Understanding Service Quality Through Experience: Unveiling The Consumers’ Perspective

Stream 23: Critical Marketing: Visibility, Inclusivity, Captivity

Sharon Schembri
Griffith University

Jörgen Sandberg
The University of Queensland

School of Marketing and Management
Griffith University
PMB 50 Gold Coast Mail Centre
Queensland 9726 Australia
Telephone: +6 (0)7 5552 8081
Fax: +61 (0)7 5552 8085
s.schembri@griffith.edu.au

UQ Business School
The University of Queensland
St. Lucia 4072 Australia
j.sandberg@business.uq.edu.au
Understanding service quality through experience: Unveiling the consumers’ perspective

Abstract

Predominantly, service quality researchers seek to objectively measure the quality of service perceived by consumers. In simplifying the multidimensional construct of service quality in terms of various component attributes, a ‘true’ and objective measurement of service quality is achieved. However, while a consumer orientation is typically emphasised within an objective measurement of service quality, it fails to achieve a genuine understanding of what quality of service means to consumers. Moreover, an objective view of service quality fails to incorporate the inherent dynamism in experiencing quality of service. Thus, in seeking to further understand the meaning of service quality, we address the question of how do consumers experience service quality? Through an interpretive investigation, three qualitatively different consumer understandings of service quality have emerged. In this study, the context of application is General Practice (GP) medicine and the particular methodology employed is phenomenological phenomenography. Through this interpretive application, we arrive at an alternative service quality framework, which accommodates the experiential meaning of service quality and offers an alternative means by which to improve quality of service as experienced by consumers.

Objectively measuring service quality

Reflecting the rise of the services sector, service quality research largely emerged in the mid 1980’s. From that time, several models and schools of thought continue to dominate today. Grönroos (1984) for example, proposed the Perceived Service Quality (PSQ) model, which is a two dimensional model with service quality considered to be evaluated against expectations of technical quality and functional quality. Also, Parasuraman, Berry and Zeithaml’s (1985, 1988) Gap Analysis model proposes a five dimensional model, where service quality is considered to be evaluated in terms of tangibles, reassurance, empathy, responsiveness and reliability. Like, Grönroos’ PSQ model, Parasuraman et al.’s Gap model measures service quality relative to consumer expectations. While, Grönroos’ work is reflective of the Nordic school of thought, Parasuraman et al.’s work is reflective of the American school of thought in terms of the objective measurement of service quality. Many points of difference distinguish these views, but the general consensus across these schools of thought is that service quality is a complex, multidimensional attitudinal construct requiring objective measurement.

Designed to accommodate measurement of service quality across a broad spectrum of services, Parasuraman et al.’s (1988) SERVQUAL is the instrument developed to measure the five generic service quality dimensions. Originally developed through research involving 12 focus groups across four service settings, SERVQUAL offers a practical and useful approach to the complexities involved in quality service provision. In line with the Gap Analysis model, this instrument measures service.

---

1. Four research settings of Parasuraman et al. (1988): retail banking, credit card, securities brokerage and product repair and maintenance.
quality as the gap between perceptions and expectations for each of the five dimensions (Q=P-E). However, SERVQUAL critics question the empirical accuracy of measuring service quality in terms of this discrepancy. Brady and Cronin (2001) for example, suggest service quality to be a performance based construct and more appropriately measured with perceptions, rather than expectations, as the point of reference. Other authors concur particularly questioning the validity of the P-E specification (see for example, Teas 1993; Cronin & Taylor 1992, 1994), even suggesting the P-E measurement framework to be a potentially misleading indicator of service quality perceptions.

From Grönroos (1984) to Parasuraman et al. (1988) to Brady and Cronin (2001), service quality research is predominantly focused on the delineation of service attributes comprising multiple service quality dimensions. Furthermore, a common research goal amongst service quality researchers is the identification of generic dimensions, applicable across service contexts. In line with this common goal, Brady and Cronin (2001) set out to identify generic service quality dimensions, testing their theory across eight service contexts. Beginning with Rust and Oliver’s (1994) three-dimensional framework, which presents service quality as comprising of service interaction, physical environment and the service outcome, Brady and Cronin (2001) model service quality as a multilevel, multidimensional hierarchical construct. They consider overall service quality perceptions to comprise of the three primary dimensions (interaction, environment and outcome), where each of the three primary dimensions has three sub-dimensions. Brady and Cronin (2001) used open-ended questions within a descriptive survey to elicit consumer evaluation of the nine sub-dimensions. In turn, these nine sub-dimensions are considered to be modified by Parasuraman et al.’s (1998) five service dimensions. Effectively, Brady and Cronin (2001) propose a four-level hierarchical model of service quality. However, Brady and Cronin’s findings were consistent across only four of the eight industry contexts.

