THE PATIENT’S PERSPECTIVE

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Abstract

The paper outlines the context in which patients’ views have been emphasized and the evidence from survey research about the criteria users employ to evaluate health care. Evidence from qualitative research shows that users are ambivalent about modern medicine and are particularly sceptical about the value of drugs and medicine.

Sociologists writing about the perspectives of the doctor and the patient have, at least until recently, depicted them either in terms of a shared perspective or a difference or even a clash of perspectives (10). The shared perspective implies that both doctor and patient accept the biomedical model, which involves the use of criteria that characterize disease and illness as a fundamentally biological phenomenon. This perspective also implies that the patient accepts the authority of the profession and has faith in medical knowledge and medical expertise. In this context the patient is depicted as passive and uncritical. In contrast, an alternative perspective suggests that the doctor and patient may have different and even conflicting views. The image of the lay person in this approach is one who is active and critical, manages his or her own health requirements, and is discriminating in the use of medical knowledge, advice, and expertise. The doctor is seen by the potential patient as one source of advice within a network of consultants. There is a shift away from an emphasis on explaining behavior in terms of medical rationality and toward attempting to understand the lay person’s actions in terms of his or her own logic, knowledge, and beliefs (1).

Both of these perspectives are rather simplistic and, although there is an acknowledgment that doctors’ and patients’ perspectives are different, they are not as different as some argue. In the everyday practice of medicine, doctors do not necessarily draw on the biomedical perspective but use a perspective closer to the lay perspective. Certainly, there is a lack of detailed empirical evidence about doctors’ perspectives. However, the emphasis here is on patients’ perspectives and how patients evaluate health care, including an assessment of the different methodologies used to elicit the patients’ perspectives.

THE CONTEXT AND PATIENTS’ PERSPECTIVES

Before the evidence about how patients judge health care is discussed, it is important to clarify the context in which patients’ or users’ views are emphasized. There are at least three reasons which have been put forward to explain why users’ views
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should be taken into consideration. The first is associated with the evaluation of health care and holds that a comprehensive assessment should not only take into account clinical effectiveness, efficiency, and equity but also include users' views about acceptability and satisfaction with care. There is some debate about whether user acceptability and satisfaction are outcomes in their own right or a part of the process of care that in turn will influence health status and medical outcomes.

Second, with the shift from acute to chronic forms of disease in developed countries the late 20th century, coupled with changes in the age structure of the population, issues involving the quality of long-term medical and social care come to the fore. With chronic forms of disease and disability, sufferers and their families play a more active part in care. Also, with the reduction in the length of hospital stay for acute conditions, increased emphasis is now being placed on users' becoming involved with a partnership with professionals as they are required, along with their careers, to play a more active part in the management of their illness and in treatment planning.

The third reason is associated with professional values and ethics. The emphasis here is placed on the altruistic concern of the doctor for the users' welfare. For example, some doctors and other practitioners emphasize the holistic nature of therapeutic care, which, by definition, requires that the users' views and interests be taken into account. In the context of ethics, some professionals emphasize the need to inform patients about costs as well as the benefits of different medical treatments and leave the decision of whether they want the treatment to them.

In each of these contexts, the importance of taking into account the users' views tend to reflect “top down” policy, in that the reasons for taking account of users' views were prescribed by governments, managers and/or health professionals. However, there is another context in which users' views have also been identified, and that is where the initiatives extolling the views of the population or sections of it emerge from the communities themselves. For example, there is the idea of “citizen advocacy,” where advocates pursue issues with relevant public authorities on behalf of their clients, who are unable to articulate fully their needs and preferences. There are also those groups that have emerged from social movements, such as those in the area of maternity care and childbirth which aim to provide support and information for the health service user and to act as pressure groups for improving users' health.

LAY EVALUATION OF HEALTH CARE

The context in which users’ views are being discussed in this paper is mainly in relation to the evaluation of health care. One of the most common ways of examining patients’ views is through patient satisfaction.

There are considerable difficulties involved with conceptualizing satisfaction and operationalizing this concept. A popular definition of satisfaction is the difference between expectations and the care actually provided. However, this definition is itself problematic in that for some health problems, expectations develop during the process of health care delivery and are revised in the light of experiences. There is also the question about whether satisfaction is fixed but changes in the light of experience. Thus, there is the problem of whether general satisfaction with care should be considered, or satisfaction with the last visit, or both.

