complex history of headaches, with shifting patterns, a variety of possible causes and unique personal biographical features. In the words of one patient: 'I felt he didn't go deep enough into what was causing them.' Another patient cited specific personal factors she thought

the doctor ought to have covered in her migraine history, particularly in relation to seasonal factors: 'Not enough questions. He could have put more in about work and spring, autumn, summer, heat. He was too quick'. Several patients felt that diet in particular should have been more thoroughly investigated.

Also because of the discrepancy between their own complex perceptions of their symptoms and the apparently superficial approach of the neurologist, this group of patients were particularly likely to feel as though they had not been taken seriously:

'I felt also he didn't have a lot of time, that he had patients with more serious things, which he probably did. I was quite trivial by comparison..'

Or as another patient put it:

'I felt as though I'm an ordinary migraine sufferer, nothing special and I'm holding other people up..... just another example of this particular phenomenon.'

Patients' very sense of legitimacy to be in the clinic seemed undermined in some cases:

'I thought what was going through his mind was that I was some sort of hypochondriac.. or fanatical about these headaches.'

Thus if migraine patients often felt impersonally investigated and not taken seriously, rather as in other contacts with medicine over migraine, so also the results of seeing the specialist were also disappointingly modest and deflating. For example, the specialist appeared to some patients to regard with some significance the confirmation of a diagnosis that the patient had never thought in doubt:



'I already knew it was migraine. Whether the specialist thought he ought confirm it. It seemed quite strange him telling me.'

The other result of most consultations, receiving a prescription was also experienced as disappointingly familiar: 'Like all doctors, they just write out a prescription'.

Another migraine sufferer explained:

'Literally all that happened was that I got a prescription out of it which I could have got from my own doctor.'

Most important of all, the routine nature of the consultation meant that the specialist had no time to explain anything about his views of what causes the patient's headaches or what the sufferer might do to avoid or reduce the severity of episodes: 'I think he just said "it's a migraine". I wanted him to explain to me what a migraine is, what causes it.'

The frustrations and disappointments of this group were the most intensely felt and the greatest source of dissatisfaction with the clinic. One patient particularly graphically draws together and conveys the perceptions of the clinic of such patients:

'He gave me the benefit of quarter of an hour, not as thorough as my G.P. had been. As a medical exercise, I don't feel I've benefited. The specialist gave me the impression he wanted to go home. Perhaps he had a migraine! He was rushing. I'd assumed that this would be a detailed discussion wandering around the subject. If you don't know what its going to be like you can't prepare yourself to get everything in the first sentence. Like the politician asked a question on T.V., "first of all let me say this..." He knows he's got about a minute and a half to say what he likes before the interviewer interrupts and says: "What about my question?". Had I known it was going to be like this, I'd have adopted the same approach and

prepared a little statement with everything thrown in. A headache is not like a broken leg - it's got to be analysed, discussed, go round the subject. He didn't seem to be doing enough to explore why I had headaches.'

In these last few sentences the patient conveys the basis of many long term migraine sufferers' frustration. The patient comes to experience his or her headaches as complex, personal almost unique puzzles in terms of the pattern of their occurrence, factors that alleviate or exacerbate them and personal or environmental factors that make the person prone to them. It is assumed that in seeing a specialist, an 'expert', this personal history will be the focus of the consultation. The whole purpose of seeing a neurologist is for such patients to obtain, for the first time, some expert interpretation of their migraine biographies. Instead, for the most part the neurologist has a different agenda, in which such personal biographical richness can play no part. His expertise in differential diagnosis, in the detection of immediate mechanisms responsible for headaches and in advice on pharmacological treatment does not depend on the elicitation of the patient's biography and the neurologist has a modest role indeed to play in bringing about any profound change of approach to coping with migraine.

### Reassurance

A second process important in influencing satisfaction was that of reassurance. Many patients came to the clinic very concerned because their symptoms did not appear normal and had come to indicate something more

frightening. The majority of such patients were reassured by seeing the specialist and were positively satisfied as a result. The relief to such patients was dramatic: 'I felt very reassured by the visit to the neurologist and came away thinking: "Well, its just tension, thank God it's nothing else."

A 47 year old man who worked as a teacher illustrates this beneficial outcome of some referrals. He described a dull pain - 'its a consciousness, rather than a real pain' - which lasted an hour or so, twice a week. He had experienced the symptoms for some six months. His father had recently died of a cerebral haemorrhage and in relation to his symptoms he said at the clinic with obvious anxiety: 'I suppose the thing that crossed my mind was blood pressure.' Afterwards he described his reaction to the diagnosis of tension headaches he had received and his treatment by the specialist:

'He was very efficient and pin pointed it so quickly. I was suprised he gave me such a thorough examination. It was all done very factually and quickly and logically and step wise.'

Int. 'Were you reassured?'

Pat. 'Oh very much so. Oh yes! Once he was specific and said what it was, and I knew what it was, then that was it. I think that's why I've been feeling better.'

The most striking thing about this patient's responses is that aspects of the neurologist's very standardised and routinized approach to the investigation of headaches, which had clearly upset patients with very different concerns, were perceived positively by this patient. The fact that the neurologist moved 'quickly' to

the diagnosis, and proceeded through a fixed sequence to reach the point of diagnosis was perceived as authoritative and reassuring by this patient whereas so many patients with a concern for a more fundamental approach to be taken to their headaches, experienced this same control of the agenda as frustrating and disappointing. His comments reflect a remarkably different perception from those of the very critical patient who described the neurologist's history taking thus: 'The questions were all laid down and obviously stereotyped.. he just rattled through them!'

Another patient who experienced immediate relief from a neurological consultation described her response thus: 'All he said was: "There's nothing wrong with your head" and that was enough for me!'

Many patients experienced this same sense of relief from receiving such authoritative reassurance. All discussions of the neurologist's role in headache emphasise this particular function. One of the neurologists in our sample clearly defined this as a role he could play to make up for occasional limitations of the general practitioner:

'If they [the patients] are not told with authority or if there is any vacillation or if they don't believe what the doctor says because he doesn't have the personality which would convey authority, then they're much better coming to me.'

It is particularly interesting, in view of such remarks, that a significant minority of patients did not find the referral reassuring and this was expressed also in our assessments of their responses to the clinic visit. How such 'failures' of reassurance occurred is beyond the scope

of this thesis, and difficult to judge from the data available. Clearly in all cases patients' symptoms were entirely benign and patients should have been completely reassured. The difficulties of conveying reassurance are well illustrated by a 41 year old woman who worked as a telephonist. She had since childhood suffered headaches. However one particularly painful attack alarmed her: 'I really thought something was going to burst. I was really frightened.' She was disappointed with the approach of the specialist: 'I expected more of an examination. I thought he'd take my blood pressure or pulse.' However the most distressing aspect of the consultation appeared to be the specialist's explanation of her symptoms:

'He told me migraine is a blood vessel playing up, a rush of blood through to the brain - hence the pain. If that is the case, why have I got the headache all the time? ..... Since Dr. Brown told me what migraine really is, it made me do some thinking. He told me it was to do with blood vessels expanding. I thought, if that keeps expanding.. is it going to do any eventual.. It did make me think. Am I going to get any eventual.. could it leave any eventual... weakness?'

Thus in this instance the explanation proved more distressing than any previous concerns! Another patient appeared little short of terrified by the regular episodes of classical migraine she suffered in which was usually physically sick and experienced 'zig zags' and double vision. 'When my vision is affected it shakes me up. Perhaps my vision will come back, perhaps I'll go blind.' She was very critical of the specialist:

'He said nothing that I didn't know all ready. He said migraine was a problem and there really wasn't much that could be done about it. I felt worse when I came away than before when I'd seen him. The mere fact that there wasn't anything that could be done. He didn't have a lot of time. He didn't seem to want



to be bothered very much. I thought I would have some sort of tests but he didn't arrange anything. I think he knew before I walked in exactly what he was going to do and say. That was the impression I got, because he said everything off pat. He didn't ask a lot of questions. I thought perhaps he would ask me more.'

It is impossible to assess on the basis of such accounts how, under similar circumstances, some patients were reassured and others left still worried. However there are certainly aspects of the last patient's account that are consistent with the advice of clinicians such as Kessel, who argues that the process of giving reassurance is far from being clinical common sense:

'The doctor may wish to consider the patient's condition within medical terms of reference - that is pathological process. The patient's terms of reference embody what he is actually going through and he will not be reassured unless he believes that the doctor is sensitive to and understands that. (Kessel, 1979:1131)

The patient's account is consistent with Kessel's argument; she felt that the doctor had not bothered to understand her personal position and concerns. The doctor had not elicited the patient's view of symptoms, the explanation and attempt at reassurance was not apparently experienced as personally relevant. Sapira also argues that reassurance is unlikely to be effective from a doctor unless it is preceded by an effort to establish what he terms the 'affective meaning of symptoms' (Sapira, 1972:603). Furthermore, as Kessel argues:

'Patients consider themselves and their illnesses to be important. They need to know the doctor does too.' (Kessel, 1979:1131)

The evidence from patients such as the one just described is that 'failures of reassurance' may arise out

of not conveying a sense of understanding and respect for the patient's complaints; the result being dissatisfaction and further distress. Barsky (1981) Buchsbaum (1986) and Appleby (1987) discuss further clinical evidence of the ways in which failure to address the patient's primary concern thus may be a major source of dissatisfaction, continued anxiety and further help seeking.

#### Psychiatric distress

Finally some patients who, from the PSE were found to have significant psychiatric symptoms, were also disappointed with the clinic visit. The relationship between psychiatric distress and patient dissatisfaction also emerges as significant in the study of patients' responses to an sexually transmitted diseases clinic reported later in the second half of the thesis. The role of affective distress in patient satisfaction is remarkably neglected and the evidence of the two studies in this thesis can be used to explore the basis of associations. A case that illustrates the association of psychiatric symptoms and dissatisfaction is that of a 39 year old Irishman who worked as a passenger guard on British Rail. His headaches were presented as dull aches in the forehead that lasted all the time. He had suffered from the headaches for some ten years. He had a severely mentally handicapped son who lived in an institution quite a long distance away from home. Particularly distressing was that the son did not recognise him at visits. He acknowledged that this situation might have something to do with his

headaches but was not settled on this view at the time he visited the hospital. In addition to his headaches, the PSE revealed numerous psychological problems. He complained of a constant sense of exhaustion during the day, difficulties sleeping and poor concentration. He frequently felt life not worth living, and complained of irritability and depression. Recently on a visit to his son, he had broken out in tears for no particular reason. The consultant, who had elicited a history of the patient's psychiatric problems and the associated social background, had recommended anti-depressant medication, but said of the referral: 'What he really needs is supportive help from a G.P. or a psychiatrist.' Thus the referral was seen as quite inappropriate for a neurologist. The patient's reactions were quite critical:

'He never explained why I was getting depressed.... didn't give me enough time to explain. I don't know whether it was me getting anxious. I think he should have explained more.. if he thought it was the boy... he never said. He just said "depression".'

One way of interpreting the association of psychiatric distress and patient dissatisfaction is to see the latter as simply a further, symptomatic expression of the former. The unhappiness and pessimism of the primary disorder is thus extended to perceptions of the value of figures such as the doctor. To some extent such an interpretation may be correct. However, the case history also suggests specific grounds or a basis for the association -the patient looked to the doctor to explain his pattern of symptoms, beyond stating the diagnosis of depression. In this sense the patient's concern for explanation and the frustrations arising from the very

limited explanation provided by the neurologist, are no different in source from those of the quite different group of psychiatrically 'well' patients who looked to the doctor to make sense of baffling histories of migraine.

A second case is more complex in that the patient does not fully recognise her affective distress as being part of the presenting problem. She comes closer than the previous case to the syndrome of somatisation discussed earlier in which affective disturbance is perceived and presented to the doctor in somatic form. A 21 year old typist married to a welder presented to the neurologist with throbbing pains that last several hours, occurred approximately twice a month and were associated with visual disturbances in one eye ('everything goes misty'). In terms of psychiatric symptoms identified by the PSE, she experienced constant restlessness, nervous tension, inability to concentrate, brooding, sense of hopelessness, depressed mood and avoided situations where she would meet people. She had taken an overdose of Mogadon and Valium four months prior to attending the neurological clinic. She had seen a psychiatrist in an outpatient clinic because of the overdose. She recognised that tension and depression might play some role in her symptoms. She described her marriage as very difficult and stressful. The drugs overdose had happened only one month prior to the onset of her headaches. However when her G.P. had linked her headaches to this dramatic event she appeared only partly to accept the connection:

'I wondered whether it was anything to do with my overdose. When I went to my doctor, they sort of read



out what's been happening to you. They bring it up. It could have been that. The doctor says "Ah well, you were in hospital a few weeks before all this." When a doctor thinks of it, then you think "maybe".'

She had not really expected to see a specialist in relation to her symptoms. She described the occasion when her G.P. referred her:

'I said to him "The headaches are getting worse. The Panadol only help for a while. Surely there must be something you can do." I didn't mean him to send me to a specialist. I only really wanted some tablets. I was a bit suprised.'

Her view of the specialist had been rather similar, hoping that he would provide some form of treatment for her headaches. Her responses to seeing the neurologist were strongly critical, as he had not prescribed anything:

'I don't think he was thorough. It was as if, before I'd entered the room he'd made up his mind, "I'm going to say that this patient's got migraine." Maybe I'm wrong. He was very pleasant. He said "There's nothing to worry about." I think he asked me if migraine was in the family. I said "yes". He said "Well, that's what it is, just migraine". If my doctor said "you're going back to him again", I wouldn't be too keen on it. I did get the impression that he didn't feel it was serious enough that the doctor shouldn't have referred me. I was a bit, not disappointed, but I thought they'd give me something for it. I thought he'd ask more questions.'

To some extent she appears to illustrate the conception of somatisation by Katon and colleagues as 'selective perception and focus by the patient on the somatic manifestations of depression' (Katon et al., 1982:1270. They describe extensive research evidence of selective focus on pain and other organic symptoms in patients with clearly established depression. Their view of somatisation is that it is a product of cognitive mechanisms in the patient produced by socialisation, which



result in a somatic interpretation of distress and dysphoria. Katon and colleagues predict that the effect of the doctor is usually to reinforce the patient's somatic model. If the patient presents with somatic symptoms and the doctor responds with a physical treatment and does not address the patient's underlying social and psychological problems, then the effect in the short term is to satisfy the patient by reinforcing inappropriate cognitive patterns. Although acknowledging that she had considerable psychosocial problems, she had a very somatic view of her problem and of the help she needed. The neurologist in this case certainly responded with a physical interpretation of symptoms, by recognizing and addressing only the migrainous aspects of her problems. To that extent one might have expected her to be satisfied with the doctor's approach. However the physical emphasis of the neurologist appears not to have been conveyed very convincingly. He had not investigated her problems thoroughly, in her view, and had not prescribed medication. It is quite speculative whether a proper discussion of her background psychosocial problems would have satisfied the patient, as writers such as Balint (1957) and Barsky (1981) have suggested. Her account only emphasises the doctor's failure to take her physical problems seriously.

One thing is notably absent from both accounts. Ben Sira's model, that is examined in detail in the second half of this thesis, emphasises the reliance of patients upon cues from the doctor's affective behaviour. It has already been seen, in examining the different comments of

dissatisfied patients earlier in this chapter, how very much more complex are patients' criteria for judging the neurologist. It might be expected that patients with affective distress might be even more ready to rely upon cues from the doctor's manner to judge the value of their consultations. The first case, the railway guard made no comments about the manner of the doctor. His disappointment was firmly based upon the lack of explanation he received. In the second case, the patient actually commented upon the pleasantness of the doctor.

The two cases illustrate the complexities of explaining the dissatisfaction of the psychologically distressed group. There appeared to be a continuum of patients in this group from those who acknowledged complex psychosocial factors in their presenting histories but felt the doctor had insufficiently addressed their problems, through to those who rather resemble the second case in which possibly somatising tendencies in the patient made any response by the clinician doomed to failure. It is clearly insufficient to explain away dissatisfaction as a symptom of an underlying affective disorder. An equally important consideration is that the referrals were quite simply inappropriate. The neurologists certainly acknowledged as much in both cases. The neurologists in the sample almost without exception regarded their main skills in relation to headache to be in terms of differential diagnosis, and the broader psychosocial investigation and management of patients' problems was seen as the general practitioner's responsibility. They

acknowledged their own lack of expertise in this field, and underlined how better placed the general practitioner was to address patients' underlying problems. It would be fruitless to argue that such perceptions of their role were really rationalisations of fundamental disinterest in psychosocial presentations. The vast majority of neurologists felt they had little to contribute to patients with psychosocial problems, and given such prevailing attitudes, it is hard to see how patients could have profited from neurological referral at the time of the study. The dissatisfaction expressed by this group may partly have reflected underlying affective distress but it is hard not to see their reactions as ultimately grounded in an accurate appraisal of the hospital visit as contributing little, if anything to their problems.

#### Concluding remarks

At this point it is possible to draw together the discussion by considering the different concerns that patients appeared to have when interviewed before the hospital visit and their perceptions of the success or otherwise of the hospital visit afterwards. As can be seen from Table 11, the vast majority of patients attending the clinic with a view to obtaining alternative symptomatic treatment were not disappointed, either with regard to treatment or indeed communication. Equally the majority of patients who wanted reassurance from the clinic found the visit very satisfactory. However a minority of this group of patients remained unreassured by the clinic visit. How

such failures to reassure came about is not possible to determine from the data in this study although some patients' accounts suggest that either the specialist's explanations were not found reassuring, or patients did not feel that the specialist was well enough acquainted with the specific details of their headaches that his reassurance could be taken seriously. A third and much smaller group primarily wanted not reassurance but rather an explanation for their headaches. None of this small group wanted symptomatic treatment and their views of the clinic reflect this in that none expressed subsequent dissatisfaction with regard to the treatment they received. Finally the most frequently disappointed group were those patients, especially with chronic histories of migraine, who looked to the clinic to intervene in a more fundamental sense in the factors that made them prone to headaches, and who did not want further symptomatic treatment. Half of this group were disappointed with regard either to treatment or to communication.

A cautionary note needs to be sounded. The data in this study are almost all derived from the patient's perspective, and no evidence has been presented that examines the outcomes of specialist referral from either the specialist's or the referring general practitioner's point of view. It is clear that the goals and expectations of the different parties to a hospital referral may differ significantly (Kaeser and Cooper, 1971; Dowie, 1980; Grace and Armstrong, 1986) and the outcomes of the sample of referrals might be differently assessed by the three

parties concerned. Nevertheless it is possible to begin to draw up a 'balance sheet' of the more and less successful aspects of specialist referral for headache from the data presented in Table 11 and also to make some tentative observations about ways in which patient dissatisfaction might be practically addressed.

Patients who really wish to receive a different medication or symptomatic treatment from that of their family doctor are likely to be satisfied. For them specialist referral is a success. For such patients the opportunity to receive symptomatic treatment from a specialist is perceived as worthwhile, and since in most instances that is the intervention provided by the neurologist, they are satisfied. On the other hand patients who hope for a fundamentally new direction to be adopted to their headaches are more likely to be disappointed. With a few exceptions neurologists are not enthusiastic about attempting to intervene fundamentally in their patients' lifestyles, diet, psychosocial coping, or social environment in ways that might alter their proneness to headaches. In a minority of cases some patients are identified by neurological referral as having a dietary aetiology for symptoms although frequently such patients appear spontaneously to observe and draw attention to such factors themselves without guidance from the neurologist. Given prevailing neurological practice, such disappointments appear structural to the neurological referral and are in the future are likely to contribute to the decision of some patients to seek less orthodox



practitioners offering alternative sources of help. There is a gap between the apparent enthusiasm of neurological clinics increasingly to become involved in the management of chronic headache by setting up special migraine clinics and the widespread scepticism or indeed pessimism amongst neurologists as to value of personalised life style advice as a basis for routine management of the disorder. Another group of patients experienced disappointments that in principle were more often avoidable. Those whose fears and concerns were not reassured might conceivably have been more successfully managed. The possibility cannot be excluded from this data that some patients were quite resistant to reassurance and their referrals may have been initiated by the family doctor for that reason. However in some cases, the failures to reassure appeared to derive more from problems of communication between the specialist and the patient either in terms of eliciting a full history that convinced the patient he or she was properly understood or in conveying a reassuring explanation of the patient's symptoms.

It must be remembered that more ambitious advocates of patient satisfaction research have argued that patients' views are an indispensable component of the evaluation of health care. The scope of patient satisfaction is, according to this view, enormous. The contribution of health care to many problems cannot be accurately assessed with the framework of conventional indices of morbidity and mortality. Although this study of neurological management of headache has been in many ways an exploratory one, it

does provide evidence of the value of the patient's perspective as a contribution to the process of evaluation. In the most general sense the study indicates that patients are capable of observing and commenting perceptively upon a wide range of aspects of their treatment. This would suggest a greater scope for patient satisfaction than is suggested by the theories reviewed in chapter 1. According to one theory patients are governed by static role expectations and judgements of the value of medical care are made in terms of the extent to which doctors conform to role expectations. Role expectations did not appear to be a salient aspect of patients' perspectives as they anticipated the clinic visit and proved too tentative and emergent to be the basis of the often strongly felt positive and negative responses after attendance at the clinic. An alternative model, that is reviewed in more detail in the next four chapters in essence holds that patients are reliant upon a narrow range of the doctor's affective behaviours as cues to judge the value of their care. The qualitative evidence assembled in this study indicates that patients' judgements are based upon a much wider range of cues in assessing the value of clinic attendance. Specific instances occurred in which the doctor was perceived as pleasant and interested but not helpful or conversely as helpful despite the routine or impersonal nature of his style. Thus there is little support from this study for those theories of the process whereby patients judge their health care, which would most delimit or restrict the value and scope of such research.

More specifically it has been possible to identify a number of different functions that are fulfilled by neurological clinics in the management of headache. These functions have emerged by identifying the different concerns which characterise patients presenting headache to neurological clinics. Similarly by relating such concerns to subsequent judgements of the value of attending the clinic, it has been possible to draw up a kind of balance sheet of the 'successes' and 'failures' of neurological management of headache. Obviously the results of such a study are provisional, and would need confirmation from further evidence. Nevertheless, if one considers again the different possible interests concerned with the uses of patient satisfaction research, there are potentially very valuable lessons to be gained from the investigation of patients' views in this particular area of health care. For health authorities investment in the provision of specialist hospital services is a major source of expenditure. The extension of neurological facilities into the more active management of a chronic disorder such as migraine is one example of the many developments that health authorities constantly face. Normally such innovations occur incrementally and without much opportunity to examine the claims of health care providers (Hunter, 1979; Ham, 1981). Yet the evidence of this study indicates that patients' views alongside other data may be of crucial importance. The role of the neurologist as advisor and educator about dietary and other life style factors is at present modest, and arguably the simple information currently available about the causes or

triggers of chronic headache could be communicated by other means, such as health education leaflets. The role of the neurologist as prescriber of medications is more successful, although, arguably it does not require the specialist to adjust simple treatment regimens commonly prescribed in general practice. The value of the role of the consultant, confirming or providing advice about the diagnosis for the G.P., is a traditional role, on which, since G.P.s views could not be elicited, this study cannot comment. However the role of the specialist as provider of firm and authoritative reassurance to the anxious patient is clearly only partly a success. At this point one should recall that patient satisfaction research also provides feedback in terms of 'the art of care'. Communication skills continue to be an important but neglected aspect of medical care. It is in principle possible to learn the interpersonal skills required to identify, address and reassure the anxieties of patients in relation to benign but distressing symptoms. Patients' views provide an immediate form of feedback where such skills may be deficient. The role of the neurologist in providing reassurance in this field is a valuable one, but is not always effectively carried out. Although imperfectly understood, the clinical task of providing reassurance for benign problems is a function that could be considerably improved.

The study of neurological clinics was not intended to provide a comprehensive medical audit of the role of neurologists in the management of headache. Nor should

over ambitious claims be made for the insights gained from focusing upon patients' views. However the main conclusion of this study must be that patients are capable of providing important evidence as to the benefits of the treatment they receive. One advantage of the exploratory and unstructured nature of the interviews in this study was that the style of interviewing appeared to facilitate patients to express views on their treatment in detail and in terms of the criteria that were most important to them. It was apparent that judgements of dissatisfaction were not easily expressed. Nor ultimately were attitudes in regard to services as informative as views as to the perceived benefits or possible benefits of treatment. Patients themselves regarded the expression of attitudes as secondary to forming judgements of the value of clinic attendance.

It is not clear how widely one can generalise from this field of health care to other medical problems. The role of health care in many disorders which are chronic, disabling, and distressing and where curative interventions have not been developed will increasingly need to be evaluated as finite resources have to be more rationally allocated. The argument of this section of the thesis is that the patient can be shown to have a central role in that process of evaluation. At present the consumer is neglected in the process. Long observes about the evaluation of services:

At present the most unaddressed area is that of the consumer's viewpoint, in terms of defining health needs, measures of health outcome, the effectiveness of services, costs of service and satisfaction with



them' (Long, 1985:54).

In the second half of the thesis the view will be more directly confronted which holds that patients respond to very limited aspects of their health care. According to this view, only the interpersonal aspects of health care are accessible to patients. Patient satisfaction research should therefore be narrowly circumscribed. The basis for such claims requires critical appraisal.

services research, in which context the mechanism has been upon description or practical problem-solving and the meaning of satisfaction has been left unexamined. Where attention has been given to the origins of patient satisfaction, the work has had many of the characteristics identified by Marsh as 'rudimentary sociology' (1985:192). In such research, a dependent variable, in this case 'patient satisfaction', is examined by means of a number of social and demographic variables such as age, sex and social class. In 'rudimentary sociology' the variable is treated as dependent on the correlations obtained with such variables; alternatively an explanation for correlations between routine independent variables and the dependent variable is invoked from material outside the data. Unmeasured common cause variables are brought in to interpret results. Very little attention has been given to the subjective evaluation of the way patients respond to and reach judgements about the health care treatment. Little is known of the process that leads to expressions of satisfaction or dissatisfaction with the services they receive.

Very little of the satisfaction research has been theory-testing or theory-building. The research has been

CHAPTER 5. A SOCIAL INTERACTIONIST THEORY OF PATIENT  
SATISFACTION

The concept of patient satisfaction has been used most frequently in very applied health services research, in which context the emphasis has been upon description or practical problem-solving and the meaning of satisfaction has been left unexamined. Where attention has been given to the origins of patient satisfaction, the work has had many of the characteristics identified by Marsh as 'facesheet sociology' (1982:102). In such research, a dependent variable, in this case 'patient satisfaction', is examined by means of a number of social and demographic variables such as age, sex and social class. In 'facesheet sociology' the variable is treated as explained by the correlations obtained with such variables; alternatively an explanation for correlations between routine independent variables and the dependent variable is invoked from material outside the data. Unmeasured common sense meanings are brought in to interpret results. Very little attention has been given to the subjective evaluations whereby patients respond to and reach judgements about their health care treatment. Little is known of the process that leads to expressions of satisfaction or dissatisfaction with the services they receive. As Linder-Pelz argues:

'Very little of the satisfaction research has been theory testing or theory building; that is, research

designed to provide data that would explain the associations between satisfaction and patient and service characteristics' (Linder - Pelz, 1982 a :577).

As a result, a number of untested assumptions abound as to how patients judge their health care. As was argued in the first chapter, it is often assumed that patients have little or no ability to form sensible judgements of the health care that they receive. When it is conceded that patients have worthwhile observations to make about their health care, they are assumed to be competent to judge only particular issues such as the friendliness of the doctor or the accessibility of the service. Both kinds of assumptions circumscribe the scope for patient satisfaction research. The study of patients attending a neurological clinic for headache, reported in chapters 2 to 4, provided some evidence that patients perceive and respond to a wider range of aspects of their medical treatment and that such responses and judgements can be used to contribute to the evaluation of health services. Little evidence could be found to support the view that the value of patients' judgements is circumscribed. However the view that patients are only capable of sensible and useful comments in relation to a narrow range of 'affective' aspects of their health care remains a powerful and cogent one and requires closer examination.

The work of Ben Sira stands as a notable exception to the 'facesheet' style of patient satisfaction research. He has used survey techniques to develop, from a series of field investigations, a more elaborated understanding of

patient satisfaction. The result of his theoretical and empirical work is an unusually explicit and complex theory of patient satisfaction. His theory is important in particular because it addresses the central but neglected process whereby patients arrive at assessments of their health care. The work of Ben Sira warrants attention primarily because it locates the concept of patient satisfaction within a theory of social interaction, rather than leaving the topic isolated in the realms of 'facesheet sociology'. His work is almost alone in being exempt from the criticism so commonly levelled against patient satisfaction research 'as having little in the way of theory guiding the variables chosen for study or the hypotheses being tested' (Like and Zyzanski, 1987:351).

The theory is of importance for a second reason. Ben Sira provides a relatively clear and specific statement of what matters to patients when they seek health care. He focuses upon the importance of the emotional needs that accompany the patient's experience of illness. These needs leave the patient reliant on cues from the doctor's affective behaviour, such as showing interest and devotion to the patient, when the patient judges the quality of health care received. The main thrust of his research is consistent with the view of patients as 'more concerned or dissatisfied with the manner and means of the processes of health care delivery..than with the outcome of care or competencies of health care personnel' (Kelman, 1976:435). The case is frequently made that patients above all value qualities such as humaneness, kindness and sympathy from

their doctor (Mourin and Mourin,1986). Speedling and Rose (1985:116) view patient satisfaction research as pointing to a clear conclusion: 'The physician's expertise in curing the illness is rarely seen to count more than his or her facility to care for the patient's psychosocial needs.' Ben Sira's work in particular is a major source of support for the view that patients' judgements of their health care are primarily determined by aspects of their treatment such as how friendly and interested in the patient the doctor is. The importance of his contribution is recognised in recent discussions of the doctor patient relationship (Segal and Burnett,1980; Hall et al.,1981; Pendleton,1983; Carmel,1985; Speedling and Rose,1985; Like and Zyzanski,1987). It has enormous relevance to clinicians because of its emphasis upon the art of care. His work is a major instance of patient satisfaction research that has substantiated the arguments of those critics both within medicine (e.g. Eisenberg, 1977) and from without (Mechanic,1968) who have converged in arguing that clinical medical practice must adopt a more holistic and more personal approach to its relations with patients.

Ben Sira's research therefore provides strong support for the view that the 'art of care' should be given a higher priority by providers of health care. However there is a further implication of his model of patient satisfaction. Patients' evaluations of the outcomes and medical benefits of their health care are, according to Ben Sira's model entirely determined by evaluations of the 'art of care' - how pleasant and interested in the patient the



doctor appears to be. If this view of the patient's judgements is accurate, it seriously delimits the possible value of patient satisfaction research. Whilst valuable as feedback on interpersonal aspects of health care, the patient's views are highly unreliable sources with regards to the content of medical treatment received. The patient would have only a limited role as a source of information in any effort to evaluate the benefits or outcomes of health care. For this reason, Ben Sira's work is of central importance in any discussion of the scope of patient satisfaction research as it is the clearest evidence for a quite circumscribed role for the patient as a source of information.

It is surprising, therefore, that so little attention has been given to the application of the theory to clinical medical settings. The empirical data that Ben Sira used to develop and elaborate his theory were based on general purpose population surveys. Since the theory is centrally concerned with patients' experiences and evaluations of medical care, it would seem essential to examine Ben Sira's approach in samples more immediately concerned with such experiences. This section of the thesis (chapters 5, 6, 7 and 8) examines the applicability of Ben Sira's model to one particular health care setting - a clinic for sexually transmitted diseases (STD). In this chapter Ben Sira's theory or model is outlined in more detail. It is then argued that there are important problems in the evidence produced in Ben Sira's research. These problems indicate the potential value of a survey of

patients actually seeking medical treatment. In chapter 6, the STD clinic and the sample of patients from the clinic are described and the methods and measures employed to explore Ben Sira's model are outlined.

In chapter 7, the satisfaction results obtained in the clinic are examined. The particular approach to the analysis of satisfaction variables adopted by Ben Sira is then used to examine patients' views of the STD clinic. There are similarities in the results of his surveys and those obtained in the STD clinic. However it is argued that the kinds of analysis of survey data reported here and by Ben Sira are limited. The data needs to be examined in more appropriate ways to test the kinds of causal hypotheses developed by Ben Sira. When further analyses of the satisfaction variables from the STD clinic are carried out, they provide results that are less supportive of Ben Sira's thesis. In particular there is no support for the causal primacy of patients' views of the doctor's affective behaviour in influencing their overall satisfaction. The implication of such further analyses is that similar problems would probably apply to the data provided by Ben Sira.

The STD clinic study is longitudinal with variables measured before and after the patient's clinic attendance. Chapter 8 examines the possible influence of variables measured before the clinic consultation upon satisfaction measured afterwards. Two approaches to analysis are used. Firstly use is made of patients' reports of various worries

and concerns in relation to their presenting problem prior to their consultations. The influence of such concerns upon subsequent satisfaction is examined in relation to different sub-groups in the clinic. Secondly multivariate analysis is used to identify the most important patient variables that predict subsequent satisfaction. This approach suggests a different way of explaining patient satisfaction from the one developed by Ben Sira. Whilst affective factors play a role in patient satisfaction, little support from the STD clinic data can be found for the specific model developed by Ben Sira. However, the interpretation of associations between concerns and other patient characteristics and subsequent satisfaction requires more careful attention to the meaning of presented problems to different sub-groups in the sample than was possible in the survey carried out. This underlines again the advantage, identified in the study of attenders of a neurological outpatient clinic, of being able to examine more closely the varying concerns and perceptions of their problems which patients bring to a clinic.

#### Ben Sira's model.

Ben Sira begins with a general theoretical problem. How can an actor judge the value of his or her interaction with another individual in circumstances where the interaction does not provide an immediate solution to his or her goals and where the actor is unable to understand the content of the other individual's response? This situation is characteristic of all professional-client

relations, in that the outcomes of interaction for the client are not immediate (for example, health is normally not immediately restored), and the professional's services are complex, esoteric and difficult for the client to judge. Ben Sira draws upon Johnson's analysis (1972) of professional-client relationships in which the kinds of personal problems presented by the client are seen as typically associated with uncertainty and anxiety. Ben Sira goes on to emphasize the evidence that, in these circumstances, clients do not suspend critical faculties and passively accept the professional's judgements as, for example, a Parsonian analysis would suggest. Clients search for evidence by means of which to judge the value of the service they receive. The social interaction between client and professional provides the most important source of such evidence. Ben Sira proceeds to argue that patients cannot judge the technical medical actions of the doctor in a consultation because of their lack of appropriate knowledge. However illness is usually accompanied by worry, anxiety and distress in relation to the presented problem. Part of the patient's goal in seeking professional help is to have this distress relieved. The patient is able therefore to judge the doctor's actions in relieving this anxiety, as a way of judging the overall value of the consultation:

' The manifest goal of the patient of having his illness problem solved is most often accompanied by a latent goal of having his anxiety problem solved. Since he is not competent to judge the extent to which the physician's technical activities contribute to the achievement of his manifest goal ('content of interaction'), the criteria he uses for evaluating the interaction are those that relate to the degree of emotional support (mode) that accompanies the course of treatment.' (Ben Sira, 1976:5)

According to this view, the patient confines his criteria of judgement to evaluating the mode and manner of behaviour of the doctor. The patient evaluates the doctor's 'affective behaviour', which is behaviour that accompanies his professional, medical behaviour ('instrumental behaviour'), and is aimed at reducing the patient's anxiety. Ben Sira cites as 'affective behaviour' the following: showing interest in the patient, allocating sufficient time for discussion of the patient's problems and demonstrating sufficient devotion to the management of the patient's problems. Ben Sira has developed a series of specific hypotheses about patient satisfaction which he sees as following from this basic principle and which can be empirically tested. The central hypothesis that he examines is that: 'A layman's satisfaction with the medical service and treatment offered by a general practitioner will be strongly correlated with the G.P.'s affective behavior toward the patient' (Ben Sira:1976:5). A survey of adult Israelis (Ben Sira,1976) provided empirical support for the hypothesis. Respondents were asked in a closed questionnaire about their satisfaction with their doctor's medical skills and treatment. In addition they were asked questions about their doctor's 'affective behaviour', 'defined as behaviour directed by the physician toward the patient as a person rather than as a 'case' '(Ben Sira, 1976:7). The specific aspects of affective behaviour were those cited above: whether the doctor allocated sufficient time to allow the patient to present his problem; whether he showed interest in the



patient's problems and thirdly whether he showed devotion to the management of the problem.

In subsequent studies Ben Sira further specifies his theory of satisfaction and tests further hypotheses. In particular he builds upon the argument that anxiety and distress in relation to the presented health problem is a crucial influence upon satisfaction. The greater the individual's anxiety or concern about health, the greater is the need for emotional support when consulting the doctor. This leads to the prediction that the greater a person's concern about health, the greater will be that person's tendency to judge the content of the physician's behaviour by the mode of its presentation, that is by the affective behaviour aimed at the reduction of anxiety. Ben Sira's hypothesis is that:

'The strength of the correlation between patients' satisfaction with the medical treatment offered by a GP and their satisfaction with the physician's affective behavior will vary directly with the level of patients' concern with health.' (Ben Sira, 1980:171)

The main theory is based on the assumption that it is lack of medical knowledge that leads patients to rely on judgements of affective behaviour. Lack of knowledge both reduces the amount the patient can judge instrumental technical actions of the doctor, and also, according to Ben Sira's theoretical discussion, may increase the emotional support needed by the patient. This would suggest that the greater the patient's ignorance of medical knowledge the greater will be the extent to which his or her satisfaction with care will depend upon their perceptions of the

doctor's affective behaviour. The second hypothesis therefore is that:

'The strength of the correlation between patient's satisfaction with the medical treatment offered by a G.P. and their satisfaction with the mode of the physician's behavior toward them will decrease as their level of education increases.' (Ben Sira,1980:172)

As the quotation indicates, the second hypothesis contains within it an assumption about how levels of medical knowledge might be assessed; that is that education may be used as a measure of the individual's ability to understand medicine and make judgements about technical medical matters. He cites in support of this assumption, evidence from his own and other investigators' research (e.g. Koos,1954; Rosenstock,1975) that levels of medical knowledge are positively related to education.