In focusing on the identification of generic dimensions, researchers are seeking a standardised, dimensional model that allows universal prediction. Seeking objective measurement, universal prediction and a delineation of construct components indicates the dominant research approach to service quality is indeed a positivist approach. Their aim of inquiry is to develop a generalisable knowledge that is context independent, which is a goal in line with the criteria of good and valid positivist research. In striving towards an objective and generalisable model of service quality, researchers focus on identifying service attributes that comprise generic dimensions. However while a research focus on service attributes effectively achieves an objective view of service quality, it is a research focus external to the consumer. More specifically, in focusing on the delineation of service attributes researchers are effectively negating the foundational marketing philosophy of prioritising the consumer’s perspective (Schembri & Sandberg 2002).

---

2 Quality (Q) = Perceptions (P) - Expectations (E).
3 Eight research settings of Brady & Cronin (2001): amusement parks, full-service restaurants, health care facilities, hair salons, automobile care facilities, dry cleaning, jewellery repair and photograph developing.
Comprehending service quality in terms of a list of service attributes denotes the research object (service quality) as separate to the research subject (the consumer). This ontological duality is a reflection of the objective goal of contemporary service quality research. While the achieved result may indeed be an objective measurement of service quality, it is not a genuine reflection of the consumer’s view (Schembri & Sandberg 2002). Rather, it is an objective view or a third-person perspective of what service quality means to consumers (Schembri & Sandberg 2002) and as Grönroos (1993) has highlighted, we need to get closer than that.

As suggested by Grönroos (1993), the PSQ model is a static model of service quality because it fails to accommodate the complex dynamism of the service quality concept. Parasuraman et al.’s (1988) Gap model is similarly a static model because it is a deliberately generic and simplified picture of a complex phenomenon (Schembri & Sandberg 2002). Indeed, a standard instrument measuring generic service quality dimensions is an oversimplification and predefinition of what consumers are indeed looking for (Schembri & Sandberg 2002). And, any model that takes the PSQ model and/or the Gap model as its foundation (such as Brady & Cronin 2001, for example), is effectively building on a static base. While Grönroos (1993) makes the call for future service quality models to incorporate the inherent dynamism of service quality, efforts to this effect have been limited. In not fully understanding the dynamic experience of service quality and continuing to build on a static foundation, the fundamental problems remain unchanged (Grönroos 1993). In order to further our understanding of service quality therefore, it is necessary to shift the research focus away from service attributes and towards the consumer’s service experience. In order to do this an interpretive approach to service quality research is employed.

**Interpreting the experience of service quality**

When researchers are faced with questions that traditional methodologies cannot address, they must turn to other options. This issue is explicitly addressed by Gummesson (2001) who suggests that the lack of theoretical development in marketing can partially be attributed to researchers opting for inappropriate methodologies for the questions they seek to make a contribution towards. If circular arguments are present within the literature, as is the case with service quality measurement, then traditional methods and their underlying assumptions may need to be re-evaluated. While dominant service quality research has contributed greatly to our understanding of service quality, it has not yet adequately solved the question of ‘What is service quality?’ Moreover, as Grönroos (1993) highlights, dominant service quality models have failed to incorporate the inherent dynamism of service quality. Schembri and Sandberg (2002) further suggest that dominant service quality models have failed to genuinely capture the consumer's perspective on service quality. Therefore, a shift away from the objective measurement of service quality research may be fruitful.

In moving away from dominant methods, the question of service quality is posed in a different light, from a different perspective, hence deriving a different result. An interpretive approach to service quality research approaches the research task with
different assumptions and a different research focus, thus leveraging the potential for an alternative service quality framework to emerge.