However, doubts also have been raised about the validity of patient satisfaction surveys and question the underlying assumption, namely that “patient satisfaction”
exists in a population, simply awaiting measurement. For example, it is suggested (14) that some users might simply remain passive and do not evaluate health care and that others do evaluate health care but not in terms of being “satisfied.” The conclusion is that the conceptual framework derived from patient satisfaction research provides only partial, and sometimes misleading, insights into the perspectives of the patient. Surveys tend to produce results that inflate levels of satisfaction. Thus, it is difficult to judge whether high levels of satisfaction reflect users’ high ratings of the quality of their care or whether such results are an artifact of the methods used. There is some evidence to suggest that studies employing qualitative methods such as focus groups or informal interviews are more likely to uncover areas of criticism than are questionnaire surveys (11).

QUALITY OF CARE: EMPIRICAL EVIDENCE

A common finding from survey research carried out in the United Kingdom that has examined users’ views, irrespective of the type of service provided or the setting in which it is provided, is the emphasis placed on the quality of the professional-patient relationships. For example, Williams and Calnan (14) examined the extent to which there is convergence or divergence in assessing the criteria of consumer satisfaction across general practice, dental care and hospital settings. Their findings showed clearly that issues concerning professional competence, together with the nature and quality of the patient-professional relationship, were consistently the most important predictors of overall consumer satisfaction with general practice, dental care, and hospital care. Some typical comments were:

I never feel my GP has enough time for me and therefore often end up telling him only half the reason why I came.

I feel very much at ease with (my dentist) because he always explains what is necessary to be done.

I was dissatisfied (in hospital) because basically there was no personal care given and the doctors were unfriendly and they didn’t bother to try and treat my needs and worries separately.

The nature and quality of the doctor-patient relationship is of particular importance in general practice, and there was some concern that the changes in the new general practitioner (GP) contract in the United Kingdom in 1990 would have a detrimental effect on this interaction in that the changes might have accorded a more formal and bureaucratic role to the GP with less time for consultation. The results of a recent study in Canterbury comparing consumer perceptions before (in 1988) and after (1991), the new GP contract was implemented (5) showed that these fears were unfounded. Overall satisfaction with general practitioners was broadly similar in 1988 and 1991, and there was little change in concerns about time restriction. Nevertheless, the question of quality of time in the consultation still remains a difficult issue. The importance for the patient of the doctor-patient relationship in general practice was also clearly shown in this study. It showed that the strongest influences of overall satisfaction with general practice were whether the doctor was understanding, had good medical skills, was good at explaining things, and was liked as a person. Thus, the findings demonstrated the continued importance of the more diffuse social and psychological aspects of primary care to the consumer.
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A similar survey (6) was carried out in 1988 in three other European cities: Moscow, Belgrade, and Ioannina (Greece). Overall, the survey found more convergence than divergence in patient views. The only major source of divergence was that at both the general and specific levels, respondents in Moscow were much more dissatisfied than respondents in the other three cities. This may reflect the poorer quality of services in Moscow at that time or the higher expectations of the user or both.

Some aspects were a common source of dissatisfaction, such as whether the GP takes a problem seriously enough, whether personal problems are discussed, and whether the GP communicates enough information.

The second aim of the international study was to assess which dimensions and aspects of health care most influence overall levels of satisfaction and to see if it was possible to identify certain criteria of assessment common to general practice in different health care settings. These criteria might be used by those who wish to develop sensitive instruments for evaluating and monitoring the quality of care in general practice. The analysis of the data from the four cities suggested that the key dimensions of overall satisfaction with practitioner care in primary health care are both the nature and quality of the doctor-patient relationship and the primary health care doctors’ skills. These were found to be key criteria in all four countries.

In other settings there are also specific aspects which patients emphasize. For example, for hospital inpatient services (8), rigid timetables, poor quality of meals and a lack of privacy are sources of complaints. In breast cancer screening services (11), concern with the pain and discomfort of the mammogram and delay in receiving results were the important sources of dissatisfaction.

In areas such as general practice and breast screening services, overall user satisfaction levels are high. In a recent study of general practice (5), 97% of respondents were satisfied specifically with their general practitioner and 86% thought their primary care rather than just their GP to be good or very good. Questions about specific aspects of primary care also showed generally high levels of satisfaction. For example, 85% of respondents were satisfied with the access they had to their GPs, although a lower level of satisfaction was found with their practices’ preventive care. In the case of breast screening (11), a recent study of attenders in three districts showed satisfaction averaged 4.5 on our 5-point scale and 95% of the combined sample said they would return when invited in 3 years’ time.

