Within the world of health care and medical services, there is some resistance to the notion of recognizing patients as consumers. Traditionally, patients seek medical assistance or health care services when ill, faithfully adhering to the doctor's advice. However, patients are increasingly sophisticated and assertive, yielding a certain power or autonomy of their own. This paper empirically investigates the evolving role of patients to consumers and beyond. Findings from an interpretive study of General Practice (GP) medicine indicate that the degree of participation and responsibility patients willingly accept varies according to how and what patients understand as their role in the doctor-patient interaction. A range of patient perspectives are identified that vary from a passive understanding of GP quality of service, through a monitoring understanding of GP quality of service, to a partnering understanding of GP quality of service. Through this alternative, interpretive approach to the study of service quality, an alternative service quality framework is thus proposed. This framework is a Hierarchy of Perspectives ranging from the least to the most comprehensive understanding of what constitutes quality of service.

Introduction

Quality of service is a contemporary issue of great importance in our society, particularly when it concerns the delivery of health care services, such as General Practice (GP) medicine. From the professionals' perspective, quality standards are well established and documented within professional associations and ethical codes. Yet, what and how consumers focus on with respect to quality of service is not well understood. Service quality researchers typically focus on identifying the combination of service attributes that constitute a quality service (see Schembri & Sandberg, 2002). In contrast, this study focuses on the consumer's experience of quality service in the specific context of GP, arriving at an alternative service quality framework. In reporting the findings of this interpretive study, we begin by highlighting the tension involved with incorporating a consumer-oriented approach with the traditional notion of medical professionalism.

Professionalism and quality of service

As a traditional profession, the medical profession proudly espouses values such as professional autonomy and an altruistic service ideal (Freidson, 1970a,b, 2001; Parsons, 1964/1951). Doctors have the authority to define patient needs and how those needs are serviced (Moloney & Paul, 1993). Accordingly, doctors have traditionally assumed the right for “doctor's orders” to be accepted (Haug & Lavin,
Moreover, professional autonomy also means doctors have the right not to have anyone else interfere with their work (Haug & Lavin, 1983). Within the traditional model of medical beneficence, the patient is sick and vulnerable, thus requiring the help of a medical professional. Moreover, the patient as a lay person does not typically hold the necessary expertise to enable them to make any medical decisions associated with their ailment (Parsons, 1964/1951). Considering this dependence, the patient as an autonomous consumer of medical services is contrary to the traditional model of medicine and the role of medical professionals in our society. However, Parsons (1964/1951) connects unshared knowledge between doctor and patient as the right of the physician in exercising control over patients and effectively providing a professional and quality service. Indeed, the asymmetrical doctor-patient relation is a cornerstone of Parson's functionalist perspective, where societal equilibrium is maintained via shared values and interrelated functions.

Parsons holds that the 'sick role' involves certain reciprocal rights and obligations for both doctors and patients. The sick patient is entitled to legitimately withdraw from work and home responsibilities, without loss of salary or position and without blame for suffering. The sick patient is obliged however, to seek and follow professional medical advice in order to assist and accelerate recovery. In turn, the doctor is obliged to act in the patient's best interest and provide the highest quality of care and attention. The patient's cooperation and trust, as well as full disclosure of relevant information, is basic to this arrangement. Indeed, Parsons presents patient cooperation and trust as the doctor's right, which enables their professional obligations. In this way, the 'sick role' entails an ill and vulnerable patient, who must responsibly seek expert medical help and comply with treatment as recommended by the doctor. As a lay individual, the patient does not hold the technical competence to make any judgment of professional service quality and accordingly, the doctor makes the decisions. The essence of the 'sick role' therefore, is an autonomous doctor and dependent patient.

From this perspective, the client is required to unreservedly trust the professional expert and the professional is required to be objective, impersonal and impartial in their manner. In this way, professionalism is considered as a means to control the asymmetric expert-client relation and indeed society itself (Carr-Saunders & Wilson, 1964/1933; Parsons, 1964/1951). According to the traditional model of medical professionalism therefore, contribution from the patient does not facilitate the provision of quality medical service, possibly even denigrating quality of service provided. Paradoxically however, this contradicts the altruistic service ideal where client interests are indeed the priority. At the extreme, active and assertive patients challenging medical authority, potentially hinder achievement of quality service, professional standards and the means of social control (Lupton, 1997). Consequently, there has been some resistance from medical professionals with respect to health care consumerism (see for example Fairhurst & May, 1995; Imanaka, 1997).