An interpretive approach assumes person and world as inseparable (Merleau-Ponty 1962/1945; Heidegger 1962/1927; Husserl 1970/1900). More specifically, Sandberg (2001) explains that person and world are internally related through the person's lived experience of the world. This non-dualistic ontological position in an interpretive study of service quality, translates to the research object (the service context) and the research subject (the service recipient) being considered as the one relation. In effect, this underlying philosophical assumption enables the contextual and dynamic nature of service quality to be taken into account (Thompson 1997; Edvardsson & Mattsson 1993). In shifting from a dualistic ontology and objectivistic epistemology to a non-dualistic ontology and non-objectivistic epistemology, we move beyond a static representation of the meaning of service quality. In moving away from a static representation towards a dynamic understanding of service quality, the research focus shifts from attributes to meaning of attributes, or experience. Accordingly, an interpretive study of service quality enables a closer appreciation of the consumer’s perspective.

This paper reports the findings of an interpretive study of service quality conducted in accordance with phenomenological principles. In taking this alternative, interpretive approach and unlike the dominant approach to service quality research, reality is assumed to be socially constructed where consumer and service are assumed as the one relation and experience is taken as the point of departure. However, while a phenomenological study of service quality would produce a thematic description of the meaning of service quality, this study goes further than that.

This study employs a phenomenological phenomenographic methodology, which specifically enables investigation of the variation in how service quality is experienced by consumers. Effectively, this approach acknowledges that different people in different contexts may hold different meanings for similar service quality experiences. Moreover, though exploration of the varying meanings of service quality, a range of understandings can be established that extend from the least to the most comprehensive. Schembri and Sandberg (2002) discuss in detail this particular methodological approach. Essentially however, the outcome space of this work translates to a foundation of an alternative service quality framework that allows for the dynamic nature of a service quality experience.

Phenomenography of GP service quality
Focusing on the consumer’s service quality experience, this work takes a phenomenographic approach to achieve a direct description of ‘What is quality of service?’ The aim of this research effort is to recognise the variation in how consumers experience service quality, thus reaching a genuine understanding of what service quality means to consumers. In recognising consumers may have different priorities and interpretations for particular services, we recognise the context dependency of service quality assessments for consumers. Hence rather than deliberately striving to identify generic service quality dimensions applicable across a
range of contexts, we focus on the consumer's service quality experience within the specific context of medical services.

The research setting for this study was chosen on the criteria of high intangibility and complexity so as to minimise any distraction from the ‘pure’ experience focus. As it happens, the Australian vision for General Practice (GP) medicine into the 21st Century identifies the need to encourage consumer participation in the quest to provide quality service (Commonwealth Department of Health and Family Services 1998). Furthermore, this Australian quest for achieving GP quality of service is reflective of the current focus throughout the medical world, including Britain’s NHS (see for example, Laing & Hogg 2002). Given the significance of health care services in our (post) modern society and combined with the focus on providing quality service, GP is the chosen context of application for this study. Through application to the context of GP, this phenomenographic research design is suggested to be a way of genuinely understanding GP quality of service, “through the patients’ eyes”.

In terms of techniques, we employed indirect and undisguised observation combined with follow-up interviews. Observation, by way of recording the doctor-patient consultation on video, was used to gain an initial understanding of the service process experienced by the patient. Interviews were then used to gain a further insight into how the patient experienced the quality of GP service. Both doctor and patient were interviewed independently post-consultation.

Research participants were recruited from a low socio-economic area in Brisbane, Australia. Participating GPs worked within a busy and hectic community health center regularly used for research purposes. Participating patients were first screened to exclude those considered too ill, frail, hearing-impaired and/or non-English speaking. However, in selecting participants, the aim was to achieve a wide-ranging sample in order to arrive at the maximum variation of service quality experience. Both male and female, educated or not, young and old were therefore approached. In approaching potential participants, the study was simply explained as an investigation of the patient’s perspective on GP service quality.

Data was collected between late September 2001 and June 2002 and non-response is reported at 33.6%. Eight GPs collectively supplied 39 patients, of which 20 were male and 19 female. Table 1 below shows a further breakdown of this sample in terms of age and education. Only those respondents providing written consent participated in the study and in accordance with ethical guidelines, all data collected was held in the strictest of confidence. Consultation lengths varied from 10 minutes to 37 minutes and interviews ranged from 15 minutes to 62 minutes.