Ben-Sira examined these two hypotheses about the influences upon satisfaction of health concern and of medical knowledge by means of a second survey of Israeli adult respondents (Ben Sira,1980). The results strongly support his theory in that, as the level of patient's concern about health increases, the association between satisfaction with a GP's instrumental (technical, medical) and satisfaction with affective behaviour increases. The evidence from the survey supports his second hypothesis, in that, as educational level decreases, the stronger is the association between satisfaction with affective behaviour and satisfaction with instrumental behaviour.

A third survey (Ben Sira, 1982a) examines the role

of the stress potential of patients' presenting problems. He hypothesizes that, as the stress potential of the problem increases, so the satisfaction of a patient with his or her treatment will be more strongly determined by the affective behaviour of the doctor. The survey examined the stress potential of problems for which professional help was sought. Stress potential was measured by questions examining the perceived seriousness of the problem, the degree of worry and thought given to the problem and the respondent's sense of ability to solve the problem. The pattern of correlations obtained in the survey supported the hypothesis in that, the greater were individuals' scores for the stress potential of problems taken to a professional, the higher were the correlations between satisfaction with instrumental and affective aspects of professional behaviour. The role of the stress potential of the presented problem in Ben Sira's model of patient satisfaction is very similar to that of concern about health, in that both factors are thought to increase the reliance of the patient upon affective behaviour and emotional support at the time of consulting. A fourth survey (Ben Sira, 1982b) examines the hypothesis that the close association between affective and instrumental satisfaction in respondents' views will decrease as the distance from the emotion-arousing illness episode and consultation increases (Ben Sira, 1982b).

The core of his approach may be found in the model which relates anxiety or health concern, affective and instrumental satisfaction and it is the hypotheses and

theoretical discussion concerning these factors, examined in his first two surveys (Ben Sira, 1976, 1980) that are examined here. He relates patients' anxiety and concern at the time of seeking medical help to satisfaction with affective and instrumental aspects of the doctor's behaviour as judged by the patient after the consultation. As argued earlier, the components of Ben Sira's model are more appropriately examined by means of patients at the time of seeking medical help. This section of the thesis reports the results of a survey of patients attending a clinic, which provides data more suitable for examining Ben Sira's model. The issue of appropriate sampling is one of a number of possibly serious problems in Ben Sira's concepts, methods and empirical evidence in relation to his theory that need to be examined therefore, prior to a presentation of the results of the STD clinic study.

### Problems of evidence and method in Ben Sira

#### (a) The problem of appropriate sampling

Ben Sira's theory is, above all, concerned with the criteria a patient uses in the course of interaction with a doctor in order to make judgements regarding the benefits he or she has received from a specific consultation or series of consultations. Ben Sira firmly links his theory to 'the perceptual dimension of the interaction' (Ben Sira, 1980:171), and his data are intended to relate to such perceptions. The specific emotions aroused by a particular health problem crucially influence the patient's

evaluations. The evidence he presents however is of correlations between different attitudes expressed by a general cross-section of respondents at a single point in time and at an unspecified time in relation to their last medical consultation. The samples used were gathered from general populations as omnibus surveys, with presumably widely varying levels of health status and patterns of recent use of health services and included many with minimal or no recent use. This is an important point in the evaluation of Ben Sira's work. The significance of his approach is that it tackles the central issue in patient satisfaction research which is the processes and factors involved in patients' evaluations of specific uses of health services, rather than being concerned with the formation of more general, favourable or unfavourable attitudes towards the medical profession or health services. Ben Sira is concerned with patients' evaluations of specific consultations. The more removed the questionnaire is from being concerned with specific episodes of use of health care, the greater the likelihood that answers to questions may reflect as much their 'socially stereotyped conceptions of providers and services' (Locker and Dunt, 1978). In other words the questionnaire may increasingly elicit more general attitudinal material - the more general positive or negative values respondents attach to doctors generally or to their health service as a social institution. The problem with such attitudinal evidence is, as argued in chapter 1, that medicine is an occupation that is highly socially valued and health care systems such as the NHS



are held in high esteem. The contamination of patients' judgements of the benefits of consultations by such attitudinal or normative values is an enormous methodological problem, not easily solved. Linder Pelz (1982b:588) argues that patient satisfaction as an attitude can be analytically and conceptually distinguished from its more perceptual component but that in practice the two elements are conflated. It is repeatedly emphasized by Ben Sira that it is the patient's 'immediate' satisfaction with the doctor's treatment (1976, 5; 10) that is being discussed in the model, and that he means satisfaction in the sense of the perceived 'efficacy' and 'contribution to recovery' (Ben Sira, 1980:170; 178) of the doctor. Thus it is above all a model to account for specific perceptual judgements. Samples of patients who have experienced a recent illness episode and decided to seek help should therefore be more appropriate to the investigation of specific aspects of satisfaction central to his theory.

#### (b) The time order of variables

The use of cross-sectional survey material to examine the specific processes that he identified as operating during social interactions between doctor and patient is a fundamental problem in Ben Sira's research. He himself acknowledges the problem in terms of whether correlation implies causality. (Ben Sira, 1976:10; 1982b:1018). However in some crucial parts of his evidence the problem is another one - that of the time relationships

of his measured variables relative to the time order of variables in his model. Confusions occur in particular with regard to the important role that concern about health plays in his model. The question respondents were asked about health concern was in terms of concern at the time of completing the questionnaire ('To what extent are you worried about your current state of health?'). As Ben Sira acknowledges (1980:179) this question refers to the present whereas the questions about satisfaction refer to the past. On the other hand the model relates concern about health at the time of consulting to satisfaction with that consultation. Ben Sira justifies this by arguing that levels of concern about one's health are constant characteristics of individuals and that concern about health expressed at interview would therefore correlate with feelings at the time of consultation. He suggests that a possible mechanism for such stability of health concern might be the individual's social standing. However, this assumption -that health concern is a constant characteristic of individuals- contradicts the theoretical thrust of his model. The starting point for his analysis is 'disease as a state of physiological disturbance that is accompanied by a certain degree of anxiety as a consequence of the patient's evaluation of the meaning, seriousness and possible outcome of the disturbance. Patients' concern about their health may to a great extent be a product of their subjective evaluation of the disturbance' (1980:171).

The preceding quotation from his theoretical model

is consistent with all of the evidence from medical sociology that patients form quite complex evaluations of their symptoms before consulting (Stimson and Webb, 1975) and may sharply distinguish between more general dimensions of their health (such as their general fitness or 'stock' of health) and specific illness problems (Williams, 1983). However this theoretical recognition of the specificity of patients' perceptions is negated by an approach to measurement in which views about health are treated as static and unidimensional. Furthermore the approach to measurement adopted by Ben Sira does not allow for the possibility that current health concern may in various ways be a product of past levels of satisfaction. Evidence has been produced in this thesis that satisfaction with consultations may be a direct influence upon patients' subsequent reassurance about their health problems (Fitzpatrick and Hopkins, 1981). Such problems suggest that a more appropriate way of examining his model would be one in which health concerns at the time of consulting could be more directly assessed for possible subsequent influences upon satisfaction. Indeed a longitudinal research design would appear a more promising way of identifying the influence of anxiety and distress at the time of consulting to subsequent satisfaction.

### (c) The time reference of variables

Similar confusions occur with regard to Ben

Sira's treatment of the time reference of central variables in his model. The questions about instrumental behaviour in the 1980 survey refer to a specific consultation ('Did the G.P. give you a feeling that he knows how to cope with problems such as yours?'). However the questions about affective behaviour appear to invite a general judgement about the doctor's behaviour from the patient ('Does the GP allocate sufficient time?'). The discrepancy between the consultation - specific reference of the instrumental questions and the general reference of the affective items may be important, since causal priority is attributed to the second dimension - affective aspects. However the approach to measurement in his survey is such that, if the associations between affective and instrumental items should be positive and significant, the possibility cannot be excluded that it is general attitudes (in this case general affective attitudes) that influence patients' perceptions of the benefits of specific consultations. Again this suggests a quite different model of patient satisfaction, much closer to the view that the general social standing of medicine, as reflected in socially stereotyped attitudinal responses are the prime influences upon lay evaluations of their health care. A more appropriate way of examining the specific content of Ben Sira's thesis would appear to involve a consistent approach to time-reference in which respondents are asked about their perceptions of the affective and instrumental aspects of a single illness episode. Ben Sira did not use measures that most exactly corresponded to the elements of his model. Because of these considerations, Ben Sira's own

questionnaire items could not be regarded as appropriate for testing the relevance of his model to a setting such as the STD clinic that is studied in the following chapters. It was important to use a patient satisfaction questionnaire that consistently referred to patients' perceptions with regard to a single episode - a requirement that is met by the patient satisfaction questionnaire developed by Linn and Greenfield (1982).

(d) The problem of contrasting concepts

Ben Sira's theory is unusual in the extent to which it is founded upon a series of contrasting pairs of concepts. His theory progressively builds up from the basis of contrasts between 'mode' and 'content'; 'affective' and 'instrumental'; 'latent' and 'manifest'; 'anxiety' and 'physical disturbance'. At times the sets of contrasting pairs of concepts appear to be running in parallel tracks. Thus it is as if the patient's 'physical disturbance' is the 'manifest goal' which is addressed by the 'content' of the doctor's behaviour and ultimately reflected in the patient's attitudes to the 'instrumental' aspects of the consultation. In parallel, there is a process in which the patient's 'anxiety' is the 'latent' goal which is addressed by the 'mode' of the doctor's behaviour and ultimately reflected in the patient's attitude to the 'affective' aspects of the consultation.

No objections can be made about the concepts themselves which in varying guises, have been common



currency in the literature on the doctor patient relationship. Moreover the development of a conceptual framework is an essential prior step to the testing of hypotheses. The problem in the concepts used by Ben Sira which may at this stage be identified is that they over-compartmentalise and separate out processes that in reality may be intimately connected - the 'affective' and the 'instrumental' aspects of illness and medical help seeking. To take one example, may not the patient receive support from both technical aspects as well as affective aspects of the doctor's actions? The patient may not fully appreciate the technical complexities of any particular medical procedure but such procedures may still play a role in inducing emotional satisfaction as well as contribute to the treatment of the patient's problem. His operational demarcation of 'affective' and 'instrumental' aspects of the consultation is not without problems. For example Ben Sira identifies 'reassurance' as an instrumental item of medical behaviour, and 'allocating sufficient time' as an item of affective behaviour. A case could easily be made for reversing the classification of those particular items.

#### (e) Problems in the meaning of patient satisfaction

Ben Sira variously discusses his central dependent variable 'patient satisfaction' in terms of satisfaction with the content of the consultation, with the medical treatment, with the efficacy of treatment or with the instrumental aspects of his or her relationships with the

doctor. Whilst some of these concepts stand out clearly by contrast with their opposites (satisfaction with the content of the consultation is opposed to satisfaction with the manner of the consultation; instrumental and affective satisfaction are contrasted), the different versions of the dependent variable nevertheless refer to different aspects of the doctor patient relationship. This raises the important issue of what Ben Sira understands by the concept of satisfaction. In particular, as he uses it in the two surveys examined here (1976,1980), it could be taken to refer either to patients' views as to the quality of medical treatment in the consultation or to patients' views as to the possible effects or benefits of such treatment upon the problem that led to the patient consulting. To adopt Donabedian's distinction (1966), the first would be a measure of views about the 'processes' of treatment, that is about the activities carried out in the course of treatment, the second would be a measure of views about the 'outcomes' of treatment, that is, the impact of treatment upon symptoms. These concepts are analytically distinct and the investigator needs to clarify whether he sees his dependent variable as closer to the first or second kinds of views. In the neurological clinic study it was clear that patients' views as to the processes of their care were quite independent of views of the value or appropriateness of care. Much of the theoretical discussion in Ben Sira's work suggests that he is concerned with patient satisfaction as a judgement of outcomes, of the appropriateness or value of the doctor's treatment to recovery. The following conclusion to his second survey in

addition to illustrating his use of contrasting pairs of concepts, appears to support this interpretation:

'The significance of this study lies in its supporting empirically the suggestions of an earlier study (Ben Sira, 1976) that patients' assessments of the efficacy of the GP's treatment activities (content) on the basis of the mode of their presentation will be related to the patients' (a) level of concern about their health and (b) ignorance of medical techniques. (and hence incapability of judging the contribution of the GP's activities to their recovery' (Ben Sira, 1980: 178).

In this quotation he has therefore emphasised the concept of satisfaction with 'efficacy'. He acknowledges the ambiguity in his discussion of patient satisfaction in a subsequent and separate survey of a different sample:

'Earlier studies focused on the satisfaction with the physician's treatment and not on the assessed level of his professional competence. We posit that analytically these are two distinct aspects of assessment: a person may be highly satisfied with medical treatment given by his family GP, but perceive him to be at a limited level of professional competence.' (Ben Sira, 1982b:1014).

However, whilst acknowledging the ambiguities in his dependent variable, this attempt to 'unpack' the concept is not satisfactory. The items used in this fourth study to assess satisfaction with treatment are essentially the same as those used in the previous surveys and are referred to as items relating to 'the instrumental dimension of behavior (content of treatment)' 1982b:1015). The other, newly introduced item - competence - is operationalised as a ranking of the doctor's competence by the patient on a scale. The patient's evaluations of the outcomes of his or her consultation in relation to goals or concerns is still not clearly brought into the model. The central issue of whether the patient's views of outcomes

are or are not included in the model or its supporting evidence, is not directly addressed. This is an important issue in the general area of patient satisfaction and can be summarised in terms of the following question:

To what extent does the concept of satisfaction refer on the one hand to patients' views of the outcomes and value of consulting in relation to the presented problem or on the other hand to the attitudes adopted and judgements made about the consultation itself and the doctor's behaviour within the consultation?

In the neurological clinic study earlier in this thesis, it became clear that patients' judgements of the value and benefits of consultations were independent of and indeed more revealing than attitudes adopted with regard to the doctor's technical competence. There are good reasons therefore to take the view that the most interesting formulation of his model by Ben Sira is that which does clearly regard attitudes with regard to the doctor's technical competence on the one hand and perceptions of the value and appropriateness of treatment on the other hand as distinct dimensions in patients' responses. A more appropriate investigation of Ben Sira's thesis would include measures of satisfaction in which these different aspects of satisfaction can be distinguished. One of the advantages of the patient satisfaction questionnaire devised by Linn and Greenfield (1982), and used in the study of an STD clinic reported here, is that it is based on a clear conceptual distinction between the two aspects of

instrumental behaviour that Ben Sira inconsistently distinguishes, namely technical competence and efficacy.

(f) Other problems

There are other specific conceptual and methodological problems associated with Ben Sira's model. It may be argued that the use of educational level as a 'facesheet' variable to indicate level of medical knowledge is problematic. In many forms of chronic illness, for example, experience of coping with the disorder may make patients into 'experts' regardless of their formal educational qualifications (MacIntyre and Oldman, 1977). Ben Sira's model would suggest that it is knowledge in relation to the presenting problem, rather than general medical knowledge, that is most important in influencing the patient's dependence upon the doctor's emotional support. Clearly there would be enormous practical difficulties in assessing such knowledge in a sample of primary care patients with diverse presenting problems. For similar reasons, no direct assessment of relevant knowledge and understanding is attempted in the STD clinic study, and education is used instead. However the variable of education does raise other problems that need consideration. There are several alternative ways in which education might relate to satisfaction. The most favoured interpretation of its role in Ben Sira's data is that it indicates variation in basic abilities to judge instrumental aspects of medicine or indeed to distinguish at all between affective and technical aspects of



consultations. However Ben Sira acknowledges alternative interpretations. Firstly he points to evidence that educational level is inversely related to level of concern about health (Antonovsky and Arian, 1972). A related view would be that lower social standing is associated with greater needs for emotional support from the doctor in relation to illness. However a more parsimonious explanation also needs to be considered. As discussed in the first chapter, education or social class is often positively associated with tendencies to express more criticism in relation to health services. Whether through a relative lack of deference, or the wider diffusion of consumerist culture amongst the middle classes, this tendency influences satisfaction surveys. The possibility exists therefore that the simplest explanation for Ben Sira's educational results is as follows: as educational level increases, respondents may express more critical comments about either instrumental or affective aspects of their health care. Conversely the less educated are more reluctant to criticize any aspect of these same services. They therefore express more positive satisfaction on all scales than do more highly educated respondents. These simple differences alone could produce the higher correlation coefficients between different satisfaction items in lower educated groups that are the basis of Ben Sira's thesis. Less educated respondents give more uniformly positive answers.

It might also be noted that this explanation, as well as being simpler, makes fewer controversial

assumptions about perceptual aspects of less educated patients' experiences of medical consultations. Even if it is accepted that such patients have less formal medical knowledge, there is no reason to think that less educated patients may not perceive and discriminate between broad categories of medical and affective behaviour in consultations. For example, there is no reason to believe that less well educated patients are more likely not to be able to distinguish between a doctor taking a history and showing general interest in the patient as an individual. Nor is it reasonable to assume that they are less able to form some kind of view or judgement of both aspects of the doctor's actions. It is important to be clear about why alternative possible explanations for the role of education in relation to patient satisfaction surveys need consideration. The foundation for the important and distinctive social psychological theory of satisfaction proposed by Ben Sira rests on the correlations found between sub-groups identified by variables such as health concern and education. The greater reliance of less educated patients upon cues from doctors' affective behaviour is crucial supporting evidence for the overall general theory of how patients judge their health care. If more parsimonious explanations are available and especially if they can be supported with evidence, the overall theory is more vulnerable.

#### The need to reassess Ben Sira's model

Ben Sira has himself provided a candid summary of

the possible limitations in his own investigations: 'Since all of the studies were post hoc reports, the question was whether those reports reliably reflect the manner of assessment at the time of the interaction with the practitioner' (Ben Sira, 1982b:1018). Various suggestions have been made in this chapter as to ways in which the theory could be more closely examined and elaborated. The following points summarise the main areas in which it has been argued that Ben Sira's use of survey research to examine and develop a model of patient satisfaction ought to be further developed. Firstly the model needs to be examined in terms of a more appropriate sample - in particular, patients seeking medical care. Secondly more attention needs to be given to the time order of measured variables which are central to the model. Thirdly the time reference of satisfaction items, as measured, needs to be more appropriate to the time reference of a model of immediate satisfaction with a specific consultation. A similar problem exists with the time reference of the concept of health concerns. Finally, Ben Sira's work does not have a consistent and clear view of the dependent variable of patient satisfaction. Judgements of the technical quality of care and of the doctor's competence need to be distinguished from judgements of the value of treatment provided.

Ben Sira also remarks (1980:177; 1982b:1018) that aspects of his survey results may reflect peculiarities of Israeli culture or of the Israeli health care system. There is an inverse relationship, for example, between

social class and health service utilisation. He links this phenomenon with a cultural inclination towards doctor shopping which is motivated by a search for humane care. The greater need for such affective care by lower social classes and medical disinclinations to respond to such demands may create a vicious cycle which results in significant class differences in utilisation. He also notes a high overall rate of health service utilization in Israel which may also be linked to the lack of rewards or incentives for doctors to provide such affective services. Thus he urges that research is needed in other societies to examine the value of his approach.

Ben Sira has developed a model of patient satisfaction, the importance of which may be attributed to the fact that it addresses the otherwise neglected processes whereby patients judge care. Furthermore his work provides strong support for the importance of interpersonal aspects of health care and of the crucial significance of the doctor's 'art of care'. His approach would attach much less significance to the outcomes and value of health care in terms of potential benefits to the patient as determinants of patient satisfaction. The patient's main goals and concerns in seeking health care are the solution of medical problems. Yet, for reasons that have been outlined, the patient is not regarded by Ben Sira as able directly to judge the benefits of a consultation in terms of the progress he or she has made in obtaining solutions. The patient has to rely on more indirect cues such as the manner of the doctor, to such an

extent that the manner and affective behaviour become the main concern of the patient. The degree of emphasis placed upon 'affective' aspects of medicine may have become excessive if the goals, motivations and problems presented by patients to doctors become lost from sight and patients are portrayed as satisfied primarily by the 'niceness' of their doctor. Patients would appear to have very limited capabilities of observation or judgement. One consequence would be the validation of the assumption that patients have only a limited role to play in the evaluation of health care. The role of patient satisfaction research would be to provide feedback on clinical issues with regard to the art of care (for example in relation to the friendliness or empathy of health professionals). It would be far less appropriate for patients to play a role as a source of information in the evaluation of services, especially with regards to issues such as the quality of care or the outcomes of care. However before such conclusions are reached, the basis of patients' evaluations, as identified by Ben Sira's model, must be subjected to closer investigation. The next chapter describes the context, sample and methods of a study of patient satisfaction with a sexually transmitted disease clinic, which is used to examine Ben Sira's model.



CHAPTER 6. THE CONTEXT, SAMPLE AND METHODS OF A STUDY OF A  
SEXUALLY TRANSMITTED DISEASES CLINIC

It was argued in the last chapter that Ben Sira's model of patient satisfaction is of sufficient importance to warrant examination by means of patients actually seeking medical help. This chapter is used to describe the Sexually Transmitted Disease clinic sample and the methods by means of which the applicability of Ben Sira's model is to be examined. Something must first be said about the nature of Sexually Transmitted Diseases (STD) clinics to provide some context for the report on patients' views that follows. Such clinics, now often termed Departments of Genito-Urinary Medicine, are responsible for a range of health problems that have increased significantly in the recent past. Thus the number of cases seen in STD clinics in England and Wales rose three fold in the period from 1970 to 1985 and the total number of cases is now over half a million per annum (Adler, 1985). The large London clinics, one of which was the setting for the reported study, play a particularly important role in this field. Forty one per cent of patients in England and Wales with STDs (sexually transmitted diseases) are seen in London clinics (Belsey and Adler, 1981). The clinics function as providers of both primary and secondary health care in the sense that patients may attend either on a self referred

'walk-in' basis or referred by a G.P. The majority of patients prefer to attend on a self referred basis.

Such clinics provide a form of medicine which, in some senses, is particularly vulnerable to the impersonal, mechanical and reductionist practices regarded by many critics as the origins of patient dissatisfaction. The clinics deal with very large numbers of patients and, it has been maintained (DHSS,1985), the clinic facilities and staffing are inadequate to cope with the recent increase in cases. Certainly the waiting areas of the two clinics (male and female) in this study were observed to be constantly full at the time the surveys reported here were conducted. The male clinic in particular rarely contained fewer than ten or twelve patients throughout a long day of clinics, carried out by 'shifts' of doctors. In a typical consultation, the doctor takes details of the presenting symptoms, and of other information relevant to the diagnosis, such as general health, the timing of symptoms in relation to sexual activity, and type of contraception used. Generally a local examination is necessary, and specimens are taken for local microscopy and cultures. If the patient is prescribed a medication, most often an antibiotic, a follow up visit is arranged for a week or so after the patient has completed the treatment. The problems presented require relatively simple and routine management in many cases. The most common form of management is the prescription of a simple course of antibiotics. Attention to 'the whole person' need not be considered as essential to the diagnostic or therapeutic

tasks as is the case in many other branches of medicine. The routinisation of such procedures is a familiar sociological observation in other clinical contexts (Bloor, 1976; Strong, 1979).

In so far as they involve single aetiological explanations (infectious organisms) and simple treatments (the antibiotics) that are often quite effective symptomatically, the sexually transmitted diseases most closely resemble the kinds of health problems that are often seen as the source of medical reductionism. Berliner and Salmon view many of the failures of modern medicine in its relations with patients as deriving ultimately from the initial successes of 'germ theory and specific etiology' (Berliner and Salmon, 1980:136). In clinical terms, STD clinics represent the continuation of this form of medicine. Yet there are factors in the practice of genito-urinary medicine that militate against too mechanical or reductionist an approach. In the first place, a large part of the public health responsibility of such clinics is the identification and treatment of contacts of patients through 'contact tracing' or 'health advising' as it is becoming known. Such interventions involve an intrusion into patients' privacy that patients may refuse to accept. Thus good relations with patients are essential to the continuation of such work. It is also significant that male homosexuals attend certain of the London clinics more often than other clinics (Belsey and Adler, 1978a; Satin and Mills, 1978). The rise of AIDS as a major health threat in this group has increased the

distress experienced by this group particularly and has resulted in enormous increases in the amounts of counselling and reassurance required in the course of routine primary care in the London clinics (Miller and Green,1985; Sonnex et al.,1987). Thirdly and more generally, the specialty is concerned to change its own identity from that of a stigmatised and separate public health service, dealing solely with sexually transmitted infections, to that of a fully fledged scientific medical discipline, dealing with 'ordinary people'. Thus Adler (1985) stakes a claim for genito-urinary medicine as:

'a specialty in its own right, offering total care to people with a wide variety of conditions. The increased breadth of the specialty, and the knowledge that many patients seen in clinics do not have a sexually transmitted disease, have helped to reduce the stigma attached to clinics' (Adler,1985:3)

Thus against the pressures to routinisation, there may be detected counterveiling forces to offer 'total' or holistic care. Such pressures to raise the specialty in these terms are certainly reflected in the growing attention, in academic genito-urinary medicine, to broader aspects of clinical practice. Evidence has recently grown of the psychosexual problems to be found in patients attending clinics (Slatford and Currie,1984), of the psychosocial impact disorders such as hepatitis have (Lok et al.,1985) and of the influence psychosocial factors may have in illness behaviour and help seeking (Harrison,1982).

Genito-urinary medicine departments or STD clinics are therefore important providers of primary care in an area of health care in which problems are increasing. Thus

it is surprising that so little attention has been given to patients' views in relation to such clinics. A few studies have examined patients attitudes on specific aspects of such clinics. Perfrement and Overfield (1978) examined patients' attitudes to staff in a London teaching hospital STD clinic. The majority of patients were reported as finding staff 'reassuring, capable and friendly'. One of the more specific items of the study however showed that 74% wanted more information about STDs. Balsdon et al. (1978) examined patients' views primarily about waiting rooms, privacy and the accessibility of an STD clinic in Southampton. Again, whilst patients' responses were favourable, this study supported the previously cited investigation in showing that seventy nine per cent of patients wanted more reading matter about STDs. Such investigations are consistent with the findings of other patient satisfaction research in underlining the salience of problems of information giving in health care.

An opportunity to investigate patient satisfaction in relation to such clinics arose as part of a series of studies involving the author and two psychiatrists - David Frost and George Ikkos - in an examination of the extent and nature of psychological disturbance in STD clinic attenders and the influence such disturbance may have upon management (Frost, 1985; Fitzpatrick et al., 1985; 1986; 1987; Ikkos et al., 1986).

As has been indicated, the recognition that psychosocial factors play an important part in explaining



patterns of STD infection has grown (Ross, 1984). For example, psychological distress has been implicated in the recurrence rate of certain disorders (Goldmeier and Johnson, 1982) and it has been suggested that it can have an important influence on the outcomes of treatment programmes (Catalan et al., 1981). Thus specialist psychological services are increasingly advocated as essential parts of primary provision in such clinics (Bhanji and Mahony, 1978).

Previous surveys have suggested that psychological disturbance is common in patients attending clinics for STD (Pedder and Goldberg, 1970; Mayou, 1975). The interpretation of such morbidity has been limited, however, because of the reliance of most studies upon the investigation of the small proportion of patients (<1%) who are referred on to psychiatrists (Frost, 1985). A few studies have examined the psychiatric morbidity amongst all attenders. Thus Catalan and colleagues (1981) examined the role that sexual dysfunction may play in the origins of psychological disturbance. However the nature of psychological distress in STD clinics has generally remained unexamined. Furthermore, essential to the discussion of the potential role of psychological services or counselling is the evidence that doctors may not be very accurate in their psychological assessment of patients in such clinics (Catalan et al., 1981).

In order to investigate these issues, three surveys were undertaken which examined aspects of psychological

disturbance in STD clinics. In the first survey (Frost, 1985), 100 consecutive patients, referred for specialist psychiatric services, were assessed. Patients with three broadly different types of problems were distinguished as a result of the study: (1) somatic complaints, (2) sexual difficulties and dysfunctions and (3) primary psychiatric disorders such as depression. The first group complained of various concerns and worries in relation to somatic symptoms for which the STD clinic staff could find no significant organic basis. In many of the patients in this group, Frost identified clinical evidence of 'morbid bodily concern' (1985:135) involving preoccupations with disease that could not be reassured by negative findings. He also discusses the concept of 'abnormal illness behaviour' in relation to this first group:

'The most obvious features of consultation behaviour were dissatisfaction and hostility. Three patients were openly hostile in talking about their treatment by the physicians, but many more were clearly dissatisfied with the clinic.' (Frost, 1985:135).

He observed that in many cases it was difficult to decide clinically whether such 'abnormal illness behaviour' was due to a primary psychiatric disorder or was 'an understandable reaction to unexplained physical symptoms' (Frost, 1985:135). Frost's comments on the association of psychological disturbance and dissatisfaction with medical treatment were based on a selected sample referred to psychiatrists but they provoke a question also suggested by the association of PSE scores and dissatisfaction in the neurological clinic study discussed earlier in the thesis, namely, what is the nature of the relationship between psychological disturbance and patient satisfaction amongst

a more representative sample of attenders of an STD clinic.

The remaining two surveys focused upon samples of unselected patients attending the STD clinic, rather than referrals to psychiatry. The results of the second survey (Fitzpatrick et al., 1985; 1986), of 381 new patients attending the STD clinic, indicated that 43% of patients had scores on a psychiatric screening schedule - the General Health Questionnaire, (Goldberg, 1970) - that indicated possible psychiatric illness. Other evidence however was used to argue that much of this psychiatric morbidity was less severe and different in character from the kinds of illnesses normally seen by psychiatrists and might be understood as distress arising from the meaning to the patient of the presented STD problem. The concept of illness concern was used in this second survey and concerns about serious illness and about the social implications of illness were found to be extremely widespread and to be significantly associated with psychological disturbance.

A third questionnaire - based survey of outpatients attending the STD clinic was conducted. The purpose of the third survey (which is the focus of this section of the thesis) was to examine further four related and overlapping issues: (i) the nature and range of illness concerns in an STD clinic; (ii) the association between illness concerns and psychological disturbance; (iii) patient satisfaction with an STD clinic and (iv) the association between psychological disturbance, illness concerns and patient

dissatisfaction. The fourth aim would also enable an examination of the role of affective factors in patient satisfaction as presented in Ben Sira's work.

#### The selection of instruments

Instruments were selected that would be appropriate to these various aims. Before describing the instruments and methods of this third survey in more detail, the considerations involved in selecting instruments need to be outlined. Firstly, an instrument was needed that would assess psychological disturbance in a questionnaire format. A considerable number of such instruments exist. However, as is outlined in the methods section, the General Health Questionnaire has been widely examined with regards reliability and validity, and had proved to be acceptable to subjects and easy to complete in the previous (second) STD clinic survey. With regards to illness concerns, the concept has not received extensive attention and validated instruments were not available. Moreover, an instrument was needed that would be of relevance to the range of medical problems presented to a STD clinic. Thus it proved necessary to develop an instrument to examine a range of concerns that might be experienced in relation to the presenting problem. Such an instrument would also be useful in providing a measure of concern about health appropriate to examining Ben Sira's model. As was argued above, in his theoretical discussion, Ben Sira viewed concern about health as a product of specific 'subjective evaluation of disturbance' at the time of consulting (Ben

Sira, 1980:171). This suggests that the model is concerned with the patient's appraisals of the seriousness of the presenting problem. Thus questions were needed that asked patients directly to assess their concern about the presenting problem. On the other hand, it was also clear that Ben Sira's approach, in practice, was to treat concern about health as a more stable, generalised orientation to health, rather than an appraisal of specific health problems. For this purpose, a measure of concern about health in general was needed. As is indicated in the methods section below, the Illness Behaviour Questionnaire (IBQ) is designed to assess in some considerable detail just such aspects of patients' experience. As an instrument generally to explore the relationship between psychological disturbance, illness concerns and patient satisfaction, the IBQ has the merit of containing a number of distinct sub-scales that might contribute to exploring the relationship between disturbance and dissatisfaction. Secondly one scale of the IBQ (Disease Conviction) was specifically developed to explore aspects of problematic relationships between the doctor and the patient such as the rejection of the doctor's reassurance. With regard to the examination of Ben Sira's model, IBQ scores are used to measure a central concept in Ben Sira's model - concern about health. Ben Sira measured this concept by means of a single question (To what extent are you worried about the state of your health?). The reliability of the item is not known and the distribution of the responses to the item in Ben Sira's survey proved to be so skewed that the five original response categories were reduced to three in all



analyses (Ben Sira, 1980:179). The measurement of concern about health by means of the IBQ used in the STD clinic study has the advantage over Ben Sira's single question about health concern that effort has gone into establishing the reliability and validity of the instrument. Moreover, there are advantages in using a scale over a single item, provided that the items of a scale measure a unitary phenomenon. The reliability of measurement may be increased, as the use of more items reduces random error. It may also allow more precision in measurement (Sellitz et al., 1965:182; Hirschi and Selvin, 1973:207; de Vaus, 1986:84). De Vaus argues for the merits of scales with multiple items :

'The way in which a question is worded can affect substantially the way people answer it. If we rely on only one question people's answers could be largely a function of the wording of the question. Using a number of questions should minimise the effect of one which is badly worded.' (de Vaus, 1986:84)

Despite the amount of attention given to patient satisfaction, there are no established and widely used instruments. Investigators have tended to develop instruments for use in their specific field of enquiry rather than use existing questionnaires. This may partly reflect the problems of finding questions that are appropriate to a variety of medical settings and health care treatments. It was argued in the previous chapter that, in many respects, the questionnaire items used by Ben Sira were inappropriate for testing his theoretical model. An instrument was identified that did appear applicable to the STD clinic - a patient satisfaction questionnaire developed by Linn and Greenfield (1982) and described below

in the methods section. It had several specific merits which made it appropriate for use in the STD clinic. Firstly the instrument focused on attitudes to a specific consultation or related series of consultations in relation to a single illness episode. Secondly the instrument clearly and explicitly distinguishes between two aspects of the technical aspects of care - competence and efficacy - that previous research in the neurological clinic had suggested needed to be measured separately. Thirdly the instrument provides scale scores for the three dimensions of satisfaction measured - art of care, technical competence and efficacy of care. As was argued for the measurement of concern about health, one may increase the reliability of measures by the use of a scale of several items rather than a single item. Finally frequencies of responses to the items of Linn and Greenfield's questionnaire are available for comparison from other medical populations, whereas this basic data is not available for the items of Ben Sira's questionnaire.

For converse reasons, the items used by Ben Sira were not appropriate to examine satisfaction in this clinic. Most importantly, as has already been stressed, the time reference of different items varies. Ben Sira's items are not based on a conceptual distinction between dimensions considered to be important to distinguish - competence and efficacy. More specifically there were particular problems in the wording of questionnaire items in Ben Sira's study. Thus some items were based on the fact that patients were evaluating primary care doctors so

that items referred to 'your doctor', whereas in the STD clinic it could not be assumed that patients would regularly see the same doctor if they reattended.

As was argued in the previous chapter, Ben Sira's conceptual treatment of patient satisfaction is sometimes unclear and in need of clarification. In addition, his empirical examination of the model also suffered from fundamental limitations. Thus instruments were selected that would, in many respects provide clearer and more precise measures of the concepts that might be regarded as central to Ben Sira's model of patient satisfaction.

#### Methods

Patients attending the clinic were asked by one of the investigators to complete a questionnaire after they had booked in to the clinic for their appointment that day but before they saw the doctor. Patients generally had ample time to complete the questionnaire while they waited for their appointment, in the reception area. In this time they completed the General Health Questionnaire (GHQ), the Illness Behaviour Questionnaire (IBQ) and the Illness Concern Questionnaire (ICQ) together with items about demographic characteristics. These questionnaires are described in the next section. The last item on the package of questionnaires asked patients if they would be prepared to have a questionnaire sent to their home to ask about aspects of their clinic visit. It was pointed out that the letter would be in a plain envelope and the questionnaire

would not directly identify the nature of the clinic attended or their particular health problem. The permission of patients had to be sought in this way in order to protect fully the confidentiality of patients and to ensure voluntary participation in the study. The confidential reputation of the clinic had to be a paramount concern given the nature of the health problems presented there, and the particular need for the clinic to retain a favourable reputation specifically for such preventive activities as 'contact tracing'. Thus no further action was taken in relation to those patients who stated that they did not wish to participate.

Doctors filled out a brief questionnaire for each patient. This questionnaire was based on an instrument used in investigations of doctors' recognition of psychological disturbance in primary care by Marks et al. (1979). Doctors' clinical judgements of the extent of patients' psychological disturbance were elicited, together with information on the patient's sexual orientation (which is routinely asked by clinic doctors). They were also asked to assess the level of the patient's concern in relation to the presenting problem.

Finally those patients who had agreed to participate further in the study were sent in the post a two page Patient Satisfaction Questionnaire (Linn and Greenfield, 1982) with a stamped and addressed return envelope. This was sent out one month after their first questionnaire had been completed.

## Questionnaires

### (1) The Illness Behaviour Questionnaire.

This instrument was developed by Pilowsky and Spence as a 62 item self report questionnaire to record 'aspects of illness behaviour, particularly those attitudes that suggest inappropriate or maladaptive modes of responding to ones state of health' (Pilowsky and Spence, 1983). The individual items of the questionnaire require simple 'yes' or 'no' answers. The items are formed into seven scales (see Appendix). An important feature of the instrument is that considerable attention has been given by Pilowsky and Spence to its reliability and validity.