Regardless of this proportion of resistance, a collaborative partnership between consumers and medical professions is recognised as essential in improving population health and effective primary care (Commonwealth Department of Health and Aged Care, 2000). In Australia for example, there are instances of ongoing community involvement such as exemplified by the activities of the Consumers’ Health Forum. However, in a recent report commissioned by the Australian Department of Human Services and Health in conjunction with the Consumers’ Health Forum, it is
highlighted that how consumers define quality health care is yet to be investigated (see Albany Consulting Group, 1996). This work is a small step in that direction.

**Recognising the consumer**

Consumerism implies buyer's challenge of seller's claims and it represents a cautious rather than faithful approach (Haug & Lavin, 1983). The rise of consumerism observed during the 1960's (see Miles, 1996), saw a critical mass of people create a powerful momentum demanding their voice be heard and their basic rights, such as equality and freedom, be respected. Also at this time, education levels rose significantly, white-collar service occupations predominated over blue collar and the media increasingly highlighted medical mishaps and mistakes. Consequently, there was a general rise in community expectations concerning rights and benefits (Haug & Lavin, 1983), particularly with regard to medical care in terms of rights, accountability and evaluation (Banks, 1979).

Reflecting the shift towards respecting patient rights including patient autonomy, Levenstein, McCracken, McWhinney et al. (1986) propose a patient-centered rather than a doctor-centered model of medical service. While a doctor-centered approach focuses on the process of attaining the patient’s medical history, a thorough physical examination and appropriate laboratory investigation in order to arrive at an accurate diagnosis, a patient-centered approach entails an understanding of the patient as well as their suffering, illness or disease. The patient-centered approach is a process of negotiation, where the doctor seeks to understand the patient and the world that person derives from. In other words, the aim is for the doctor to see the illness “through the patient’s eyes”. In shifting to a patient-centered approach, the impetus had arrived to then further investigate the experience and perceptions of patients and the community. As Vuori (1991) highlights, patients 'feel' the quality of service they receive and while they may not have the competence to assess the technical quality of medical care, they are the best judges on the 'art of medicine'.

Given that patient views may be inaccurate because they lack the technical competence, there has been an increased emphasis on evaluating the patients' subjective view by measuring satisfaction (for extensive reviews see Aharony & Strasser, 1993; Hall & Dornan, 1988; Lewis, 1994; Taylor, 1994; Wensing, Grol & Smits, 1994; Williams & Calnan, 1991). In this way, patient satisfaction has gained widespread recognition as an appropriate measure of quality (Williams, 1994). However, the broad application of patient satisfaction measurement within health care services reports a generally satisfied community of patients (Vuori, 1991; Williams & Calnan, 1991; Jolley, 1995) with specific studies reporting up to 96.5% patient satisfaction (see for example, Dougall, Rubin & Ling, 2000). The lack of variation in this measurement is just one aspect that has led professionals to question the validity of such measurement. Paradoxically therefore, the 'success' of patient satisfaction measures has contributed to their dismissal as an appropriate measure of quality of medical service (Vuori, 1991).

Empirical evidence to support this argument of the inadequacies of patient satisfaction as an indicator of quality is provided by Dougall et al. (2000). While measures of patient satisfaction in two hospitals indicated high levels of satisfaction, further in-depth qualitative investigation revealed a more complex picture. Dougall et al. therefore argue standard quantitative measures of patient satisfaction are inadequate
indicators of patients' experiences of health care services. They suggest that unstructured interviews and patient-led narratives yield a depth of understanding of the patient's experience. They further emphasise the valid quality assessment this insight provides.

**Focusing on patient experience**

In the consumption of services, consumers can play a variety of roles with varying degrees of participation (Bettencourt, 1997; Claycomb, Lengnick-Hall & Inks, 2001; Guiry, 1992; Lengnick-Hall, Claycomb & Inks, 2000). Investigating consumer roles within the doctor-patient interaction and focusing on the patient's experience, we observed and interviewed 39 patients visiting their GP in an Australian Community Health Center. Seeking to genuinely understand the patient’s perspective, an interpretivist approach was taken. This means research subject and object were assumed as the one relation, or in other words a non-dualistic ontological position was adopted. The specific methodology employed in this work was that of phenomenography\(^1\).