---

4 In total 59 potential respondents were approached, rendering a non-response rate of 33.9%.
Table 1: Demographics of patients sample

<table>
<thead>
<tr>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt; Yr 12 education</td>
<td>&lt; Yr 12 education</td>
</tr>
<tr>
<td>18-45 yrs</td>
<td>18-45 yrs</td>
</tr>
<tr>
<td>5</td>
<td>2</td>
</tr>
<tr>
<td>46-69 yrs</td>
<td>46-69 yrs</td>
</tr>
<tr>
<td>6</td>
<td>6</td>
</tr>
<tr>
<td>70+ yrs</td>
<td>70+ yrs</td>
</tr>
<tr>
<td>4</td>
<td>6</td>
</tr>
<tr>
<td>&gt; Yr 12 education</td>
<td>&gt; Yr 12 education</td>
</tr>
<tr>
<td>18-45 yrs</td>
<td>18-45 yrs</td>
</tr>
<tr>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>46-69 yrs</td>
<td>46-69 yrs</td>
</tr>
<tr>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>70+</td>
<td>70+</td>
</tr>
<tr>
<td>2</td>
<td>1</td>
</tr>
</tbody>
</table>

In preparation for the patient interviews, the researcher first watched the recorded doctor-patient consultation several times. This allowed the researcher to become familiar with the happenings in the consultation and also to recognise any significant (good and/or not so good) moments for either doctor and/or patient. The patient interviews were approached as a simple discussion with the patients about their experience, with the aim of uncovering the patient’s focus in terms of quality. The patient interviews were therefore geared towards coming as close as possible to the patient’s own understanding of service quality. Primarily, the interviews took an open-ended and unstructured approach. However, three questions formed the basic line of questioning, while respondent dialogue primarily shaped the direction of the interview.

Respondents were first asked about the purpose of their visit with the GP and while some patients were there for simple requests or regular checks, others were there to address on-going issues and concerns. Once the purpose of their visit was established, respondents were then asked how they found the ‘treatment’? The word ‘treatment’ here is used in the broadest sense and therefore encompasses all experiential, existential and embedded elements relevant to the respondent’s experience. In other words, those elements influencing the respondent’s interpretation as mentioned by the respondent. Once a description of the patient’s experience was attained via the first two questions, researcher and respondent then viewed the recorded consultation. In this way, the recorded consultation was also used as an interview tool. This assisted the patient in recalling and reorienting themselves to their experience. It also allowed the researcher to gently probe the respondent about specific consultation moments. ‘How did they feel?’ ‘What did they think?’ And, ‘Was it a good, or not so good moment, for them?’

The third question put to respondents simply asked, ‘What is a good doctor for you?’ Respondents were allowed to make their own interpretation of the meaning of words used in the questions. The word ‘good’, for example was not defined by the

---

5 In most, but not all, patient interviews the researcher and respondent watched the recorded consultation during the interview. At times, viewing facilities were not available and so interviews were conducted without the viewing component. For these interviews, respondents were still quizzed on specific moments within the consultation and respondents were forced to rely on memory recall to describe their experience.
researcher, but rather the respondent’s focus as indicated by their dialogue defined the meaning. The aim with this third question was to identify the respondent’s foreground focus of their experience. Whereas, the first two questions were designed to identify the respondent’s background focus and answers to each of the three questions therefore collectively form three parts of a whole. From these interviews, the next step was to recognise common parts and wholes across the sample.

**Recognising the consumer’s experience**

In order to recognise how respondents experienced quality of service in this particular context, the analytical process of phenomenological reduction as outlined by Sandberg (1994, 2000) was employed. To start the analytical process, interview transcriptions were read, re-read and read again. This initial step allowed the researcher to gain a general understanding of each respondent’s description of their experience. Transcripts were then 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. From the ‘what’ dimensions, the researcher then turned to examining ‘how’ each respondent understood GP service quality. To do this, the transcripts were grouped in terms of extremities by first separating the most contrasting and then grouping those that displayed similarities while simultaneously recognising differences within the groupings.

Throughout this iterative process, the researcher is alternating between the whole and the parts of what and how respondents understand GP service quality. In this way, the focus is on the contextual meaning of the respondent’s message with the process resulting in repeated grouping and regrouping. The goal however, was to arrive at a point where, despite further cross checking each group remained stable. From this analysis, a variation of what GP service quality means for patients has emerged. These findings demonstrate that the focus patients hold in experiencing GP service quality varies and the results presented here are simply a description of that variation.