In other areas or settings in the United Kingdom, dissatisfaction is higher. As was mentioned earlier, hospital services occasion more dissatisfaction than general practitioner services. Concerns about hospital services focus mainly on the hospital waiting list for a non-emergency operation and the waiting time before getting an appointment with a hospital consultant. In the 1990 Social Attitude Survey (4), 83% and 82% of respondents, respectively, said that these areas were in need of a lot or some improvement. However, between 1983 and 1994 the proportion who were dissatisfied with in-patient treatment and care rose from 7% to 10%. This increase is reflected in the rising number of complaints being received by hospitals, and the major cause of dissatisfaction is poor communication.

In other areas, such as services for people with disabilities and the chronically ill, levels of satisfaction are lower. For example, in a study of patients’ evaluation of the Artificial Limb Service (9) based on a sample of above-knee amputees (n = 110), 64% of respondents expressed dissatisfaction with the service; the major causes of concern were in the areas of communication, comfort, and choice. Users were particularly dissatisfied with the fitting of the limbs and the lack of counseling and
support. This finding may indicate that this type of service is of low quality, although in this setting sufferers, because of their regular visits to health care about the same problem and having to live with the problem, become expert and well-informed themselves and are thus able to be more critical of professional practice. The continuity of contact may make the effectiveness or ineffectiveness of care more visible to the consumer.

Satisfaction varies not only with the type of service provided but also with the characteristics of the patient population being served. For example, among those who have had recent treatment, satisfaction levels tend to be higher than with those who have not recently used the specific service (5). Also, of the socio-demographic characteristics of the population, age is the most important influence, and satisfaction seems to increase with age (5). This finding may reflect real differences in the actual experience of health care, or it may reflect lower expectations of the older generation, or more realistic expectations in that they experienced the health service before NHS existed or do not expect too much of modern medicine and accept its limitations. Alternatively, the older generation may have a greater degree of deference and respect for the medical profession as a whole, although this may be "strategic" in that they use the professional medical care more often than their younger counterparts.

PERCEPTIONS OF MODERN MEDICINE

Evidence from patient satisfaction studies using structured, standardized questionnaires typically show that patients are rarely critical of medical practice. This is in many respects surprising, given that some studies have highlighted the constant possibility of strain and tension in the doctor-patient relationship because of the many ways in which such encounters can prove unsatisfactory (3). One possible source of strain is that medicine cannot successfully solve all the problems with which it is presented. Yet, where criticisms are found, they usually focus on the personal qualities of the doctor or on her or his performance in the consultation, such as the ability to listen to patients' stories, to reassure, or to clearly communicate information about the patients' conditions (5).

Evidence for this lack of patient criticism of medical practice and, to a greater extent, modern medicine, that emerges from surveys may either reflect a high level of public satisfaction or lack of concern about medicine and medical matters. Alternatively, it might simply be an artifact of the perspective and methodology adopted (i.e., patients' views about medicine and medical practice may not have been an issue that was seen to be relevant or appropriate for the particular investigation, or was not given priority in the investigation). The quantitative survey method may discourage the identification of critical comments through its use of structured questions that give little scope for articulation of ambivalence or critical thought. In contrast, studies have been carried out, two of which are described here, that have adopted qualitative methods to explore lay perceptions of medicine. Qualitative methods value collecting information about the meaning that informants put on events as well as the need to understand the context in which activities take place. Methods used include observation and focus groups, but the studies described here use in-depth informal interviews where emphasis is placed on informants' giving "spontaneous" explanations based on their own perceptions rather than imposing ideas on them through more directive, structured questions. The first study (2), carried out in 1982 in the United Kingdom, involved tape-recorded interviews with
women from working class and middle class backgrounds (10). All the women were married and had children, and the sample incorporated a broad age range (21–55 years). The evidence presented here focuses on informants’ discussion of the theme about faith in modern medicine as well as their evaluation of medical practitioners. This study raised a number of questions (not least whether the perceptions were gender-specific) that were explored in a later study (7) carried out in 1988 and 1989. Once again, qualitative tape-recorded interviews were carried out, but this time with men and women who were married or living as married. The households were divided into 10 couples from professional backgrounds and 10 from manual labor backgrounds. The male partners were between 40 and 60 years old. The interviews in the later study had a more specific focus and explored informants’ perceptions of a range of medical procedures, including antibiotics, heart transplants, test-tube babies, hip replacements, tranquilizers, vasectomy, hysterectomy, and hernia repair. Once again, participants were asked about their general faith in modern medicine. The aim of the selection was to attempt to span a broad spectrum of medical interventions ranging from those of a more common everyday nature, such as antibiotics, to those of a high-technology, life-saving nature, such as heart transplants, to those areas of more recent technological innovation, such as test-tube babies.