Phenomenography is a research approach that enables description of qualitatively different ways in which reality is experienced (Sandberg, 2000, 1994; Marton, 1986, 1981). Developed in the 1970s by Swedish education researchers seeking to better understand learning, phenomenography offers an established methodology to identify how people experience specific aspects of reality, such as GP service quality. The point of departure for this research effort is therefore, the consumer’s experience of GP service quality. In recognising that we are inextricably related to the world through our experience of it, the research focus is therefore the consumer’s ‘lived experience’ (Merleau-Ponty, 1962/1945) of GP service quality and the research aim is to identify and describe the varying ways consumers experience GP quality of service.

In focusing on the consumer’s experience of GP service quality, observation was achieved via a video recording of the doctor-patient consultation and interviews were conducted post-consultation\(^2\). Interviews were predominantly unstructured and conducted in accordance with phenomenological principles. Respondent dialogue directed the interview, but essentially interviews were based around the question of “What is a good doctor for you?”

In seeking to understand the quality of doctor-patient interaction “through the patient’s eyes” in a rigorous manner, both observation and interviewing techniques employed included deliberate efforts to maintain reliability and validity. Using interviewing as the primary research instrument facilitates a holistic explanation of the consumer’s lived experience of GP service quality. Gentle probing techniques further allow the researcher to assist respondents in giving rich accounts of their particular experience, as well as a convenient means to check and recheck initial interpretations. The video recording of the doctor-patient consultation enabled discreet observation and was also used as an interview tool to orient the researcher towards the patients experience prior to the interview. The videos were also used during the interviews to encourage respondent reflection of their experience. And finally, the videos also served as a reliability check following final analysis. In this

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instance, each recorded consultation was viewed in terms of the researcher’s interpretation of the consumer’s experience, to ensure it was indeed an accurate reflection of what had played out during the consultation.

After meticulously transcribing each interview, the transcribed text was interpreted with a focus on the meaning of experience. To do this, transcriptions were first read many times over. Criteria and comments of relevance were classified in terms of their context, rather than separated out, in order to leave the meaning of the context intact. This selection forms the basis for the next step where the researcher's attention shifts from each transcript to the meaning embedded in the comments themselves. To do this, the transcripts were first examined in terms of ‘what’ each respondent considered with respect to GP service quality. In doing this, the researcher was not looking for specific words or even statements, the researcher was looking to understand the meaning each respondent held for the particular ‘whats’, or service quality aspects. For example, many patients talked about being comfortable and comfort is considered a service quality aspect, or ‘what’. But not all patients held the same meaning for comfort. Some patients, in talking about comfort focused on reducing uncertainty through accurate and relevant information. While other patients, in talking about comfort focused on feeling confident enough to comply with the doctor’s recommendations. From the ‘what’ dimensions, the researcher then turned to examining ‘how’ each respondent understood GP service quality. This process sees the researcher's analytical focus swing between the comments to the meaning behind the comments. Gradually, comments were categorised on the basis of their similarities and then categories were differentiated on the basis of their differences. This iterative process of grouping and regrouping continued until relative group stability was attained.

In carrying out this interpretive analysis, three qualitatively different patient understandings of GP service quality are reported, which vary in terms of assumed patient role within the doctor-patient interaction. The varying roles recognised in this study are: Passive, Monitoring and Partnering. In brief, the focus for passive patients is faith in their GP, while the focus for monitoring patients is their distrust of medical people and processes, whereas the focus for partnering patients is the process involved in effectively managing their health.

These qualitatively different ways of understanding the patient’s role vary in meaning across a range of dimensions as well as the scope of dimensions within each variant understanding. The narrowest scope of dimensions is found with patients holding a passive perspective, while the partnering perspective involves the broadest scope of dimensions. Similarly, the least depth of dimension meaning is found within the passive perspective, while the greatest depth of dimension meaning is found within the partnering perspective. Therefore, the three perspectives identified form a Hierarchy of Perspectives, where the passive perspective is considered the least comprehensive and the partnering perspective is considered the most comprehensive. Table 1 below presents the varying dimensions relevant to each of the perspectives, which differ in terms of both scope and meaning. Table 1 also shows the hierarchical inclusion identified across the varying perspectives. Figure 1 illustrates the recognised hierarchy of perspectives. Beginning with the passive role, each role will now be outlined in more detail.
Table 1: GP service quality consumer perspectives