**Unveiling the consumer’s perspective**

From this empirical examination, three distinct understandings of GP service quality have emerged: *Passive*, *Monitoring* and *Partnering*. For patients holding a *passive* understanding of GP service quality, authority in the doctor-patient relation is asymmetrical, resting entirely in the doctor’s hands. These patients are willingly dependent on the doctor for information, diagnosis and prescription and hence passively experience the quality of service. Whereas, patients who understand GP service quality in the *monitoring* sense may be more inclined to assert themselves. While reluctant to trust due to negative past experiences, monitoring patients find themselves dependent on the medical profession due to circumstances, such as unexplained or chronic illness for example. Consequently, the patient holds sovereignty, carefully monitoring the process throughout. In contrast to both passive and monitoring patients, for *partnering* patients accountability is at least partially shared, as in a meeting between equals. Partnering patients are focused on the task of health management and are looking for an informative dialogue combined with a
humanistic, holistic approach that goes beyond the biomechanics. For them, GP service quality is about choice. The following discussion outlines in more detail these three qualitatively different understandings of GP service quality.

**Passive.** Patients understanding GP service quality in the passive way are patients focused on an acquiescent relation with their doctor. The following respondent quote illustrates this focus, “...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.” Patients holding a passive perspective are not there to question, or assert themselves. They are ill and they are there for a specific reason, therefore presenting themselves as a responsible patient. For passive patients, trust in their doctor is very much in focus. They assume dependence on the doctor and confidently comply with recommended treatments. When the doctor prompts them for information, they are willingly forthcoming but not necessarily predisposed to disclose otherwise. In assuming dependence, passive patients are also not necessarily inclined towards becoming informed on relevant issues. Being predominantly uninformed means information from the doctor is vital to the process as it may be the only information the patient will take in regarding their situation. Passive patients trust the doctor because they are a doctor, the respected expert and medical professional, while the passive patient is the mere lay individual. The passive patient experiences quality service when the doctor takes a thorough diagnostic approach and caringly reassures along the way. Consequently, they feel they have understanding and willing trust the doctor’s decisions. This patient is simply there for the doctor’s expert advice and in this way, the patient passively experiences the quality of service provided.

**Monitoring.** Patients understanding GP service quality from the monitoring perspective are somewhat reluctant to trust doctors due to negative past experiences. They are forced to trust however, due to circumstances, such as unexplained and/or chronic illness for example. They are patients who have shifted towards being assertive, questioning patients and they are simply looking for the 'truth'. The following respondent quote encapsulates this perspective: “...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. Like I say, 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.”

Monitoring patients need to be understood in terms of their issues and concerns, their problems and situation, which can be a difficult task given their skeptical posture. They also need to specifically understand how the doctor sees the situation, what procedures/medication are being prescribed and why, as well as the possible side effects involved. The doctor therefore needs to listen intently to the messages presented, in order to recognise both explicit and implicit communications. The doctor also needs to listen for misconceptions on gathered information, as these patients will seek to make their own decisions. They see doctors as educated beings, looking down on the less educated population. Their focus is mistrust in medical people and processes. It is therefore refreshing for them to experience an informative, affable and sensitive approach. Being informed is a relatively new experience, as is being listened to and being understood. They are seeking to be recognised as the individual, whole person and responsible patient that they are. As willing and active
learners, they are open to information put to them in a sensitive and caring manner. But because of chronic illness and/or negative past experiences, they are reluctant patients maybe holding little hope. They reluctantly visit the doctor but responsibly go when it is absolutely necessary. Similarly, they reluctantly trust the doctor and comply with recommended treatments. A genuine interest in the patient, their life context and difficulties faced however, encourages and develops a degree confidence and comfort for the patient. Ease of caring communication is therefore a foundational element in improving the process of the interacting with patients holding a monitoring perspective.

Partnering. Patients understanding GP service quality from a partnering perspective typically arrive at the doctor’s office in good health with an open mind and gathered information (including information attained from other doctors). First and foremost, partnering patients visit the doctor to work with the doctor in terms of managing their health. As the following quote summarises, these patients seek a partnering process: “….it’s good to be informed. …understanding what’s going on and how you can treat yourself rather than run to the doctors all the time …. …I will respect his opinions and I will take that away with me, process it and then work it out for myself. But I certainly expect equality. …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 umm well validated that way.”