The dimensions and criteria that emerged from informants’ accounts from which to judge the value of modern scientific medicine and the range of technological procedures included in the investigation were (a) life-saving/threatening; (b) quality of life enhanced/diminished; (c) natural/unnatural; (d) moral/immoral; (e) necessary/unnecessary; (f) restoring independence/dependence; and (g) value for money. The following analysis illustrates how these different criteria emerged by considering the different types of procedures in turn. It shows how informants use a range of criteria to assess and evaluate these technological procedures.

**Life-Saving Technology: The Case of Heart Transplants**

Informants used a range of criteria to evaluate heart transplants that reflected both the benefits as well as the negative aspects. In relation to the benefits, it was the life-prolonging aspect that informants emphasized. Those who emphasized the positive tended to be men and working-class informants. First, a middle-class man:

Well, I think that if it can prolong someone’s life for a short time, then they are a good thing.

And a working-class woman noted:

Yes, very good, it gives someone another lease of life, lets them live a bit longer. Im all for that.

Informants who were more ambivalent or critical evaluated heart transplants in terms of three other criteria. The first was a feeling that heart transplantation was in some sense unnatural. This is illustrated in the following quotation:

Well, I don’t think you have a normal life afterwards. . . . You have got to take drugs and the fear of rejection, that is kept very, very quiet, I think, and I think it is still in the experimental stage at the moment.

The second theme was associated with the religious and moral dilemmas involved. For example, a working-class woman stated:

I can’t honestly say, probably if I needed one I’d be all for them. It’s a very peculiar feeling I get, but I don’t like the idea of them . . . I don’t mind kidney transplants but the heart . . . Perhaps, it’s sort of semi-religious. I really don’t know, it’s a bit sacrilegious.
While a working-class man remarked:

I’m a bit unsure of this. I had one of those donor cards that you carry around and I sat and looked at it and read it, and then I didn’t sign it. It’s a good thing, but there was a case on the radio today. Britain’s youngest heart transplant, well, it’s all right providing it’s going to be all right for her. But if it’s kept her going for something else to go wrong and mess her up for the rest of her life, would they have been better leaving her as she was?

The issue of age could also be included under this criterion. For example, a working-class woman stated:

Not wishing to sound cruel, but I think heart transplants on younger people are more valuable than on older people . . . I feel that a man of 65 or over who has had a good life, we accept that their time comes, but we don’t accept that with a child of nine.

Finally, the third theme to emerge from the accounts was that of economic cost and the management of finite resources within a health care field of competing needs and priorities. For example, one middle-class woman stated:

If I had a husband who needed one, I’m sure I would be very positive, and I know that this is a very selfish attitude for me to take, but overall I think too much money is spent in this area and not enough in routine care.

This issue of resource allocation relates to the previous theme concerning the moral and ethical dilemmas of organ transplantation surgery. Moreover, as these quotes suggest, there was an important difference in attitude between people’s general attitudes and orientation toward this procedure and their views if the circumstances involved a loved one.

Medicine and Drugs: An Antidrug Culture?
The informants in the earlier study (2), particularly the working class women, tended to focus their greatest criticism of medical technology on medicines and drugs, and there was some evidence of an antidrug culture, as the following informant suggested:

Well, the stuff we swallow? Well, a lot of it I don’t agree with, and I would rather do without, but there again, if the children are ill, I would rather go to the doctor and get something for them, but for myself I would rather suffer or take something that I know, like dispirits or whatever.

This study showed that the greatest criticisms focused on the use of drugs, whereas procedures such as heart transplants and kidney machines were believed by the majority to be making an important contribution. Hence, in the second study the issue of an antidrug culture was explored more fully by focusing on informants’ evaluation of two different types of prescribed drugs: antibiotics and tranquilizers.