Test-retest estimates for the instrument, with the retest done between one week and twelve weeks after the initial test were satisfactory. For only one of the seven scales (Affective Inhibition, 0.67) was the correlation between the two test scores less than 0.70 and four of the seven scales produced correlations greater than 0.80. The validity of the instrument was assessed by asking individuals to complete the instrument as they believed their spouse would respond. The spouse also completed the questionnaire. Correlations between spouses were satisfactory with a range from 0.50 to 0.78. Where possible concurrent validity has also been examined in terms of correlations with other instruments. Discriminative ability has been examined by comparing scores of general hospital patients with groups such as patients attending pain clinics or psychiatric clinics, considered on other



grounds to have abnormal perceptions of health. Significant differences have been found in the predicted directions. For the purposes of this analysis the issue of the 'abnormality' or otherwise of respondents is of less concern than the possibility that the instrument identifies relatively stable aspects of health perceptions.

The 7 scales are described by Pilowsky and Spence as follows:

- (1) General Hypochondriasis. 'A general factor marked by phobic concern about one's state of health.'
- (2) Disease Conviction. 'Characterised by affirmation that physical disease exists, symptom preoccupation, and rejection of the doctor's reassurance.'
- (3) Psychological vs. somatic perception of illness. 'A high score indicates that the patient feels somehow responsible for his illness.'
- (4) Affective inhibition. 'A high score indicates difficulty in expressing personal feelings, especially negative ones to others.'
- (5) Affective disturbance. 'Characterised by feelings of anxiety and / or sadness.'
- (6) Denial. 'A high score indicates a tendency to deny life stresses.'
- (7) Irritability. 'Assesses the presence of angry feelings, and interpersonal friction.' (Pilowsky and Spence, 1983:3).

As has been indicated, the scale of 'General Hypochondriasis' is of particular importance to this study because it assesses individuals' levels of general or

stable concerns about health, a factor of importance in Ben Sira's thesis. This scale produced a very satisfactory test-retest reliability score of 0.87 in Pilowsky and Spence's study, and may be considered a measure of concern about health that is of more established reliability than Ben Sira's single item measure of the concept.

The internal consistency of replies in the STD clinic to the seven scales of the IBQ was examined by means of Cronbach's Alpha coefficient (Cronbach, 1951). This provides an expression of the average reliability of items from all possible ways of splitting a scale. The results are shown in Table 12. The reliability of five of the seven scales may be regarded as satisfactory. One scale - Psychological versus somatic perception of illness - has a coefficient of 0.11 which suggests that the items are highly heterogeneous and the scale unreliable. Another scale - Disease Conviction - has a coefficient of 0.50 which is at the very lowest recommended level for group scores (Helmstadter, 1964; Eisen et al., 1979). In order to see whether the reliability of the scale could be improved, the correlations between individual items and the scale were examined. Only one item had a markedly lower correlation (0.46) with the scale. Removing this item from the scale did not significantly improve the Alpha coefficient (0.54). Thus the original scale was retained for analysis.

(2) The General Health Questionnaire.

The General Health Questionnaire is a self administered instrument, designed for screening of non psychotic psychiatric illness (Goldberg,1972). The 30 item version has been validated for use in the community (Tanopolsky et al.,1979). The questions are about recent feelings, thoughts and behaviours and respondents select from four choices for any item, ranging from 'not at all' to 'much more than usual'. A positive score is given to any symptom or problem that is described by the respondent as present 'rather more than usual' or 'much more than usual'. Five or more positive responses to items is recommended as a cut off point for identifying possible psychiatric cases.

(3) Illness Concern Questionnaire.

This questionnaire is a nine item self administered questionnaire which asks respondents about particular worries and concerns they may have in relation to sexually transmitted diseases. This questionnaire was developed by the investigators to examine more closely patients' concerns in relation to the presenting problem. Some of the questions were about particular worries the patient might have, such as fear of a serious illness, or fears that the presenting problem might have harmful consequences for the individual's sexual life or future fertility. Other questions were designed to elicit how seriously the patient was worried in relation to the presenting

problem, e.g.

'Has thinking about such an illness in any way disrupted your daily life?'

or:

'Have other people been able to reassure you about your problem?'

Two of the nine items have three response categories (e.g. 'yes', 'no', 'uncertain'). The remaining seven items have four possible responses: 'not at all', 'a little', 'moderately' and 'very much'.

#### (4) Patient Satisfaction Questionnaire.

This questionnaire was designed by Linn and Greenfield (1982) as a 19 item self completed questionnaire to assess satisfaction with care. Particular advantages of this questionnaire over the items included in Ben Sira's surveys have already been emphasised: firstly, that the focus of all the items is on perceptions of particular consultations and their value and secondly, that the questions do permit separate examination of two important components of 'instrumental' medical behaviour, namely the technical aspects of care, and the perceived value, efficacy or appropriateness of treatment. The questions also permit examination of views of the doctor's affective behaviour, referred to by Linn and Greenfield as his 'art of care'. The questionnaire has a Likert - type format

with five response categories ranging from 'strongly agree' to 'strongly disagree'. The 19 items are grouped into three different categories:

- (a) satisfaction with the art of care (9 items), for example: 'No one seemed to care very much about my privacy',
- (b) satisfaction with the technical quality of care (6 items), for example: 'The doctors seemed very competent and well trained', and
- (c) satisfaction with the efficacy of care (4 items), for example: 'I am in better health now because of the care I received there.'

The Cronbach's Alpha coefficient for the three scales was calculated for the STD clinic sample to provide an estimate of the internal reliability of the three scales. The results were highly satisfactory: art of care scale (0.87), technical quality scale (0.87) and efficacy scale (0.77).

The Patient Satisfaction Questionnaire was to be used firstly to examine the relationship between psychological distress and patient satisfaction and secondly, more specifically to examine Ben Sira's theoretical model in relation to patients seeking medical care. For some parts of the analysis of patients' views of the STD clinic, the three overall categories are used. These categories involve all 19 items of the Linn and Greenfield's questionnaire which are grouped into the scales of either 'Art of care', 'Technical quality of



care' or 'Efficacy of care'. Where these scales are used in the analysis, the scores of items are appropriately summed to produce a single additive score for each scale. Ben Sira examined his model of patient satisfaction by means of correlations between individual items. For this part of the analysis it was also decided to use respondents' answers to individual questionnaire items in order to maximise the comparability between the two studies and to explore the logic behind Ben Sira's analyses and interpretations. Items from the Linn and Greenfield patient satisfaction questionnaire were selected which appeared to measure the same constructs as those referred to in Ben Sira's model. As is demonstrated below, in most cases the items so selected from the Linn and Greenfield questionnaire generally resembled quite closely the items with which Ben Sira measured his concepts. Ben Sira distinguishes between two groups of satisfaction items - firstly, satisfaction with treatment or the instrumental behaviour of the doctor and secondly, satisfaction with the affective behaviour of the doctor. The following section describes the items selected to measure each of the dimensions of patient satisfaction and also indicates the corresponding questionnaire item used by Ben Sira.

#### Satisfaction with treatment, or with the doctor's instrumental behaviour

Ben Sira distinguishes between three different dimensions of satisfaction with medical treatment: satisfaction with the doctor's skills, satisfaction with

the doctor's medical treatment and satisfaction with reassurance from the doctor's activities.

Satisfaction with doctor's skills is measured in this study by Linn and Greenfield's item: 'The doctors seemed to have experience with my kind of problem'. Ben Sira's measure of the concept is 'Did the physician give you a feeling that he knows how to cope with a problem such as yours?'

Satisfaction with the doctor's medical treatment is measured by means of an item from Linn and Greenfield: 'The doctors did as much as could be expected to help me get well'(Q.10 Appendix). Ben Sira measures satisfaction with treatment by means of the item: 'Did the doctor give the required treatment?'

Satisfaction with reassurance from the doctor's activities. The item from Linn and Greenfield's questionnaire is: 'The doctors did their very best to keep me from worrying about things' (Q.6 Appendix).

Satisfaction with reassurance in Ben Sira's survey is measured by: 'Did the doctor give you a feeling of reassurance?'

#### B.Satisfaction with the doctor's affective behaviour

Ben Sira examines three aspects of satisfaction with affective behaviour - patients' views with regard to whether doctors (a) allocate sufficient time for a

satisfactory presentation and discussion of the patient's problem (b) show an interest in the patient as person and (c) demonstrate sufficient devotion to the problems presented.

Satisfaction with the doctor's time is assessed by the item from Linn and Greenfield's questionnaire: 'The doctors took time to put me at ease and tried to make me more comfortable' (Q.12, Appendix). Ben Sira assessed this aspect of satisfaction by means of the item: 'Does the doctor allocate sufficient time?'

Satisfaction with the doctor's interest is assessed by the following item from Linn and Greenfield: 'The doctors seemed to have a genuine interest in me as a person.' (Q.1 Appendix). The construct was assessed by means of the following item by Ben Sira: 'Do the doctors show sufficient interest in their patients' personal problems?'

Satisfaction with the doctor's devotion is measured by the following item from Linn and Greenfield's questionnaire: 'The doctors were very friendly, seemed devoted to me and other patients.' (Q.11, Appendix). This is measured by means of the following question in Ben Sira's study: 'Does the doctor demonstrate sufficient devotion to the management of the problem presented?'

### Statistical Methods

Most of the data in this study have been gathered using either nominal or ordinal levels of measurement. Chi square test has been used to test the significance of relationships between nominal variables, and the Mann - Whitney test has been used as a test of significance for differences for variables measured on an ordinal scale.

For some purposes in this study, the Pearson product moment correlation coefficient has been used to measure relationships between variables, for example, to measure the relationship between different items from the Patient Satisfaction Questionnaire or between satisfaction items and scales from the Illness Behaviour Questionnaire. This usage requires comment since the variables so analysed have been measured at the ordinal level. Thus the level of patients' satisfaction with whether the doctor showed interest toward them was assessed by means of an item with five possible responses from 'strongly agree' to 'strongly disagree'. The assumption is made in such a scale that patients can be ordered on a continuum in terms of the degree to which they hold a particular view. However this ordering does not permit any assumptions to be made about the magnitude of the differences between points on the item. One cannot compare or make assumptions about the distances between, for example, on the one hand 'strongly agree' and 'agree' and on the other hand between 'strongly disagree' and 'disagree'. This makes it difficult to determine the numerical values of each category. As a

result it is difficult to adopt the assumptions of higher levels of measurement - interval and ratio scales. In particular the use of statistics designed for measures of relationships between variables at the interval level - the Pearson product moment correlation coefficient and regression has been regarded as problematic.

However, because so much sociological data is in the form of, at best, ordinal data, statisticians' strictures against the use of correlation and regression have received considerable attention. Investigators have examined the consequences of making interval assumptions in relation to ordinal data. Labovitz (1970) analysed a data set of the prestige rankings of a number of occupations and their suicide rates. Twenty different scoring systems were used for expressing the prestige rankings of the occupations in the data set (the relative positions of occupations in relation to each other staying the same). The scoring systems included methods in which both ordinal and interval distances between occupations' prestige scores were used. Labovitz then calculated the correlations between different scoring systems. He found consistently high correlations and inferred a 'high degree of interchangeability among the 20 scoring systems' (1970: 518). In addition he found a very high level of similarity between scoring systems in predicting suicide rates. He concluded that, as different scoring methods were largely interchangeable, assumptions of an interval level of measurement in the data, did not significantly distort the relationship between variables. In another study, Labovitz (1967) used a simulated data set of ordinally measured



outcomes of alternative medical treatments. He varied the method of scoring outcomes to include ordinal and interval levels of measurement and found that they produced similar results in tests of significance between treatments. Similar results have been obtained in other studies conducted to examine the problem of interval level assumptions in ordinal data (Boyle, 1970). Galtung (1973:217) examined the effect, in simulated ordinal data, of various numerical expressions of the ordinal scale upon the size of correlation coefficients. Whilst he emphasised the problem of violating assumptions, the actual differences between correlation coefficients were small, indicating only modest practical consequences arising from the use of interval based statistics.

The empirical investigation of interval level assumptions applied to ordinal data therefore suggests that the practice may not be significantly misleading. The greater the number of categories or values in a variable, the greater can be the confidence in assigning interval scoring systems to ordinal data (Boyle, 1970; Labovitz, 1970). Lin (1976) argues that at least five values are needed in ordinal variables in order to use interval level statistics. This condition is met in the case of the variables used in this study. In addition to empirically demonstrating the limited practical consequences of using interval measurement on ordinal data, other arguments have been put forward in favour of treating ordinal scales as if they conformed to interval assumptions. In the first place, it does permit the use of well developed and interpretable

multivariate techniques such as multiple regression (Labovitz, 1970). Secondly the alternative strategy of dichotomising or trichotomising ordinal variables certainly loses important information about responses in the original scale (Blalock, 1964). Furthermore such a step may introduce more serious measurement error than that arising from assuming interval levels (Blalock, 1964, 185). Blalock argues that it is unclear whether the more serious violations arise from using the wrong level of statistics in relation to ordinal data or from reducing such data by arbitrary cut off points and cautiously concludes:

'For exploratory purposes it may not be entirely unwise to make use of the rationale developed in connection with higher levels of measurement, even when actual measurement cannot be so precise' (Blalock, 1964:94).

Theoretical and methodological problems involved in the use of interval level assumptions with ordinal data may still be expressed (Wilson, 1971). However, in the field of patient satisfaction research, statistics such as Pearson correlation coefficients and regression have become by far the most widely used methods of expressing relationships between variables (Note 1).

The use of interval level assumptions facilitates the use of statistics such as partial correlation coefficients and multiple regression. Both of these techniques are also used to explore the patient satisfaction variables measured in the STD clinic. Partial correlation coefficients are used in particular to examine alternative causal models according to principles advocated by Blalock (1971). Again, it has been argued that

assumptions of interval level measurement are required if partial correlations are to be used and that ordinal variables do not meet this requirement (Wilson, 1971). Reynolds (1974) examined, by means of simulated data, the effects of ordinal level data in causal modelling in which partial correlations are employed. Data with known characteristics were created for a sample size of 600. Three variables were used and Pearson correlation coefficients ( $r$ ) and partial correlations (partial  $r$ ) were calculated, with the aim of testing for a known spurious relationship between two of the variables produced by the third variable. Partial  $r$  performed reasonably well in showing the presence of the spurious relationship. Reynolds found that the greater the number of categories in the control variable, the greater was the success of the partial  $r$  in showing spuriousness. It proved to be sufficient if ordinal variables were measured with at least five categories. The pattern of results also strongly indicated that problems arose from collapsing variables into a smaller number of categories.

In a similar study, Blalock (1964) examined the effects upon artificial data with known characteristics, of measuring relationships between variables by means of interval, ordinal and nominal scales. The data was constructed to contain a spurious relationship, and the ability of total and partial correlations to show this spurious relationship was examined. When the control variable contained four categories, the partial was reduced to zero, but, as with Reynolds' study, dichotomising the

control variable did not satisfactorily reveal the spurious relationship. Both Blalock's and Reynolds' studies provide practical evidence of the adequacy of partial correlation coefficients in examining simple causal models for ordinal data. Blalock concludes that, as long as sociological theories are of the simple form - 'If X increases, Y will increase' (Blalock, 1974: 426) - and the precise degree of relationship between variables is not predicted, the examination of causal models of ordinal data by techniques such as correlation and partial correlation is warranted.

The data on patient satisfaction in this study are finally examined by means of multiple regression. This method permits the identification of the effects of a number of independent variables upon a dependent variable. For exploratory purposes this technique may therefore be invaluable; Hirschi and Selvin compare its use in survey analysis to 'aerial photographs' and conclude that 'With a continuous or an ordinal dependent variable, stepwise multiple regression searches out the most important variables' (Hirschi and Selvin, 1973: 168). It also provides an expression of the amount of variance in the dependent variable explained by the independent variables (R square). The method is very widely used in patient satisfaction research (examples are discussed in chapter 8). It is therefore important to include this method of analysis for the purposes of comparing the results of the STD clinic study with those of other studies.

### The sample

In all, 851 patients completed the first phase of questionnaires before seeing the doctor. Of these, 623 consented on the last item of the questionnaire consented to a further questionnaire being sent to their home. This group were sent the follow up questionnaire and eventually 320 of these were returned. This represented 37.6% of the original sample and 51.4% of those who had consented to participate further. Resources were not available to consider a further follow up of those who did not return the questionnaire sent to patients' homes. Had resources been available, other problems would have remained. Patients' concerns to protect their privacy with regard to their health problem are probably higher with regard to STD than many other health problems. This could well account for the low rate of return. It would have become a consideration in deciding whether to attempt further follow up questionnaires. A second problem with the mailed questionnaire was that many of the young population which the clinic serves are considered by clinicians in the clinic to be quite geographically mobile. The address for them provided by the clinic may not have been up to date, or indeed accurate. Nevertheless the response rate has to be considered a low one. It raises the problem of whether the follow up sample was representative of those who were recruited into the initial phase of the study sample. In particular the possibility exists that those who did not return the questionnaire were over-represented either in terms of the positively satisfied or of the dissatisfied.



The data can be inspected in two ways to examine how serious is the low overall response rate of the satisfaction questionnaire. Firstly, characteristics of the original 851 patients who completed questionnaires before their clinic consultations can be examined and those who did and those who did not participate in the follow-up survey can be compared to see whether participants in the follow-up study are over- or under-represented with respect to any particular variables on which measures were available. The follow-up sample can also be examined in terms of whether the rates of satisfaction are different from other samples using the instrument or different from the broad trend of patient satisfaction results.

With regard to the first issue, there were no significant differences in terms of age, sex or education between those who participated in the follow-up study and those of the original sample who did not participate.

There were, however, significant differences between the follow-up sample and the rest of the initial sample with regard to a number of other characteristics. Working class patients were less likely to participate in the follow-up study than middle class patients (Chi square 6.17;d.f.=1;  $P < 0.02$ ). Patients who were married were less likely to participate than other patients (Chi square 6.69;d.f.=1;  $P < 0.01$ ). Amongst male patients, heterosexuals were less likely to participate than homosexual patients

(Chi square 9.27;d.f=1;  $P<0.01$ ). Patients who had previously attended the clinic ('old patients') were more likely to participate than those for whom this was their first visit ('new patients') (Chi square 12.965;d.f.=1;  $P<0.001$ ).

It may be noted that two of the variables in terms of which the follow-up sample differed from non-participants are related. Homosexual patients were more likely to be 'old' rather than 'new' patients.

With regard to medical and psychological variables, there were no significant differences between the follow-up sample and the rest of the original sample with regard to STD diagnosis, psychological caseness (GHQ) or on six of the seven scales of the Illness Behaviour Questionnaire. However those with lower scores on the 'affective disturbance' scale were somewhat less likely to participate (Chi square 13.05;d.f.=5;  $P<0.05$ ). With regard to concerns in relation to the presenting problem, there were no differences except that those who were concerned about how their presenting problem might effect their sex life (Chi square 10.52;d.f.=3;  $P<0.02$ ) and those who were worried about the possibility of a serious disease (Chi square 7.83;d.f.=3; $P<0.05$ ) were both more likely to participate in the follow-up study.

Of the variables in terms of which the follow-up sample differed from the rest of the original sample, only two variables also proved to be related to satisfaction:

middle class patients were more dissatisfied than working class patients (although the numbers of working class patients in the follow-up sample was too small to attach much significance to this difference) and 'old' patients were more likely to be dissatisfied than 'new' patients. Thus in relation to these two variables the follow-up sample was biased slightly towards individuals more inclined to be dissatisfied with care. In other words the characteristics of the follow-up sample provide no evidence that dissatisfied patients were less likely to participate in the follow-up part of the study although it is still possible that some unmeasured variable might be associated with dissatisfaction and non-participation.

#### Characteristics of the follow-up sample

The discussion of results is based on the follow-up sample who completed the satisfaction questionnaire. The follow-up sample of 320 patients included slightly more males (52%) than females. Information on patients' sexual orientation was obtained from the doctor concerned with each patient. This information was available for only 211 out of the 320 patients. Amongst female patients only 2 (2%) were identified by the doctors as homosexual. Of the 111 male patients for whom information was provided, 42 (38%) were identified as heterosexual, 67 (60%) as homosexual and 2 (2%) as bisexual. Other studies from the same clinic (Mindel and Sutherland, 1984) estimate that between 13% and 20% of homosexuals attending the clinic may be bisexual but this is often not acknowledged by the

patient in the clinic. The mean age was 29.5 years (s.d.=8.1). The majority of the sample were single (75.6%). The sample was predominantly middle class; in terms of the Registrar General's classification, only 12.2% were classified as Social Class 3 Non Manual, Social Class 4 or 5. Seventy one per cent held A level or higher educational qualifications. Fifty five per cent of the sample had previously attended the clinic ('old' patients) whereas for 45% of patients ('new' patients) this was their first visit.

The medical notes were examined to obtain the diagnosis. This material was then classified into the nine diagnostic categories used by Belsey and Adler (1981b) in their study of STD clinics in England and Wales, except that the category 'No abnormality detected' was added, because such a large proportion of the sample's notes contained this category. It is clear from another discussion by Belsey and Adler (1981a:288) that where clinics report 'Other conditions not requiring treatment', this is a heterogeneous category and may include patients with symptoms not easily classified elsewhere and patients with no presenting problem, attending, for example, for the purposes of a check-up. The extra category in this study enables these two kinds of presentation to be distinguished. As indicated in Table 13, the most common diagnosis in the sample was 'nothing abnormal detected', followed by 'non specific infections', 'warts', and 'candidiasis'. The proportion of patients with 'No abnormality detected' recorded in their notes is quite high

(30%). Belsey and Adler (1981a) report that one quarter of heterosexual males and females in STD clinics in their study were recorded as having no disease diagnosed or treated. However they also report that a higher proportion of homosexual patients (30%) fall into this category. It may be that the high proportion of homosexual patients in this sample explains the frequency of the category 'No abnormality detected'.

The rate of caseness (GHQ) was quite high - 35.2%. However this is consistent with the rate of caseness in the previous survey we conducted - 43% (Fitzpatrick et al., 1986) - and with other results (Pedder and Goldberg, 1970; Catalan et al. 1981). The scores of the sample on the 7 scales of the IBQ can be compared with normative data provided by Pilowsky and Spence (1983). This comparison (Table 14) indicates that on many of the scales, especially those that more directly measure psychological disturbance such as 'affective disturbance', STD clinic attenders' scores are not particularly high compared to general practice patients. Indeed on the previous clinic survey similar comparisons were made between STD clinic attenders and other normative data, using the Crown Crisp Experiential Index (CCEI) (Crown and Crisp, 1966). Comparing cases (GHQ) in the STD clinic and normative data for both the IBQ and CCEI, it consistently emerges that the psychological symptoms of distress in the cases amongst STD clinic attenders may not be as severe as is found in patients with established psychiatric illness normally seen in psychiatry clinics.



Having introduced in this chapter the methods and patient sample in terms of which Ben Sira's model is to be examined, the next chapter examines the applicability of the model to data on patients' responses to an STD clinic.

### Notes

1. The following studies of patient satisfaction all express the relationship between patient satisfaction (measured by ordinal scales) and other variables by means of Pearson product moment correlation coefficients: Gray, 1980; Roghmann et al., 1979; Segall and Burnett, 1980; Davies and Ware, 1981; Linn and Greenfield, 1982; Thomas and Penchansky, 1984; Carmel, 1985; Dutton, et al., 1985; Deyo and Diehl, 1986; Lewis et al., 1986; Like and Zyzanski, 1987; Linn et al., 1987; Roter et al., 1987; Zapka and Stoddard, 1987.

## CHAPTER 7. PATIENT SATISFACTION IN A SEXUALLY TRANSMITTED DISEASES CLINIC

In this chapter, the satisfaction scores of the STD clinic sample are examined in terms of the conceptual framework and methods of data analysis employed by Ben Sira in his two surveys discussed in chapter 5. Ben Sira's approach to his results is a form of survey analysis involving the 'specification' of associations (Hirschi and Selvin, 1973) in sub-groups of his sample. The same approach is adopted in the analysis of the STD clinic data. In this way, it will be possible to examine the extent to which Ben Sira's model applies to a sample of patients at the time of seeking care. The pattern of results found in the clinic do not consistently support Ben Sira's model. In addition, it is argued in this chapter that there are other methods in survey analysis, not used by Ben Sira, by means of which such data may be analysed, especially where a causal hypothesis is being examined. When the clinic patients' views are examined by alternative means, specific questions emerge as to the validity of Ben Sira's model.

### Satisfaction scores in the sample

Before Ben Sira's approach to the analysis of satisfaction data is employed, a summary of the results of

the patient satisfaction questionnaire is given. It may be noted that, in the publications examined here (Ben Sira, 1976; 1980), the raw frequencies of satisfaction scores, and zero order correlations are not given by Ben Sira. This makes an evaluation of his results difficult. Patient satisfaction survey results are invariably positively skewed in that few patients express dissatisfaction. Moreover social and demographic variables exert significant influence in zero order correlations. However neither factor is directly discussed in relation to his survey data. Thus comparisons of this aspect of the results in the two studies cannot be made. The results of the patient satisfaction questionnaire administered to the STD clinic sample can however be compared with results obtained by Linn and Greenfield (1982) in their assessments of patients' views using the same instrument. Their investigation was of the views of patients attending clinics in Rheumatology, Cardiology, Endocrinology and General Medicine. Thus the range of health problems are quite different from the STD clinic, and the average age of patients higher. Nevertheless, a comparison of the frequencies of results in the two studies offers some indication as to whether STD clinic attenders' responses were significantly different from other medical populations. The results of the satisfaction questionnaire are shown in Table 15 together with the results obtained by Linn and Greenfield. The figures in parentheses are the results of Linn and Greenfield's study using the same instrument.

The first point to be noted is that on all items only 20% or less of the STD clinic attenders are dissatisfied with care. As in virtually all patient satisfaction surveys, the majority of respondents express positive satisfaction with their care. The comparison with Linn and Greenfield's results indicates a similar level of overall satisfaction in the two samples. There are also a few specific similarities between the two samples. Thus the item that elicited the most favourable response was the same for both samples - the item concerning views about nurses. Both samples express relatively less satisfaction with regard to item 16 - assessing the impact of care upon their health.

On the other hand especially with items on 'the art of care' and 'efficacy of care', the STD clinic attenders appear more dissatisfied, although the differences between the two samples are not large. With two items with regard to the technical quality of care, the pattern is reversed. The STD clinic attenders were somewhat more satisfied than Linn and Greenfield's sample with views in relation to the doctors' level of experience and level of organisation. One reason that the STD clinic attenders express somewhat less satisfaction about the technical quality and efficacy of care may be the fact that they are a younger sample and, as indicated in chapter one, therefore somewhat more willing to express negative attitudes in relation to health care. In general terms it may be said that the sample expresses a pattern of views that are typical of such surveys.

Simple associations between satisfaction and social and demographic variables together with the overall score 'possible psychiatric caseness' (GHQ) are first examined. To make the presentation of associations manageable, the three additive scales of satisfaction employed by Linn and Greenfield are examined. The results (Table 16) indicate no significant differences for several of the demographic variables such as social class and sex. The absence of any association between age and satisfaction scales should be commented upon, given that age is one of the demographic variables which is sometimes found to be linked with satisfaction. However this sample contained very few older patients, and it is this group which normally expresses more positive satisfaction scores. There is however a weak but significant association with education, with more educated respondents more frequently expressing dissatisfaction with the art and technical quality of care. This is consistent with other studies cited in chapter one. The other social variable in which significant differences occurred was sexual orientation amongst males; heterosexual attenders were more frequently dissatisfied with the efficacy of care, compared with homosexuals. The most consistent set of differences can be seen between patients who had attended the clinic previously ('old patients') who were more dissatisfied with the clinic than patients attending the clinic for the first time ('new patients'). The interpretation of these differences is not clear at this stage and discussion is postponed until later in this section of the thesis.



Possible differences in levels of satisfaction between patients with different diagnoses were examined. Each of the diagnostic categories was compared in turn with the rest of the sample. No significant differences were found for any of the three satisfaction scales between any of the diagnostic groups.

Finally those with 'possible psychiatric caseness' were more dissatisfied with the technical quality and the efficacy of care. The association of patient dissatisfaction with psychological unhappiness or disturbance is found in the study of neurological clinics reported in the first half of this thesis. Similarly Linn and Greenfield (1982) report that depressed patients were more dissatisfied with care. Only a few other studies have examined the association of patient satisfaction and aspects of mental health (Lebow,1982). Greenley et al. observe that, in view of the fact that service providers find the psychologically disturbed and dissatisfied client particularly difficult to help, it is surprising that 'no prior empirical research has focused specifically on patients' psychological distress and satisfaction with services' (Greenley et al., 1982:374). The interpretation of the associations found in this study is postponed until after further analysis of the data.

#### An empirical exploration of Ben Sira's model

The data on satisfaction in the clinic were of

particular interest in examining the value of Ben Sira's model of patients attending medical care. This section now examines that issue. Ben Sira adopts two approaches to testing his hypotheses with regard to the relationship between satisfaction with affective behaviour and satisfaction with medical treatment. Firstly he examines the overall correlations between the two sets of variables. He shows (1976) that measures of satisfaction with affective behaviour correlate highly with satisfaction with medical treatment. In addition to such overall correlations, the second approach is to examine the strength of correlations in different sub-groups selected in accordance with his theory. Thus correlations between satisfaction with 'affective' and 'instrumental' items are examined separately for those with differing levels of education. The same approach is adopted here to examine the relevance of Ben Sira's theory to the STD clinic attenders. However, this kind of 'specification' of relationships is not the only way in which Ben Sira's model can be tested from such survey data. Ben Sira's model clearly states a number of causal hypotheses, involving a small number of variables, which can be tested by other means than specification. Subsequently it will be argued that, in addition to analysis by correlations, it may be helpful to explore the causal relations between variables by means of the methods developed by Blalock and others for testing causal models, by examining partial correlations.

### Zero order correlations

The first form of evidence that can be compared with data presented by Ben Sira are the overall correlations - between measures of satisfaction with affective behaviour and satisfaction with medical care. These are referred to throughout the discussion as attitudes in relation to 'affective' and 'instrumental' items or elements of behaviour in accordance with Ben Sira's own use of the distinction.

Ben Sira reports overall correlations between affective and instrumental items from two studies (Ben Sira;1976, 1980) and the two samples produce two very similar sets of correlations, thereby providing apparent weight to the overall approach and theory adopted by Ben Sira. The figures from his second survey are used for the purposes of comparison in this discussion. The correlations from Ben Sira's study are shown in Table 17. They can be compared with the correlations obtained in the STD clinic (Table 18) using similar measures as outlined in the previous chapter.

There are a number of points to be made about these two sets of correlations. Firstly in both Ben Sira's general practice sample and the STD clinic, all of the measures of satisfaction with the doctor's affective behaviour correlate quite highly with all of the measures of satisfaction with treatment. However the correlations are higher in Ben Sira's sample. This may be because of

the different kinds of correlation coefficient used in the two studies. The weak monotonicity coefficient used by Ben Sira tends to produce absolute levels of correlation somewhat higher than the Pearson's coefficient used in the STD clinic study (Ben Sira, 1976: 8; 1980:173).

Secondly in both of Ben Sira's samples, 'devotion' was the affective component that most strongly correlated with instrumental satisfaction items. According to Ben Sira it may therefore be the most salient aspect of a GP's behaviour. Views about the doctor's devotion contribute to the patient's views about 'more diffuse and less observable areas of the physicians response (skills and giving a feeling of reassurance)' (Ben Sira, 1976:8).

On the other hand, in both of Ben Sira's samples, satisfaction with the doctor's interest was most weakly correlated with instrumental items. Yet satisfaction with interest was more strongly correlated with satisfaction with treatment than with the other instrumental items and in both of his studies, Ben Sira's interpretation is that 'the physician's showing of interest in the patient as a person represents a relatively more tangible facet of affective behaviour and hence is more strongly associated with the technical activities connected with the treatment itself' (Ben Sira, 1980:174).

Both the general practice and STD clinic studies indicate that affective and instrumental items are highly related. However there is no obvious similarity in the

specific pattern of overall correlations obtained in Ben Sira's G.P. studies and the STD clinic study. In particular, whereas devotion is important in Ben Sira's study, none of the affective items in the STD study appears to be distinctly strongly correlated with instrumental items. The only apparent pattern in the STD clinic study (Table 18) is for satisfaction with affective items to correlate more with 'satisfaction with reassurance' than with the other two variables. It might be argued that the other two items of medical care represent more purely instrumental items whereas perceptions of feelings of reassurance from the doctor represent a more affective - type item. Further interpretation of differences between Ben Sira's studies and the STD clinic study must await further comparisons between the two sets of results. However, in relation to the greater apparent importance of 'devotion' in Ben Sira's surveys, it may be suggested that judgements of devotion are somewhat difficult for patients in relation to an unfamiliar out-patient doctor such as in an STD clinic. The very term implies a degree of continuous, personal involvement by the doctor in the patient's welfare that such medicine normally precludes. On the other hand 'devotion' may be a more appropriate concept in terms of which to judge the doctor in the more stable and enduring relations of general practice, investigated by Ben Sira.

At this point it may be said, however, that despite differences in detail between the two studies, generally the STD clinic study provides some support for Ben Sira's



thesis. In Ben Sira's view, however, the more elaborate evidence in support of his thesis is provided by the analysis of how the overall correlations are influenced by relations with third variables. His approach is to look at his original correlations in terms of different values or sub-groups of third variables.

#### Correlations in relation to education

Ben Sira examines sub-groups of two variables, education and level of health concern. Firstly the correlations between affective and instrumental items may be examined in relation to education. The data in Ben Sira's sample (Table 19) support his thesis in that there is a trend of increasing correlation between satisfaction with the doctor's affective and instrumental behaviour, as level of education decreases. Indeed he observes that this role of education is greater than the effect of the other control variable he examines - concern about health - in the sense that the differences between the extremes of education in the strength of correlations are greater than the extremes with regard to concern about health. This evidence of the role of education can be interpreted according to Ben Sira in two alternative but complementary ways, both of which support the general direction of his theory of patient satisfaction. Firstly it may be remembered that a crucial element of his theory is that:

'the inclination to judge the content of the physician's treatment by the mode of presentation is a consequence of patients' ignorance of medical techniques and hence incapability of judging the content of the physician's response during the course of the interaction with the G.P.' (Ben Sira, 1980:171)

As he goes on to argue, education may be regarded as a measure of an individual's ability to judge a professional's activities. The ability to judge the medical content of a doctor's activities separately from his affective behaviour should increase with educational level. Thus the survey results obtained indicate that education 'helps patients judge the physician's contribution to their goal achievement' (Ben Sira, 1980:175).

A second, slightly more speculative interpretation of the results is also presented by Ben Sira. He argues that, from the point of view of the therapeutic process, his theory of patient satisfaction and the evidence that supports it 'would stress that the lower a patient's level of education, the greater the need of accompanying treatment with emotional support' (Ben Sira, 1980:172) (emphasis added). This is partly elaborated upon later when he explains that those with more education are not only better able to evaluate the doctor's contribution but have more resources for coping with their health problems. They are therefore less dependent on the doctor's emotional support in coping with their illness. He thus argues that a complementary interpretation of the educational differences found in the data of Table 19 is as follows: 'The variance in the strength of the mode - content relationship may serve as an indicator of increasing need of emotional support throughout their medical treatment as social standing increases' (Ben Sira,

1980:178). In other words, the stronger correlations between affective and instrumental items amongst less educated respondents may be due to both their greater dependence upon affective cues from the doctor to judge the quality of their care and also their greater need for affective behaviour in the form of social support as part of their treatment. This interpretation is more speculative in terms of evidence. To support this interpretation he points to evidence from other research that less educated individuals experience more stress, and present problems to doctors which have less purely medical content and, by implication, involve more affective needs. He also points to evidence (Antonovsky and Arian, 1972) that education is inversely related to levels of concern about health (and by implication need for affective support).

Ben Sira creates his sub-groups by means of years of schooling. In the STD clinic study, three sub-groups of similar size were created by dividing the sample into three groups according to the level of educational qualifications held: (1) 'O' level or less educational qualifications (2) 'A' levels and (3) further qualifications. When the STD clinic correlations are examined by means of Ben Sira's method of sub-group specification (Table 20), it is clear that there are similar though weaker trends in the same direction. Comparing the extremes of educational level, seven of the nine sets of affective - instrumental correlations exhibit differences in the direction predicted by Ben Sira's theory. The exceptions are the correlations

of 'satisfaction with interest' in relation to 'skills' and to 'treatment'. In two of the seven correlations that are consistent with Ben Sira's thesis ('time' and 'skills', and 'devotion' and 'reassurance'), the differences in correlations between the extremes of educational levels are greater than those found in Ben Sira's data. On the other hand, whilst the majority of correlations support Ben Sira's thesis, it must also be noted that the data do not show the step-wise progressive patterns with changing levels of education that are found more consistently in Ben Sira's data. Nevertheless at this point the overall pattern of results appear consistent with Ben Sira's results. It has already been observed that the sample holds quite high levels of educational qualifications and may not have the full range of educational experience necessary to exhibit the interactions identified in Ben Sira's studies.

#### Correlations in relation to health concern

The second variable to be considered in relation to satisfaction is that of concern about health. It was argued in the last chapter that there are considerable inconsistencies between the theoretical and empirical approach to concern about health adopted by Ben Sira. In his theoretical model he discusses the concept in terms of concerns about the presenting problem at the time of consultation. In his survey however, he asks about current concern with the question: 'To what extent are you worried about the state of your health?' Three groups are

formed: worried, not worried, and definitely not worried. The correlations that Ben Sira obtained between affective and instrumental items by sub-groups of concern about health (Table 21) indicate weak but consistent trends in the direction predicted by his theory; as concern about health increases the strength of the correlations between the two types of satisfaction variables increases. As observed above, in his results, 'interest' is the affective behaviour that most weakly correlates with instrumental items overall. In relation to concern about health however, Ben Sira underlines the finding that interest: 'has the relatively strongest association with 'treatment' for those worried about their health...the physician's showing of interest in the patient as a person represents a relatively more tangible facet of affective behaviour and hence is more strongly associated with the technical activities connected with the treatment itself' (Ben Sira, 1980:174). He goes on to argue that this result 'stresses again the significance for emotionally involved patients of the physician's 'interest' in their problems in these patients' evaluations of the quality of the treatment' (Ben Sira, 1980:174). Such perceptions may in turn influence further outcomes such as compliance and the recovery process.