In seeking to manage their health in an optimum manner, partnering patient are there to share information with the doctor, to spend time engaging in an informative dialogue with the doctor and to discuss available choices with respect to the current situation as well as present and future options. They are looking for a humanistic approach; a personalised and empathetic approach that addresses the patient’s individual needs at this particular time under these particular circumstances. Essentially, they are looking for a doctor who is willing to delve into the deeper context of the patient’s life and to investigate beyond the symptoms presented. Accordingly, partnering patients seek a ‘real’ doctor, who is genuinely understanding and caring in their manner rather than simply functional and time-efficient. This doctor is ‘human’, and recognises the patient as a ‘real person’ too. Equality between doctor and patient is an assumed fundamental and therefore language is at a communicative and comprehensible level for both parties. The doctor’s expertise is current and enhanced by the doctor's ability to access the fast evolving body of medical knowledge as needed. Similarly, the patient’s expertise is recognised and encouraged. While the patient is enlisting the professional service provided by the doctor, this patient willingly takes responsibility for themselves and their health. In this way, partnering patients are not reliant on the doctor in terms of health management. From a non-dependent position, they are seeking a genuinely consultative process. For these patients, the doctor-patient relationship is a partnership: two trusting individuals working together in the task of managing the patient’s health in the context of their life situation.

These results show that how patients understand GP service quality directs their focus in judging GP service quality, ultimately defining quality in variant form. Recognition of this variation in meaning contrasts with dominant service quality theory and
consequently an alternative service quality framework is generated. Table 1 presents the identified dimensions within each of the three qualitatively different perspectives of GP service quality. This table outlines the variation in structural meaning across the three perspectives and it also shows the hierarchical inclusion inherent within the three perspectives. Table 1 shows that partnering patients have a more comprehensive understanding, in terms of what they are looking for with respect to GP service quality, than both monitoring and passive patients. Monitoring patients similarly, have a more comprehensive understanding of GP service quality than passive patients. And, passive patients have the least comprehensive understanding of what constitutes GP service quality. However, while Table 1 shows the variation in scope of the dimensions across the three perspectives, what is not evident in this table format is the variation in inherent meaning of the dimensions across the three perspectives.

A common dimension across the three perspectives for example is that of information management. However, the management of information for each of these three qualitatively different ways of understanding GP service quality has varying meaning. In other words, educating and informing patients has a different significance to patients holding different perspectives on the constitution of service quality in the GP context. For partnering patients for example, patient education is essential to the partnering process as the patient recognises their responsibility for their own health. However, because the partnering patient proactively takes responsibility in managing their health issues, they diligently prepare for the consultation ensuring they are fully informed prior to arriving at the doctor's office. Whereas for monitoring patients, information gathered prior to their consultation with the doctor becomes a control mechanism by which the patient can use to protect themselves. In other words, proactive attempts at self-informing is driven by a different goal to that of the partnering patients. Doctors consulting with a monitoring patient therefore need to focus on educating the patient in terms of what the information means that they have gathered in their quest to inform themselves. Misconstrued information, misinformation and miscommunication may be more likely when the patient holds a distrusting perspective. Unlike both the partnering patient and the monitoring patient, the passive patient is not focused on becoming informed as the passive patient is focused on trusting the doctor and is therefore dependent on the doctor's expertise. For these patients, quality service means information is managed by the doctor and then appropriately passed to the patient.

Throughout the three perspectives and within each dimension, there is variation in the inherent meaning according to the focus held. Within the partnering perspective, a more comprehensive understanding within the scope of the dimensions as well as within the inherent meaning of each dimension is found to be more comprehensive than with either of the other two perspectives. Given the focus of the partnering
Table 1: Meaning structures of patient perspectives of GP service quality