Antibiotics. Informants from the first study expressed concern about the over-prescribing of antibiotics.

Some of it, okay, it’s fair enough, but I think a lot of it has gone on a bit too far. A bit too advanced. Penicillin, I think, is not given out correctly and is given out by some people as if it’s aspirin. Some doctors give it out like aspirin, and yet we found with the granddaughter, she suffers from a bad cold or cough and she needs something extra and she’s given cough linctus. You know, so, sometimes I wonder if it’s worth getting any medication at all or just going along and letting things take their course.

The informants in the second study generally expressed positive opinions with respect to antibiotics but, as in the previous study, there was a frequently expressed
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caveat that antibiotics were all right provided they were not abused or over-pre-
scribed, but due to the risk of immunity, their efficiency would decline. This issue
appeared to be raised more often by women than men and by more middle-class
informants than working-class informants. For example, this was a response from
a middle-class woman:

Well, I mean antibiotics have revolutionized treatment, haven't they?

Interviewer: In what way?
Well, because people just died by the score, didn't they, but antibiotics now enable people
to live longer.

The question of overuse or abuse was again well illustrated by a middle-class
woman:

If they are not abused and used in moderation, yes . . . we've got a great problem if they
are abused because that means we have got to go on and develop new types of antibiotics,
because the more frequent penicillins have been abused and bacteria have become immune
to them.

In general, antibiotics were seen to be beneficial when used in moderation and
they were judged in terms of their good and bad effects on illness and its control.

**Tranquilizers.** In contrast to antibiotics, there was evidence of strong anti-
tranquilizer culture among the lay population. None of the informants was wholly
positive in the evaluation of tranquilizers. The negative or ambivalent feelings
expressed about tranquilizers illustrated that they were evaluated in terms of their
propensity to induce addiction or dependency, and that they were unnecessary and
were prescribed too frequently. First, the concern that they were or could be
addictive was well illustrated by the following working-class informant:

No, I don't believe in tranquilizers, not really. Well, they can get a hold on you and trying
to get off them is very, very hard, if you can do without I would say, yes, do without.

The second reason was that they were given too frequently, as a working-class
woman stated:

They are addictive. I don't care what you say, and if it keeps the patient quiet, then I think
the doctors issue them willy-nilly. I mean, when I was having problems with Andrew, Doctor
W said to me, 'You know, I can put you on tranquilizers.' But I said, 'Oh no, I could not
have that, well, they don't make the problems go away.' They just dull them, don't they?

This last quotation also illustrates the third explanation, in that tranquilizers
made the problems more tolerable but did not usually deal with the root cause.

These strong negative attitudes tended to be expressed more frequently by the
working-class informants, although the ambivalent attitudes of the middle class also
included these negative aspects. However, middle-class respondents also tended to
stress that they did have a place or function in certain specific cases, such as for
short-term treatment, if used prudently and monitored closely. For example, a
middle-class woman said about tranquilizers:

Only in extreme cases. I doubt they solve the problem that is causing the need for them.
You have got to get to the bottom of the problem. I don't think they are a good idea, only
in extreme cases. Maybe you have a bereavement and something drastic has happened to
you and you need a little help for a little while, well maybe it's OK but not the way they
are doled out year after year.
Elective Surgery

Hip replacements and hernia operations were the elective surgical procedures explored, and similar criteria were used to evaluate both.

**Hip Replacements.** This particular form of medical technology was one of the most highly regarded and praised for its intervention, possibly because its benefits were readily apparent in terms of reducing pain and suffering, increasing mobility, and improving the quality of life of these recipients. This perception was evident in most informants’ accounts, irrespective of their class or gender. For example, this is well illustrated in the comments of a working-class man:

Yes, great . . . well, my mother-in-law, she’s had two done and seeing the pain and agony she was in before, I think they are doing absolute wonders for the patients who need them. Yes, I think it’s wonderful.

Similarly, a middle-class man remarked:

I think they are a very important operation. A lot of patients have had a revived lease of life from the operation.

Indeed, the only note of dissent came from a middle-class man:

I have not known personally anybody who has had a completely successful hip operation. They really don’t seem to be that comfortable afterwards.

**Hernia Operations.** As with hip operations, it seemed that the benefits of hernia operations were readily apparent: mitigating pain and suffering and improving the person’s quality of life. For example, a working-class man dramatically remarked:

Well, I look on that the same way as I do hip operations: without them I think we would be lost. Yes, I think the medical people and people who pioneered such operations, they have done a lot of good to mankind.