It is again worth underlining the theoretical interpretation placed upon the evidence. As with his views on the role of education in relation to satisfaction, the emotional involvement of a patient in his or her illness is taken to result in needs for emotional support. Thus the



more emotionally involved, i.e. concerned about health, the greater is the need for support. A crucial, but unexplored step in the argument is that it is primarily the patient's perceptions of the doctor's affective behaviour that influence this part of the patient's evaluation of outcomes; as Ben Sira puts it 'their subjective feeling of improvement will in large measure be determined by the G.P.'s success in relieving their anxiety' (Ben Sira, 1980:171).

Because of the ambiguities in Ben Sira's use of the concept of health concern, two alternative approaches to this concept were examined in relation to satisfaction in the STD clinic study. Firstly a measure was adopted which directly examined the influence of concerns in relation to the particular health problem presented in the clinic; a second measure was adopted which examined the influence of more general and stable levels of concerns about health.

To examine the influence of different levels of concern about health in relation to the presenting problem, the responses were used of the nine item Illness Concern Questionnaire which asked patients about different specific concerns they might have in the relation to the problem they were presenting to the clinic. It may be noted that many of the items in the Illness Concern Questionnaire address similar issues to those included in Ben Sira's concept of 'the stress potential' (Ben Sira, 1982a) of presenting problems: the seriousness of the problem; the extent to which the individual thinks about and worries

about the problem; whether the individual feels capable of solving the problem. The Likert type responses to the Illness Concern Questionnaire were summed in a simple additive fashion to form a single index of increasing levels of concern with a range of possible scores from 9 (No concerns) to 34 (High level of concerns). Three approximately equal groups were then formed from this index of high, medium and low levels of health concern. The correlations between satisfaction items in the three sub-groups thus formed are shown in Table 22. In the case of correlations between satisfaction with affective behaviour and two of the three instrumental items - skills and reassurance - there are no trends in the predicted direction. Indeed, for all six correlations between affective items and 'skills' and 'reassurance', the trends are clearly in the direction of correlations being weaker as level of concern about health increases. In two correlations - those of 'time' with 'skills' and 'time' with 'reassurance' - the differences between extremes of concern about health are not only in the opposite direction but slightly larger than the equivalent differences in Ben Sira's data. On the other hand support for Ben Sira's theory is provided with regard to the third instrumental item - medical treatment - in which the correlations increase in the predicted direction of increasing health concern. Moreover the differences between the lowest and highest levels of health concern are greater in the case of two affective items (time and devotion) than is the case in the equivalent correlations in Ben Sira's data.

Thus with regard to the role of health concern in the first sense - concern about the presenting problem - it would appear that perceptions of affective behaviour are not more strongly associated with perceptions of the skills of the doctor as individuals become more concerned about the presenting problem. Perceptions of affective behaviour are however increasingly associated with perceptions of the quality of treatment as the individual becomes more concerned in relation to the presenting problem. The affective items that are correlated most strongly with treatment in the STD data are 'devotion' and 'time' whereas 'interest' is the most highly correlated with treatment in Ben Sira's data.

Stronger support for Ben Sira's thesis can be found in relation to the second measurement of concern about health - general concern about health. The second measure of concern about health examined in the sample is the scale of the IBQ termed 'General Hypochondriasis' and described as 'a general factor marked by phobic concern about one's state of health' (Pilowsky and Spence, 1983:3). Patients were assigned to one of three groups according to their score on this scale. In this case (Table 23), there are trends in relation to all three instrumental items in the direction of Ben Sira's theory. If one considers again the extremes of concern in relation to health, in six out of nine correlations the correlations increase as level of concern about health increases. The amount of increase is

slightly greater (comparing the extremes of health concern) in the correlations between affective items and skills than in the correlations between affective items and treatment. In comparison with Ben Sira's results however, it has to be said that the size of the differences in correlations between extremes is generally not as great as those found in his data. Moreover only one correlation - 'interest' and 'skills' exhibits the progressive step-wise increase with level of concern that is characteristic of Ben Sira's results.

#### Summary of specifications in the STD clinic study

The extent to which the above sets of correlations provide support for Ben Sira's theory is a complex question. Firstly the data on education can be considered. Generally the STD clinic data do apparently provide support for Ben Sira's thesis because there is a consistent trend for correlations between affective and instrumental items to be stronger as level of education declines. It should be underlined that the sample as a whole was quite highly educated so that it is possible that educational effects of the kind identified by Ben Sira were thereby dissipated. Ben Sira presents two different, although not inconsistent interpretations of the educational effects in accordance with the overall thrust of his own approach but there is little in the STD clinic results that facilitate theoretical interpretation of the educational effects at this point in the analysis.

The other component of Ben Sira's thesis examined here is the role of concern about health. This concept, it has been argued, has at least two components: (1) concern about one's health arising from the presenting problem, and (2) general and more stable levels of concern or worry about one's health. The former is more theoretically relevant to Ben Sira's thesis in that it is 'the patient's evaluation of the meaning, seriousness, and possible outcomes' (Ben Sira, 1980:171) of the disease that he presents to the doctor to which the latter's affective behaviour is addressed. On the other hand, Ben Sira's approach to the measurement of health concern was to rely on more general and more stable levels of health concern to test his theory. The main ground for viewing health concerns as stable is, according to Ben Sira, that health concerns are associated with social standing, and that social standing is a stable attribute.

The STD clinic study was able to assess the influence of both types of health concern upon judgements of satisfaction. The more consistent support for Ben Sira's thesis was found when patients' general level of concern about health were measured rather than concern in relation to the presenting problem. For two thirds of correlations between affective and instrumental items, there was a weak increase in correlations as general levels of health concern increased. There were some exceptions to this trend: as level of concern increased the correlations of 'time' with 'reassurance' and 'treatment' and the correlation of 'devotion' with 'treatment' did not



increase. In other words these results are consistent with the empirical evidence of Ben Sira in suggesting that there is a modest but general trend for those with higher levels of general concern about health to show closer correlations between their judgements of affective and instrumental behaviour. These effects upon correlations were strongest and most consistent in relation to judgements of the skills of the doctor. On the other hand perhaps more striking is the quite weak levels of correlations of affective items with 'skills' items - ranging from 16% to 49%.

The alternative measurement of health concern, focusing upon the varying extent to which patients had worries and concerns in relation to the presenting problem, produced quite different results. In two of the three instrumental items, the trend was the opposite of the predicted direction. If these results are described in terms of Ben Sira's causal model, those who were more concerned about their presenting problem were less reliant upon the doctor's affective behaviour than were those who were unconcerned. Moreover the strength of correlations indicates only modest influences of affective items upon perceptions of skills. In only one third of the correlations - between affective items and 'treatment' was pattern of correlations in the direction predicted by Ben Sira's model. The results of concern with the presenting problem in the STD clinic are of relevance to another of Ben Sira's concepts - the 'stress potential' of problems presented to the doctor (Ben Sira, 1982a) in that similar

indicators are used in both surveys, for example, the salience and seriousness of the presenting problem. The results of affective-instrumental correlations for different levels of 'stress potential' of problem in the STD clinic survey are largely in the opposite direction from that hypothesised by Ben Sira.

Overall therefore the results of this approach to analysis provide mixed support for Ben Sira's theory. Judgements about affective behaviour appear to be quite strongly correlated with judgements about instrumental behaviour. Given the strongly positively skewed nature of such data, it would be surprising if different satisfaction items on such a questionnaire did not exhibit such relationships. Thus the more crucial issue is the way correlations behave in the sub-groups identified by Ben Sira. On the one hand the educational data are consistent with Ben Sira's model. On the other hand the evidence about the effects of level of concern about health appears to be supportive but not in terms of those measures which directly examined the meaning to the patient of the presented problem. Further, the largest effect of such generalised concern was in correlations between affective items and perceptions of the skills of the doctor and in relation to reassurance. It must not be forgotten that Ben Sira's theory is ultimately meant to be a theory of the factors that influence perceptions of the treatment received from doctors. As Ben Sira himself puts it:

'the affective component of the physician's behaviour toward the patient (mode of behaviour) will be a major factor in the latter's assessment of the instrumental component of the physician's behaviour (content of

behaviour) i.e. the efficacy of the medical treatment. (Ben Sira, 1980:170)

To the extent that measures of general concern about health provide support for the theory, it is in their influence upon two more attitudinal measures; concern about health plays less of a role in influencing the correlations between affective items and judgements of treatment efficacy. It has already been argued that there are problems in the concept of instrumental behaviour in that it is used by Ben Sira to refer to a range of heterogeneous aspects of medical treatment from the skills and competence of the doctor through to the benefits of medical treatment. At this point it may be pointed out that in the STD clinic study the correlations between affective and instrumental items exhibit least the predicted patterns of change by sub-group in relation to that instrumental variable -satisfaction with medical treatment - that theoretically is the central dependent variable of Ben Sira's model.

#### Satisfaction, causal inferences and causal models

Ben Sira has consistently recognised the problem of implying causality from the correlations identified in his data. In his original study he observed that: 'the study was not able to ascertain whether such correlations imply causality' (Ben Sira, 1976: 10). In a more recent study the point is again made: 'Yet as in any other study in the social sciences which is entirely based on correlations, questions regarding the direction of causality could be raised' (Ben Sira, 1982b: 1018).

Ben Sira thereby acknowledges the well recognised position that correlations merely measure the degree to which variables vary together. However, equally widely recognised is the position that, philosophical reservations about the notion of causality aside, correlational analysis can be used to make inferences about causality if alternative causal models are tested by means of statistical correlations (Blalock, 1962; Simon, 1954). As Marsh argues: 'The key to the correct use of survey data to provide corroborative evidence of a causal process is in the adoption of a model' (Marsh, 1982:72). One general principle behind making such causal inferences is the examination of what happens to zero - order correlations when control variables are introduced. Ben Sira makes some use of third variables to elaborate his causal model, notably the introduction of variables such as illness concern and education. Although he does not discuss his use of third variables in this way, the role of such variables as illness concern in his analysis comes close to what Hirschi and Selvin call 'specification' - 'a strong form of interaction in which at least one partial relation is larger than the original relation' (Hirschi and Selvin:1973:111). However this is but one use of multivariate analysis and the kind of data provided by Ben Sira and by the STD clinic study can be subjected to further analysis to examine more closely the plausibility of causal models suggested by Ben Sira's theory. In particular predictions about zero order and partial correlations can be used to distinguish between direct and

more indirect influences of variables in a causal chain (Blalock, 1962).

The use of correlational data to make causal inferences involves an initial series of simplifying assumptions. Firstly, the number of variables examined must be quite small since, otherwise the number of correlations to be examined becomes unmanageable. The analysis here is mainly confined to three satisfaction variables that are theoretically important to Ben Sira's theory and a fourth variable - concern in relation to the presenting problem - which is both theoretically important to his model and also appears from the zero order correlations in Table 24 to play an important role. The three satisfaction variables are:

- (1) satisfaction with the doctor's interest (Art of Care Scale, Quest. 1)
- (2) satisfaction with the doctor's skills (Technical Quality Scale, Quest.13)
- (3) satisfaction with the doctor's medical treatment (Efficacy Scale, Quest. 10).

The level of concern is the variable used earlier in the analysis, summing answers to the Illness Concern Questionnaire to a single additive scale.

It must be remembered that in Ben Sira's theory satisfaction with the doctor's interest (as an affective item) plays an important direct role in influencing satisfaction with the doctor's medical treatment. It is



this hypothesis that partial correlations will be used to examine.

A second assumption necessary in Blalock's methodology is that 'variables which have been left out of the causal model create "error" terms which are essentially random' (Blalock, 1962:185). With just four variables, there are still a large number of different possible causal models that might be examined. Some further assumptions of a theoretical nature need to be made to enable a clearer focus upon more conceivable alternative models. In this study concern about health was measured before the consultation, satisfaction variables at least one month later. Therefore one assumption that will be made is that causal influences can only flow from health concern to satisfaction variables. A second and more problematic assumption in terms of time order of variables concerns the causal sequence of satisfaction variables. This is somewhat more arbitrary since the satisfaction variables were measured simultaneously. Nevertheless it will be assumed that judgements about the manner (affective behaviour) and skills of the doctor (instrumental behaviour) are made prior to judgements about the likely benefits of medical treatment that he gives. In reality, accounts by patients reported in studies such as Stimson and Webb (1975) indicate a continuous and interactive process of forming views in terms of satisfaction with a medical consultation. Nevertheless, as it is an assumption of Ben Sira's that judgements of the form of the consultation are prior to judgements of the benefits of the

consultation, the same assumption is used here to the extent that the causal influence of other variables upon 'satisfaction with medical treatment' is examined rather than the reverse. In other words the latter variable will be treated as the dependent variable.

There are three alternative causal models (see Figure 1) that might plausibly be posited to explain the relationship between concern about health and the three satisfaction variables, in the light of the zero order correlations in Table 24. In all three models concern about health plays the same role of directly influencing both 'satisfaction with skills' and 'satisfaction with treatment'. The models differ in the role of 'satisfaction with skills' and 'satisfaction with interest'.

In Model One, 'satisfaction with interest' (affective behaviour) directly influences both 'satisfaction with skills' and 'satisfaction with treatment', whereas 'satisfaction with skills' plays no direct role upon 'satisfaction with treatment'. This model is the one which is most compatible with the Ben Sira thesis in that it would attribute considerable direct influence of 'satisfaction with interest' as an aspect of satisfaction with affective behaviour, upon two measures of satisfaction with instrumental activities, and, like Ben Sira's model, attributes no significant influence to judgements about the doctor's skills. The assumption of this model is that a positive correlation found in the data between 'satisfaction with skills' and 'satisfaction with

treatment' is a spurious one produced by the independent operation of 'satisfaction with interest' and 'concern about health'. If this assumption is correct, the partial correlation coefficient of 'satisfaction with skills' with 'satisfaction with treatment' should be considerably reduced or disappear, once we have controlled for 'satisfaction with interest' and 'concern about health'. Following the logic of Blalock's prediction equations for four variable models (Blalock, 1962), the relevant prediction for the partial correlation coefficients for this model (using the variable notation in the diagrams, for the sake of brevity) is therefore:

$$r_{YZ.AX}=0$$

(i.e. the partial correlation between Y and Z, controlling for A and X should be zero.)

The partial correlation coefficient is in fact: .32. This is only a small reduction from the zero order correlation coefficient of .50. Thus it seems unlikely that the zero order correlation between Y and Z is spurious in the sense that it is due to the independent operation of 'health concern' and 'satisfaction with interest'. There is likely to be a substantial direct effect in which 'satisfaction with skills' has a direct influence upon 'satisfaction with treatment'.

The other two models both still assume a similar role for 'concern about health' as is indicated by the first model. Both also assume a direct effect of Y upon Z

('satisfaction with skills' upon 'satisfaction with treatment'), as appears to be indicated by the above partial correlation coefficient. They differ in that, whereas Model Two assumes a direct influence of both X and Y upon Z, Model Three assumes a direct effect of only Y upon Z. In other words, Model Three is the furthest model from Ben Sira's because it assumes no direct role for the affective item of 'satisfaction with interest'. Only 'satisfaction with skills' and 'health concern' are thought to influence the dependent variable. This model assumes that the relationship between X ('satisfaction with interest') and Z ('satisfaction with treatment') is an indirect one, produced partly through the indirect effects of X upon Y and Y upon Z and partly through the conjoint effects of A upon Y and Z. Therefore both Y and A have to be controlled for, if the correlation between X and Z is to be considerably reduced or disappear. If model three were the more appropriate model, the following partial would be predicted:

$$r_{XZ.AY}=0$$

(i.e. the partial correlation between X and Z, controlling for A and Y should be zero)

The partial correlation coefficient  $r_{XZ.AY}$  is .39. This is only a slight reduction compared with the zero order correlation and suggests a considerable direct effect of 'satisfaction with interest' upon 'satisfaction with treatment'. If model two were the more appropriate model, the above partial ( $r_{XZ.AY}$ ) would not be expected to

disappear. According to this model there would still remain direct effects of X upon Z, after controlling for the effects of Y and A. The partial correlation of .39 does indeed indicate a direct effect of 'satisfaction with interest' upon 'satisfaction with treatment'.

Thus of the three possible models considered it seems that model two is the most consistent with the zero order and partial correlation coefficients obtained. This model indicates direct effects of 'concern about health', 'satisfaction with interest' and 'satisfaction with skills' upon 'satisfaction with treatment'. Model Two is consistent with Ben Sira's model to the extent that 'satisfaction with interests' appears to have a direct effect upon 'satisfaction with treatment' when the effects of 'satisfaction with skills' are controlled for. This would be consistent with affective items of satisfaction causing instrumental items. However, by the same logic, the partial correlation coefficient of 'satisfaction with skills' with 'satisfaction with treatment' controlling for 'health concern' and 'satisfaction with interest' remains high. 'Satisfaction with skills' must exert just as much influence upon 'satisfaction with treatment'.

#### Assessment of the causal model

This method of examining alternative possible causal models by means of partial correlations does not support the thesis that 'satisfaction with interest' has any particularly strong effect upon instrumental



satisfaction compared with other satisfaction items, such as satisfaction with skills. Models which assigned greater direct causal influence to either 'satisfaction with interest' alone (Model one) or to 'satisfaction with skills' alone (Model Three) were not satisfactory. The only model consistent with both the zero order and partial correlation coefficients is one (Model Two) which assigns equal importance to both 'satisfaction with interest' and 'satisfaction with skills' in directly influencing the dependent variable - 'satisfaction with treatment'. It is difficult by this method to support either instrumental or affective items as having any stronger influence upon the dependent variable of 'satisfaction with treatment'. It would appear therefore, that, to the extent that any speculation about causality is warranted by such data, it is not justified to regard affective items such as 'interest' as more important in influencing 'satisfaction with treatment'. The central proposition of Ben Sira's model is thus highly doubtful.

It may be argued that any causal interpretation of the zero order and partial correlation coefficients obtained in the STD clinic is unwarranted. It may be said that the different dimensions of satisfaction are insufficiently distinct as concepts. They refer to closely connected elements in a single process and are inappropriate for causal modelling. Clearly satisfaction questionnaires result in positively skewed data in which most items are highly correlated with each other so that quite strong evidence is needed to assign some variables

causal priority over others. Such considerations might make some regard the very use of causal thinking doubtful in this context. However it needs to be remembered that Ben Sira has advanced a causal model from just such data as that analysed here. It is a model which has important clinical and policy consequences in so far as it quite narrowly defines the patient's range of competence and interest in the realm of evaluating health care. Ben Sira's work therefore involves both a bold claim to causal understanding and enormous policy relevance. However the ambitious scope of the model is not matched by an appropriate range of methods to test the model. The data from the STD clinic do not provide support for any causal primacy of affective factors. Judgements of the instrumental dimensions of the doctor emerge as just as closely connected to satisfaction with treatment. If causal interpretations of such data are unjustified, the conclusion remains the same - that affective factors cannot be shown to be particularly important from the pattern of results obtained in this satisfaction survey. The same analyses in relation to Ben Sira's data are not available, although it is unlikely that an examination of partials in the Israeli community surveys would produce dramatically different results. It is surprising that such simple tests were not applied to the data, given the considerable implications of Ben Sira's model. The patient cannot be shown to be dependent upon doctors' affective behaviour by this method. The next chapter will examine other ways in which affective factors may play a role.

## CHAPTER 8. AN APPRAISAL OF THE ROLE OF AFFECTIVE FACTORS IN PATIENT SATISFACTION

The analysis of patterns of patients' responses to the STD clinic has suggested that it is difficult to assign prominence to 'satisfaction with the doctor's affective behaviour' in a causal explanation of patients' overall satisfaction with medical treatment. Because the responses to different components of the satisfaction questionnaire are intercorrelated, the selection of some items as causally prior is somewhat arbitrary. The overall theory, emphasizing the importance of the doctor's affective behaviour and emotional support in influencing patients' responses to consultations, may still be a useful way of thinking about relations between doctors and patients, and could be examined by other research approaches. However it receives very limited support from an examination of correlations between items within satisfaction questionnaires alone. It has been argued in previous chapters that many of the limitations of the evidence used by Ben Sira to support his theory stem from examining cross-sectional survey responses of individuals not currently concerned with evaluating the specific benefits of a medical consultation in relation to a specific health problem. An advantage of the survey data gathered in the STD clinic is that it was collected longitudinally and

patients were asked to report current health concerns in attending the clinic in relation to which their subsequent views of treatment could be examined. In this chapter an assessment is made of the extent to which such prior concerns about health problems are directly associated with subsequent satisfaction. This will lead to a very different emphasis upon the role of affective factors in patient satisfaction from that of Ben Sira. His model is then assessed in the light of the STD clinic study.

#### Distress, concerns and satisfaction

Patients completed three questionnaires prior to their consultations with the clinic doctor - the General Health Questionnaire (GHQ), the Illness Behaviour Questionnaire (IBQ) and the Illness Concern Questionnaire (ICQ). The association of GHQ 'caseness' with two of the three satisfaction scales was noted in the previous chapter. The more psychologically distressed patients were more often dissatisfied with the clinic. Greenley and colleagues' comment (1982) that this area of patient satisfaction is remarkably neglected was also noted in chapter 7. The relationship between psychological distress and dissatisfaction with medical care could arise for a number of very different reasons. The other two instruments completed by patients offer an opportunity to consider some possible explanations for the association of GHQ 'caseness' and patient dissatisfaction.

Distress as 'abnormal illness behaviour'

Pilowsky and Spence (1983) developed their questionnaire - The Illness Behaviour Questionnaire - 'to record aspects of illness behaviour' (1983:1). Although they derive the concept directly from Mechanic (1968), their use of the concept is more informed by psychiatric than by sociological assumptions, with an emphasis on 'abnormal illness behaviour' such as hypochondriasis and conversion reactions, in which 'there is a fundamental discrepancy between the objective pathology present and the patient's response to it' (Pilowsky and Spence, 1983:1). Observers of STD clinics have noted that various fears and worries about disease are common in STD clinics (Kite and Grimble, 1963; Macalpine, 1957). Often such investigations focus on the atypical phobias such as 'venereophobia' - inappropriate fear of contracting venereal disease - which are said to represent a considerable part of the workload of an STD clinic (Oates and Gomez, 1984). Mayou, however, argues that illness fears may be so common in STD clinics that it is difficult to distinguish normal from abnormal responses to symptoms (Mayou, 1976:58). He suggests that there may be a continuum of fears involving one extreme in which they are quite resistant to reassurance, whilst other patients' fears may normally be allayed. The results of the seven scores of the IBQ in the clinic (chapter 6) confirmed that, whilst the mean scores of more purely psychiatric syndromes such as 'affective disturbance' were lower than those normally found in General Practice samples, the mean of the 'General Hypochondriasis' scale



was much higher and the mean of the 'Disease Conviction' scale somewhat higher than occurs in general practice samples. This was taken to lend some support for the arguments of a previous survey (Fitzpatrick et al., 1986) that much of the 'caseness' found in STD clinics reflects distress arising from the meaning to the individual of the presenting problem, and that, as Mayou (1976) has suggested, such concerns are extremely common.

The relationships between IBQ scales and the three satisfaction scales are examined in Table 25. The correlations between IBQ scale items and satisfaction are quite modest. The scale of Affective Disturbance has been examined for concurrent validity with other anxiety and depression scales and is presented by Pilowsky and Spence (1983) as strongly reflecting these primary aspects of psychological disturbance. It is important therefore that Affective Inhibition, and the similar scales of Affective Disturbance and Irritability, do not correlate significantly with satisfaction, whereas the two scales directly addressing perceptions of symptoms and of health status - Hypochondriasis and especially Disease Conviction - are significantly correlated with the satisfaction scales. This might be taken as evidence that primary aspects of psychological disturbance such as anxiety and depression are less important as influences upon satisfaction compared with distress arising immediately from the presenting complaint or other health perceptions. The largest correlations with satisfaction are for the scale of Disease Conviction. It is particularly

significant that Pilowsky and Spence (1983:3) see this scale as detecting not only beliefs that the individual has a disease but also the likelihood of 'rejection of the doctor's reassurance'. The relationship found here between the scale and subsequent satisfaction might be seen as providing support for this interpretation of the scale and as evidence of a significant group of patients in the clinic with concerns about disease that are resistant to reassurance.

The overall associations found here between GHQ 'caseness' and satisfaction and in a few other studies (Lebow,1983) need to be explained. They may reflect the general tendencies of a minority to be unhappy and dissatisfied with all aspects of life and with all efforts by professionals to help them (Greenley et al.1982). Although very speculative, the interpretation of the pattern of associations found by means of the IBQ is that psychological distress in the sense of more generalised moods and orientations, such as depression or anxiety, is less strongly associated with patient dissatisfaction than more specific distress, especially arising from 'illness behaviour'. It is distress in relation to current perceptions of health and of bodily symptoms that is more likely to result in dissatisfaction. Barsky and Klerman (1983) summarise the clinical evidence that links hypochondriasis and patient dissatisfaction:

'Hypochondriacal patients relentlessly and tenaciously seek medical care.....Not surprisingly, their medical care experiences are as unsatisfactory as they are extensive. ...Hypochondriacal patients feel they have not received good medical care, they speak disparagingly of their physicians, and their

physicians speak unflatteringly of them' (Barsky and Klarman, 1983:275).

However they go on to acknowledge that the concept of hypochondriasis is confused and value laden and advocate a more neutral concept with fewer implicit evaluative or aetiological assumptions - the concept of 'amplifying somatic style'. This concept applies to individuals who particularly assiduously monitor their bodily symptoms, and who are particularly likely to attribute symptoms to physical disease rather than to normalise them. Barsky and Klarman argue that unlike the concept of hypochondriasis, this concept 'does not imply the presence or absence of concurrent medical disease or psychopathology' (Barsky and Klarman, 1983:280). Attention to one's bodily state is associated with 'more negative appraisal of one's health' (Barsky, 1988).

Elsewhere Barsky takes up and develops these ideas into a more sociological concept of 'illness attribution' (Stoeckle and Barsky, 1981) drawing on an earlier discussion by Mechanic (1972). Mechanic had discussed the social psychological processes whereby individuals may arrive at distressing or alarming interpretations of symptoms that might otherwise be normalised. Cultural factors and socialisation processes may both be important influences upon how individuals interpret symptoms and in some instances form more alarming or distressing interpretations of symptoms. Stoeckle and Barsky discuss illness attributions in terms of the process whereby individuals arrive at explanations for their illnesses. Explanations

are shaped by culturally sustained systems of health beliefs upon which individuals rely, as well as by individual characteristics of personality. Both Mechanic's and Stoeckle and Barsky's discussions avoid the psychiatric emphasis of the concept of hypochondriasis. Both discussions conclude that problems of management, such as patient dissatisfaction, may arise where doctors are unsuccessful in addressing and modifying such illness attributions. These theoretical discussions lend some weight to the interpretation of correlations between IBQ scales and satisfaction scores found in this study. In the STD clinic, psychological unhappiness is associated with dissatisfaction with care at least in part because of distress arising from interpretations of current somatic symptoms. Where such distressing attributions are not modified or assuaged as a result of the clinic visit, dissatisfaction may arise.

However when the raw scores for the IBQ were presented in chapter 6, it was noted that the alpha reliability coefficient for Disease Conviction was quite modest compared with most of the other scales. The scale may be heterogeneous in terms of content. It may not therefore be legitimate to interpret the scale in terms of the meanings imputed to it from its use in other populations. In the context of pain clinics, it appeared to indicate abnormal, unreasonable resistance to reassurance in the sense that concern and distress was disproportionate in relation to the presenting problem. Because the scale may be heterogeneous and inappropriate in

this population, and in order to identify which aspects of the scale were contributing to the correlations of the scale as a whole with satisfaction scores, all 6 individual items comprising the Disease Conviction scale were examined in terms of correlation coefficients with the satisfaction scales. The IBQ item that was consistently more strongly correlated with satisfaction compared to the other scale items (albeit very weakly, in absolute terms) was the item: 'If the doctor told you that he could find nothing wrong with you would you believe him?'. This item correlated with the art of care scale (0.12), with the technical quality scale (0.24) and the efficacy scale (0.20). One interpretation of this association could still be that of a process whereby some patients were so concerned by serious disease that they acknowledged their resistance to reassurance in their responses to this (IBQ) item and were subsequently dissatisfied with clinic staff's efforts to reassure. This would still involve an emphasis inherent in the scale upon 'abnormal' preoccupation with disease. The significance of the scale will need to be reconsidered later in the chapter after its importance in multivariate analysis has been examined.

Of particular interest is the correlation between satisfaction and the Denial scale of the IBQ which is in the opposite direction from the correlations involving the other six scales. This result runs counter to Greenley and



colleagues' (1982) finding that the sub-group amongst their distressed sample who were particularly dissatisfied were those who were both psychiatrically distressed but also denied and failed to recognise such problems. This denial was seen by the investigators as resulting in quite unrealistic expectations of the professional from whom they sought help. However the concept of Denial in psychiatry is particularly problematic and its operationalisation in the IBQ involves some questionable assumptions. Five items comprise the scale and the following two items are typical:

Except for your illness, do you have any problems in your life?

Do you have any financial problems?

Negative replies to either item are scored as positive on the scale of Denial. Denial is conceived of as denying the presence of such problems. The positive correlation of satisfaction scores and the Denial scale arises because those who maintain that they do not have various financial, family and other problems also report themselves as positively satisfied with their health care. Obviously the assumption behind the construction of the Denial scale is that many respondents may actually have such problems but deny their existence. However a simpler assumption than that contained within the IBQ is that many negative responses to questions about problems represent accurate perceptions of their lives! Unlike the other scales in which there is a face validity to self reported

symptoms or concerns, this scale involves considerable interpretation of the responses, which may not be warranted in the absence of further supporting evidence. If this interpretation of the Denial scale is correct, then those who have more problems in their lives also report more dissatisfaction with the STD clinic. This would be consistent with the association found in Patrick and colleagues' study (1983) between high life events scores and patient dissatisfaction.

#### Distress as concern about the presented problem

The Illness Concern Questionnaire was constructed specifically to record the frequency and types of worries, fears and concerns in STD clinics. It was developed out of questions asked in a previous survey (Fitzpatrick et al., 1986), and made no assumptions about the normality or appropriateness of such concerns. The results of responses to this questionnaire are given in Table 26. It is clear that there are a diversity of concerns amongst patients attending the STD clinic. Research in this field has largely focused upon the abnormal concerns of those who have no organic disease (Kite and Grimble, 1963; Oates and Gomez, 1984), whereas the concerns and fears of the majority of patients with symptoms originating from organic disease have remained unexamined. Moreover most discussions consider fears about serious disease. This has also been the almost exclusive focus of research into patients' concerns in other areas of medicine (Brody and Miler, 1986; Deyo and Diehl, 1986). Certainly such concerns

are commonly acknowledged in this sample. However it is noticeable that the most frequently cited concern is about a particular possible social implication of the presented problem - 47% of the sample expressed the concern that their symptoms might interfere with their sex life. A large number of patients also report worries that their problem will not clear up quickly. In many cases such concerns may be based on an accurate appraisal of the presenting problem. Thus the diagnostic group which was most likely to express concern that the presenting problem might not clear up quickly comprised those patients who received a diagnosis of Herpes; 41% of this group of patients expressed themselves as 'very much' concerned about this aspect of their health problem, and their concerns are quite consistent with the chronic course of the disorder (Hutfield,1968).

The correlations between Illness Concern Questionnaire items and the three satisfaction scales are shown in Table 27. They indicate that many of the particular concerns expressed by patients before seeing the doctor are modestly but significantly correlated with subsequent satisfaction scores. The greater any particular concern, the higher the probability of subsequent dissatisfaction. A few items are unrelated to satisfaction; the fear that the presenting problem may be a serious disease, for example. Other questions however show a consistent relationship with satisfaction; 'worry that the problem might not clear up quickly' is significantly related to all three satisfaction scales. This question

also shows the highest correlation of a concern item with a satisfaction scale - having a correlation of  $-0.30$  with 'satisfaction with the efficacy of care'.

It is apparent from the table that specific illness concern items had similar relative effects on all three scales of satisfaction. Thus the concern that 'the problem may not clear up quickly' was more strongly correlated than any other concern item with 'satisfaction with efficacy'. This same concern was also the most strongly associated of all the concern items with the other two satisfaction scales. Similarly the questionnaire items on 'concerns whether the presented problem would prove straight forward' and 'concern that the problem may prove painful' were both correlated with all three satisfaction scales. On the other hand, the question regarding concern about the possibility of a serious illness was equally weakly correlated with all three satisfaction scales.

#### Affect in medical sociology

At this point it may be worthwhile both to delineate the common ground in Ben Sira's research and in the approach advanced here, and to draw out certain contrasts between the two approaches. Both approaches assign an important role to emotional distress and concern in the experience of illness and help seeking. Indeed in Ben Sira's model 'anxiety as a consequence of the patient's evaluation of the meaning, serious and possible outcome of the disturbance' (Ben Sira, 1980:171) plays a pivotal role

in the model. In the results of the STD clinic study factors such as concerns about health also play an important role. In this sense both approaches may be said to contrast with the dominant approaches within medical sociology, which, in issues such as relations between doctors and patients have increasingly neglected that aspect of illness which involves affective concerns. In identifying a greater role for sociology in this field, authors such as Freidson (1970), Dingwall (1976) and Locker (1979) have tended to place greater emphasis upon individuals' cognitions and interpretations of illness as essential to any explanation of their illness behaviour.

In particular this approach to understanding action in response to illness has focused upon the importance of lay health knowledge, and lay cognitive theories of illness (Boulton et al., 1986). As Calnan observes (Calnan, 1987:144), very few empirical sociological studies have pursued the largely theoretical claims for the importance of lay theories and lay health knowledge. The momentum for exploring this dimension of illness behaviour has largely been sustained by medical anthropologists such as Kleinman (1980), Blumhagen (1980), Helman (1978) and Good (1977), who have developed a more formal and elaborate approach to the investigation of lay theories and their significance in issues such as illness behaviour and communication between patients and doctors. In this approach patients' views about the causes, course and appropriate treatment for their illness become decisive factors in determining the outcomes of consultations



between patients and their doctors. The value of this approach can be illustrated in a study by Harwood (1971). He found that many Puerto Ricans suffering from heart failure did not comply with medical advice requiring them to supplement their diet with orange juice. Their non compliance could be directly related to folk theories of hot and cold humours, in which oranges were perceived as harmful. In such a study, illness behaviour, in this instance non compliance, is directly related to lay health beliefs. Such research indicates an important role for the social sciences in investigating such belief systems and also is of immediate practical relevance to the providers of health care.

Whether investigators have focused upon decision - making approaches such as the Health Belief Model (Rosenstock,1975), or have adopted anthropological interests in 'folk classifications' of illnesses (Helman,1978), the common territory to many recent social scientific approaches has been an emphasis upon cognitive components of illness experience, concentrating upon how individuals 'theorise' 'define' and 'interpret' their health states. However although a valuable way of establishing the importance of the patient's perspective in health care, it may be that cognitive beliefs and theories have now been too exclusively emphasised. Young (1981) warns of the risks of this one sided emphasis upon the cognitive search for 'Rational Man' in studies of illness behaviour and related areas. In his view, the 'Explanatory Models' perspective has excessively overemphasised the

rational, logical and ordered qualities of individuals' experiences of illness. In particular he indicates three types of problems. Firstly, the explanatory models that patients may produce in medical anthropological enquiries may be artefacts of the investigator's line of questioning and the fact that respondents can produce such models should not be used as evidence that they constitute a salient dimension of illness experience. Secondly, individuals' perceptions may be determined by other cognitive principles than that of causal thinking. He is particularly concerned about unwarranted emphasis upon lay ordering of experience into causal forms of organised knowledge. He discusses 'chain complexes', for example, in which lay accounts of illness are not formed by their beliefs about the causes of their symptoms, but by 'strings of contiguous and salient events, sensations, symptoms' (Young,1982:69). In chain complexes individuals link together different dramatic phases of their unique experience of the course of an illness, but there is no effort towards 'theoretical' or causal linking. Lastly, Young implies, but does not elaborate upon, the idea that the Explanatory Model approach neglects the purpose of the lay knowledge about health and illness focused upon in Explanatory Models (Young,1982:62). Health beliefs and health knowledge are recalled or mobilised by individuals to resolve some particular concern or achieve a particular goal, such as finding relief from pain. Illness results in emotional distress, out of which emerges in turn the goal to seek relief from distress. This point is not developed by Young, but is of some importance. Illness behaviour and

medical help seeking occur to achieve solutions to problems. The goal may be symptom relief, reassurance, reduction of disability or stigma, or support. Cognitive beliefs and lay theories about causation may frequently enter into such goals (for example, where beliefs about certain symptoms being signs of cancer may motivate a patient to seek medical reassurance). Nevertheless it is the patient's goals and concerns that make most sense of his or her illness behaviour, not the content of cognitive beliefs alone. In the hypothetical example, beliefs about the signs and symptoms of cancer do not by themselves determine the patient's decision to consult; it is the distress that attends thoughts about cancer that prompt the need for help from a health professional. Thus it may be argued that the dimension that is missing from recent accounts of the experience of illness in authors such as Dingwall, Freidson, Locker and Kleinman is any explicit focus upon those goals and emotional concerns, (other than purely cognitive goals such as seeking an explanation) which motivate illness behaviour such as seeing a doctor. Illness may result in pain, stigma, discomfort, disability, anxiety, fear, concern about the future, as well as the need for the resolution of the cognitive problems that have been so emphasised by the recent medical anthropology and medical sociology of illness behaviour. Illness results in a range of emotionally distressing experiences that may prompt the need for action.