<table>
<thead>
<tr>
<th>Partnering Dimensions</th>
<th>Monitoring Dimensions</th>
<th>Passive Dimensions</th>
</tr>
</thead>
<tbody>
<tr>
<td>b. Patient Satisfaction</td>
<td>b. Info search</td>
<td>b. Trust in doctor</td>
</tr>
<tr>
<td>c. Patient sovereignty</td>
<td>c. Patient sovereignty</td>
<td></td>
</tr>
<tr>
<td>d. Doctor as human</td>
<td>d. Doctor as human</td>
<td>2. Physician behaviour</td>
</tr>
<tr>
<td>e. Trust in doctor</td>
<td></td>
<td>c. Thoroughness</td>
</tr>
<tr>
<td>2. Physician behaviour</td>
<td></td>
<td>d. Caring communication</td>
</tr>
<tr>
<td>a. Technical competence</td>
<td></td>
<td>i. Reassurance</td>
</tr>
<tr>
<td>b. Caring Communication</td>
<td></td>
<td>ii. Understanding</td>
</tr>
<tr>
<td>i. Informative dialogue</td>
<td></td>
<td>iii. Information</td>
</tr>
<tr>
<td>1. Patient education</td>
<td>1. Patient education</td>
<td></td>
</tr>
<tr>
<td>ii. Reassurance</td>
<td>ii. Understanding</td>
<td></td>
</tr>
<tr>
<td>iii. Understanding</td>
<td>iii. Honesty</td>
<td></td>
</tr>
<tr>
<td>iv. Honesty</td>
<td>c. Patient as person</td>
<td></td>
</tr>
<tr>
<td>c. Patient as person</td>
<td>d. Doctor sovereignty</td>
<td></td>
</tr>
<tr>
<td>d. Trust/respect in/for patient</td>
<td>3. Time</td>
<td>f. Doctor sovereignty</td>
</tr>
<tr>
<td>3. Time</td>
<td></td>
<td>i. Enablement</td>
</tr>
<tr>
<td>4. Enablement</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
perspective is that of a proactive team approach, patient behaviour tends towards facilitating a genuinely consultative process. Partnering patients are focused on managing their health in an optimum manner, so arrive at the doctor’s office in a healthy rather then ill state of health. What the patient is looking for in terms of physician behaviour is effort that welcomes a health management approach and encourages patient participation, thus facilitating the partnering process and. For the partnering patient therefore, the time dimension infers that the facilitation of this process takes time. Consequently, when this patient finds a doctor who takes a partnering approach, they willingly wait for the appointment with little grievance regardless of any lengthy time spent in the waiting room. Essentially therefore, helping the partnering patient, or enabling this patient in other words, is about the extent to which a partnering approach is adopted.

Within the monitoring perspective, the scope of the dimensions as well as the inherent meaning of the dimensions reflects a lower level of comprehension as to what constitutes quality of service. Given the focus of the monitoring perspective is that of distrust, patient behaviour tends towards reinforcing their sovereign position. Monitoring patients are reluctant patients, but eventually arrive at the doctor’s office when absolutely necessary. What this patient is looking for in terms of physician behaviour is effort that demonstrates that the doctor is indeed seeking to prioritise the patient's interest, thus potentially (re-)establishing a trusting environment. For the monitoring patient therefore, the time dimension translates to the doctor taking the time to fully investigate problems presented. Consequently and as with the partnering patient, when this patient finds a doctor willing to take the time necessary to fully investigate unsolved and complex problems, monitoring patients willingly wait for the appointment with little grievance regardless of any lengthy time spent in the waiting room. Essentially therefore, helping the monitoring patient, or enabling this patient in other words, is about accepting their skeptical focus and working through the issues that have contributed towards this.

Within the passive perspective, the scope of the dimensions as well as the inherent meaning of the dimensions reflects yet a lower level of comprehension in terms of what is quality of GP service. Given the focus of the passive perspective is that of faith in the doctor's expertise, patient behaviour tends towards reinforcing this focus and away from a participative approach. In line with this, what the patient is looking for in terms of physician behaviour is an authoritarian approach where the doctor takes charge and drives the process. Therefore helping the passive patient, or enabling this patient in other words, is about the doctor's sovereign position facilitating a passive experience. For the passive patient therefore, the time dimension incorporates a functional and efficient meaning.

Interpretation of the meaning of GP service quality through a genuine understanding of the patient's perspective therefore unveils a variation in the meaning of quality. The above discussion demonstrates that the extent of this variation occurs in the form of differing perspectives, or meaning structures, as well as within the inherent meaning of the dimensions that make up those structures. Effectively, we arrive at an
alternative service quality framework that is distinctly different from current service quality models.

**An alternative service quality framework**

This alternative framework profiles a range of consumer perspectives of service quality, where what and how the consumer understands is recognised without prejudice for accepted conventions. Moreover, there is empirical evidence to suggest that consumers may be transient in their understanding of quality service. Passive patients experiencing prolonged illness without any answers for example, may be forced to become more assertive and support for this suggestion is found within the data. Similarly, monitoring patients experiencing a trusting environment may be more inclined to work with the doctor rather than reluctantly comply. In essence, the dynamic nature of service quality is captured through the dynamism of contextual understanding.