While a middle-class woman remarked:

Oh yes, I think hernia operations for those who have the problem are very good, and I wouldn’t have thought they were tremendously expensive operations. I think it is a great shame that very many people have to wait months on some occasions to have one done.

Reproductive Technology

Hysterectomy, vasectomy, and test-tube babies were the reproductive technological procedures explored, and each procedure was generally perceived in a different way, although similar lay criteria for assessment were in evidence.

**Hysterectomy.** The benefits of hysterectomy were well accepted, particularly in terms of improvement in the quality of life. For example, a working-class woman said:

That’s the womb being taken out isn’t it? If it’s diseased, yes, I believe in having it taken away.

And a middle-class woman stated:

I would say, ‘yes,’ because I’ve got so many friends who have had them and are living such a much better quality of life, so I would say ‘yes.’

There were, however, a small number of middle-class women who expressed certain qualifications, particularly in terms of whether it was really necessary:

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If it’s really necessary. A lot of it is only done, you know, people have hysterectomies who 
really can’t be bothered with the change. You know, you hear these stories, and in certain 
cases, such as with cancer, you’ve got no choice.

**Vasectomy.** The question of whether a particular medical procedure was really 
necessary also emerged in the context of informants’ discussions about vasectomy. 
This was expressed by a group who represented about half of the informants, who 
might be described as ambivalent about this procedure. For example, a middle-
class man stated:

They are sort of unnecessary really, unless it’s essential. I don’t know of any essential 
indicators for a vasectomy.

While a working-class man remarked:

Well, I suppose they serve a purpose. I mean, I’m not against birth control and things like 
that as such, but, I mean, there are other forms of birth control without vasectomy. I think 
it’s a bit over-drastic.

In contrast, the other group of informants all emphasized the positive aspects 
of this procedure with comments such as the following:

Well, I think it’s probably a good thing, I suppose.
Well, I suppose it solves any unwanted babies or that sort of thing.

**Test-tube babies.** A number of interesting themes emerged in informants’ 
evaluation of test-tube babies. One of these concerned the benefits for couples who 
could not have children. For example, a working-class woman stated:

Well, I think there are a lot of couples in the world who would like to have children but 
can’t, so, yes, it’s a help, isn’t it?

And a middle-class woman shared a similar view:

Yes, I think if a couple really long for a child, and this is the only way they can do it, yes.

Other themes emerged among a second group of people who were more ambiva-
lent about this form of technology. For example, there was the suggestion that it 
was in some sense unnatural and that it was a bad thing that could be taken too 
far. For example, a working-class man stated:

I don’t altogether believe in that, I don’t like it at all. I think it should be a natural function 
between two parties, not done artificially in a test tube.

While a middle-class woman remarked:

There again, it’s all right for me, I’ve got five. If I had got no children, then maybe. I would 
go to any lengths to get a child, and that would be quite acceptable. I think in moderation, 
but again, it can be taken too far. Genetics is a dodgy business.

As before, it was clear that there was a division between general attitudes 
concerning the issue of test-tube babies and people’s opinions if their circumstances 
were different and they were childless. Again, the issue of the cost of such technology 
was also stressed, compared with other competing needs and priorities.

**CONCLUSION**

The evidence presented in the previous sections illustrates first that users have their 
own criteria for assessing health care. These criteria vary among medical settings,
but studies have consistently shown, irrespective of setting, that users put an important value on the quality of their relationship with health professionals. Second, it is also clearly evident that the methods of eliciting information about users' views shape the type of response and information collected. For example, in relation to lay perceptions of modern medicine, clearly qualitative methods identified the ambivalence about medicine and medical technology that did not emerge from survey research. It is important, therefore, that research into users' views adopt a range of methods and not restrict itself to the patient satisfaction survey. What of the relationship between quantitative methodology and qualitative methodology? Most commonly, they can complement each other, with qualitative methods, such as informal interviews or focus groups being used initially for exploratory work for generating hypotheses that can be tested out in a full-scale design using quantitative methods, such as surveys or studies with experimental or longitudinal designs. Alternatively, qualitative methods can follow quantitative methods to try to explain the statistical relationships found in larger-scale surveys. However, in some circumstances, qualitative methods can best be used as a substitute for quantitative methods, where statistical relationships may create a misleading picture.

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