When Mechanic (1968) first set out the research issues involved in illness behaviour, a wide range of

variables were included. He discusses the importance for understanding illness behaviour of issues such as: whether individuals regard symptoms as serious (1968:144); pain tolerance (1968:147); anxiety and fear (1968: 152) and stigma (1968:151). A common element of such factors is that they involve emotional as well as cognitive components. In a subsequent discussion (Mechanic,1972), he emphasises the important role that emotional arousal may play in the experience of symptoms. More recently, the diversity of such goals and concerns in prompting illness behaviour has been less salient in research. One recent exception is a study by Brody and Miller (1986), which examined the illness concerns of patients seeking medical help for upper respiratory infections. They examined concerns about the seriousness of presenting symptoms, fears about the future seriousness of the problem and beliefs about whether symptoms could easily be cleared up. They concluded that such concerns were remarkably common and needed further investigation.

In this sense therefore Ben Sira's approach is particularly to be welcomed. His theory is developed with conscious attention given to the interplay of emotional and cognitive factors in the experience of illness and to the affective goals that motivate help seeking. Yet the specific approach to emotional or affective factors adopted by Ben Sira has two major limitations. In the first place it treats concern and anxiety as a single psychological continuum. Individuals are seen to vary on a single and static scale of concern about health. This is to work with

a quite simplistic psychological construct, given the evidence of complex situational factors that may influence thresholds and perceptions of one's health state and concern about health and illness. The anxiety levels of hospitalised patients are known to vary enormously during the course of a stay in hospital and to be determined by situational factors such as the amount of information given about their treatment and the types of procedures experienced, as much as by individual variation in such variables as coping style or personality (Newman, 1984). By discussing a single static and undifferentiated 'concern about health', no allowance at all is made for the cognitive - affective interplays involved in the experience of illness. The theory of emotions proposed by Lazarus (1966) depends upon a continuous flow of cognitive appraisals acting to shape emotional responses to stress. Thus the degree of threat and emotional arousal posed by stressors such as illness is mediated by the meaning given to the threat by an individual. Cognitive appraisals and reappraisals constantly modify the nature of emotional responses to threat in a way that are inconsistent with a static concept of health concern.

The second problem in Ben Sira's approach to affective concerns is that the concept does not allow for the diversity of possible concerns in any given patient population. To reduce patients' affective concerns to a single dimension of concern about health is to ignore the diversity of concerns in clinics. Concerns about symptoms in the STD clinic may variously focus upon personal threat



to long term health, limitations imposed on current sexual behaviour, incapacity and disability, or simple pain and discomfort. Ben Sira operates with a concept of concern which only really incorporates fear about disease. The diversity of concerns in the STD clinic suggests the need for different concerns to be recognised. The heterogeneity of such concerns cannot be contained in a single continuum. Moreover clinics may be very successful at addressing or helping some strongly felt concerns yet fail with regard to others. Only an approach in which the diversity of patients' concerns is recognised will permit a balance sheet of the successes and failures of medical work. Just as appeared to be the case in the neurological clinics, in the context of the STD clinic, different concerns varied in the extent to which they subsequently gave rise to dissatisfaction.

The final problem with Ben Sira's use of affective concerns has already been repeatedly emphasised. The presence of anxiety and fear in a patient is considered to result in reliance upon the doctor's affective behaviour. This assertion has been shown to have both logical and empirical flaws.

#### The need to examine sub-groups and interactions

It has been established that three different kinds of variables are associated with subsequent satisfaction

with clinic care in the STD clinic:

- (1) background social and biographical variables such as education and whether or not a patient had previously attended the clinic,
- (2) psychological variables assessing different aspects of psychological distress, such as the GHQ measure of 'caseness' and particular scales from the Illness Behaviour Questionnaire, especially those which relate to concerns about health, namely, Hypochondriasis and Disease Conviction, and
- (3) variables specifically relating to the patient's perceptions and concerns in relation to the presented health problem at the time of consulting the STD clinic.

So far these variables have been presented separately, whereas, as is usually the case in such data, many of the variables that have been related to satisfaction are also related to each other. Several of the background social variables are associated with each other, so that, for example, amongst men homosexual patients are more likely to be 'old' rather than 'new' attenders of the clinic. Background variables are also associated with some of the psychological variables measured by the IBQ. Thus 'old' patients are more likely than 'new' patients to score highly on the scale of hypochondriasis (Chi square = 23.35, d.f.9,  $P < 0.01$ ). Furthermore background variables are frequently associated with specific illness concerns. For example male heterosexuals compared with homosexuals are much more likely to report themselves as concerned about possible

implications for their fertility arising from the presented problem (Chi square = 19.08 d.f. 3  $P < 0.0001$ ). There are limitations in examining separately the different types of variables that relate to satisfaction. This does not allow for the possibility of interactive effects upon satisfaction to emerge. Hirshi and Selvin (1973:111) make the point that sociologists often use the terms 'interaction' 'conditional relation' and 'specification' interchangeably. 'Interaction' is here used to refer to a situation where the relation between two variables depends on the values of a third value. One example of such interactive effects can be seen by examining the relationship between patient status ('old' or 'new'), Disease Conviction and the three satisfaction scales.

In Table 28 the differences between 'old' and 'new' patients' satisfaction scores on the three scales are shown for three different values of the Disease Conviction Scale of the IBQ. In all cases it is the 'old' patients who are more likely to express dissatisfaction. Amongst patients with a low Disease Conviction score, the Z values (Mann-Whitney test) are quite small and the differences not significant. However as the level of Disease Conviction increases, so too the Z values increase for all three scales of satisfaction. However amongst the patients with a medium score on Disease Conviction, only one of the three differences - satisfaction with the technical quality of care - is significant. For those patients with a high Disease Conviction score, the differences between 'old' and 'new' patients are highly significant for the art of care

and technical quality scales.

An alternative way of examining interaction in this instance is to examine the correlations (Pearson  $r$ ) between the scale of Disease Conviction and the satisfaction scales separately for 'old' and 'new' patients. The results are shown in Table 29. Whilst the correlation coefficients are significant amongst 'new' patients, if only 'old' patients are considered the size of the correlation coefficients increases for all three satisfaction scales. The implications of these two sets of sub group data seem clear. The two variables - patient status and Disease Conviction - have some independent association with all three satisfaction scales, but there is an interaction between the two variables such that 'old' patients with high scores on Disease Conviction are particularly likely to report dissatisfaction with their care. The meaning of this interaction is less clear. It is difficult to infer why patients with prior experience of the clinic and with higher scores for Disease Conviction should be particularly likely to express dissatisfaction. It is interesting that Linn and colleagues (1982) in a study of primary care in the USA found the greater the amount of prior experience of the clinic under investigation, and the more severe the level of presenting illness, the greater the level of dissatisfaction. At this point the example does however clearly indicate the importance of looking at more than one variable at a time in relation to satisfaction scores.

Sub-groups and the search for explanations of patient satisfaction

Hirschi and Selvin argue that 'the investigator who finds an unexpectedly weak relation should continue his analysis before abandoning his belief in the causal status of his independent variable' (Hirschi and Selvin, 1973: 110). Several recent studies in patient satisfaction research reveal such a persistence in the search for meaningful explanations for patient satisfaction results. It has to be remembered that in the vast majority of studies, only a small minority of patients express dissatisfaction. In addition, in many studies the use of routine social and demographic variables or relatively simple characteristics of the health care provider offer few significant associations. As few significant zero order correlations emerge from such investigations, effort is invested in more clearly delineating specific sub-groups within the data who are more significantly satisfied or dissatisfied with health care. Snider, in discussing patient satisfaction research, expresses the problem thus:

'The lack of variation in the dependent variable requires that a covariate be included in the analysis in order to properly understand the context in which satisfaction with doctors operates.' (Snider, 1980: 528)

In most cases, such research has attempted more clearly to identify sub-groups who differ significantly in level of satisfaction. A very simple example is a study by



Patrick et al. (1983) which found high levels of satisfaction with their health care amongst disabled people of Lambeth. However amongst a group with very high levels of stress as measured by life events scores, the rate of dissatisfaction became much higher. Greenley et al. (1981) found quite weak associations between psychological distress and dissatisfaction with professionals, but found a small sub-group of clients exhibiting signs of denial of their psychological distress who were much more likely to express dissatisfaction. The identification of this group both produced much stronger associations with satisfaction and also provided a theoretical interpretation of the original zero order correlation between psychological distress and satisfaction. Thomas and Penchansky (1984) were concerned with the relationship between patient satisfaction and utilisation of health care services in Rochester, New York. They found that, overall, such relationships were weak. However by looking at more 'homogeneous sub groups' (1984:553), differences in the relationship between satisfaction and utilisation became clearer. The authors conclude 'It seems that demographically defined sub-groups vary in response to dissatisfaction with access' (1984:66). Snider (1980) examined satisfaction with primary health care among the elderly. He examined two sub-groups based on whether respondents subjectively rated their health as poor or good. Only amongst the former group was patient satisfaction associated with whether their physician showed personal interest in them. In a randomised controlled trial of consumer acceptance of Health Maintenance Organisations

compared with traditional fee for service, Davies and colleagues (1986) found the greatest levels of difference between the two types of organisation in terms of patient satisfaction when high income enrollees with poor health were examined.

A more elegant use of third variables is a study by Ross et al. (1981) which began with precisely the kind of research dilemma identified by Hirschi and Selvin. They noted that some previous research had failed to find a difference in satisfaction between patients of 'group' - and 'solo' health care practices, despite evidence that the psychosocial aspects of care in group practices is superior and that psychosocial aspects of care are important influences upon satisfaction. The reason for the absence of an association, they show, is that a third variable - time in the sense of years of experience with a doctor - needs to be introduced. Amongst patients who have spent only a short period of time with either system, patients have negative images of the large group practice and also 'normalise' or excuse the poor quality of psychosocial care of the doctor in either system. As a result, under these conditions, solo practices are more favoured. Over time however the patient is less able to normalise or forgive poor psychosocial care. The better quality of group practices is experienced and recognised by the patient and the positions of the two types of health care provision in client evaluation is eventually reversed. Thus with time as the conditional variable, the real effects of type of practice upon patient satisfaction were clarified. In all

of the above studies, investigators make use of sub-group analysis in order to obtain a clearer view of the role of satisfaction since zero order correlations are less informative.

Ben Sira makes extensive use of a similar method. He examined his theory of patient satisfaction by inspecting the correlations between different satisfaction items - satisfaction with affective and instrumental aspects of the doctor's behaviour - in terms of third variables. However, as has been argued earlier, there is little justification for separating out one component of satisfaction as causally prior to others, in the analysis of interactions that he pursues, especially since all satisfaction items are likely to be highly correlated with each other. This is indeed the case.

As shown earlier, in all of the items of the questionnaire the majority of clinic attenders report positive satisfaction. The consistently skewed nature of responses to the questionnaire produces correlations that make the use of such variables in causal enquiry quite difficult. This is made clear if instead of the particular items that have been used so far to examine the applicability of Ben Sira's approach, I consider the three overall scales of satisfaction measured by the questionnaire - satisfaction with the art of care, with the technical quality of care and with the efficacy of care.

The correlations between these three scales are high:

(1) 'Art of care' and 'technical quality', 0.80

(2) 'art of care' and 'efficacy', 0.75

(3) 'technical quality' and 'efficacy', 0.77

This pattern of correlations between the three scales is also apparent in Linn and Greenfield's (1982) use of the same questionnaire. They found that intercorrelations between the three scales varied from 0.79 to 0.75.

On the other hand, the illness concerns that were reported prior to patients' consultations, represent a quite separate conceptual stage in the process of help seeking, and in terms of operational measures, concerns and satisfaction were assessed at two points in time separated by at least a month. The correlations between illness concerns and satisfaction are unlikely to be due to overlapping measures of the same underlying construct - a clear risk with affective and instrumental satisfaction. Indeed the correlations may be consistent with a causal model. In the neurological clinic study concerns emerged as important influences on satisfaction with the clinic. Thus it makes more sense to examine the correlations between concerns and satisfaction under different conditions, in other words, to use Ben Sira's approach to specification but in relation to a more promising set of correlations. This will involve a search for interactions - conditions of third variables under which the correlations between illness concerns and satisfaction are increased or decreased.

The relationship between specific illness concerns and satisfaction was examined for possible interactions with background social and psychological variables. For this purpose each of those variables from the IBQ and socio-demographic data in which there were significant zero order relationships with at least one of the three satisfaction scales were divided into two sub-groups. The seven variables dichotomised were: education, sexual orientation (males only), 'old' versus 'new' patient, caseness, Hypochondriasis, Disease Conviction, and Denial. The correlation coefficients between the nine illness concern items and the three satisfaction scales were then examined separately for each-sub group of the seven background variables. The volume of correlations from this analysis is large and a cut off point was selected in order to present and examine interactions between illness concern satisfaction and background variables. Only those correlations between illness concern and satisfaction which were increased by at least 50% in a sub group compared with the original zero order correlations will be regarded as significant interactions. To take an example, the correlation between the concern that the problem may not prove straight forward and satisfaction with the art of care is -0.17. However amongst those patients in the high education sub-group, the correlation coefficient reaches -0.40. The interactions between illness concern, background variables and satisfaction with the art of care that fall within the criterion set are shown in Table 30. The equivalent interactions for satisfaction with efficacy



are shown in Table 31. Only one significant interaction occurred in relation to satisfaction with the technical quality of care. The zero order correlation coefficient between the concern that the problem may not prove straight forward and satisfaction with the technical quality of care is  $-0.23$ . Amongst those patients in the high education group, the correlation coefficient rose to  $-0.39$ .

The first observation to be made from this data is the consistency of the interaction between the concern that the problem may not prove straight forward, high educational level and all three satisfaction scales. This is the only interaction between an illness concern and a background variable that can be found in all three satisfaction scales.

There are two interactions that can be found in relation to two of the three satisfaction scales. The correlations between the concern that the presented problem may affect the patient's sex life and satisfaction with the art of care and the efficacy of care are  $-0.11$  and  $-0.12$  respectively. Amongst 'psychological cases' (GHQ), the correlations, although still quite modest, double in strength to become  $-0.24$  and  $-0.25$ . Similarly the correlations between the view that the patient finds it difficult to be reassured about the presented problem and the art of care and efficacy satisfaction scales both become twice as strong in the low educational level subgroup.

The second point to be made in relation to this data is that in several instances the values of the background variable that produces interactions differs from one correlation to another. Thus as already seen, whereas it is low educational level that produces consistent interactions between the patient finding it difficult to be reassured and two satisfaction scales, it is high educational level that increases the correlations between the concern that the problem may not prove straight forward and all three satisfaction scales. Similar discrepancies between the values of background variables are found with sexual orientation.

The third observation is that in a small number of cases, the size of the correlation coefficient becomes quite large. Thus amongst heterosexual males, the correlation between the concern that the problem may affect future health and satisfaction with the art of care is  $-0.51$ . On the other hand amongst male homosexuals, the correlation between the concern that the problem may not clear up quickly and satisfaction with the efficacy of care is  $-0.46$ .

It is difficult to interpret the significance of the interactions found in the data. Many of the coefficients in sub-groups remain quite modest. Also it has to be recognised that if one extends a search for significant correlations, one increases the probability of finding chance associations (Marsh, 1982:67). Any further interpretation of such patterns must be postponed until

after the most important main effects have been identified.

### The prediction of satisfaction

In order to obtain some impression of the variables that have the strongest independent association with satisfaction, a multiple regression was performed to obtain predictions of each of the three satisfaction scales from a number of independent variables.

The use of multiple regression to predict satisfaction has produced modest but interesting results. Thus Carmel (1985) used this method and from the analysis, such factors as the patient's 'perceived improvement in health', social networks and age were shown independently to predict satisfaction. However if one considers the amount of variance explained by the variables in Carmel's equation, the results are modest - in the case of satisfaction with physicians' and nursing care on surgical wards for example the R Square is 0.13 and 0.20 respectively. Almost invariably the variance explained in patient satisfaction scores from multiple regression is modest. In a study of ambulatory care, Dutton and colleagues (1985) obtained an R Square that varied between 0.06 and 0.14 depending on which dimension of satisfaction was examined. Linn and Greenfield (1982) used multiple regression to examine satisfaction with care amongst different groups of chronically sick. They used the questionnaire and scales employed in this STD study and

obtained R Square of 0.12 for satisfaction with the art of care, 0.13 for the technical quality of care scale and 0.21 for the efficacy scale. Pope (1978) analysed patient satisfaction with the Kaiser Permanente Health Maintenance Organisation. Significant variables only explained a small amount of variance (R Square= 0.11). Similarly Fox and Storm (1981) used multiple regression to predict satisfaction with medical care from a number of social and demographic variables in a sample of adults of Baltimore. They found that the predictability of satisfaction was very low (R Squared=0.08). This was explained as due to the almost uniformly positive satisfaction found in the sample. The modest amount of variance explained is characteristic of other studies in the field (Ross and colleagues,1981; Linn and colleagues,1982; Zastowny and colleagues, 1983;Thomas and Penchansky,1984).

It is interesting to note the kinds of variables that emerge as important from multiple regression. In Pope's study (1978) of an HMO, age and subjective health status were important predictors of satisfaction. In the Baltimore study (Fox and Storm,1981), and in Linn and Greenfield's (1982) study of the chronically sick, age was again one of the most important predictors. In other studies the patient's current health status emerges as a strong independent predictor with poorer health associated with dissatisfaction ( Roghmann et al.,1979; Linn and Greenfield, 1982; Linn and colleagues,1982; Patrick and colleagues,1983). Greenley and Schoenherr (1981) observe from their multiple regression analysis of satisfaction

that client characteristics explained much more variance than did organisational variables.

In relation to the STD clinic study, all of the social demographic and IBQ items that were found to be significantly associated with at least one of the three satisfaction scales in the zero order associations (Tables 16,25) were selected for this analysis: education; sexual orientation; 'old' or 'new' patient; caseness (GHQ); Hypochondriasis; Disease Conviction; Denial. Concerns from the ICQ were included on the same basis (Table 27) so that concerns in relation to the following aspects of the presented problem were selected: that it may not prove straight forward; that it may prove painful; that it may not clear up quickly; that it may affect future health; that it may affect the patient's sex life; that it may affect fertility and that the patient finds it difficult to be reassured. The variables were entered in a stepwise fashion. The criteria for entry and removal of variables from the equation were the SPSSX default criteria for multiple stepwise regression, namely a probability of F-to-enter = 0.05 and a probability of F-to-remove = 0.10. Stepwise method of entry involves the variables that add most to the prediction equation being entered.

The results of the multiple regression analyses are shown in Tables 32 to 34. With the exception of two variables that each only appear once, the Denial scale of the IBQ and concern about whether the presenting problem would prove straightforward (ICQ), the same independent



variables appear as significant predictors in relation to all three satisfaction scales. The most consistently important predictor variable in the regression equation is the variable from the ICQ regarding worry that the problem may not clear up quickly. The more worried a patient was in this way, the more likely he or she was to express dissatisfaction afterwards. In relation to the technical quality and efficacy scales, this item accounted for over half of the explained variance as indicated by R square. In the third aspect of satisfaction, the art of care scale, worry that the problem would not clear up quickly contributes almost half of the total explained variance.

Three other variables contribute significantly to all three prediction equations. The higher a patient's level of education, the higher his or her score for Disease Conviction and if the patient was an 'old' patient, the greater was the likelihood of reporting subsequent dissatisfaction. These three variables contribute very similar amounts to the three prediction equations.

Finally, Denial accounts for 0.035 of the variance in satisfaction with the art of care scale and concern as to whether the presenting problem would prove straightforward accounts for a very small amount of variance (0.009) in the efficacy of care scale.

The squared multiple correlation (R Square) is equivalent to the proportion of variation in the dependent variable that is predictable from the best linear

combination of the independent variables. The proportion of the three satisfaction scales predicted by the combinations of variables shown in Tables 32 to 34 varies from 0.13 to 0.18, with the highest proportion explained in the Satisfaction with Technical Quality scale. Although modest, such levels of prediction compare well enough with the regression analyses produced in other studies cited earlier.

These results add to and support the impressions of factors influencing satisfaction in this clinic that have been gained from analysing the results by bivariate statistics. Different kinds of psychological distress appear to have a direct effect upon patient satisfaction in the clinic. These effects although modest, are consistent. One kind of distress is worry that the presenting problem may not clear up quickly. Thirty six per cent of the sample had expressed this worry (Table 26). There was no statistically significant association between this particular concern and any of the diagnoses given to patients' problems in the sample. This may be because many of the problems presented to genito-urinary medicine clinics give rise to such concerns. Certainly problems such as non specific infection, candidiasis and herpes, whilst responsive to treatment, are known to be recurrent, and problems such as genital warts are often resistant to treatment. Problems such as herpes may become psychologically distressing because of their chronicity and recurrence (Adler,1985; Lok et al.,1985). Patients who were particularly distressed by the possibility of their

problem not clearing up quickly were more likely to express dissatisfaction with all aspects of their medical treatment. This response would appear therefore not simply to reflect disappointment with the lack of effectiveness of their treatment but also dissatisfaction with the way in which they were treated. The survey itself provides no further information with which to interpret this relationship. Nevertheless one possible interpretation may be that patients with a concern about the chronicity of their problem had actually experienced recurrent infection. Rather like the chronic migraine sufferers in the neurological clinic study, they may have felt that the routine and impersonal management of their problem did not match the complexity, severity and importance of their symptoms.

Some support for this interpretation comes from a study of non-compliance in another genito-urinary medicine clinic (Perfremont and Overfield, 1978). They noted that female patients with candidiasis 'tended to show more negative or reserved attitudes. One possible explanation is that candidiasis tends to be perceived as "only thrush" (Perfremont and Overfield, 1978:204). In other words such patients were upset by the apparent attitude of staff in treating their presenting problem as routine and trivial. Whether real or perceived, such attitudes may be felt by patients presenting with other troublesome and recurrent symptoms. It has already been argued that the clinic in this study was very busy and appeared to deal with too many patients to permit doctors to elicit more lengthy personal

details than was essential for immediate diagnostic and therapeutic tasks. One indication of this was that doctors were unable to make very accurate appraisals of the personal distress amongst their patients when asked to complete simple assessment scales (Fitzpatrick et al., 1985; Fitzpatrick et al., 1987). It may also be the case that impersonal management is socially functional where, as is usually the case in clinics such as this one, the doctor has to conduct an intimate sexual examination of the patient (Emerson, 1970). Whether routine impersonal management arises from constraints of social interaction, pressures of large numbers of patients, or the repetitive treatment of familiar infections regarded as 'minor' from within the medical model, it may be speculated that for some of the patients concerned about potentially very troublesome and disruptive symptoms, the clinic staff's response would appear superficial and disappointing.

None of the other variables explained as much variation in satisfaction. Of the three variables that did consistently appear in the regression equations, the Disease Conviction scale of the IBQ appears to represent another aspect of distress in relation to the presenting problem that also influences subsequent satisfaction. Although developed to identify patients with symptoms of minor medical significance who might prove difficult for the doctor to manage and reassure, the IBQ as a whole and this scale particularly have been examined for wider possible applicability. The instrument has been used more recently to investigate problems in patients' responses to

coronary artery by-pass surgery (Pilowsky et al.,1979) and reactions to myocardial infarction (Byrne and Whyte,1979). In the STD clinic, high scores for Disease Conviction were as likely to occur in patients with significant medical disease as reflected in a substantial diagnosis such as candidiasis or warts, as in those without, those who were recorded as 'no abnormality detected' in their medical records. The discussions of Mayou (1976), Barsky and Klerman (1983) and Mechanic (1972), cited earlier, indicate that the concerns and distress about disease reflected in the Disease Conviction scale are common in medical settings and make the concept of abnormal hypochondriacal illness behaviour problematic. The judgement as to whether such perceptual responses were appropriate or unwarranted, assuming it would be helpful, cannot be made with the information available about this sample. More important, the evidence of Cronbach's alpha suggested that the scale of Disease Conviction may not be homogeneous, as applied to this clinic population. Earlier in this chapter it was noted that the item in the scale which correlated most with satisfaction was a question about whether the respondent would accept the doctor's reassurance that nothing was wrong. Again it is only possible to speculate about the meaning of the association of this item with all three satisfaction scales. One possible interpretation of this association would be to infer a similar process as with the ICQ item about concern that the problem might not clear up. Patients with experience of recurrent genito-urinary infections may come to feel over time that medicine does not acknowledge the importance of such problems, as



suggested by patients in Perfrement and Ovefield's (1978) study. They particularly do not wish to have their problem treated as unimportant. This is reflected in their response to the IBQ item that they would not accept the doctor's view that they had nothing wrong with them. The routine management of their problem by the clinic is more often perceived by these individuals as disappointing in all respects, in terms of degree of personal appropriateness and quality of treatment as well as in terms of the value of treatment.

Patients who had attended the clinic prior to the study visit ('old patients') were also significantly more likely to be dissatisfied on all three scales. A few other studies have considered the effects of level of prior experience of medical care upon current satisfaction. Linn and colleagues (1982) found in their study of ambulatory care, that, in separate analyses of younger and older patients, the greater the number of prior clinic visits, the greater was the likelihood of patients' expressing dissatisfaction. In a study of patients attending an outpatient clinic for back pain, previous experience of any kind of hospital treatment for back pain was the strongest independent predictor of dissatisfaction (Fitzpatrick and colleagues, 1987). One possible way in which prior experience of a service may be influential is that the individual's expectations become more clearly defined. Stimson and Webb (1975:31-2) found that in general practice, patients' expectations of health care become more concrete and clear as their experience of the particular

health care setting increased. They note that repeat attenders of general practice with long standing conditions may form particularly definite expectations of the doctor. By contrast patients with no prior experience of a particular doctor or a particular illness may have more fluid expectations of a general practice consultation. Past prescribing practices of a doctor influence patients' expectations in any subsequent consultation (Rapoport,1979). Parents of children with epilepsy become more knowledgeable and less passive and satisfied with care over time (West,1976). The influence of experience in sharpening expectations and satisfaction over time has already been discussed in relation to Ross et al.s' (1981) investigation of different forms of primary medical practice in the USA. Such evidence lends support to the speculation that repeat attenders at the STD clinic form more definite expectations of the clinic over time. Conversely new attenders may be less clear in their views and, perhaps more importantly, are more ready to normalise or forgive aspects of their treatment. Regular attenders may simply be less forgiving. Flexibility of orientation was a salient feature of almost all of the patients included in the neurological clinic study reported earlier in the thesis. As patients with no prior experience of neurological clinics, their expectations proved highly fluid and their readiness to accept or normalise potentially upsetting aspects of their clinic visit quite striking. However one group of patients, chronic migraine sufferers proved less forgiving and were more disappointed with the clinic visit. It was argued that their

perceptions were different in the sense that the routinised response of the doctor did not match the more elaborate and complex picture of their disorder that patients had, of necessity, developed. In all these instances, it may also be that prior experience above all provides some kind of 'bench mark' against which to judge current experience, and greater confidence to express dissatisfaction as a result of such bench marks.

This interpretation of the effects of previous experience of the clinic may also be consistent with the interaction effect noted earlier in this chapter between whether or not an individual had previously attended the clinic, his or her Disease Conviction scale score and satisfaction. Those with a high score for the scale were much more likely to express dissatisfaction if they had also previously attended the clinic. The most important element measured by the scale in this context may have been the wish not to have the presenting problem treated as routine or unimportant. This wish would be stronger in those with actual experience of clinic practice and would be more likely to result in disappointment afterwards.

The other variable to have a consistent effect in all three regression equations was level of education with more highly educated individuals reporting higher levels of dissatisfaction. This finding is consistent with a number of other studies cited in chapter one, in which it has been found that more highly educated respondents are more ready to express critical comment. It is possible, but unlikely,

that, in this clinic, such differences in responses reflect differential treatment. No direct evidence is available to examine this possibility. One piece of indirect evidence is the finding in two separate surveys of the clinic (Fitzpatrick et al., 1985; Fitzpatrick et al., 1987) that there were no differences in doctors' awareness of patients' level of psychological distress for patients of different educational background. Thus more plausible is the view taken in most such surveys that differences in satisfaction primarily reflect attitudinal differences in the sense of different propensities to express negative comment about any form of service or goods.

Denial (IBQ) appears amongst the significant predictors, in this case with a positive coefficient in relation to satisfaction with the art of care. It has been argued earlier that the concept and measurement of denial is problematic and that many of the items in the factor may simply be accurate reports by patients of their views as to whether they have various problems in their lives. The theoretical discussion and survey results of Greenley et al. (1982) are concerned with the negative association of denial and satisfaction. In that discussion, dissatisfaction with health care is linked to denial in terms of a concept of profound difficulties in some patients in recognising psychological problems, which results in frustration when seeking professional help. The Denial scale is positively associated with satisfaction in this study. This is unlikely to be in any way related to processes of denial. The extent to which patients

report problems in other areas of their lives is associated with the extent to which they report problems in their medical consultations. This finding is more appropriately interpreted in terms of Patrick and colleagues' finding (1983) of an association between high life events scores and patient dissatisfaction.

Thus a variety of different variables measured before the patients attended the doctor together throw light upon the limited variability in subsequent questionnaire responses. Different aspects of the experiences of symptoms and of prior treatment, for certain patients, appear to result in dissapointments in the clinic. The interpretation of the concerns and worries of clinic patients has been somewhat speculative. It has however been based on a very different approach to the role of affective concerns in patient satisfaction than the approach with which this study began - that of Ben Sira. A final appraisal of Ben Sira's model is needed.

#### Affective factors in patient satisfaction: an assessment

Ben Sira has developed a distinctive approach to the examination of patient satisfaction, and has provided both theoretical and substantive discussions of the central processes whereby patients evaluate their health care. This work is the most extensive response to those who would call for research 'to elucidate the social psychological



processes involved in consumer satisfaction' (Lebow,1982:256) or to those who would fault patient satisfaction research for 'having little in the way of theory guiding the variables chosen for study or the hypotheses being tested' (Like and Zyzanski,1987:351-7). The model has been extensively described above and it remains to draw together this examination of the strengths and weaknesses of the model as applied to one particular health care setting. This review will also be a prerequisite for the main question guiding this thesis - the overall scope and value of patient satisfaction research - in so far as Ben Sira's work most clearly circumscribes the scope of such information.

The model depends primarily on the view that patients' overall sense of satisfaction with the health care that they receive is determined by the health professional's affective behaviour toward them. One way in which such an analysis has been pursued in other research has been by linking specific aspects of the processes and content of health care, such as the friendliness of doctors' communication styles in consultations, measured directly from tape recordings of their consultations, to outcomes of care such as patient satisfaction or compliance (Korsch et al.,1968). This is the most robust test of the role of affective factors in that variables such as the doctor's affective behaviour are measured quite independently of the patient's response in terms of degree of satisfaction. Such research does show that the manner of the doctor can be an important influence upon patient

satisfaction. The affective tone of the doctor's speech has been shown to be associated with subsequent satisfaction (Hall and colleagues, 1981). Showing interest in the patient, by, for example, asking questions about the patient's family, may also be positively associated with patient satisfaction (Weinberger and colleagues, 1981). Qualities in the doctor such as empathy have been shown to influence satisfaction (Linn et al., 1987). However, it is by no means clear from all such studies that the doctor's affective behaviour is the sole or primary basis or source of overall patient satisfaction or that affective behaviour is confused or conflated by the patient with instrumental behaviour. Roter and colleagues (1987) asked patients to assess their satisfaction with consultations in a general medical clinic. The consultations were also tape recorded and rated by researchers. Ratings of doctors' technical behaviour were much more closely associated with patients' global satisfaction than were the investigators' ratings of affective behaviour. Similarly, observer ratings of the doctors' technical behaviour correlated more with the technical scales compared with the affective scales of the patient satisfaction questionnaire. The authors concluded very firmly that patients' judgements on the two dimensions of technical and affective aspects of their consultations seemed quite sharply distinguished.

Ben Sira's model is not supported by the pattern of views expressed by patients attending an STD clinic. Satisfaction with all items of care are positively skewed and correlate highly with each other. Thus satisfaction

with treatment correlates just as much with satisfaction with 'instrumental' as with 'affective' items. It would appear arbitrary to select out affective items and instrumental items in the way Ben Sira does, examining the changes of correlations under different values of third variables and assign causal primacy to 'affective' items of satisfaction in the underlying causal model. The data would equally well support a model based on the primacy of instrumental judgements in the evaluation of health care.

There are other elements in the model of patient satisfaction. Anxiety and distress arising from the patient's interpretation of symptoms are a common accompaniment of illness and increase the patient's reliance on the professional's affective behaviour in the sense of emotional support, according to the model. In these circumstances the patient is particularly dependent upon judgements of professional affective behaviour to determine the value of treatment. However in this particular health care setting, patients with more concerns in relation to the presenting health problem did not exhibit the pattern of responses to the satisfaction questionnaire predicted by Ben Sira's model. Moreover on common sense grounds, it is difficult to maintain that patients with higher levels of concern or worry about their symptoms should focus upon affective rather than instrumental aspects of health professional's behaviour since both aspects are relevant to the reassurance of a patient. Taking a full and careful history of the patient's problem or initiating appropriate tests may

reassure a patient as much as being treated as an individual rather than a case. As Roter and colleagues (1987) point out, Ben Sira confuses the intrinsic purpose of a communication and its affective significance for the recipient. A particular statement may be intended by the doctor to elicit the patient's history (i.e. it has a technical purpose), but may be experienced by the patient as reassuring (i.e. as having an affective function). In relation to both aspects of the doctor's actions, the patient is making lay rather than technically informed judgements of the doctor's behaviour; but to assume that patients can only make subjective judgements of affective behaviour seems difficult to justify.

The other aspect of this affective model of patient satisfaction examined by means of the STD clinic sample is the role of the patient's level of education. Here both the current study and Ben Sira's surveys are equally limited in the sense that meanings are read into the associations between educational level and satisfaction. Ben Sira views the patient's education as an indication of the the amount of social psychological resources available to cope with illness and as inversely related therefore to the need for emotional support from the doctor. In addition, education is inversely related to the ability to discern and judge instrumental aspects of professional behaviour. Although the specification of relations between affective and instrumental items of satisfaction by groups of patients with differing levels of education appeared to be consistent with Ben Sira's model, an alternative

explanation was suggested, namely that the lower correlations of different satisfaction items amongst patients with higher levels of education was produced by their greater readiness to express critical or dissatisfied views on any particular item. As most responses in the sample were positive, such occasional negative responses alone would reduce overall correlations between different satisfaction items among the more educated group. Further support for this interpretation of the role of education was obtained from both zero order correlations and multiple regression analysis (neither of which were used by Ben Sira) in which education was indeed consistently and inversely related to satisfaction. The interpretation of the role of this variable in the clinic sample is that the more frequent expression of dissatisfaction by patients with higher levels of educational achievement is a reflection of attitudinal differences. Educational and social status variables are often found to be major influences on patient satisfaction surveys (e.g. Pope, 1978; Fox and Storms, 1981) and indeed educational level was inversely related to satisfaction in Linn and Greenfield's (1982) original use of the questionnaire employed in this study. Differences in satisfaction surveys between respondents with differing levels of education may reflect either profound differences in levels of aspirations and expectations of the world or situational factors regarding readiness to be critical in expressing views in questionnaire. Either approach to explanation ultimately indicates attitudinal differences between individuals in educational levels that provide a relatively simple and



parsimonious explanation of the role of education in this study. The emphasis of this explanation of the role of education is upon attitudinal differences in readiness to criticize rather than in more fundamental differences in needs for emotional support or abilities to distinguish between and appreciate such elementary aspects of a doctor's behaviour as his history taking and his showing an interested manner.

In part, the problems of Ben Sira's model derive from methodological difficulties in survey research which have been discussed fully above. There are limitations in using general purpose survey samples to develop and test models relating to the perceptual and evaluative processes which enter into patients' satisfaction with health care, especially where the model concerns emotional and affective responses arising from the experience of illness. Such respondents may be expected to vary enormously in the salience of health and illness as an issue, in their current and recent health record and in other relevant dimensions. Above all many respondents will not recently have experienced the emotional and personal immediacy of help seeking for a health problem and their answers will reflect more stereotypic attitudes. Just as important for a model of perceptual aspects of patient satisfaction is the ability to sort out the time order of relevant variables such as illness concerns which may be expected to have complex relations with other variables such as satisfaction. The time reference of variables is also important. If the focus of a model is upon perceptual

judgements of specific health care consultations, questions need to make that as clear as possible to the respondent rather than asking views of health care with an unspecified time reference, which again invites more attitudinal responses.

The affective model of patient satisfaction also has potential conceptual limitations which the last four chapters have discussed. Central concepts such as 'concern about health' and 'satisfaction with instrumental behaviour' appear to be more multidimensional concepts than is allowed for in Ben Sira's work. Individuals attending a primary care clinic experience a variety of different concerns, worries and fears about their general health and their presenting problem. Some concerns appear to influence patients' responses to their medical treatment more than others. In particular, certain concerns of patients in sub groups identified by social or demographic variables were quite directly associated with level of subsequent satisfaction. The model also operates with an unnecessarily condensed concept of satisfaction with 'instrumental' aspects of medical treatment, since that concept variously covers such different judgements as the perceived competence and training of health professionals, and the thoroughness of their investigations on the one hand, and on the other hand perceptions of the potential value and relevance of medical treatment. Qualitative evidence from the neurological clinic study strongly suggested that perceptions of medical competence and the application of that competence to one's own case are

separate dimensions and that the latter is what matters in judging the value of a consultation.