Recognition of any variance in meaning contrasts with dominant service quality theory, which assumes there are generic dimensions throughout heterogeneous consumer groups and across service contexts. These results however, show that how patients understand GP service quality, directs their focus in judging quality of service in the GP context. In challenging dominant service quality models, this alternative approach suggests that essential aspects of service quality have different meanings depending on which perspective they form a part of. A genuine understanding of what quality means for consumers allows more accurate customisation efforts. Effectively, this alternative framework of service quality enables an alternative segmentation tool. Services tailored to a particular consumer understanding are more likely to be considered a quality service for those consumers. Beyond that particular perspective however, the evaluation may not be so favourable.

Both the (Australian) Commonwealth Department of Health and Family Services and the Australian Medical Association advocate a partnership approach to the doctor-patient relationship. Ideally, this entails promotion of a GP consulting style, which encourages consumer participation in treatment choices as well as responsibility for their own care. Promotion of such an ideal is a commendable effort, but as these results suggest, not all patients are looking for a ‘partner’ in the management of their health. This study shows that an alternative framework for service quality has implications in terms of how social marketing and health promotion efforts are carried out and ultimately how consumer awareness is raised. In recognising a hierarchical range of perspectives, an alternative segmentation platform is identified, which may enable a more tailored message to a more specific consumer group. If the message is more precise and more accurately reaches the right people, then the effort involved is likely to produce more effective results. Hence, recognising consumer understanding is key.

Effectively, this alternative framework allows service managers and marketers to recognise and potentially develop consumer understanding of service quality. In this way the focus becomes managing the quality of service experienced, rather than managing the service per se. In other words, providers can appropriately ‘coach’
consumers towards a more comprehensive form of meaning structure - effectively moving consumers up the hierarchy of perspectives through the developing their level of comprehension. Providers recognising the meaning consumers hold for a particular service aspect, such as responsiveness, can work towards developing consumer understanding of that aspect. For example, prompt and punctual service is usually considered fundamental to quality service, but may not always be attainable – as is often the case with medical services. In contrast to dominant service quality theory, these results show some patients are very willing to wait for a ‘good’ doctor. However, what they understand a good doctor to be varies in meaning, as does their understanding of responsiveness. ‘Coaching’ patients towards a more participative approach therefore entails encouraging patients to move towards a partnering conception. At the extreme of this approach, clinic traffic is effectively reduced, waiting times are lessened and patients are more actively involved in their health management issues. But the question then becomes, how do we successfully develop patient understanding?

Regardless of the patient’s perspective, the doctor’s role is instrumental within the doctor-patient interaction. In this research effort, data has been collected on the doctor’s perspective, but is yet to be juxtaposed against the patient perspectives unveiled in this paper. Dall’Alba (1998) however, has investigated how medical students characterise medical practice. Taking a longitudinal approach, she similarly uses a phenomenographic approach and reports six perspectives, which range from a simple perspective focused on helping or saving the patient to the more comprehensive perspective of enabling the patient to better deal with their situation. Dall’Alba’s findings parallel the findings reported here in that the perspectives range from a functionalist perspective to a perspective that incorporates the patient’s life context. Combining Dall’Alba’s results with the patient perspectives found in this study, highlights implications that include how GPs approach the doctor-patient consultation. Dall’Alba for example, highlights the need to address the variation in how medical practice is characterised, how medical care is viewed and how medical encounters are experienced. More specifically, from this study we can suggest that a partnering approach with a patient who understands doctors as the authority may not convey a quality process. Similarly, a passive patient may not appreciate a doctor encouraging a participative approach. This highlights that there is room for improvement in terms of how doctors understand their patients, how they approach the consultation process and what focus is put on ‘coaching’ the patients in terms of quality comprehension. More specifically, in seeking to provide quality service, doctors must work towards recognising how patients understand service quality, or in other words, how their patients experience GP quality of service.

The alternative service quality framework derived from this interpretive approach allows service providers and researchers alike, an insight into the variation of consumer understanding in terms of what is service quality. In shifting the research goal away from objective measurement of service quality towards understanding how consumers experience service quality, we have generated a genuine understanding of the consumer’s perspective. Effectively, an alternative approach to the study of service quality has derived an alternative framework that goes some way towards incorporating the dynamic nature of service quality.
References