<table>
<thead>
<tr>
<th>Passive Dimensions</th>
<th>Monitoring Dimensions</th>
<th>Partnering Dimensions</th>
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<tbody>
<tr>
<td>a. Patient responsibility</td>
<td>a. Trust in doctor</td>
<td>a. Info search</td>
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<tr>
<td>b. Trust in doctor</td>
<td>b. Info search</td>
<td>b. Patient Satisfaction</td>
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<td>2. Physician behaviour</td>
<td>c. Patient sovereignty</td>
<td>c. Patient sovereignty</td>
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<td>c. Thoroughness</td>
<td>d. Doctor as human</td>
<td>d. Doctor as human</td>
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<tr>
<td>d. Caring communication</td>
<td>e. Trust in doctor</td>
<td>e. Trust in doctor</td>
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<tr>
<td>i. Reassurance</td>
<td>f. Doctor sovereignty</td>
<td>f. Trust/respect in/for patient</td>
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<td>ii. Understanding</td>
<td>i. Enablement</td>
<td>g. Patient as person</td>
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<td>iii. Information</td>
<td>3. Time</td>
<td>d. Trust/respect in/for patient</td>
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<td>e. Patient as person</td>
<td>4. Enablement</td>
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<td>f. Doctor sovereignty</td>
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<td>i. Enablement</td>
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Figure 1: Hierarchy of Perspectives
Passive patients willingly accept the doctor’s position as authoritative and faithfully adhere to the doctor’s word. These patients consider the doctor as the trained professional who holds the power of knowledge but simultaneously recognise the doctor as someone who is not infallible. They trust the doctor simply because they are the doctor, so willing and passively experience the ‘treatment’. They trust the doctor to make the decisions and they consider the patient’s responsibility in terms of getting to the doctor when ill. They need to be listened to, they need to be helped and they require honesty from their doctor. The doctor helps them by ‘treating’ the presented symptoms and making explicit their recommendations. Therefore information passed from doctor to patient in terms of instruction and education is critical. In this way, passive patients are dependent patients. The following respondent quote encapsulates the passive patient perspective:

“…If you’re sick you come to the doctors and if you’ve got no faith in the doctors, well, you may as well stay at home.”

Unlike passive patients, monitoring patients are sovereign and skeptical patients – they are active participants in the service process and willing take part in the decision-making process, continuously monitoring the service process throughout. They know themselves best and expect the doctor to respect that they are in charge. This perspective is strongly grounded in a basic distrust of medical people and processes due to negative past experience and/or chronic illness. Monitoring patients have experienced many unanswered questions and accordingly, arrive at the consultation armed with gathered information (which is sometimes misinformation), fully prepared to protect themselves if necessary. For these patients, medicine and medical treatment is an unfortunate necessity. They are not pleased they are in need of medical attention. They hesitate visiting the doctor and are typically reluctant to comply with treatment. These are people that don’t like needles, tablets, hospitals and doctors, but circumstances have induced a certain degree of assertiveness. In effect, they carefully monitor the consultation and treatment process. These patients therefore need to be fully listened to because truth and trust, for monitoring patients, are closely linked. Their entire story needs to be heard because the key to them and their health may not be easily articulated and/or teased out. Past experience and illness has blocked their propensity to easily discuss their issues and concerns. Effectively, they seek ‘truth’ from their doctor. Truthful doctors are doctors who willingly share information, give ‘full’ explanations and attentively ‘treat’ the patient as a person. A genuine interest in what the patient has to say is very important for these patients. When they feel they are being listened to and recognised as the responsible patient they are, they perceive a degree of control. Giving these patients this perceived control then generates a trusting environment in which they feel comfortable and secure, therefore encouraging disclosure of information and compliance with the doctor’s recommendations. The following respondent quote captures the essence of this perspective:

“I don’t like doctors very much…. Instead of being one-to-one they just think they’re that one step above, you know and they talk down to you and they don’t tell you what to expect. We’re not stupid. We deserve to be told the truth and that’s all we want from a doctor. Just to be told the truth.”
Like the monitoring patients, partnering patients are similarly active participants in the service process. However while the monitoring patients are focused on continuous monitoring of the service process, partnering patients are focused on managing their health and working with the doctor in order to achieve that goal. While the monitoring patients consider themselves sovereign consumers, partnering patients consider themselves partners with the doctor in their health management task, assuming the doctor will fall into the partnering role. Partnering doctors are therefore trusted doctors. As the partnering is focused on optimally managing their health, they will likely visit the doctor when healthy rather then ill. To them it is irresponsible to allow problems to escalate before consulting the doctor. They see the patient and the doctor as equally responsible for the quality of the process as well as the outcome of the consultation. As an assertive person and an informed patient, they are most interested in genuinely consulting with their doctor about their current condition and available options both now and in the future. They have come to the consultation with information of their own and are visiting the doctor in order to ensure they are fully informed. Similarly, they are also ensuring that the doctor is fully informed as to their condition/situation. The doctor is another source of information for them, someone to discuss the alternatives with and another opinion apart from their own. To them, quality service is about the opportunity of choice, as illustrated in the following respondent quote:

“…See I think it is an equal thing – he’s entitled to have his rights as I am and he is responsible as I am in terms of having a beneficial outcome for the consultation. [but]…I will respect his opinions and so forth and I will take that away with me, and you know, process it and then work it out for myself….I feel the patient needs to be empowered, be able to make some decisions and have choices. And you meet you know, half way. It’s a partnership. …yeah, I feel pretty well validated that way.”

**Health care consumers as partnering patients**

Consumer participation in the process of delivering quality health care services involves benefits for both doctor and patient alike. The partnering perspective for example, necessarily involves a participative style of interaction. Partnering patients take on an active role, engaging in an informative and constructive dialogue with the doctor. In this way, the doctor-patient relation is a partnership between equals, with doctor and patient working together as a team. In striving to optimally manage their health, partnering patients willingly participate in the service process in order to ensure a quality process and outcome. In focusing on managing their health, they are striving to attain and maintain a healthy status, implying the patient’s commitment to the formulated treatment plan. And, more than that, a partnering approach provides a degree of freedom from dependence on the medical profession, which the other two perspectives do not.

Given the egalitarian approach of the partnering patient, the service process is one that encourages open discussion and negotiation, rather than professional dominance. In this way, a partnering approach goes some way towards resolving the tension between consumerism and professionalism. In other words, a partnering approach involves a compromise that in the end encompasses both independence and...
dependence. As suggested by Haug and Lavin (1983), such an approach is the ideal result of intelligent consumerism in medicine.

Yet, as this study demonstrates consumer understanding of their role in doctor-patient relations varies and participation levels differ accordingly. Not all patients understand their role in the doctor-patient interaction as requiring a partnering approach. Indeed some patients understand a responsible role to be a passive role. Passive patients responsibly take themselves off to visit the doctor when ill and responsibly heed the doctor's advice. They willingly accept information that the doctor passes to them but do not consider it part of their role to actively inform themselves. Passive patients therefore, passively experience quality of GP service in a non-participative manner.

Unlike both the passive patient and partnering patient, monitoring patients are skeptical in their approach. They understand a challenging approach is required in order to ensure their best interests as a patient are indeed the priority. In this way, the monitoring patient is a sovereign and demanding consumer. As a health care consumer, monitoring patients are active and informed, carefully and continuously monitoring the service process, the people involved and any actions undertaken. Their focus is distrust of medical people and processes and their assertive posture illustrates this focus. The monitoring patient prioritises their rights as a patient and the doctor's obligation to serve the patient and their health needs. For the monitoring patient therefore, the patient has the final say as to what treatment will be entered into, if any at all. This brief outline of the monitoring patient's perspective, details the components of medical consumerism as identified by Haug and Lavin (1983): belief in patients' rights to information and to make decisions about their health; questioning a doctor's power and acting accordingly.

From a marketing perspective, the interactive, dynamic process of service consumption is more than a passive transaction (Claycomb et al., 2001; Bettencourt, 1997). Often consumers are required to actively contribute in creating the services they experience (Guiry, 1992; Ennew & Binks, 1999) and this is particularly the case with GP medicine (Enehaug, 2000). Active and intelligent consumers of high-contact complex services, such as medical services, can influence the constitution of the service and mode of service delivery, as well as the quality of service achievable (Lovelock & Young, 1979; Lengnick-Hall et al., 2000; Mills, Chase & Marguiles, 1983). Consumers actively participating in constructing the service they experience therefore potentially enhance the service for both themselves as well as the service provider (Solomon, Surprenant, Czepiel & Gutman, 1985; Webb, 2000).

Understanding consumers and their role as active participants broadens the traditional medical profession perspective of patients merely acting as passive service recipients. However, as demonstrated in the findings of this investigation, the extent to which consumers choose to participate varies. While some patients choose a dependent and passive role, others choose to become co-producers of the service actively contributing to the process of service delivery.