A more basic difference between the study reported here and Ben Sira's work hinges rather upon a fundamental difference in the conceptualisation of behaviour. A major assumption of Ben Sira's theory is that concerns about health or illness create emotional needs in relation to treatment. This results in the patient judging the doctor solely or mainly in terms of emotional support provided in terms of affective behaviour. The basic model of human behaviour postulated by this series of theoretical steps in the causal chain requires explicit discussion. In particular, Ben Sira's thesis depends on a series of quite rigid dichotomies between instrumental and affective factors in the doctor patient relationship which are pursued throughout the analysis. The patient has affective needs (for reassurance, for example) and instrumental needs (for treatment, for example). Similarly the doctor acts in terms of affective behaviour (for example, showing devotion) and in terms of instrumental behaviour (treating the medical problem). There are dangers in pursuing this dichotomous mode of thinking about relations between doctors and patients. In particular there seems to be no reasonable grounds for assuming that patients who are worried and concerned in relation to their current health will not look for every possible cue as to the benefits of the care they are receiving. Such cues will include their perceptions of the doctor's medical actions as well as his emotional support since, subjectively, impressions may be

formed of both, regardless of the objective qualifications of the patient to judge technical medical matters. Since affective disturbance arises from distress in relation to the presented problem, would it not be strange if the patient did not form strong impressions (albeit necessarily subjective) of the doctor's medical actions towards treating the presented problem? The difference in basic assumptions about behaviour between Ben Sira and the approach pursued here is that illness is here conceived as having inextricable emotional and cognitive or instrumental components. Illness represents both a potential or actual threat to the sufferer but also involves elements of cognitive calculation. Similarly there are likely to be subjective emotional benefits obtained from supportive or affectively appropriate behaviour by the doctor. But in addition patients are also likely to calculate in more cognitive terms the benefits obtained from care. The very language with which Ben Sira describes the experience of being a patient rigidly compartmentalises the patient's perspective. The crucial summary of Ben Sira's theory cited earlier can be read as a series of over rigid dichotomies and contrasts which sustain an ultimately limiting and confusing set of assumptions:

'The manifest goal of the patient of having his illness problem solved is most often accompanied by a latent goal of having his anxiety problem solved. Since he is not competent to judge the extent to which the physician's technical activities contribute to the achievement of his manifest goal ("content of interaction"), the criteria he uses for evaluating the interaction are those that relate to the degree of emotional support (mode) that accompanies the course of treatment.' (Ben Sira, 1976:5)

It needs to be restated that the model claims above all to explain the perceptual factors that enter into and influence patients' judgements of the value and potential efficacy of the medical treatment that they receive. However it has been argued in detail that the support for the model from the pattern of correlations between questionnaire items in the STD clinic sample is weak indeed. The results of the satisfaction questionnaire are similar to the vast majority of such surveys of patients' views. The kind of raw frequencies, cross-tabulations and multiple regressions necessary to assess Ben Sira's own survey data are not available, but it is likely that, for example, the positively skewed pattern of results also obtain there. It is also therefore likely that the kinds of simple four variable modelling used on the STD clinic data would produce similar results in relation to Ben Sira's omnibus samples and provide little foundation for the statistical primacy of affective items in the model.

Instead, such data as are produced from questionnaire based surveys support the view that patients' perceptions of the art, technical quality and efficacy of care are generally positive and hence difficult to disentangle. Which judgements are causally prior is a question impossible for such data to address. Furthermore to the extent that one can find variability in satisfaction questionnaire results that is significantly associated with other patient variables, it is often the case that these latter variables produce similar variability in all three dimensions of satisfaction. Such different variables as



education and Disease Conviction appeared to exert similar types and amounts of influence upon all three satisfaction scales. This surely requires that more attention be given to the background patient variables that can exert such consistent influence rather than isolating for analysis, particular items of a satisfaction scale in relation to one another.

The thrust of the argument has been that general purpose survey data are ill suited to the exploration of the affective model of patient satisfaction and furthermore that the STD clinic survey does not support the primacy of affective judgements in determining satisfaction. However the model is nevertheless a vital counterbalance to many trends in patient satisfaction research. It has been argued that there is a 'cognitivist' bias in those few studies which have attempted to use social scientific concepts to elucidate the 'facesheet' data of patient satisfaction surveys. Whether the approach has been that of role theory, explanatory models analysis or symbolic interactionism, the focus of most conceptual frameworks has been upon rational cognitive processes that influence patient satisfaction. Such research has provided invaluable insights into the subtleties and complexities of many patients' experiences. However distress, emotion, goals and concerns have been ignored in the process. It would be wrong to discard such processes as psychologistic or reliant upon psychopathological processes beyond the scope of sociology. Social factors play a central role in the aetiology of distress (Brown and Harris, 1978) and in

shaping the course and content of emotions (Schacter,1975), and environmental factors shape the cognitive appraisals which are the antecedents of emotion (Lazarus,1966). The social investigation of the experience of illness and of help seeking must integrate concepts such as distress and concern as well as health belief and sick role. Ben Sira's model firmly and repeatedly remind us that illness has multiple consequences:

'Disease [is].. a state of of physiological disturbance accompanied by a certain degree of anxiety as a consequence of the patient's evaluation of the meaning, seriousness and possible outcome of the disturbance.' (Ben Sira;1980:171)

and:

'In turning to a physician, one therefore has two goals: the solution of an illness problem and the solution of an anxiety problem, both problems being interrelated and hence requiring simultaneous attention.'(Ben Sira;1980:176)

It is not simply that emotion and distress are intrinsic to much illness. It is now clear that many of the results of patient satisfaction surveys are influenced by patients' distress characteristics. Depression was inversely related to satisfaction with treatment in Linn and Greenfield's (1982) chronically sick patients. More indirect indicators of and influences upon psychological well being such as life stress (Patrick et al. 1983) and social support (Carmel, 1985) have also been shown to exert significant influence upon patient satisfaction.

The different purposes of patient satisfaction research need to be kept in mind in considering the STD clinic survey. Firstly, some of the primary purposes of patient satisfaction enquiries in addressing practical

problems in the provision of health services, need to be considered. The 'consumer response' to the STD clinic in so far as it is reflected in the simple to administer self completed questionnaire employed in this study was very favourable, especially bearing in mind the young, well educated characteristics of the clinic population. Such clinics are busy, deal with potentially stigmatising problems and involve forms of treatment in which 'whole person' medicine may not appear essential or be practically feasible. They have many of the characteristics of 'bureaucratic medicine' (Strong,1979). It is interesting therefore that on questionnaire items regarding respect, courtesy and privacy, the vast majority of patients responded positively. Both patient and organisational characteristics are such that higher levels of dissatisfaction might have been expected. Instead a majority of patients were satisfied on every item.

Patient satisfaction has been an extremely useful concept in clinical art of care research, in which it assists in identifying problems or limitations in the psychosocial dimension of clinical medicine. The STD clinic survey confirmed the initial hypothesis, based on speculation from psychiatric referrals alone (Frost,1985), that there may be a significant syndrome of somatic concern and dissatisfaction with medical care in such clinics. Such patients represent a considerable problem of management for clinical staff (Dates and Gomez,1984; Appleby,1987). Relatively simple instruments were used to identify patterns of distress and dissatisfaction.

Instruments such as the IBQ are developed as adjuncts to the clinician to alert him or her to patients with unusual distress in relation to symptoms (Pilowsky and Spence, 1983) and the satisfaction questionnaire proved useful in supporting general ideas about patients unhappy with the clinic and more specific hypotheses such as that of Pilowsky and Spence that a high score on one factor in particular - Disease Conviction - is predictive of poor response to routine reassurance and management. On the other hand a less psychiatric interpretation was postulated for these results. Much of the dissatisfaction appeared to arise from patients who may have experienced chronic recurrent problems which caused understandable distress and to which the clinic may have failed to contribute anything of benefit. Further elucidation would require the more detailed style of investigation used in the neurology clinic.

Another function of satisfaction is as an outcome variable in the evaluation of health services. This function is problematic given the strong influences exerted upon questionnaire results by social values held by different demographic groups such as the young compared with the old and the educated and less educated. For satisfaction questionnaires to be informative about the value or quality of services such 'extraneous' influences need to be controlled for. It would appear from the work of Ben Sira and results presented here that distress is another influence that needs to be carefully considered in the design and analysis of evaluation research. In this

clinic population at least, such factors explain as much variance in satisfaction as the social and demographic variables normally used to explain results.

Lastly one may consider the purpose of satisfaction research in the development of more basic social scientific knowledge about illness behaviour and help seeking. The merit of Ben Sira's model is its relative clarity and comprehensive nature. Much of the model does not appear to apply to the particular clinic investigated. In other health care contexts, it may provide a useful framework for explaining variation in patients' responses to treatment. Enough has been said in these chapters to indicate that if the applicability of the model is to be tested in other settings - for example, inpatient care - or for other health problems - whether more life threatening or more acute - then considerably more methodological care needs to be given to the study than was permitted in the surveys with which Ben Sira developed our appreciation of the role of affective factors.

The model has, above all, a number of major limitations in its central ambitions, namely to delineate the processes involved in patients' judgements and assessments of their health care. There are some specific ways in which one could try to identify more clearly such processes given the conclusion that this aspect of the experience of illness remains something of an enigma as examined by the survey method, despite the ambitions for the affective model. To elucidate the judgemental



processes in terms of which patients respond to their medical treatment, a method of enquiry can be used which facilitates patients in describing their evaluations of health care in their own terms. This proved valuable in the neurological clinic study, in which, by paying attention to overall judgements of the value of the clinic visit as well as attitudinal statements about satisfaction, it was possible to build up a view, from the patient's perspective, of the different functions of the clinic and the 'successes' and 'failures' of the neurological management of headache. There seemed to be little reason to think that patients' views had been determined by a narrow range of affective factors in the neurological clinic study and patients' views were an invaluable contribution in the process of evaluating health care in this area. In this section of the thesis Ben Sira's model has been more directly examined and little support could be found for a model that so narrowly circumscribes the patient's capacities to contribute to the evaluation of the health care he or she receives. However there are valuable insights gained by work such as Ben Sira's that need to be retained and built upon. In particular the STD study has supported the broad principle that it is necessary to focus upon how patients evaluate health care in terms of their goals, concerns and fears in relation to their health problems. Patients' evaluations of medical treatment need to be more closely articulated with their perceptions of their health problems.

CHAPTER 9. A DISCUSSION OF RESULTS AND AN ASSESSMENT OF THE SCOPE OF PATIENT SATISFACTION RESEARCH

Discussion and concern about patient satisfaction continues to increase, in health policy and management, as well as in clinical contexts. The satisfaction of the patient appears to provide a goal or outcome towards the achievement of which all levels of health services should be directed. Whilst clear, practical and convincing measures of outcomes in health care remain a distant prospect and often a purely rhetorical device, patient satisfaction appears to be a tangible, worthwhile and feasible objective for more pragmatically inclined analysts of health services. The need for a shift of emphasis from the provider's and the professional's interests to that of the recipient or potential recipient is one of the most widely voiced and universally acceded social policy nostrums of recent times. In health policy in Britain, the consumer began most explicitly to emerge as a focus with the debates surrounding the 1974 reorganisation of the NHS and with the apparent institutionalisation of the consumer's voice in the Community Health Council. Subsequently Parliament, through a select committee, specifically directed the DHSS as a most urgent priority to direct its attention to measures of patient satisfaction (Expenditure Committee, 1978). The Griffiths Report (1983) most

explicitly and most cogently criticized health authorities for their insensitivity to the consumer of health services and was swiftly followed by appointments by health authorities of senior posts whose function was to remedy such deficiencies. Private sector consultants, who were increasingly used in the NHS in the 1980s, also advocated that health authorities should obtain consumers' views (Pollitt, 1987).

However there is another side to such developments, which may be interpreted as widespread unease about the real importance of patient satisfaction. Health authorities are suspected of making purely symbolic appointments in this area, with a view to be seen as 'doing something' in the absence of any clear conviction of the value of the consumer's views. Clinicians largely continue to ignore the relevance of patient satisfaction and the surveys of patients' views that are now more frequently conducted can normally be expected to produce tame, unchallenging results that reassure the sponsor at the same time as promoting doubts about the value of similar exercises being repeated.

The role of the social sciences in Britain in these developments has been curious. With a few notable exceptions ( Cartwright, 1967; Cartwright and Anderson, 1981; Arber and Sawyer, 1979; Jefferys and Sachs, 1983), sociologists have conducted few substantial investigations into patient satisfaction, certainly compared with the volume of research activity in the United States. Still

less have British sociologists engaged in enquiry as to the processes underlying consumers' responses to health care, apart from some isolated but important contributions (Locker and Dunt, 1978; Stimson and Webb, 1975). The reasons for this disinterest are varied. Johnson (1977) views patient satisfaction surveys as inherently erroneous and as presenting a systematically false image of the satisfied patient. Smaller, more qualitative studies more accurately pick up the differences and conflict that may exist between the doctor and the patient:

'Evidence from medical sociological studies is tantalisingly conflicting. Large scale surveys are almost unanimous in telling us that patient satisfaction with doctors is very high. Smaller scale studies are equally in agreement that doctor - patient interactions are problematic and conflict ridden.'  
(Johnson, 1977, 62)

Large scale surveys are seen as producing misleadingly positive results. Other sociologists have found this area wanting because the picture of the patient is too static and devoid of meaning (Davis and Horobin, 1977). For Mauksch (1972) satisfaction surveys are fundamentally flawed because the respondent is above all concerned with acceptable self presentation to the interviewer rather than to report views and feelings. As we have seen, those sociologists who attempted to examine satisfaction in relation to general practice (Stimson and Webb, 1975) ultimately despaired of assessing in any systematic fashion the concept of satisfaction because of the inherent complexity and fluidity of patients' views. To some critics, satisfaction may be entirely a creation of the act of asking questions (Leventhal, et al., 1985:417). The lack of involvement of medical sociologists in this

area may even reflect a more widespread distrust that Marsh suggests may exist in British sociology for the survey as 'a foreign cultural product' (Marsh, 1982:47). The opinion survey may also be associated with intellectually unchallenging and mechanical research (de Vaus, 1986:8).

For whatever reasons, sociology has not substantially participated in conceptual enquiry into the processes whereby patients judge their health care, let alone engage in serious debate about the merits of systematic investigation of the subject. Something of a gulf has grown between the enormous volume of satisfaction survey work in health services and the disdain for such work in academic sociology. The danger of this gulf is that a false impression is conveyed - that the intellectual issues in patient satisfaction have been resolved. In fact the starting point of this thesis was that the value of patient satisfaction research is still quite unresolved. How much may be learned from systematic enquiry into patients' views of their health care is quite unclear. The broad and unresolved issues to which this thesis is intended to be a contribution concern the value and scope of patient satisfaction research. The remaining discussion in this thesis attempts to address these issues by examining the results and implications of the two surveys, carried out with quite different research methodologies, which have formed the focus of this thesis. Questions about the scope and value of patient satisfaction research often turn upon uncertainties about how patients evaluate their health care.



The process of evaluating and responding to health care

Firstly, the two studies may be considered in terms of the light they throw on the process whereby patients evaluate their health care. In this context it must be underlined that the experience of outpatient medical care may have unique features, so that one may not be able to generalise from these results to other medical contexts. Thus, patients often have no prior experience of the particular doctor they are consulting and, compared with primary care, have little opportunity to develop stable expectations of the doctor on the basis of prior experience, of the kind described by Stimson and Webb (1975). Moreover, even compared with inpatient treatment, the patient in clinic settings often has only brief contact with the doctor on the basis of which to form judgements. It may be that a wider range of experiences become important in evaluating inpatient care, simply because one is totally immersed in the hospital environment for the duration of stay. Thus a general caveat needs to be expressed at this point against incautious generalisation from outpatient medical care.

Nevertheless, even with regard to such unfamiliar forms of medical care, and with such minimal treatment as both clinics involved, it is apparent how complex were patients' judgements, especially in the first study where patients' reasoning about their judgements were, whenever possible, elicited. Patients made quite complicated and

differentiated judgements about their treatment, for example observing how reassuring the manner of a doctor was at the same time as criticizing his peremptory style of history taking. Contrary to the views of Ben Sira and others, the study of neurology patients suggested that, far from being confined in their observations to a narrow range of affective and supportive aspects of behaviour, they perceived and evaluated a wide diversity of actions on the part of the doctor. Thus there was no evidence of the 'halo' effects commonly thought to govern patients' judgements, whereby positive judgements of one dimension of treatment influenced other perceptions. Judgements were differentiated.

These judgements included observations about the more technical aspects of their consultations, contrary to the widely held view, discussed in chapter one that patients are less concerned with the technical aspects of their care (Pope, 1978:293; Gray, 1980:65). Patients readily reached evaluations of such apparently technical issues as the range of medical factors covered by the doctor in his history taking and the appropriateness of his treatment decisions. The neurology clinic study in particular provided no support for the view that patients are quite unable to perceive or evaluate technical aspects of their medical care. The criteria used may not be those deriving from the specialised body of knowledge which the profession of medicine uses; patients tended to use common sense constructs such as the 'depth' or the length of time spent on the history to judge the technical quality of their

care. For Ben Sira, the reliance of the patient upon affective criteria is a necessity because of the patient's incompetence to judge a broader range of more technical aspects of his or her care. However this is to ignore the possibility, identified some time ago by Freidson (1961), that in deciding their satisfaction with care, patients may still make judgements of the doctor's interest and competence as applied to their case. Patients do credit doctors with a basic level of technical proficiency (Freidson, 1961:53; Pope,1978:293; Segall and Burnett,1980:277) but may still seek evidence of its application to their personal problems. Perceptions of the application of competence and technical proficiency involve patients in attending to and judging a wide diversity of technical and affective aspects of the doctors' actions. The patients that Freidson interviewed and on the basis of which he argued that competence and interest are inseparable concerns to the patient, resembled those patients in the neurology study who were particularly concerned by perfunctory history taking as evidence that the doctor was not getting to the heart or essence of their problem.

Neither study provides any support for the view taken by Ben Sira that perceptions of affective aspects of the doctor's actions have primacy in determining satisfaction. Although Ben Sira is right to take the view that actual levels of technical proficiency (if such a phenomenon could actually be measured) are unlikely to be the determinant of satisfaction, that is not a basis for

also maintaining that perceptions of competence - especially the application of competence - also play no role in patients' judgements, and less still is it good grounds for assigning causal influence to perceptions of affective behaviour alone. Appropriate multivariate analyses of the STD clinic survey and qualitative evidence from the neurology clinic both point to the probability that complex judgements in relation to technical and affective actions of the doctor are important to the patient.

Moreover Ben Sira's model does not allow for a third and independent dimension to patients' judgements, in addition to those relating to the affective and technical quality of care; namely, perceptions of the value of the treatment they receive. This third type of judgement Ben Sira often views as entirely derivative of other perceptions. Ben Sira misses an important conceptual distinction between on the one hand perceptions of the technical competence or quality of care and on the other hand perceptions of the value or effectiveness of care. Calnan also, in his discussion of patients' evaluations of care, wrongly conflates the observation that 'patients very rarely evaluate medical care in terms of the technical competence or expertise of the provider' with the view that they 'rarely evaluate modern medical practices, such as the value of drugs' (Calnan,1987:163). Thus patients are seen as uncritical of the value and effectiveness of treatment because of their acceptance of technical competence (Calnan,1984:77). Where the two concepts have not been

confused or conflated, observers have treated patients' perceptions of outcome as either derivative or indeed of secondary concern to patients. Thus Kelman concludes from patient satisfaction research that 'recipients of care are more concerned with the manner and means of the processes of health care delivery... than with the outcome of care' (Kelman, 1976:436).

No analysis of attitudes expressed in the STD clinic supported the view that satisfaction with the value and benefits of treatment were derived from attitudes to the 'art of care' provided in the clinic. As has been repeatedly emphasised, judgements of the doctor's affective behaviour could not be shown to govern any other dimension of views. In the neurological clinic study, at the time of patients' follow up interview to assess satisfaction, patients' perceptions were not yet focused on the impact of treatment on the course of symptoms as it was generally felt that more time was needed for any effects to occur. Nevertheless judgements were made, at the time of, or immediately after consulting, of the value in the sense of personal appropriateness of treatment. Patients had clear and strongly felt views, where, for example, the doctor prescribed a medication that had already been tried and found to be of no use, or where no advice about dietary factors was given. Again, this is not to maintain that such perceptions of the appropriateness or value of treatment will coincide with those of the medical profession. However Ben Sira's thesis - that perceptions of the value of treatment are almost entirely determined by



perceptions of the doctor's affective behaviour - is supported neither by the survey results of the first study nor by patients' accounts in the second study. Several patients in the neurology study were quite capable of conceding the 'niceness' of the specialist whilst doubting the value of their attendance, or vice versa.

Other studies indicate that patients make judgements of the value of treatment, independently of judgements of the affective components of their care. Indeed, from a study of inpatient satisfaction, Carmel reaches conclusions that are the very opposite of those entailed by Ben Sira's model:

'Perceived improvement in health is found to be the predictor of patients' general satisfaction and satisfaction with all the studied hospital services.....The major conclusion derived from the results of this study is that when a client feels that he is achieving his goal, he adapts to the deficiencies in the process of achieving it by attaching less importance to the process.' (Carmel, 1985:1249)

Thus, far from being reliant upon the process, upon affective aspects of treatment, for Carmel, patients regard the process of their treatment as of less significance and are concerned more with the value of such treatment for their overall goal of recovering health. This view is remarkably consistent with the evidence from the neurology study of patients who quite sharply distinguished between the way in which they were treated and the apparent value of the clinic visit. This approach to satisfaction, which emphasizes the patient's primary goal in seeking health care and views satisfaction as being determined by perceptions of the extent to which goals, in

terms of perceived health outcomes, are achieved, has intuitive appeal but has received relatively little attention from research. Deyo and Diehl (1986) examined patient satisfaction in a sample of low back pain patients in the United States. Their satisfaction scale was significantly related to self-rated outcome in terms of pain. Similar results were obtained in an English study of an outpatient back pain clinic (Fitzpatrick et al., 1987). Similarly, Wooley et al., (1978), in a study of primary care, found satisfaction to be positively associated with perceptions of symptomatic improvement. Brody and Miller (1986) found that satisfaction with care was related to improvement in symptoms in a sample of patients presenting with urinary tract infections. In all of these studies, the most obvious interpretation of results is that the perceived impact of treatment over time on the course of symptoms naturally determines the patient's views of the quality of care received. The argument here is that another dimension of patients' views needs to be considered in patient satisfaction research - that is the perceived value or appropriateness of treatment as judged by patients before the treatment influences symptoms. There are other reasons for seeking medical help than the desire to reduce symptoms (for example obtaining advice or reassurance) and the extent to which other such goals are furthered may also be judged by the patient. Indeed the strongest and most clearly distinguished of views held by patients in the neurology clinic was on this distinct dimension of the value of clinic attendance. Patients' perceptions of their visit as either 'worthwhile' or a 'waste of time' were

quite distinct responses to their attendance and also the most useful judgements from the point of view of providing any kind of overall evaluation of the clinics. Whether or not such judgements of treatment from patients rely upon perceptions of symptom change, there is sufficient evidence from the studies reviewed here and from the neurology clinic to warrant further investigation of this aspect of patients' views. Certainly there seems little justification in a priori ruling out the possibility of patients being able to make useful judgements of outcomes without reliance on judgements of the process of care.

It is of potential importance that this dimension of patients' judgements seemed less influenced by social or educational differences in attitudinal readiness to criticize. It has been argued at various points in the thesis that one of the main limitations in using patient satisfaction for any policy related purpose is that survey responses seem to be heavily influenced by patients' social backgrounds. The influence of educational level in the STD study is an instance. In the neurology study, such background variables seemed minimally to influence the scales of satisfaction used. Perceptions of the value of treatment and of communication were more associated with and understandable in terms of the compatibility of different kinds of patient concerns and the treatment received, rather than in terms of the influence of background social variables. This lack of social attitudinal effects could be due to the method of data collection in the neurology study, in that patients had the

opportunity to give detailed answers on the value of their visit. Most questionnaires appear to invite respondents to adopt summary attitudes to their treatment by the doctor. It may be that such attitudinal responses are more heavily influenced by the differential readiness of different social groups to express critical attitudes than are more considered judgements of the value of care.

Patients did experience problems in expressing attitudes in relation to their neurological clinic visit and such difficulties clearly contributed to the complexity of patients' judgements noted in the neurology clinic. Patients were reluctant to criticize or express dissatisfied attitudes, and, even when the hospital visit was experienced as extremely disappointing, patients would still search for reasons that avoided expressing unqualified criticism. Some reasons given by patients may be peculiar to the brief encounters with health care typical of outpatient medicine. Thus patients found it difficult to infer what had actually happened in their visit, so quickly did it happen. They usually had only one experience of the specialist on the basis of which to make judgements. Other reasons given by the sample for not adopting negative attitudes to their care provide support for the views of Mauksch (1972) that respondents feel the need to provide socially acceptable answers in relation to health care. Quite strong reservations have to be overcome for many people to express dissatisfaction in a survey on health care, and the reasoning behind such reservations given by patients in the neurology study may provide one

explanation for the very positively skewed nature of responses found in the STD clinic survey, as in virtually all other studies.

In both studies, one major emphasis, in understanding the process whereby patients' evaluated their health care, was upon the variety of patients' concerns in relation to their presenting problem. In different ways such concerns were important influences upon patients' judgements. The diversity of patients' problems in health care is often commented upon but seldom incorporated into research. One exception is the study by Brody and Miller (1986) which found that concerns about the seriousness and chronicity of urinary tract infections were extremely common in the clinic sample they studied, and argued that patients' concerns needed further investigation. In the neurology clinic study particularly, asking patients' about their expectations of treatment was not successful since patients generally were unable to focus on specific actions or outcomes that they hoped for or expected of hospital attendance. This may partly be due to lack of prior experience with the specialist and uncertainty as to alternative possibilities. 'Expectations', as assessed in many satisfaction studies, is a very medically oriented concept; it focuses upon the specific actions by the doctor that the patient may hope for or expect. For more specialised forms of health care at least, patients seem not to hold such specific expectations. Lipton and Svarstad anticipate this problem:

'There are many dimensions of expectations and many ways in which the concept can be operationalized. It



is obvious that when parents are asked to express their expectations regarding particular types of tests, specialists and treatments they are very uncertain; however had expectations been measured with the use of other indices, the degree of parents' certainty and specificity might have increased.' (Lipton and Svarstad, 1974:165)

Thus instead of concluding that patients' have no agenda by means of which they evaluate their hospital attendance, as some research appears to conclude (Reader, 1957), the concept of 'concern' attempts to capture in a more patient centered way, the matters of importance to the patient. The concept of 'concern' is addressed more to the meanings an individual attaches to his or her illness; 'expectations' assumes such meanings are translated to a specific agenda or 'shopping list' of actions for the doctor to carry out - an extreme consumerist assumption for which no support could be found in the neurology study. The symptoms which the patient presents to the doctor become a matter of concern in specific ways for each patient; in the neurology study for example, headaches became a source of fear and anxiety requiring reassurance, or alternatively a recurrent part of everyday life that the patient felt he or she should somehow be able to avoid or prevent. Such concerns do not, at the time of attendance translate into concrete expectations of the doctor that may be stated in so many words.

A focus upon patients' concerns and the diversity of such concerns also made it possible to understand many of the different reactions to the neurology clinic obtained afterwards. Concerns for symptomatic treatment were most

easily met by the clinic and seemed least often the source of disappointment. At the other extreme, those patients who looked to the clinic to contribute in some way to assist them in avoiding or preventing their recurrent headaches, whether by medical intervention or by life style advice, were most frequently disappointed. This concern was the one least compatible with the types of care provided by the clinic. Knowledge of this group of patients' concerns also alters our understanding of the reasons for their dissatisfaction. Where such patients complained of not being taken seriously as a person or of being rushed through their medical histories, they were not complaining of impersonal treatment per se, but because important goals in attending the specialist were frustrated.

In the STD clinic also, the concerns of patients were diverse. Problems presented to the clinic by some patients had become a concern because of their impact on the individual's sexual activities, for others because of fears about serious illness. Similarly, such concerns were differentially related to satisfaction. Concerns about the chronicity of symptoms were most strongly associated with dissatisfaction. The meaning of this association could only be considered speculatively because of the absence of further data from patients. A possible parallel with some of the chronic headache sufferers in the neurological clinic was suggested, in that chronic, recurrent genito-urinary infections may be a source of considerable distress and discomfort which may not appear to be matched

by medical concern at the time of seeking treatment.

Both studies provide strong evidence of the diverse ways in which psychological distress may enter into the process of evaluating health care. In the STD clinic study, a variety of measures of different dimensions of psychological distress all appeared to be significantly associated with patient satisfaction. General psychological well being, as reflected in the General Health Questionnaire, as well as more specific psychological distress in relation to one's physical health both seemed to have some influence on subsequent satisfaction. Separating out such effects, statistically or theoretically is difficult. Clinical literature indicates that the extent to which an individual is concerned about health is frequently linked to general psychological well being (Kenyon, 1976; Kellner, 1985). Multivariate analysis in this study seemed to indicate that Disease Conviction, seen by Pilowsky and Spence as preoccupation with physical disease and bodily symptoms, but speculatively interpreted in this study as a felt need to have distressing symptoms taken seriously, was particularly associated with all three scales of satisfaction, independently of other levels of psychological well being or distress. The results would provide some support for the view that problems of reassurance and preoccupation with health and consequent problems in relationships with doctors such as dissatisfaction, should not simply be subsumed under more general affective disorders such as depression and have an

important, independent influence (Mayou,1976; Barsky and Klerman,1983; Sensky,1986; Appleby,1987). Several studies have also found that patients' low subjective appraisal of physical health is associated with dissatisfaction with care (Linn and Greenfield,1982; Mirowsky and Ross,1983).

In the neurological clinic study, the influence of worry about serious illness and of general psychological well being on satisfaction seemed to be independent of one another. On the one hand patients who were not reassured in relation to their worries were particularly disappointed with hospital attendance. On the other hand patients with significant symptoms on the PSE were also dissatisfied. One possible interpretation (Greenley et al., 1982) is that this latter association reflects the generalisation of unhappiness to focus upon all matters including the individual's health care. An alternative interpretation one might make on the basis of this study, and one consistent with the views of neurologists interviewed for the study, is that the disappointments of the psychiatrically unwell were accurate appraisals of the inappropriateness of referral of their problems to the neurologist, given his exclusive concern with diagnostic assessment of physical disorder.

Another, more speculative parallel exists in the results of the two studies, and may reveal something of the process of patient evaluation. In the STD clinic study, patients with prior experience of the clinic were more likely to express dissatisfaction. This effect could not

be explained entirely by means of other aspects of such patients' experiences, although it was noted that there appeared to be an interaction of prior experience and satisfaction with concern about health as indicated by the IBQ Disease Conviction Scale. In the neurology study, patients with the longest histories of suffering headaches were more likely to express dissatisfaction. The experience of dissatisfaction amongst chronic migraine sufferers was related to McIntyre and Oldman's concept of the patient as 'expert', in which the individual accumulates personal experience and knowledge, the very complexity and sophistication of which inevitably contrasts with the apparently routine and superficial approach of the specialist. Other studies underline the importance of prior experience of health care in increasing levels of dissatisfaction (Linn et al., 1982; Fitzpatrick et al., 1987). Stimson and Webb observed that 'the concreteness of expectations appeared to be related to the concreteness of the patient's own diagnosis and perceived treatment requirements. This is evident in the case of the chronic sick repeat attenders' (Stimson and Webb, 1975:31). These results suggest a number of related processes that may occur. The experience of repeated visits for treatment for a chronic illness may clarify the individual's perceptions of his or her personal needs. Patients may become less flexible and ready to accept treatment that departs from their own clearly established goals in seeing the doctor. It is equally possible that the association between frequency of prior treatment and dissatisfaction arises out of more frequent disappointment with medical care. Because



a minority of patients with any chronic disorder will experience repeated failure from medical care, which will reduce their tolerance to accept the level and quality of care provided at their next consultation. A different interpretation, favoured by Barsky (1981), would simply identify a personal syndrome or coping style of some individuals whose personal problems result in regular medical attendance. Because their 'real' problems' are never addressed by the doctor, they remain for ever dissatisfied. Clearly different explanations for the association between regular experience of treatment and a tendency to be more critical of care may apply to different health problems or health care settings. In the neurological clinic, it did not appear that the group of chronic headache sufferers who were disappointed with their care felt so because of a general orientation towards health care, as suggested by Barsky. They did not appear generally critical of their experiences of medicine. Rather, as already argued, their disappointments arose out of the clash between their own more complex experiences of migraine and its management and the routine and superficial approach of the clinic. Whatever the processes at work, both studies provide evidence for the view (Locker and Dunt, 1978:289; Calnan, 1987:163-4) that the greater the amount of prior experience with a health service, the greater the readiness to be more critical.

## Conceptual approaches to patient satisfaction

### 1. The cognitive anthropological approach

Having considered some of the dimensions in terms of which patients appear to judge their health care, together with some of the processes that enter into such judgements, it is important to reconsider the social scientific concepts distinguished in the first chapter that attempt to explain how patients evaluate their health care. These approaches may be reviewed again in the light of the two studies reported in this thesis. The first approach - the cognitive - anthropological approach - stresses the importance of patients' health beliefs and cognitions as determinants of aspects of behaviour such as communication with health professionals and compliance. In its most formalised approach, people are viewed as having or seeking 'Explanatory Models' for their sickness problems (Kleinman, 1980). Explanatory Models provide explanations of sickness in terms of (a) aetiology (b) time and mode of onset (c) pathophysiology (d) course and (e) treatment. Kleinman (1980) predicts that the greater the difference or disparity between patients' views and those of their clinician, the greater the likelihood of communication being more difficult and of more problems of patient dissatisfaction arising. Very few empirical studies have been conducted to support this approach to patient satisfaction. An exception is a study by Blumhagen (1982) of patients attending a hypertension clinic. Patients'

Explanatory Models of their hypertension were elicited in careful detail and patients' satisfaction with the clinic also obtained. Particular beliefs about the aetiology of hypertension - specifically that narrowed blood vessels and chronic external stress caused hypertension - were positively associated with patient satisfaction. Interestingly these beliefs explained quite a significant amount of variance in satisfaction scores. However the study reveals one basic problem with this approach. As Blumhagen explains:

'Unfortunately I cannot explain why the results come out this way.. Why is the perception of vessels constrictory as a cause of hypertension associated with greater satisfaction?' (1982:315).

Blumhagen does not discuss the applicability of the concept of cognitive disparity to his findings, presumably because other cognitions about hypertension, equally remote from those established by medicine, were not significantly associated with satisfaction. Another problem may be that, given that professional views as to the aetiology of hypertension are quite varied and still contested, it would be quite difficult to operationalise the concept of cognitive distance and disparity between patient and doctor. In any case, the meaning of the finding that certain lay beliefs are positively related to satisfaction remains obscure. In isolation it is not clear how such beliefs play a role in influencing satisfaction.

Another study deriving from the 'Explanatory Models' approach is a study by Pill of womens' experience of cystitis and its treatment in general practice (1987).

There is no attempt to measure patient satisfaction, but the author observes that the source of dissatisfaction in the sample of women appeared to arise, not out of the distance between lay and medical models of the disorder of cystitis, but out of the fact that women closely adhered to the medical model. The medical model depends upon infectious aetiology, the use of tests to confirm the presence of a treatable condition, and antibiotics as treatment. Where, as is often the case, women experience distressing symptoms but there is no laboratory confirmation of infection, the medical model provides no satisfactory alternative courses of action, to the frustration of many women. Alternative responses, such as self treatment or preventative strategies are undermined by their acceptance of the medical model. The paradox of this research would appear to be therefore that the greater the proximity or congruence between lay and medical model, the greater the chances of frustration and dissatisfaction with medical care by patients.

In neither the STD clinic nor the neurology clinic studies were Explanatory Models formally elicited. However, in the neurology clinic study, patients were asked about their views on the causation, timing and onset of their headaches. Only a minority of patients had clearly established views that would correspond to Kleinman's conception of the Explanatory Model. This group was sufficiently distinct to be categorized on the basis that they did have clear views of their headaches as being migraine. The majority of patients were in varying degrees

quite uncertain as to the causation and reasons for onset of their headaches. A primary reason for attendance was for many that they had no acceptable (to themselves) explanation for their symptoms and were to varying degrees anxious or alarmed. This is one of the limitations of the cognitive anthropological perspective. To be more appropriate to samples such as the one investigated in the neurology clinic, the Explanatory Model approach has to incorporate the possibility of patients who have no clear views of their symptoms. It might be argued that for many of this sample who were anxious about their symptoms, their EM focused upon such possibilities as brain tumours and haemorrhages, and that these cognitions were important in determining patients' satisfaction with the consultant. However many other patients did not focus their worries on any particular possibility, but had exhausted any normal explanation for symptoms. The EM approach also needs to incorporate the possibility that patients who are anxious because they lack an explanation for symptoms may be reassured less by a substantive explanation of the nature of their symptoms, than by a brief statement that their symptoms are normal. With some exceptions neurologists reassured patients, not by providing EMs - extensive explanations of the pathophysiology and aetiology of their symptoms - but by more condensed statements that their symptoms were normal and not based on serious disease.

The cognitive anthropological approach thus needs to allow for such minimal communication of substantive content being successful. Thus although discussions of



successful reassurance emphasise the need for the clinician to provide explanations, that is information, they also stress the importance of how communication is conveyed (Sapira,1972; Kessel,1979). As Buchsbaum argues: 'The way the physician presents information to his patient can be as important to patient reassurance as the content of the information' (1986:426).

For other patients - for example, many of those seeking symptomatic treatment - cognitive explanations for their symptoms were of secondary concern indeed to the more pragmatic concern of obtaining some form of treatment. To the extent that EMs existed at all, they were highly condensed, partly unconscious, and not the prime influence upon behaviour. Such patients simply suffered headaches, for which they wanted some form of treatment. They were not particularly concerned to make up their cognitive deficit, and were not therefore particularly concerned by the lack of explanations provided by the specialist.

One group of patients had clear EMs, at least in the sense that they definitely viewed their headaches as migraine and, in various ways organised their views of the onset, course and treatment of their symptoms around this concept. This group of patients were also particularly likely to express dissatisfaction, both in terms of the medical treatment and the communication they received from the neurologist. Certainly their ideas about their health problems differed from those of the clinician. To some extent this group of patients' often strongly negative

reactions to their treatment may be understood in terms of Kleinman's model. However the conceptual framework needs refinement and adaptation. The emphasis in the model is upon the 'disparity' between two substantive sets of ideas. The most striking difference between the two parties in this case was not the cognitive disparity between their EMs but their quite different agenda. The neurologists in the sample were most concerned about differential diagnosis - that is eliminating the remote possibility of certain serious lesions being responsible for symptoms and then distinguishing between a small number of other more 'functional' symptoms. Personalised explanations of cause, and of fundamental pathophysiology, of the specific reasons for onset and of the likely course of any particular case were of no apparent concern to the clinician and certainly not focused upon in discussions with patients. Thus the basis of disappointment for many of this group of patients was less the distance between their views and those of their doctors - less a matter of substantive cognitive differences - and more a difference of practical agenda. Patients, it may be recalled, believed that such factors as 'stress' and 'diet' might be amongst the biographical issues the neurologist would wish to consider. In this sense their EMs were quite close to many sections of the medical research community, for whom both factors are also of great potential interest. However the concerns and interests of those involved in fundamental research may diverge from those of the practicing clinician. In this field of medicine, dietary, allergic, or psychosomatic mechanisms appear of purely 'theoretical' interest to the

majority of clinicians, and are of only modest practical consequence in the management of most patients.

To return to Blumhagen's dilemma, the question remains as to why certain beliefs are associated with satisfaction or dissatisfaction. Again, it is suggested from the neurology study that the EM approach needs to be expanded. The views and grounds for subsequent dissatisfaction of one group of patients were more clearly understandable in relation to particular concerns and particular stages in the illness career of the migraine sufferer. Their sense of the personal complexity of symptoms, and the need for the clinician to take serious account of the patient's particular biography made sense in the context of long term migraine suffering and MacIntyre and Oldman's concept of the chronic illness sufferer as 'expert'. The limitation of The EM approach is that it may isolate patients' cognitions from their social and biographical context and thereby lose some of the explanatory power of that context.

Thus to summarise, this approach to the understanding of patient satisfaction has been under-investigated. Its value is most clear in the case of major cultural differences arising from cultural migration in which serious communication problems in the practice of medicine clearly arise. The applicability of this approach to more mundane medical contexts remains to be examined. Certain problems persist. The role of anxiety and emotion is neglected. The affective components of becoming ill,

seeking help and reassurance and receiving support from seeing a doctor, which play such an important part in Ben Sira's model, are neglected in this approach. The result is an unbalanced account of the experience of illness and help seeking. The role of condensed communication in which nothing much is said, but communication appears successful, is not easily approached by this perspective. Above all the case that cognitions are the primary determinant of illness behaviour is not established. On the other hand, more than the other approaches, this perspective does insist that satisfaction with care is predicated upon the meaning of illness to the individual. However as a model of patient satisfaction the cognitive anthropological approach is flawed because of its emphasis upon lay cognitive models as determinants of evaluation without reference to the goals, plans, concerns, and anxieties which motivate patients to search for cognitive patterns.

## 2. The role expectations approach

A second approach to patient satisfaction that was considered as offering a possible model of the process whereby patients evaluate health care focused upon patients' expectations. This perspective offers a variety of possible insights into the determinants of satisfaction. One approach to the concept of expectations is Mechanic's view that patients have an 'image of the physician's role and the way it should be performed' (Mechanic, 1978:407) in terms of which the patient evaluates the doctor and the treatment he or she receives. 'This image', Mechanic

continues, 'reflects the societal definition of the physician's role, and sub cultural expectations, as well as the conceptions formed by the patient through prior experience' (1978:407). Thus Mechanic suggests that cultural differences in expectations of the doctor's role may be important sources of variation in satisfaction. Henley (1979:58) provides evidence of such cultural variations in conceptions of the doctor's role with regard to East African Asians hospitalised in England who are suprised by the more impersonal style of doctors.

Several investigators have attempted to extend this approach to explain intra cultural variations in satisfaction, on the basis of variations in patients' role expectations. Thus Larsen and Rootman draw on role theory to argue that '...both the physician and patient hold expectations of their own and the other's role... The more a physician's role performance meets a patient's expectations, the more satisfied the patient will be with the physician's services' (1979:29-30). Their method of investigation is a 'physician conformity index' which elicits patients' views of the extent to which the doctor conforms to various expectations. The items are generally phrased questions such as 'Make house calls' and 'Avoid giving advice over the phone'. Perceptions of conformity were found to be correlated with satisfaction and this was unrelated to socioeconomic background. A similar approach is adopted by Segall and Burnett (1980). Both studies examine views in relation to the doctor that the patient regularly attends. Thus this approach stresses the



importance of static, stable role expectations, held by the patient, as determinants of patient satisfaction.

The most frequently examined alternative, less clearly derived from social theory, more simply examines the notion that patients at any specific consultation have particular expectations of what should happen in terms of which they evaluate their treatment. This approach to satisfaction has been quite commonly used to examine treatment expectations and satisfaction in general practice, especially with regard to patients' views on prescriptions (Jones,1979; Fitton and Acheson,1979; Rapoport,1979).

Thus there are several different interpretations of the concept of expectations. Conceptual and semantic ambiguities as to the meaning of the term 'expectations' in this field are a particular hazard (Uhlmann et al., 1984). The neurological study found little evidence that patients approached the clinic with clear role expectations however conceived. Patients held some tacit expectations of the specialist, such as for example that he was an expert, knowledgeable in the field of headache, and that, as a consultant, he would have somewhat more time than their general practitioner to take their complaints seriously. Patients were so lacking in knowledge of neurology that they could only guess at the ways in which the specialist might help them. In this respect expectations were as ill defined and fluid as other patient groups attending unfamiliar forms of care (Lipton and Svarstad,1974; Skuse,

1975). The approach of investigators such as Larsen and Rootman involves assumptions regarding the stability of expectations that for the setting of the outpatient clinic at least were inappropriate. Many of patients' expectations were continuously revised in the light of fresh evidence such as the research interview itself. Expectations elicited before patients' consultations were not expressed with sufficient conviction that they were likely to be the basis or criteria of patients' judgements of their treatment. Moreover there was little apparent variability in expressed expectations of the kind that might be associated with and explain subsequent satisfaction.

The frustration of some patients' tacit expectations was quite apparent in their critical comments of the hospital visit. In particular the doctor had appeared not to take them seriously and had been no less cursory than their general practitioner. Thus there is in such patients' dissatisfaction support for the concept of role expectations as a determinant of satisfaction. In the sense that patients' expectations of aspects of the specialist's role - that he take problems in which he is an expert more seriously than a GP - were the source of disappointment. However to find the reason why only some patients were frustrated when it appeared that all received rather similarly routine treatment, one has to look beyond patients' role expectations. Here the concept of concerns proved invaluable. The concept underlines the diversity of goals and purposes that may exist in a clinic population

that is rather homogeneous when viewed from a purely medical perspective. The concerns of some patients to obtain symptomatic treatment were such that the routine, cursory treatment they received was not a particular source of disappointment; for patients with a concern for more fundamental preventive interventions, the same treatment was a disappointment since, by seeming not to take the patient's problem seriously, the doctor had made the hospital visit a 'waste of time'. To summarize, such tacit expectations as existed in the sample were universally held and could not provide the basis of an explanation for such diverse responses; the diversity of patients' concerns explained why such tacit expectations became salient for some patients.

### 3. The role of emotional and affective factors

Finally, the conceptual framework provided by Ben Sira may be evaluated in relation to the two surveys. It has been frequently observed in this thesis how important is this perspective because, by contrast with the cognitive emphases of both the Explanatory Models approach and, in a different way, role expectations theory, Ben Sira's concepts underline the emotional and affective aspects of illness and help seeking.

Ben Sira's specific affective model was not supported by the STD clinic survey. There seemed no reason to assign primacy to perceptions of the doctor's affective behaviour over perceptions of technical, instrumental

behaviour in determining satisfaction with treatment, since both sets of positively skewed variables were equally strongly associated with satisfaction with treatment. His view of emotions in relation to illness is unnecessarily static and unidimensional - people are viewed as having a 'level of concern about health' which is relatively stable over time. This ignores evidence of the different levels at which people conceive of their health (Williams, 1983), and does not allow for the possibility of reassurance as a major outcome of consultation. The model does not allow for a diversity of different kinds and focuses of concerns amongst patients seeking medical care. Consequently the model makes few useful predictions in relation to the determinants of satisfaction in patients who do not happen to be anxious about their health, and who consult for other concerns. On the other hand his model does affirm the importance of concerns in the experience of help seeking. Although it is unnecessary and indeed unwarranted to see patients as solely reliant on affective support to judge their care, nevertheless the affective dimension of illness experience is important. Certain kinds of distress and certain kinds of concerns were more strongly associated with patient dissatisfaction in the STD clinic. Although not directly predicted by Ben Sira's model, the occurrence of such problems in the STD clinic was detected as a result of pursuing the affective meaning of their illness for patients.

In the neurology study, affective and instrumental aspects of the doctor's behaviour were quite closely

connected in patients' judgements. Thus patients who were disappointed with the doctors' treatment expressed this in terms of aspects of the doctor's technical behaviour as well as affective items such as showing interest. The doctor was perceived, for example, as having inadequately examined the patient and as having shown no personal interest. Specific predictions from Ben Sira's model do not appear to be supported. In particular, the groups of patients who were especially concerned with preventive interventions and who had clear views of their headaches in terms of migraine might be thought to be less reliant upon the doctor's affective behaviour because of the importance of knowledge in Ben Sira's model. However they seemed particularly to judge closely the benefits of their consultations on the basis of how personally interested the doctor appeared in their case histories. Affective and instrumental aspects of the doctor's behaviour were intimately connected in such judgements. However these patients were very definitely not anxious or worried about the meaning of their symptoms. Nor were they seeking emotional support. In contradiction therefore to Ben Sira's theory the importance to this group of affective behaviour such as interest did not arise out of anxiety and the need for emotional support. It arose from a (mistaken) view that the specialist would be able to pay some attention to their biographical and personal details in order to help prevent their recurrent migraines. Once again, the reasons for the importance of affective factors for this group of patients in the sample is not provided for by the general conceptual model of patient satisfaction



and only emerged from closer consideration of the meaning to particular groups of patients' of their symptoms.

*The value of patient participation*

At a more general level Ben Sira's model ultimately emphasises affective factors on the basis that evidence of interest and personal concern shown by the doctor to the patient are the most important consideration in the patient's evaluation of treatment. This was difficult to support in detail from the second survey, and it was suggested that Ben Sira's own samples and methods were no more convincing. Above all, the emphasis in his model is upon a single explanatory concept - the importance of perceptions of affective behaviour. This simple explanation neglects the very diversity of different reasons why the doctor's interpersonal behaviour may come to be a focus of concern. One consequence of the finding that the model does not stand up to detailed criticism is that the patient's role as observer and judge of his or her health care is restored. There are no grounds for narrowly limiting the patient's capacities to judge the value of care.

Common to all three of the conceptual approaches considered here is the absence of consideration of the goals and concerns of patients when seeking care and the role they play in shaping patient satisfaction.

### The value of patient satisfaction research

The direction in which this analysis has gone so far is consistent with Linder-Pelz's conceptual definition of patient satisfaction as 'the individual's positive evaluations of distinct dimensions of health care' (Linder-Pelz, 1982:580). This definition is a useful one because it underlines the importance of evaluation and also because it stresses the multidimensional nature of the phenomenon. The evidence of the two surveys reported here indicates that patients evaluate a wide variety of distinct aspects of their health care. Few surveys of patient satisfaction reflect this by examining patients' judgements with regard to a wide range of dimensions of their care, but tend instead to be selective in focus, depending on the specific interests of the investigator. At the outset it was argued that quite diverse types of enquiry arising from different interests converge upon the subject of patient satisfaction and any assessment of patient satisfaction research needs to address these different interests. The distinctions between different uses and interests in patient satisfaction used in the first chapter is to some extent arbitrary. Health authorities were treated as primarily concerned with the structure of the services for which they are responsible, although, clearly, their responsibility extends also to the clinical behaviour of health professionals. Similarly clinicians were regarded as being concerned with lessons to be gained from patient

satisfaction research in areas such as the 'art of care'. However particularly in primary care, the structure of services is of increasing importance to the health professional and the patient's assessment is of central value. Thus there is a somewhat artificial element to the divisions. On the other hand there may well be some basis for maintaining that health authorities will in the immediate future be largely interested in patient satisfaction with regard to the organisational, and 'hotel' aspects of care; clinical interest will focus on patient satisfaction with 'the art of care' and health services research will be the main interest group likely to use patients' views with regard to outcomes.

#### Health authorities

Most actively investigating the views of patients are the statutory Health Authorities who, since Griffiths have been enjoined to seek out the perceptions of their consumers more energetically. Most district health authorities appear at least to have accepted the responsibility and have in the first instance acted by creating posts such as the 'consumer affairs officer' in Brighton (Bowden et al., 1986) and the quality control manager in Tameside and Glossop (Fisher, 1986), or managerial groups such as the 'patients' perception group' in South Tees (Donaldson, 1986). In all cases such offices or groups have been created out of preexisting positions but are now charged with the new responsibility of monitoring and assessing consumer opinion or patient

satisfaction.

Health authorities have most often employed the simple attitudinal survey, whether addressed to a specific service or in relation to views of hospital services generally. The measures of patient satisfaction used in the STD clinic survey were not too dissimilar to questionnaires used in this context. The STD study produced results similar to most such surveys in the sense that the vast majority of respondents expressed positive satisfaction. Often such results provide only modest amounts of useful information, even at the level of identifying least and most favoured institutions, given the small proportions of patients with negative comments from which significant differences must be sought. As Moores and Thompson observe, such surveys 'typically lead to levels of satisfaction in excess of 90 per cent which makes comparison between scores obtained in different hospitals virtually impossible' (Moores and Thompson, 1986: 892). The influence of social class, education, and age, as was argued in chapter one, generally explain more of the variance in such surveys than any part of the service under examination. To this list of 'contaminating variables', the studies reported in this thesis indicate that we must add respondents' psychological well being. Other psychosocial variables such as the qualities of patients' social networks and levels of environmental stress have also been identified as influences on satisfaction in other surveys. Especially where the respondent is asked to express favourable versus unfavourable attitudes in

relation to health care, as was illustrated in the neurological clinic study, a number of social pressures and reservations evidently enter into responses although their effects are unseen in most surveys. Such surveys can nevertheless point out problematic aspects of health care provision such as waking times in hospital (OPCS,1978), the unattractive nature of general practice surgery waiting rooms (Cartwright and Anderson,1981) and most consistently of all the unsatisfactory nature of explanations received from health workers in every sector of the health services (Moore and Thompson,1986). The inertia of health care systems to change relatively specific problems such as waking times, clearly and frequently complained about by large numbers in patient satisfaction surveys, has already been noted (Stocking,1985). Where problems are identified in surveys by only a small minority of respondents, it is hard to conceive of the patient survey as a major impetus to change. Some authorities, because of difficulties in the survey approach, have become more consumer oriented by alternative strategies, for example by regularly having the management team hold meetings in which the object is to attempt to empathise with hypothetical patient problems (Donaldson,1986)! The public relations officer of the Royal Sussex County Hospital tours the outpatient clinics asking patients to describe their experiences, which are tape recorded and played back to doctors, nurses, managers and clerical staff (The Health Service Journal,1987). The exercise is reported to have brought about numerous simple but important administrative improvements to the hospital, for example reducing waiting times in outpatient clinics by



the introduction of appointments systems. The public relations officer comments: 'We chose tape recordings rather than handing out questionnaires because we thought the findings would be harder to ignore' (The Health Service Journal, Feb 1987:205). Problems will surface as quality assurance becomes more established in the health service. How often should service users be surveyed? Normally the exercise appears to be conducted on a 'one off' basis. How does the health authority rationally select amongst the myriad of issues and services about which to obtain services? Above all what kinds of long term relationships can be set up between the collection of data about consumers' views and the implementation of change on the basis of this data? At present insufficient thought is given in advance to the consequences for managers and health authorities of obtaining patients' views (Henderson,1987).

This thesis suggests three possible directions in which health authorities might develop satisfaction surveys in order to extract more information content, given the fact that presently, often expensive surveys produce such uniform results. Firstly the STD clinic study indicated that more significant associations between variables could be found by sub-group analyses. Generally satisfaction surveys are never analysed or presented with the use of any other technique beyond the level of frequencies and, sometimes, cross-tabulations. This would appear to result in underutilisation of the potential of the survey, particularly in the sense that sub-group analysis may point

to more significant sources of dissatisfaction. Secondly there seems to be no justification for underestimating, as surveys continue to do (OPCS,1978), patients' abilities to respond to questions on a wide diversity of aspects of their treatment, especially where effort is made to devise precise questions on relevant issues (Martin,1986). Authorities should not therefore restrict the focus of surveys to narrowly defined aspects of the process of care. In particular, issues such as whether services are valued and perceived as 'worthwhile' can be tackled when respondents are interviewed and given opportunities to express their concerns (Bollam et al.,1988). Consideration needs to be given to the suggestion that either 'managerial bias' (Calnan,1987:164) or a tendency to focus on issues that 'do not directly trespass on the doctor's domain' (Pollitt,1987:85) have governed the scope of patient satisfaction surveys. Thirdly and most importantly both studies reported here benefited from examining more closely the reasons for patients' responses. Expressions of satisfaction and dissatisfaction were more informative when considered in the light of specific meanings, concerns and goals in seeking medical care. The interview may be essential to obtain such information. It is of importance that in the neurological clinic study positive as well as negative aspects of the clinic were highlighted by interviews. Interviews may elicit more praise as well as criticism, compared with postal questionnaires (Cartwright, 1987). The cost and effort required to go beyond the basic attitudinal survey are high and have to be carefully weighed against the increased quality of information

(Cartwright,1987). It is difficult to see how the requirements of piloting, and study-specific questionnaire and interview development, that are important in finding out patients' concerns and goals, can match for economy the more familiar survey questionnaire. It is therefore likely that the more informative, 'in depth' satisfaction surveys would have to be more strategically deployed and be targetted to very specific services or populations, about which the health authority happened to be concerned.

#### Clinical relevance of patient satisfaction

Whereas the two studies presented in this thesis have served to underline some of the difficulties of patient satisfaction surveys as a means for statutory authorities to monitor the consumer acceptability of their services, they provide encouraging evidence of the value of investigating patients' views from a clinical point of view. It was argued in the first chapter that clinically oriented studies such as the series conducted by Korsch and colleagues (1968) have been widely cited and influential in the development of new approaches to the practice of medicine. Korsch and colleagues showed that many the concerns and expectations of mothers attending a paediatric clinic were not addressed and such failures of communication influenced their level of satisfaction, which in turn influenced compliance. Satisfaction and compliance were related back to specific failures of communication in the clinic. The study demonstrated the potential importance of satisfaction as a clinical outcome, and as a

means of identifying the sources of problems in the doctor patient relationship. Similar studies followed in which satisfaction was used as an outcome measure which might relate to problems in relations between patients and their doctors identified independently from tape recordings of consultations (Stiles et al.,1979; Stewart,1984; Roter et al.,1987). In particular this tradition of research has been used (Pendleton,1983) as evidence to argue for a more patient focused style of medical communication, in which more emphasis is placed on eliciting the patients' goals, concerns and expectations in relation to the presenting problem.

The neurology clinic study offers further insights into the nature of the doctor patient relationship that may be investigated by means of assessing patients' views. One major source of dissatisfaction for many patients with differing concerns was the sense of not having their problems properly discussed and addressed in terms of being personally understood by the doctor . Most clinically oriented patient satisfaction research underlines the importance to patients of this factor. It has been one of the main sources of evidence for the widely cited view, discussed in the first chapter, that for patients the process of care is of greater concern than the outcome. Evidence from the neurology study can be used to look more closely at why being treated and understood as an individual comes to be an issue for some patients.

Freidson offers an important starting point. His

view is that relations between doctors and patients have always involved potential conflict, arising from a structural clash of perspectives between the two parties (Freidson, 1970:286). Such differences may arise from social differences between the two parties or because lay definitions of health and illness may be particularly at odds with the scientific form of medicine in terms of which the doctor works. However Freidson identifies a third source of potential conflict between the patient and the doctor. The doctor sees many cases of any common problem and rapidly develops routine, familiar ways of managing any particular case. 'The routine of practice not only makes varied elements of experience equivalent - it also makes them ordinary' (Freidson,1970:287). For the patient however the problem is personal, immediate, distressing and definitely not routine. The dilemma for the patient is summarised by Freidson thus:

'The problem for the patient is: when are subjective sensations so reliable that one should insist on special attention, and when can one reasonably allow them to be waved away as tangential, ordinary and unimportant.' (Freidson, 1970:288)

Thus Freidson outlines an almost structural clash of perspectives that may arise with any 'ordinary' problem, and indeed the examples of ordinary symptoms he cites as likely to provoke such clashes of views are most appropriate to the current study - upper respiratory tract infections (Freidson, 1970:288) and chronic headaches



(Freidson, 1961: 55). According to Freidson, most cases in which a patient presents with such symptoms, the doctor correctly treats as an ordinary case of cold or headache. In a few cases he may be missing the real nature of the problem as allergy or as migraine. The patient is aware of this probabilistic approach to management with which the doctor works and can never be sure whether the doctor is neglecting the 'real' nature of the case in front of him by typifying and routinising the problem as an ordinary headache. This is the patient's dilemma. From this dilemma identified by Freidson, it is possible to infer some of the reasons for the patient's need to feel that the specific personal and unique qualities of their presenting problem have been recognised by the doctor. However one may go one step further than Freidson by asking the question - why do not all patients feel dissatisfied with routine 'impersonal' treatment?

In the neurology study, most patients received a similar routinised management from the specialist. Two kinds of situation were associated with patients feeling disappointment on the grounds that the specialist had not been interested in them as individuals. One group of patients were fundamentally disappointed because, having finally consulted a specialist about their chronic migraines, the treatment they received seemed no more personally appropriate than the routine history taking and prescription of medication they had become accustomed to from their general practitioner. Such patients frequently complained of being treated as 'just another case of

migraine' as a result of which the hospital attendance had seemed a 'waste of time'. From the specialist's point of view, more detailed biographical information would have been irrelevant to the management decisions involved in migraine (primarily, identification of appropriate medication). Thus Freidson's analysis in part applies to this group of patients' experiences in that their need to be treated as 'special' clashed with the routine orientation of the doctor. However Freidson's analysis does not allow for the possibility that such conflict may arise from internal differences within medicine. The expectations of this group of patients arose from the popularisation of the ideas of academic medical research in which dietary and psychosomatic factors in migraine are the subject of active inquiry. The evidence of such 'lifestyle' factors playing a role in the causes or course of migraine are enthusiastically taken up and disseminated by the media. The public naturally attributes an interest in 'life style factors' to the medical profession as a whole, whereas, in reality such interest is confined, on the whole, to academic medical researchers. From the more practical point of view of the consultant neurologist, only a minority of patients have migrainous episodes that are likely to be traced to dietary or psychosomatic origins. To the practicing neurologist, few patients would actually benefit from intensive allergic, dietary or life style investigation. Thus the patient, who has come to believe that medicine is concerned with understanding and intervening in individuals' personal risk factors for migraine, is inevitably disappointed by the reality. Such

disappointments arise out of differences in approach to the same problem between different sections of medicine. Thus one group of patients' complaints about not being treated as an individual arose out of the contradictory messages and intentions of the medical community.

Freidson's analysis of the patient's dilemma more directly makes sense of the second group of patients' problems. Anxious about their symptoms as possibly indicating more serious disease, this group of patients remained unreassured after the visit and were dissatisfied with the treatment they had received. Freidson's portrayal of their dilemma is exact. If the specialist appeared to this group not to have made every effort to understand their specific symptoms and concerns, this could well be the basis of their lack of confidence and subsequent disappointment. Clinical discussions of the problems of conveying reassurance have certainly recognised this problem.

Buchsbaum (1986) discusses the problems of conveying reassurance for benign problems. The doctor needs to uncover the meaning of symptoms to the patient so that he can redirect the patient's misconceptions more accurately and must provide information with which the patient can construct less threatening meanings. On the basis of the neurology clinic study it is clear that the doctor needs to convey to the patient the feeling that he or she has understood the patient's problems. This is most effectively achieved by eliciting the patient's concerns in

relation to the presenting problem. Thus Kessel recommends that reassurance is based on the following principle:

'...the doctor should understand the patient as an individual, appreciate his feelings and his fears.. The doctor may wish to consider the patient's condition within medical terms of reference - that is pathological process. The patient's terms of reference embody what he is actually going through and he will not be reassured unless he believes that the doctor is sensitive to, and understands that.'  
(Kessel,1979:1131)

Even a simple survey questionnaire on satisfaction as used in the STD study was sufficient to indicate a group of patients who had various concerns and worries about health as assessed before their consultations but who were dissatisfied with their consultations afterwards. Two variables - the Disease Conviction scale of the IBQ and concern about whether the presenting symptom would clear up (ICQ) - separately contributed more to the multiple regression equation with patient satisfaction as dependent variable than did the other significant variable, education. These two aspects of patient distress were sometimes not assuaged by the clinic. Easy to administer measures of satisfaction can be a useful clinical tool in the investigation of problems of reassurance and alleviating distress (Deyo and Diehl,1986) and studies designed on the basis of those conducted by Korsch et al.(1968), Stiles et al. (1979), and others would provide clearer understanding of the factors that promote successful communication of reassurance. Satisfaction has therefore a future as a way of further understanding such basic aspects of the 'art of care' in medicine.

The studies reported here more generally provide

further support for the value of patient - centered medical practice, and in particular for the ways in which satisfaction as an outcome may throw light on the need for more patient centered consultations. The STD clinic study identified a wide range of different concerns felt by patients attending the clinic, some of which were clearly not alleviated by attendance at the clinic. Many of the measures of distress were associated with subsequent dissatisfaction. The doctor needs to be more aware of this aspect of patients' presentations. Carter and colleagues (1982) exhaustively measured and analysed a number of tape recorded doctor patient consultations using various conceptual frameworks (methods of analysing dyadic interaction developed by Bales, Stiles and Roter) to rate events in the consultation. This data was then related to independent information on outcomes obtained from the patient. They found that the expression in the consultation of distress by the patient, and particularly distress about medical treatment, was the most consistent predictor of subsequent dissatisfaction. They argue that the association of distress with unfavourable outcomes is of major clinical importance.

The neurology study concerned patients with a quite narrow range of symptoms. However the reasons for seeking help for symptoms were diverse. Failure on the part of the doctor to address the diverse meanings of symptoms resulted in some cases in patient dissatisfaction. In different ways patients needed their particular personal concerns to be addressed, and disappointments in this respect were a



common theme in patients' accounts. Other studies have linked patient dissatisfaction with feelings of not being personally understood by the doctor (Nelson et al., 1975; Treadway, 1983). In this way patient satisfaction studies provide increasingly specific evidence in support of the arguments on the one hand of Eisenthal, Lazare and colleagues (Eisenthal et al., 1977, 1979; Lazare et al., 1975) who advocate a 'customer' approach to health care, giving patients much more opportunity to express concerns and goals than conventional history taking and on the other hand of Tuckett and colleagues (1985) who advocate more systematic eliciting by the doctor of the patient's beliefs and concerns.

A common feature of some of the dissatisfied patients in both clinics was the presentation of chronic, troublesome symptoms that from the point of view of hospital medicine may sometimes not be treated as seriously as more organic pathology. If it is the case that the possibilities of cure are limited in such cases, then the evidence of patient satisfaction suggests that medicine faces a fundamental challenge in finding alternative forms of help to patients.

Numerous other clinical tasks and procedures remain to be potentially opened up for empirical examination in this way. Simple aspects of general practice such as the length of time a patient receives for his or her appointment (Morrell et al., 1986) are now being examined with the use of patient satisfaction techniques. Patients'

views can be used to assess different ways of communicating information (Pendleton, 1983). In general practice especially there are a number of developments likely in the structure and processes of care which would warrant consideration in terms of patients' views (Donabedian, 1986) and clinicians seem more ready to consider patients' views as relevant in the context of primary care (Horder et al., 1986). Issues such as the accessibility of primary care have received particular attention in terms of patients' views. It may be somewhat artificial to consider such aspects of general practice under the heading of clinical aspects of patient satisfaction, since accessibility is also a feature of the structure of care with which authorities are concerned. In any case the patient has been a crucial source of evidence on such matters as the availability of the doctor in out of hours care (Sawyer and Arber, 1982; Bollam et al., 1988). The quality of care in general practice is viewed by many general practice commentators (Morrell and Roland, 1985; Gau and Gau, 1986) as involving patient satisfaction as a central component. Some general practitioners have argued that, in primary care, satisfaction surveys can be a means of regular professional self monitoring or audit. Furthermore satisfaction survey results have been clear enough to lead to changes in simple aspects of structure such as appointments times and accessibility by telephone with resulting increases in levels of satisfaction (Cohen et al., 1986; Steven and Douglas, 1986).

### Health services research

Much that has already been discussed in relation to the interests of health authorities and clinicians applies to more formal and scientific health services research as well. The acceptability and popularity of a particular hospital or the impact upon patients of a particular style of communication are not matters beyond the concern of health services research. However it is appropriate to reserve for separate discussion the broad implications of the studies reported in this thesis for those who would advocate a greater role for patient satisfaction in the formal evaluation of health services (Donabedian, 1980; CSS, 1982; Maxwell, et al., 1983; McPherson, 1985; Pollitt, 1985; 1987; Long et al., 1985; Martin, 1986). It is that aspect of health services research which aims to provide authoritative evidence about the outcomes of services that is of particular concern.

Calls for more scientific assessment of the benefits or outcomes of medical care have grown since Cochrane's seminal work. The view that this involves assessment of medical, psychological and social dimensions of outcomes is widely accepted (Teeling Smith, 1983). Evaluation research in health care is often politically contentious and necessitates accepting that there are a number of different objectives and interests in any health service (Carr Hill, 1984). As a result it has been suggested that the evaluation of health care requires 'pluralistic evaluation' in which the goals, aspirations

and outcomes for different groups of actors all receive attention in the research process (Smith and Cantley,1985). Patients represent one such set of interests. Nevertheless patients' subjective appraisals are still the most underdeveloped of outcome measures and the least likely to be included in evaluation research designs ( Berg and Kelly,1981; Najman and Levine,1981).

This state of affairs is slowly changing. Not only is the importance of patient based assessments increasingly accepted as a principle. Just as important is the increased availability of a variety of different survey - based techniques of assessing different aspects of outcomes of medical treatment from the patient's point of view. Questionnaire - based assessments of the patient's quality of life have been used in the evaluation of different medications for hypertension (Croog et al.,1986), of the outcomes of minor surgery (Hunt et al.,1984) and of alternative treatments for chronic obstructive airways disease (Nocturnal Oxygen Therapy Trial Group,1980). Most such instruments have in common the goal of assessing in a standardised format patients' subjective health states either in terms of subjective symptoms, as in the Nottingham Health Profile ( Hunt et al., 1980) or by means of the impact of illness on the performance of everyday functions such as sleeping and walking, as in the Sickness Impact Profile (Bergner and Gilson, 1981).

These techniques are an important step toward assessing crucial aspects of outcome not covered by

mortality and conventional morbidity measures. Hunt et al., (1984) see such techniques as more important developments than simply refinements to the measurement of morbidity. Their view is that such techniques are more revolutionary:

'The use of socio-medical indicators implies a totally new approach to the evaluation of health care. It places the judgement of outcome in the hands of the patient, who is enabled to express subjective reactions to illness and treatment.' (Hunt, 1984:106)

Now the goal of placing 'the judgement of outcome in the hands of the patient' is almost exactly the ambition of those who would advocate patient satisfaction research as the way in which the patient may participate in evaluations of health care (Kelman,1976; Van Den Heuvel,1980; Martin,1986). However Hunt and colleagues' enthusiasm, whilst understandable, may be misleading. Certainly the patient is the source of the data on outcomes in such instruments as the Nottingham Health Profile (NHP), and his or her reports are not directly mediated by professional judgements or criteria. Nevertheless such instruments are still ultimately symptom check lists of the kind conventionally used in medicine, and the patient is given no opportunity to state his or her 'judgement of outcome' except in terms of this limited set of symptoms. It may also be the case that the particular check list of subjective symptoms provided in the NHP does not even include the salient problems experienced by patients for



some health care settings. More serious a deficiency is that, as both the studies here in different ways have indicated, reduction of current symptoms may not be the main concern of many patients, whose interests are not therefore easily contained within a symptom check list. Thus Brooks is somewhat critical of the claim for such instruments that they assess consumers' concerns:

'.. perhaps, paradoxically the patient tends to be ignored, in the sense that his or her wishes, values, preferences and expectations are not often explicitly incorporated in the evaluations' instruments.'  
(Brooks,1983:90)

The emphasis in such instruments is upon the more sensitive measurement of a standardised and predetermined range of morbidity rather than the identification of the layperson's own priorities and concerns with regard to health. Even so simple a symptom as headache has been shown to become a subjective problem in such very diverse ways. Hence there still remains a need to consider methods that more directly evaluate outcomes from the patient's point of view.

Evaluation studies of outcomes of health have begun to incorporate measures of patients' views. Patient satisfaction has been included as outcome measure in such diverse assessments as: alternative forms of managing congestive heart failure (Romm et al.,1976); early discharge from hospital for varicose veins and inguinal hernia (Adler et al., 1978); treatment of rheumatoid arthritis in HMOs (Yelin et al., 1986); psychiatric referral for somatisation disorder (Smith et al.,1986); medical management of low back pain (Deyo et al.,1986;

Fitzpatrick et al.,1987). Generally such studies continue to use attitudinal questionnaires such as the one used in the STD clinic survey which produce positively skewed results. To repeat some of the main findings of the neurology study, patients are reluctant to express attitudes of a negative kind in relation to health services and this will inevitably reduce the variability of survey results and their potential contribution to the evaluation of outcomes. On the positive side however the neurology clinic study did show quite clearly that it was possible to obtain patients' views as to the value or potential benefits of their treatment. Such observations were distinct, strongly felt, and ultimately more informative as evidence of the benefits and limitations of the neurological referral for headache. However so many discussions in this field have concluded from the fact of patients' modest technical expertise in medicine that patients' observations of the benefits of their treatment are also of limited value. As a result too few studies have been undertaken in which perceptions of the benefits or value of medical treatment are given as much weight and attention as attitudes towards the health care system on other dimensions such as accessibility. In this sense patient satisfaction research has not really begun to investigate the full extent to which patients can provide useful observations with regard to their care. Most of all, patients have not been invited to appraise their medical treatment in terms of their own goals and concerns. Researchers' priorities and prejudices have focused attention in patient satisfaction on a range of issues in

which the patient is deemed fit to participate, such as the accessibility and 'friendliness' of services. Such provider determined issues are, of course of great importance. However they do not exhaust the range of consumers' concerns. It is in neglecting patients' abilities to provide their own observations of the appropriateness of treatment and the outcomes of care that researchers may be most guilty of imposing a priori and unnecessarily limiting roles for the consumer as judge.

For observers such as Martin (1986), the problem is in part methodological. Consumers need to be given a more active role in the process of evaluation: 'This means allowing them some opportunities to voice their views free from the limitation of structured questions, within the constraints of a prepared questionnaire' (Martin,1986:194). As was observed in the neurological clinic study, more open ended interviewing can facilitate the expression of important views on a wider range of issues, including benefits and outcomes. Where more structured questionnaires have to be used, then more opportunity than at present must be provided to express views on the different dimensions of care. This involves improving the specificity of questions: 'Questions about the process of service, and particularly about the consumers' opinions of staff and intervention procedures must be clearly separated from questions about the effects of the service as judged by the consumers' (Martin,1986:194).

Thus, especially given the growing need for more

sophisticated and authoritative evaluations of medical treatment, from which more precise expressions of costs and benefits can be derived (Jennett, 1986), much more sustained effort is required to include the patients' views on value and outcomes as well as more interpersonal aspects of care. If the results of such research are to be convincing, further attention needs to be given to issues such as the reliability of the instruments used to elicit views.

The neurology study may be of particular interest in that it examined varying perceptions of satisfaction in relation to varying concerns. Patients attended the clinics with a diversity of concerns, as was also the case in the STD clinic. Some of the patients' goals met with more success than others. Most items of care in health services probably are similar to the neurological consultation in that they are aimed at several problems in the same patient. Underlying pathology, pain, discomfort, mobility and social functioning, worry, sense of control and mastery of one's health to facilitate better self management in the future - these are all important dimensions of the treatment of many if not most health problems, even if the reality falls short of the ideal. If medicine is to understand which of these tasks it is achieving well and on which tasks it falls short of the ideal, then it seems particularly desirable that evidence of patient satisfaction is sought in close conjunction to the diversity of goals that motivate help seeking.

Both studies reported in this thesis should contribute to a more positive and bolder view of the role for the patient in the process of evaluating health care. In considering the basis for patients' replies to enquiries to patient satisfaction surveys, the studies examined here lead one to the conclusion that patients make their judgements on the basis of complex perceptions of what happens to them in the process of treatment. Even in a quite brief encounter, observations of the interpersonal care, the apparent technical competence and application of competence, and finally of the apparent value and appropriateness of treatment may all enter the patient's considerations. In many respects, it does not make sense to ask whether the 'affective' or the 'technical' aspects of care matter more to the patient. They can be distinguished by the patient. The model of patient satisfaction developed by Ben Sira, when examined closely, is fundamentally flawed. Personal interest and appropriate treatment are likely to be of equal concern to the patient. The technical and the affective are in reality matters of inseparable importance. The successful treatment of the patient must include in almost all cases some combination of treatment with explanation, reassurance, advice, support or encouragement. The assessment of health care systems' successes in such tasks must increasingly rely on the views of the patient.