Effectively, the more active patients working with the doctor positively contribute to service process, enhancing the quality of service experienced. For example, patients actively contributing information, effort and preparation time can accordingly
negotiate an appropriate service design, service process and appropriate treatment regime, thus enhancing the service outcome for both themselves and the doctor.

Reflection

The societal thrust towards empowering the consumer has had the unintended consequence of threatening the professional's autonomy, making it difficult for the professional to operate with independent authority and judgment. The increasingly sophisticated consumer of today seeks to be an active player within the professional service context, whereas patients of a by-gone era willingly accepted a more passive role (Prahalad & Ramaswamy, 2000). Effectively, the traditional notion of a professional's authority and status is in decline, but people are uncertain how to replace it with a contemporary customer service and quality ethic.

As forecast by Haug and Lavin (1983), this research identifies a variation in how patients understand their role as a patient. Variability of the patient's understanding of their role is evident in terms of the degree of acceptance of the doctor's authority and the degree and form of challenge to professional dominance. However, rather than dismissing or attempting to standardise patient roles, the variation of patient understanding with respect to their role is argued as a potential tool to improve the quality of service as experienced by the patient. In other words, doctors and other health care professionals can enhance the quality of service they provide, by seeking a depth of understanding of the patient's perspective. This entails not only employing competent technical knowledge and skills combined with active listening techniques, it also means a more personalised and involved approach on the part of the doctor – which departs from the traditional objective view and detached approach advocated by medical professionals. Gentle requests for patient input will initially indicate the propensity a patient may have towards participation, hence establishing the patient’s perspective as either a passive or active orientation. From there, patient narratives of past experiences will further identify their level of skepticism and (dis)trust of medical people and processes. And, the extent to which a patient is inclined towards working with the doctor in a team approach can be gauged by exploring the patient’s goals. Although this is a simplistic overview of how a doctor may practically incorporate the findings of this research, essentially it is about the doctor seeking to understand not only the symptoms presented, but the person presenting, their life context and the meaning of this illness to them. Further elaboration of what such an approach might entail can be found in McWhinney (1986), Clark and Mishler (1992) and Charon (2001). In recognising patients as passive, monitoring or partnering patients, the doctor can effectively tailor the service process in accordance with the patient's perspective and needs associated with that perspective. Thus, through recognising the health care consumer and all that that entails, professionals improve the quality of health care service the patient experiences.

An alternative service quality framework

The alternative service quality framework proposed from this research is founded on the notion that the level of actor comprehension drives quality of service assessment as represented by the Hierarchy of Perspectives shown in Figure 1. In this particular study, the consumer perspectives identified range from a passive understanding to a partnering understanding in terms of the constitution of quality GP service, with a partnering perspective considered as the most inclusive and comprehensive
understanding. What and how the patient understands of GP service quality varies. While the data reported in this work is particular to the individual clinic and patients involved, the theory put forward here is potentially context independent. The framework proposed from this empirical study, may be applicable in other medical service contexts, as well as other service contexts in general. However, application of the theory is necessarily a context dependent research exercise.

The alternative service quality framework put forward here contrasts with dominant service quality theory in that it offers a dynamic framework. The consumer brings to the interaction a particular perspective, which falls within the range of a passive and a partnering perspective. This framework is dynamic in that consumers may be transient in what and how they comprehend a particular encounter or context. While a predominant perspective may endure for certain consumers across contexts and time, other consumers may be seeking to expand their horizons, consequently developing their comprehension and broadening their understood role. Effectively, these consumers move beyond possibly long held assumptions and effectively moving up the Hierarchy of Perspectives. Initially, this may only be within certain contexts or in tandem with certain service providers and consequently for short time periods. Eventually however, the comprehension becomes a consciousness that cannot be denied and thus the higher abstraction endures across contexts and across time. Not all consumers though, may willingly seek to confront previously held assumptions and they therefore will defy any development of their comprehension.

In conclusion therefore, this interpretive study of service quality has enabled a fresh understanding of service quality and an alternative service quality framework. In identifying a variation in what and how consumers understand with respect to quality of service, the Hierarchy of Perspectives demonstrates that service quality assessment is driven by the perspective consumers hold. In recognising this variation, researchers, marketers and service providers alike are offered a more genuine appreciation of the meaning of quality service.
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