TABLE 1. FREQUENCY OF HEADACHE EPISODES IN THE CLINIC SAMPLE COMPARED WITH COMMUNITY SAMPLE OF REPORTED HEADACHES (WATERS, 1973)

FREQUENCY OF EPISODES	PROPORTION IN:	
	CLINIC SAMPLE	COMMUNITY SAMPLE
Less than one a month	10% (11)	40%
Once to several a month	33% (35)	35%
Once a week	17% (18)	10%
Twice a week or more frequently	40% (43)	15%
	100% 107	100%

TABLE 2. TYPICAL DURATION OF HEADACHE EPISODES IN THE CLINIC SAMPLE COMPARED WITH COMMUNITY SAMPLE OF REPORTED HEADACHES (WATERS, 1973)

DURATION OF EPISODES	PROPORTION IN:	
	CLINIC SAMPLE	COMMUNITY SAMPLE
Less than 4hrs.	30% (32)	65%
4 to 12 hrs.	20% (22)	16%
13 to 24 hrs.	20% (22)	7%
More than 24hrs.	30% (32)	12%
	100% (108)	100%

TABLE 3. NUMBER OF YEARS PATIENTS REPORT THEMSELVES AS SUFFERING FROM HEADACHES, IN THE CURRENT CLINIC SAMPLE COMPARED WITH PACKARD'S (1979) CLINIC SAMPLE

NUMBER OF YEARS OF HEADACHE HISTORY	PROPORTION IN:	
	PRESENT CLINIC SAMPLE	PACKARD'S CLINIC SAMPLE
Less than 1 year	32% (33)	27%
1 to 5 years	23% (24)	28%
6 to 10 years	14% (15)	14%
11 to 20 years	14% (15)	13%
More than 20 years	16% (17)	18%
	100% (104)	100%

TABLE 4. PSYCHIATRIC SYMPTOMS IN 95 PATIENTS REFERRED TO THE NEUROLOGIST FOR HEADACHE

RATING	INTERVIEWER'S RATING		PSE SYMPTOM SCORE		
	N	%	SCORE	N	%
NORMAL	60	(63%)	0-5	61	(64%)
MILD	25	(26%)	6-10	19	(20%)
MODERATE TO SEVERE	10	(11%)	11+	15	(16%)
	95	(100%)		95	(100%)

**TABLE 5. PROPORTIONS OF PATIENTS REPORTING DIFFERENT LEVELS OF BENEFITS FROM MEDICATION RECEIVED PRIOR TO NEUROLOGICAL REFERRAL**

TYPE OF MEDICATION	PERCEIVED BENEFITS		
	POSITIVE	NEUTRAL	NEGATIVE
SATISFACTION WITH TREATMENT			
	PROPORTION OF PATIENTS HELPED-		
	'CONSIDERABLY'	'A LITTLE'	'NOT AT ALL'
NON PRESCRIPTION ANALGESIC	23 (15)	11 (35%)	50 (11%)
NEUTRAL	8 (10%)	17 (40%)	8 (21%)
PRESCRIPTION ANALGESIC	13 (27%)	54 (26%)	33 (16%)
SPECIAL MIGRAINE PRESCRIPTIONS	17 (27)	40 (26)	43 (100%)
PSYCHOTROPIC PRESCRIPTIONS	4 (20,000)	28	68

**TABLE 6. THE RELATIONSHIP BETWEEN THE PATIENT'S PERCEPTION OF THE BENEFIT OF MEDICATION AND HIS EVALUATION OF ASPECTS OF HIS NEUROLOGICAL CLINIC VISIT**

**TABLE 6. PATIENTS' EVALUATIONS OF ASPECTS OF THEIR NEUROLOGICAL CLINIC VISIT**

	SATISFACTION WITH:	
	MEDICAL TREATMENT	COMMUNICATION
POSITIVE	37 (39%)	29 (31%)
NEUTRAL	27 (28%)	38 (40%)
NEGATIVE	31 (33%)	28 (29%)
OTHER DEFINITIONS	17 (95 (100%))	17 (95 (100%))

\* CHI SQUARE 9.87, D.F. = 1, P < 0.005.

\* CHI SQUARE 11.67, D.F. = 1, P < 0.001.

TABLE 7. THE ASSOCIATION BETWEEN THE TWO SCALES OF PATIENT SATISFACTION FOR NEUROLOGICAL CLINIC PATIENTS

SATISFACTION WITH TREATMENT	SATISFACTION WITH COMMUNICATION		
	POSITIVE	NEUTRAL	NEGATIVE
POSITIVE	23 (79%)	11 (29%)	3 (11%)
NEUTRAL	4 (14%)	17 (45%)	6 (21%)
NEGATIVE	2 (7%)	10 (26%)	19 (68%)
	29 (100%)	38 (100%)	28 (100%)

CHI SQUARE 42.06 D.F.=4 P<0.0001

TABLE 8. THE RELATIONSHIP BETWEEN THE PATIENT'S DEFINITION OF THE PROBLEM AND SATISFACTION WITH TREATMENT FOR SUB GROUPS OF THE SAMPLE WITH AND WITHOUT SIGNIFICANT PSYCHIATRIC SYMPTOMS

PATIENT'S DEFINITION	SIGNIFICANT PSE SYMPTOMS		NO PSE SYMPTOMS	
	SATISFIED	DIS-SATISFIED	SATISFIED	DIS-SATISFIED
MIGRAINE	1	8	6	8
OTHER DEFINITIONS	17	9	40	6
	18	17	46	14

\* CHI SQUARE 7.89; D.F.=1; P<0.005.

# CHI SQUARE 11.67; D.F.=1; P<0.001.

TABLE 9. THE RELATIONSHIP BETWEEN PSYCHIATRIC SYMPTOMS AND SATISFACTION WITH TREATMENT FOR SUB GROUPS WHO DO OR DO NOT DEFINE THEIR PROBLEM AS MIGRAINE

	PROBLEM DEFINED AS MIGRAINE		OTHER DEFINITIONS	
	SATISFIED	DIS-SATISFIED	SATISFIED	DIS-SATISFIED
SIGNIFICANT PSE SYMPTOMS	1	8	17	9
		*		#
NO PSE SYMPTOMS	6	8	40	6
	7	16	57	15

\* CHI SQUARE NOT SIGNIFICANT

# CHI SQUARE 4.69; D.F.=1; P<0.05.

TABLE 10. THE RELATIONSHIP BETWEEN THE PATIENT'S REASSURANCE FROM THE HOSPITAL VISIT AND SATISFACTION WITH TREATMENT FOR SUB GROUPS OF THE SAMPLE WITH AND WITHOUT SIGNIFICANT PSYCHIATRIC SYMPTOMS

PATIENT'S REASSURANCE	SIGNIFICANT PSE SYMPTOMS		NO PSE SYMPTOMS	
	SATISFIED	DIS-SATISFIED	SATISFIED	DIS-SATISFIED
REASSURED	12	4	22	2
		*		#
NOT REASSURED	3	7	9	6
	15	11	31	8

\* CHI SQUARE= 5.10; D.F=1; P<0.05

# CHI SQUARE=6.03; D.F=1;P<0.05



TABLE 11. THE PROPORTION OF DISSATISFIED AMONGST PATIENTS' WITH DIFFERENT CONCERNS: (A) IN RELATION TO TREATMENT AND (B) IN RELATION TO COMMUNICATION

(A) % DISSATISFIED IN RELATION TO TREATMENT

CONCERN FOR:			
REASSURANCE	EXPLANATION	PREVENTION	SYMPTOMATIC TREATMENT
31%	0%	54%	13%
(15/49)	(0/6)	(13/24)	(2/15)

(B) % DISSATISFIED IN RELATION TO COMMUNICATION

CONCERN FOR:			
REASSURANCE	EXPLANATION	PREVENTION	SYMPTOMATIC TREATMENT
22%	50%	46%	13%
(11/49)	(3/6)	(11/24)	(2/15)

TABLE 12 ALPHA RELIABILITY COEFFICIENTS FOR THE ILLNESS BEHAVIOUR QUESTIONNAIRE (IBQ) SCALES IN STD CLINIC

<u>IBQ SCALE</u>	<u>ALPHA COEFFICIENT</u>
1. GENERAL HYPOCHONDRIASIS	0.66
2. DISEASE CONVICTION	0.50
3. PSYCHOLOGICAL/ SOMATIC PERCEPTION OF ILLNESS	0.11
4. AFFECTIVE INHIBITION	0.72
5. AFFECTIVE DISTURBANCE	0.76
6. DENIAL	0.69
7. IRRITABILITY	0.65

TABLE 13. PRIMARY DIAGNOSIS OF PATIENTS IN THE FOLLOW UP SAMPLE OF STD CLINIC ATTENDERS

DIAGNOSIS	NUMBER	PERCENTAGE
GONORRHOEA	11	(3.6%)
SYPHILIS	4	(1.3%)
TRICHOMONIASIS	9	(3.0%)
CANDIDOSIS	33	(10.9%)
GENITAL HERPES	8	(2.6%)
GENITAL WARTS	36	(11.8%)
NON SPECIFIC INFECTION	60	(19.7%)
OTHER CONDITIONS REQUIRING TREATMENT	36	(11.8%)
OTHER CONDITIONS NOT REQUIRING TREATMENT	11	(3.6%)
OTHER	6	(2.0%)
NO ABNORMALITY DETECTED	90	(29.6%)
TOTAL	304	(100%)

**TABLE 14. ILLNESS BEHAVIOUR QUESTIONNAIRE (IBQ) MEAN SCORES (STANDARD DEVIATIONS) IN STD CLINIC AND SELECTED NORMATIVE SAMPLES**

IBQ SCALE	STD CLINIC SAMPLE	NORMATIVE GENERAL PRACTICE	NORMATIVE PSYCHIATRIC PATIENTS
GENERAL	2.12 (1.92)	1.44 (1.84)	2.69 (2.31)
HYPOCHONDRIASIS			
DISEASE CONVICTION	1.65 (1.29)	1.59 (1.36)	3.02 (1.69)
PSYCHOLOGICAL/ SOMATIC PERCEPTION OF ILLNESS	2.06 (0.86)	1.99 (0.84)	2.15 (1.26)
AFFECTIVE INHIBITION	1.88 (1.63)	2.46 (1.60)	2.98 (1.52)
AFFECTIVE DISTURBANCE	1.94 (1.69)	2.31 (1.62)	3.56 (1.64)
DENIAL	2.55 (1.56)	2.93 (1.74)	2.58 (1.78)
IRRITABILITY	1.38 (1.40)	2.45 (1.67)	2.9 (1.90)
<b>EFFICACY OF CARE</b>			
Health better because of care.	67 (70)	31 (17)	12 (12)
Did as much as expected.	73 (84)	17 (16)	6 (16)
Some things not very helpful.	13 (18)	18 (15)	74 (67)
Helped me feel a lot better.	67 (74)	21 (18)	13 (14)

TABLE 15. SATISFACTION WITH HEALTH CARE AMONGST STD CLINIC ATTENDERS (LINN AND GREENFIELD'S SAMPLE IN PARENTHESES)

SATISFACTION ITEM	AGREE	UNCERTAIN	DISAGREE
<u>ART OF CARE</u>			
The doctors seemed interested.	67 (82)	18 (10)	15 (9)
Noone cared about privacy.	8 (6)	11 (9)	81 (86)
Doctors don't bother with many troubles.	12 (13)	21 (11)	67 (76)
Doctors stopped me worrying.	65 (81)	18 (10)	17 (9)
Nurses were friendly.	97 (95)	2 (3)	1 (2)
Doctors friendly and devoted.	55 (88)	25 (7)	20 (5)
Receptionists were courteous.	86 (87)	7 (5)	7 (8)
Caused worry by not explaining.	13 (11)	10 (6)	76 (83)
Put me at ease.	67 (89)	16 (6)	17 (6)
<u>TECHNICAL QUALITY</u>			
Very careful examination.	77 (82)	14 (8)	9 (10)
Doctors not thorough.	10 (16)	17 (10)	73 (73)
Best care one could expect.	65 (81)	27 (12)	8 (8)
Doctors seemed experienced.	86 (70)	10 (13)	4 (16)
Seemed competent and well trained.	85 (86)	13 (11)	2 (3)
Doctors seemed very organised.	75 (71)	18 (15)	7 (14)
<u>EFFICACY OF CARE</u>			
Health better because of care.	67 (70)	21 (17)	12 (12)
Did as much as expected.	75 (84)	19 (11)	6 (6)
Some things not very helpful.	13 (18)	13 (15)	74 (67)
Helped me feel a lot better.	67 (76)	21 (10)	13 (14)

TABLE 16. DIFFERENCES BETWEEN SUBGROUPS IN SATISFACTION SCORES

VARIABLE	SATISFACTION WITH:		
	ART OF CARE	TECHNICAL QUALITY	EFFICACY
SEX	Z= -0.909 N.S.	Z= -1.193 N.S.	Z= -0.791 N.S.
AGE (30 or less, 31 & older)	Z= -0.780 N.S.	Z= -0.454 N.S.	Z= -0.481 N.S.
SOCIAL CLASS (Working class, Middle class)	Z= -0.889 N.S.	Z= -0.770 N.S.	Z= -1.166 N.S.
EDUCATION (A -Level or less, Higher educ.)	Z= -2.164 P<0.05	Z= -2.071 P<0.05	Z= -1.557 N.S.
MARIT. STATUS (Married, single)	Z= -0.293 N.S.	Z= -0.470 N.S.	Z= -0.995 N.S.
SEXUAL ORIENT. (Males only, Hetero.,homo.)	Z= -1.450 N.S.	Z= -1.541 N.S.	Z= -2.178, P<0.05
OLD/NEW PATIENT	Z= -2.608, P<0.05	Z= -3.815 P<0.0001	Z= -2.339 P<0.05
CASENESS	Z= -1.850 N.S.	Z= -2.694 P<0.01	Z= -2.057 P<0.05



TABLE 17. CORRELATION COEFFICIENTS BETWEEN  
SATISFACTION WITH AFFECTIVE BEHAVIOUR AND MEDICAL  
TREATMENT, BEN SIRA'S SAMPLE (1980)

<u>SATISFACTION WITH</u> <u>AFFECTIVE BEHAVIOUR</u>	<u>SATISFACTION WITH MEDICAL CARE</u>		
	<u>SKILLS</u>	<u>FEELINGS OF</u> <u>REASSURANCE</u>	<u>TREATMENT</u>
INTEREST	.66	.67	.78
DEVOTION	.80	.83	.83
TIME	.77	.80	.80

TABLE 18. CORRELATION COEFFICIENTS BETWEEN  
SATISFACTION WITH AFFECTIVE BEHAVIOUR AND MEDICAL  
TREATMENT, STD CLINIC

<u>SATISFACTION WITH</u> <u>AFFECTIVE BEHAVIOUR</u>	<u>SATISFACTION WITH MEDICAL CARE</u>		
	<u>SKILLS</u>	<u>FEELINGS OF</u> <u>REASSURANCE</u>	<u>TREATMENT</u>
INTEREST	.44	.68	.52
DEVOTION	.45	.64	.50
TIME	.41	.68	.50

TABLE 19. CORRELATION COEFFICIENTS BETWEEN AFFECTIVE AND INSTRUMENTAL ITEMS, CONTROLLING FOR EDUCATION, BEN SIRA

<u>AFFECTIVE BEHAVIOUR</u>	<u>SATISFACTION WITH SKILLS</u>			
		<u>YEARS OF SCHOOLING</u>		
	<9	9-11	12	13+
INTEREST	.77	.65	.67	.58
DEVOTION	.83	.83	.79	.76
TIME	.88	.81	.74	.67

<u>AFFECTIVE BEHAVIOUR</u>	<u>SATISFACTION WITH REASSURANCE</u>			
		<u>YEARS OF SCHOOLING</u>		
	<9	9-11	12	13+
INTEREST	.78	.65	.60	.65
DEVOTION	.90	.85	.79	.77
TIME	.92	.79	.73	.70

<u>AFFECTIVE BEHAVIOUR</u>	<u>SATISFACTION WITH TREATMENT</u>			
		<u>YEARS OF SCHOOLING</u>		
	<9	9-11	12	13+
INTEREST	.91	.78	.73	.70
DEVOTION	.93	.83	.81	.76
TIME	.90	.85	.68	.77

TABLE 20. CORRELATION COEFFICIENTS BETWEEN AFFECTIVE AND INSTRUMENTAL ITEMS, CONTROLLING FOR EDUCATION, STD CLINIC

<u>AFFECTIVE BEHAVIOUR</u>	<u>SATISFACTION WITH SKILLS EDUCATION</u>		
	low (82)	medium (85)	high (118)
INTEREST	.29	.41	.49
DEVOTION	.44	.48	.42
TIME	.45	.48	.31

<u>AFFECTIVE BEHAVIOUR</u>	<u>SATISFACTION WITH REASSURANCE EDUCATION</u>		
	low (82)	medium (85)	high (118)
INTEREST	.68	.72	.64
DEVOTION	.78	.64	.55
TIME	.81	.62	.64

<u>AFFECTIVE BEHAVIOUR</u>	<u>SATISFACTION WITH TREATMENT EDUCATION</u>		
	low (82)	medium (85)	high (118)
INTEREST	.54	.51	.55
DEVOTION	.64	.43	.53
TIME	.60	.48	.53

(Education: Low='O' level or less;  
Medium= 'A' level; High= Further qualif.)

TABLE 21. CORRELATION COEFFICIENTS BETWEEN AFFECTIVE AND INSTRUMENTAL ITEMS, CONTROLLING FOR ILLNESS CONCERN, BEN SIRA

<u>AFFECTIVE BEHAVIOUR</u>	<u>SATISFACTION WITH SKILLS</u>		
	Low	CONCERN ABOUT HEALTH medium	high
INTEREST	.58	.69	.71
DEVOTION	.76	.77	.90
TIME	.74	.78	.81

<u>AFFECTIVE BEHAVIOUR</u>	<u>SATISFACTION WITH REASSURANCE</u>		
	Low	CONCERN ABOUT HEALTH medium	high
INTEREST	.54	.69	.74
DEVOTION	.79	.83	.89
TIME	.73	.76	.80

<u>AFFECTIVE BEHAVIOUR</u>	<u>SATISFACTION WITH TREATMENT</u>		
	Low	CONCERN ABOUT HEALTH medium	high
INTEREST	.73	.76	.85
DEVOTION	.73	.82	.81
TIME	.78	.79	.79

TABLE 22. CORRELATIONS BETWEEN AFFECTIVE AND INSTRUMENTAL ITEMS, CONTROLLING FOR CONCERN WITH PRESENTED HEALTH PROBLEM, STD CLINIC

<u>AFFECTIVE BEHAVIOUR</u>	<u>SATISFACTION WITH SKILLS CONCERN ABOUT HEALTH PROBLEM</u>		
	low (89)	medium (107)	high (109)
INTEREST	.49	.37	.44
DEVOTION	.56	.35	.44
TIME	.49	.31	.41

<u>AFFECTIVE BEHAVIOUR</u>	<u>SATISFACTION WITH REASSURANCE CONCERN ABOUT HEALTH PROBLEM</u>		
	low (89)	medium (107)	high (109)
INTEREST	.70	.69	.63
DEVOTION	.64	.71	.58
TIME	.69	.71	.61

<u>AFFECTIVE BEHAVIOUR</u>	<u>SATISFACTION WITH TREATMENT CONCERN ABOUT HEALTH PROBLEM</u>		
	low (89)	medium (107)	high (109)
INTEREST	.50	.52	.52
DEVOTION	.45	.45	.56
TIME	.36	.47	.57



TABLE 23. CORRELATION COEFFICIENTS BETWEEN AFFECTIVE AND INSTRUMENTAL ITEMS, CONTROLLING FOR GENERAL CONCERN WITH ONE'S HEALTH, STD CLINIC

AFFECTIVE BEHAVIOUR	SATISFACTION WITH SKILLS CONCERN ABOUT HEALTH		
	low (75)	medium (66)	high (164)
INTEREST	.38	.39	.46
DEVOTION	.43	.33	.48
TIME	.38	.16	.49

AFFECTIVE BEHAVIOUR	SATISFACTION WITH REASSURANCE CONCERN ABOUT HEALTH		
	low (75)	medium (66)	high (164)
INTEREST	.64	.70	.67
DEVOTION	.57	.69	.65
TIME	.70	.61	.68

AFFECTIVE BEHAVIOUR	SATISFACTION WITH TREATMENT CONCERN ABOUT HEALTH		
	low (75)	medium (66)	high (164)
INTEREST	.47	.58	.51
DEVOTION	.47	.56	.47
TIME	.52	.53	.48

TABLE 24. RELATIONSHIPS AMONG VARIABLES INVOLVED IN SATISFACTION MODEL (PEARSON CORRELATION COEFFICIENT)

	1	2	3	4
1.LEVEL OF CONCERN ABOUT HEALTH	1			
2.SATISFACTION WITH INTEREST (AFFECTIVE ITEM)	-.12*	1		
3.SATISFACTION WITH SKILLS (TECHNICAL QUALITY ITEM)	-.23	.44	1	
4.SATISFACTION WITH TREATMENT (EFFICACY ITEM)	-.26	.52	.50	1

(All significant at  $P < 0.001$ ; except \*  $P < 0.05$ )

TABLE 25. CORRELATIONS BETWEEN ILLNESS BEHAVIOUR SCALES AND PATIENT SATISFACTION

<u>SCALE ITEM</u>	<u>SATISFACTION WITH</u>		
	<u>ART OF CARE</u>	<u>TECHNICAL QUALITY</u>	<u>EFFICACY</u>
HYPOCHONDRIASIS	-.11 $P < 0.05$	-.11 $P < 0.05$	-.08 N.S.
DISEASE CONVICTION	-.18 $P < 0.001$	-.23 $P < 0.0001$	-.18 $P < 0.001$
PSYCHOLOGICAL V. SOMATIC PERCEPTION OF ILLNESS	-.08 N.S.	-.08 N.S.	-.01 N.S.
AFFECTIVE INHIBITION	-.01 N.S.	-.04 N.S.	-.01 N.S.
AFFECTIVE DISTURBANCE	-.07 N.S.	-.06 N.S.	-.07 N.S.
DENIAL	.13 $P < 0.01$	.10 $P < 0.05$	.06 N.S.
IRRITABILITY	-.08 N.S.	-.05 N.S.	-.08 N.S.

**TABLE 26. PROPORTION OF PATIENTS REPORTING THEMSELVES AS HAVING A PARTICULAR CONCERN IN RELATION TO THE PRESENTING PROBLEM**

<u>ILLNESS CONCERNS</u>	<u>N</u>	<u>%</u>
1. May not prove straight forward	75	24.7%
2. May prove painful	57	18.8%
3. May not clear up quickly	110	36.2%
4. May affect future health	85	28.0%
5. May be a serious illness	110	36.1%
6. May affect sex life	143	46.9%
7. May affect fertility	68	22.3%
8. Illness concern disrupts life	66	21.7%
9. Difficult to reassure about problem	68	22.4%

For items 2 to 8, a positive score is based on the respondent selecting 'moderately' or 'very much' in relation to the relevant question. For items 1 and 9, a positive score is based on the respondent selecting 'yes' in relation to the relevant question. There are a variable number (15-17) of missing responses for these items.

TABLE 27. CORRELATION COEFFICIENTS BETWEEN ILLNESS CONCERN ITEMS AND PATIENT SATISFACTION

<u>ILLNESS CONCERNS</u>	SATISFACTION WITH:		
	ART OF CARE	TECHNICAL QUALITY	EFFICACY
May not prove straight forward	-.17 P<0.001	-.23 P<0.0001	-.23 P<0.0001
May prove painful	-.18 P<0.001	-.20 P<0.0001	-.21 P<0.0001
May not clear up quickly	-.22 P<0.0001	-.28 P<0.0001	-.30 P<0.0001
May affect future health	-.13 P<0.05	-.21 P<0.0001	-.17 P<0.005
May be a serious illness	-.01 N.S.	-.03 N.S.	-.06 N.S.
May affect sex life	-.11 P<0.05	-.16 P<0.005	-.12 P<0.05
May affect fertility	-.12 P<0.05	-.08 N.S.	-.10 P<0.05
Illness concern disrupts life	-.03 N.S.	-.08 N.S.	-.08 N.S.
Difficult to reassure about problem	-.14 P<0.05	-.16 P<0.005	-.17 P<0.001

TABLE 28. THE DIFFERENCES BETWEEN OLD AND NEW PATIENTS ON SATISFACTION SCALES FOR DIFFERENT VALUES OF DISEASE CONVICTION

<u>DISEASE CONVICTION LOW</u>		
ART OF CARE	TECHNICAL QUALITY	EFFICACY
Z=-0.535, N.S.	Z=-0.198, N.S.	Z=-1.118, N.S.
<u>DISEASE CONVICTION MEDIUM</u>		
ART OF CARE	TECHNICAL QUALITY	EFFICACY
Z=-1.626, N.S.	Z=-2.105, P<0.05	Z=-1.734, N.S.
<u>DISEASE CONVICTION HIGH</u>		
ART OF CARE	TECHNICAL QUALITY	EFFICACY
Z=-2.612, P<0.05	Z=-3.660, P<0.0005	Z=-2.450, P<0.05

TABLE 29 CORRELATION COEFFICIENTS OF DISEASE CONVICTION WITH SATISFACTION SCALES, FOR 'OLD' AND 'NEW' PATIENTS.

	ART OF CARE	TECHNICAL QUALITY	EFFICACY
'OLD' PATIENTS	-0.22 P<0.005	-0.31 P<0.0001	-0.27 P<0.0001
'NEW' PATIENTS	-0.11 N.S.	-0.18 P<0.05	-0.15 P<0.05



TABLE 30. INTERACTION BETWEEN ILLNESS CONCERNS,  
SOCIAL AND PSYCHOLOGICAL VARIABLES AND SATISFACTION  
WITH THE ART OF CARE

<u>ILLNESS CONCERN</u>	<u>CORRELATION COEFFICIENT OF ILLNESS CONCERN WITH SATISFACTION IN FOLLOWING SUB GROUPS:</u>
Problem may not prove straightforward	Education high -0.40 (-0.17) (N=118)
Problem may affect future health	Male heterosexual -0.51 (-0.13) (N=42)
Problem may affect sex life	'Psychological Cases' -0.24 (-0.11) (N=108)
Difficult to reassure about problem	Education low -0.25 (-0.14) (N=167)

(Correlation coefficients between illness concern items  
and satisfaction scales amongst different subgroups:  
zero order correlation coefficients in brackets)

(Correlation coefficients between illness concern items  
and satisfaction scales amongst different subgroups:  
zero order correlation coefficients in brackets)

TABLE 31 INTERACTION BETWEEN ILLNESS CONCERNS,  
SOCIAL AND PSYCHOLOGICAL VARIABLES AND SATISFACTION  
WITH THE EFFICACY OF CARE

<u>ILLNESS CONCERN</u>	<u>CORRELATION COEFFICIENT OF ILLNESS CONCERN WITH SATISFACTION IN FOLLOWING SUBGROUPS:</u>
Problem may not prove straightforward	Education High -0.35 (-0.23) (N=118)
Problem may not clear up quickly	Male Homosexuals -0.46 (-0.30) (N=69)
Problem may affect sex life	'Psychological cases' -0.25 (-0.12) (N=108)
	Hypochondriasis High -0.21 (-0.12) (N=164)
Difficult to reassure about problem	Male Homosexuals -0.37 (-0.17) (N=69)
	Education low -0.36 (0.17) (N=167)

(Correlation coefficients between illness concern items  
and satisfaction scales amongst different subgroups:  
zero  
order correlation coefficients in brackets)

TABLE 32 SATISFACTION WITH ART  
OF CARE SCALE REGRESSED  
UPON PATIENT VARIABLES

INDEPENDENT VARIABLES	STANDARDISED BETA COEFFICIENTS	ADJUSTED R SQUARED	R SQUARED CHANGE
Concern that problem may not clear up quickly (ICQ)	-0.195	0.061	0.061
Denial (IBQ)	0.145	0.096	0.035
Education	-0.124	0.109	0.013
Disease Conviction (IBQ)	-0.124	0.121	0.012
'Old' or 'new' patient	0.100	0.130	0.009

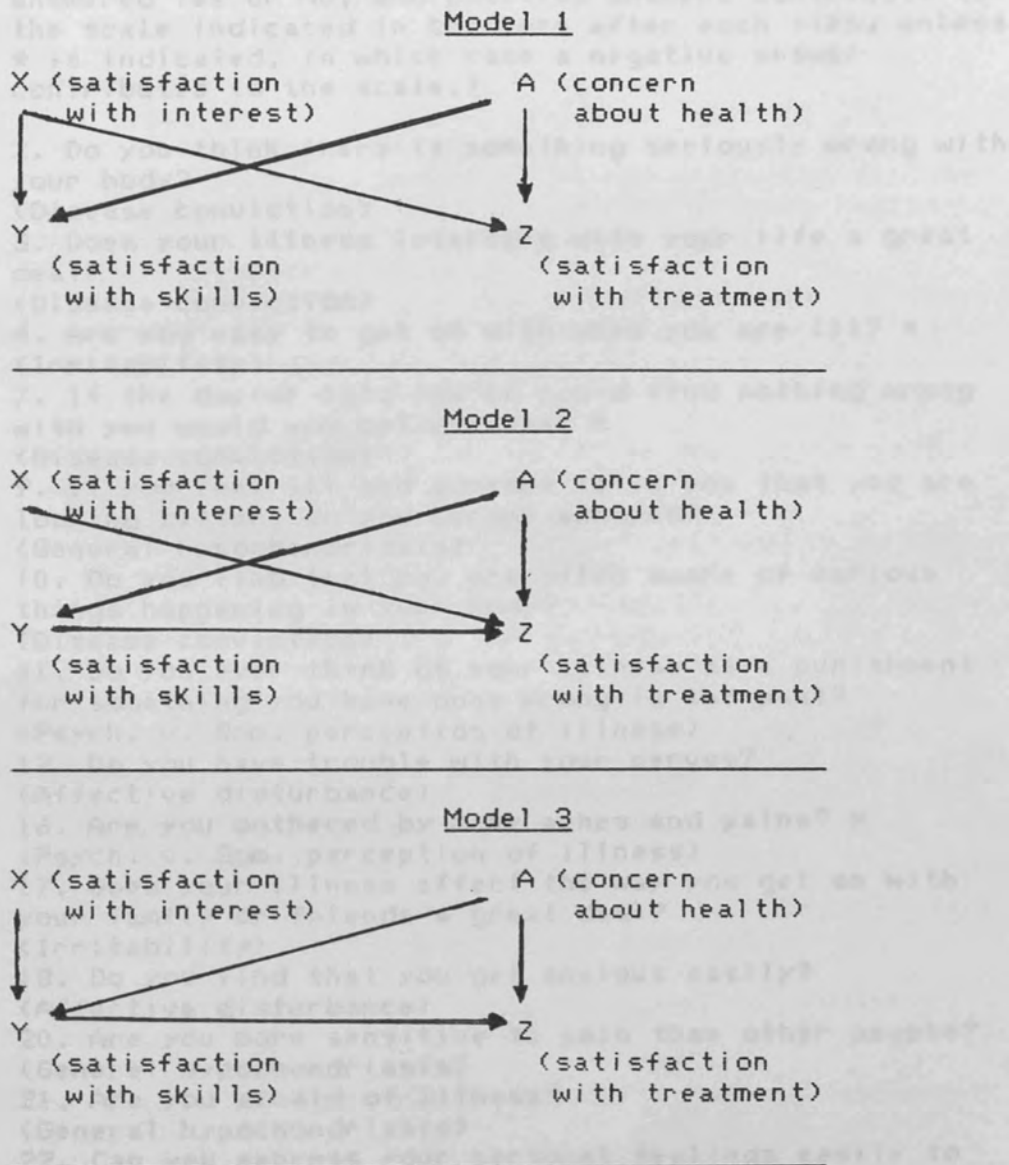
TABLE 33. SATISFACTION WITH TECHNICAL  
QUALITY OF CARE SCALE REGRESSED  
UPON PATIENT VARIABLES

INDEPENDENT VARIABLES	STANDARDISED BETA COEFFICIENTS	ADJUSTED R SQUARED	R SQUARED CHANGE
Concern that problem may not clear up quickly (ICQ)	-0.249	0.106	0.106
'Old' or 'New' patient	0.182	0.137	0.031
Disease conviction (IBQ)	-0.193	0.168	0.031
Education	-0.114	0.180	0.012

TABLE 34. SATISFACTION WITH TECHNICAL  
QUALITY OF CARE SCALE REGRESSED  
UPON PATIENT VARIABLES

INDEPENDENT VARIABLES	STANDARDISED BETA COEFFICIENTS	ADJUSTED R SQUARED	R SQUARED CHANGE
Concern that problem may not clear up quickly (ICQ)	-0.251	0.124	0.124
Disease Conviction	-0.124	0.139	0.015
'Old' or 'new' patient	0.128	0.154	0.015
Education	-0.101	0.164	0.010
Concern whether problem straightforward (ICQ)	-0.110	0.173	0.009

**FIGURE 1. ALTERNATIVE MODELS OF THE DETERMINANTS OF SATISFACTION WITH TREATMENT**





APPENDIX:QUESTIONNAIRES USED IN STD CLINIC STUDY

1. Illness Behaviour Questionnaire

(The full 62 item questionnaire was used in the STD clinic survey. Only the items that contribute to one of the seven scales are reproduced here. Items are answered Yes or No, and positive answers contribute to the scale indicated in brackets after each item, unless \* is indicated, in which case a negative answer contributes to the scale.)

2. Do you think there is something seriously wrong with your body?

(Disease conviction)

3. Does your illness interfere with your life a great deal?

(Disease conviction)

4. Are you easy to get on with when you are ill? \*

(Irritability)

7. If the doctor told you he could find nothing wrong with you would you believe him? \*

(Disease conviction)

9. If you feel ill and someone tells you that you are looking better, do you become annoyed?

(General hypochondriasis)

10. Do you find that you are often aware of various things happening in your body?

(Disease conviction)

11. Do you ever think of your illness as a punishment for something you have done wrong in the past?

(Psych. v. Som. perception of illness)

12. Do you have trouble with your nerves?

(Affective disturbance)

16. Are you bothered by many aches and pains? \*

(Psych. v. Som. perception of illness)

17. Does your illness affect the way you get on with your family or friends a great deal?

(Irritability)

18. Do you find that you get anxious easily?

(Affective disturbance)

20. Are you more sensitive to pain than other people?

(General hypochondriasis)

21. Are you afraid of illness?

(General hypochondriasis)

22. Can you express your personal feelings easily to other people? \*

(Affective inhibition)

24. Do you think that you worry about your health more than most people?

(General hypochondriasis)

27. Except for your illness, do you have any problems in your life? \*

(Denial)

29. Do you find that you get jealous of other people's good health?

(General hypochondriasis)

30. Do you ever have silly thoughts about you health which you can't get out of your mind, no matter how hard you try?  
(General hypochondriasis)
31. Do you have any financial problems? \*  
(Denial)
32. Are you upset by the way people take your illness?  
(General hypochondriasis)
35. Are you sleeping well? \*  
(Disease conviction)
36. When you are angry, do you tend to bottle up your feelings?  
(Affective inhibition)
37. Do you often think you might suddenly fall ill?  
(General hypochondriasis)
38. If a disease is brought to your attention (through the radio, television, newspapers or someone you know) do you worry about getting it yourself?  
(General hypochondriasis)
41. Do you find that you are bothered by many different symptoms?  
(Disease conviction)
43. Do you have any family problems? \*  
(Denial)
44. Do you think there is something the matter with your mind?  
Psych. v. som. perception of illness)
46. Is your bad health the biggest difficulty in your life? \*  
(Psych. v. som. perception of illness)
47. Do you find that you get sad easily?  
(Affective disturbance)
51. Do you find that you get angry easily?  
(Denial)

2. Patient Satisfaction Questionnaire (Linn and Greenfield, 1982)

Patients were asked, for each item, to underline one response that fitted their views from:

strongly agree      agree      uncertain      disagree      strongly disagree

The scale to which each item contributes is indicated after the item.

1. The doctor seemed to have a genuine interest in me as a person. (Art)
2. Noone seemed to care very much about my privacy. (Art)
3. Doctors in the clinic don't want to bother with many of the things that really trouble me. (Art)
4. The doctors were very careful to check everything when examining me. (Technical quality)

5. I am in better health now because of the care I received there. (Efficacy)
  6. The doctors did their very best to keep me from worrying about things. (Art)
  7. The nurses treated me in a friendly manner. (Art)
  8. The doctors were not as thorough as they should have been. (Technical quality)
  9. The quality of care I received there was the best anyone could expect. (Technical quality)
  10. The doctors did as much as could be expected to help me get well. (Efficacy)
  11. The doctors were very friendly, seemed devoted to me and other patients. (Art)
  12. The doctors took time to put me at ease and tried to make me more comfortable. (Art)
  13. The doctors seemed to have experience with my kind of problem. (Technical quality)
  14. The doctors seemed competent and well trained. (Technical quality)
  15. Some of the things the doctor did were not very helpful. (Efficacy)
  16. In general all the clerks and receptionists were courteous and respectful. (Art)
  17. The doctors caused me to worry because they did not explain things to me or tell me what was happening. (Art)
  18. The doctors seemed very organised, (knew what to do next and had my treatment well planned). (Technical quality)
- The doctors helped me feel a lot better. (Efficacy)
- 

### 3. Illness Concern Questionnaire

Item 1 had the following response categories:  
Yes No Uncertain

Items 2 to 8 had the following response categories:  
Not at all A little Moderately Very Much

Item 9 had the following response categories:  
Yes No A little

1. Do you feel reasonably happy that the problem that brought you here today will prove to be simple and straightforward?

2. Are you worried that this problem might turn out to be very painful?

3. Are you worried that the problem may not clear up quickly?

4. Are you worried that in some way your future health might be affected?

5. How concerned are you about the possibility of a serious illness?

6. Are you concerned that such an illness might somehow affect your sexual life?

7. Do you ever worry that such an illness might in some way influence your chances of having children?

8. Has thinking about such an illness in any way disrupted your daily life?

9. Have other people been able to reassure you about your problem?

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