THROUGH THE PATIENT'S EYES: STRATEGIC INSIGHT DERIVED FROM PATIENT NARRATIVES

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Introduction

Conceptualising and measuring patient satisfaction and service quality in a health care setting is an important task but simultaneously highly complex (Taner & Antony 2006). While traditional medical professionalism rejects corporatisation as unethical, increasingly health care and medical service organisations are realising the benefits a strong market orientation. At the same time, consumers are increasingly sophisticated and informed with regards their health care needs, options and preferences. Consequently, health care service providers have turned to business and marketing models for guidance. However, within marketing literature, there is much debate regarding the conceptualisation and operationalisation of service quality and customer satisfaction (see for example, Bitner & Hubbert 1994; Caurana, Money & Berthon 2000; Choi et al. 2004; Dabholkar, Shepherd & Thorpe 2000; Danaher & Mattsson 1994; Oliver 1993; Parasuraman, Zeithaml & Berry 1994; Taylor 1994; Taylor & Cronin 1994). The general consensus is that the concepts of service quality and satisfaction are closely related yet distinct constructs. Typically, models of consumer evaluations of service focus on a comparison of expectations and perceived performance where confirmation or disconfirmation of expectations indicates service quality and/or satisfaction. This common conceptual base of satisfaction and service quality compounds the difficulty in distinguishing the two concepts.

The general distinction between service quality and satisfaction has been proposed in terms of construct conceptualisation and their relationship to each other. Researchers conceptualising satisfaction at the transactional level and service quality as a global attitude formed over time, propose a causal link from satisfaction to service quality (Bolton & Drew 1991; Boulding, Kalra, Staelin & Zeithaml 1993; Cronin & Taylor 1992; Parasuraman et al. 1985, 1988, 1994). Meanwhile, other researchers suggest consumers assess service quality at a transactional level and that satisfaction may be useful if globally conceptualised (Bitner & Hubbert 1994; Danaher & Mattsson 1994). Yet another group of

researchers consider service quality as an antecedent of satisfaction, proposing a link from service quality to satisfaction (Cronin & Taylor 1992; Oliver 1993; Spreng & Mackoy 1996). However, regardless of the demonstrated differentiation, at times the terms are used interchangeably (for example, Kleinsorge & Koenig 1991) and even treated empirically synonymous (see for example, Zeithaml, Berry & Parasuraman 1993). Nevertheless, within particular application contexts, such as health care, satisfaction has gained widespread recognition as an appropriate measure of quality (Taylor 1994; Williams 1994).

Patient satisfaction and quality service

The focus on patient satisfaction in health care starts with the quest to enhance quality of service. In shifting to a patient-centred approach, the impetus had arrived to further investigate the experience and perceptions of patients and the community. As Vuori (1991) highlights, patients *feel* the service quality 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 somewhat technically inaccurate, there has been an increased emphasis on evaluating the patients' subjective views by measuring satisfaction (for extensive reviews, see Aharony & Strasser 1993; Gill & White 2009; Hall & Dornan 1988; Lewis 1994; Taylor 1994; Wensing, Grol & Smits 1994; Williams & Calnan 1991). However, as highlighted by Lengnick-Hall (1995), conceptualisations of service quality and customer satisfaction are for several reasons inadequate in accommodating the complexities involved between health care providers and patients.

Firstly, there are a number of factors that potentially limit the validity of satisfaction as an indicator of quality (Vuori 1991). From the functionalist perspective, patients lack the expert knowledge to accurately assess the technical competence of medical personnel. Even today, research is yet to identify how health care consumers make service quality assessments (Calnan 1988; Carr-Hill 1992; Williams 1994; Schembri & Sandberg 2002, 2011). The patient's physical or emotional state may further

hinder accurate judgment (Aharony & Strasser 1993). Patients are also influenced by proxies such as the interpersonal skills of front-line personnel (Bitner 1990) and that raises the issue of a good bedside manner masking questionable technical quality, for example. Secondly, there is also the reluctance on the part of the patient to critique medical professionals given their status and authority (Roter & Hall 1992). The broad application of patient satisfaction measurement within health care services reports a generally satisfied community of patients (Vuori 1991; Williams & Calnan 1991) with specific studies reporting up to 96.5% patient satisfaction (see for example, Dougall, Russell, Rubin & Ling 2000). The lack of variation in this measurement is just one aspect that has led professionals to question the validity of such a measurement. More than that, several health care researchers present evidence to suggest that the objective measurement of patient satisfaction is an imperfect means for measuring highly subjective phenomena associated with quality assessment (Aharony & Strasser 1993; Dougall et al. 2000). Finally, given the emphasis on professional autonomy within medicine, the measurement of patient satisfaction is considered contrary to the traditional model of professionalism. In line with the recognised resistance to medical consumerism, satisfied patients are not considered necessary in providing a quality service. Mulhall, Ahmed and Masterson (2002) along with others (see for example, Nair 1998), argue that patients are not customers and therefore business, marketing and particularly services marketing theory are not applicable to the medical context. They argue that given the complexities involved with doctors applying their expertise in an abstract manner to particular cases, health care and medicine is something far beyond the marketing concept or satisfying the consumers.

Patient satisfaction

Placing patients at the center of care is a relatively recently introduced method of quality improvement and is known as patient-centered care (Institute of Medicine 2001). Patient-centered care assumes patient autonomy and control over disease and care processes leads to better care and better outcomes (Grol 2001). Different methods can be used within the realm of patient-centered care to

encourage patient participation and increased patient autonomy including, patient satisfaction surveys. Assessment of patient satisfaction and knowledge of influencing factors will in effect enable improved quality of care. Satisfied patients may be more willing to adhere to doctor's orders and therefore better manage their health condition for example. As the American College of Healthcare Executives (2006) highlights, if patients are highly satisfied with care in the broadest sense, then the most manageable part of the hospital's mission is accomplished. In Australia and New Zealand, measurement of patient satisfaction is an integral component of the accreditation process and specialist organisations have emerged dedicated to the task. Press Ganey (http://www.pressganey.com.au/) for example suggests accurate measurement of patient satisfaction can not only deliver improved patient outcomes and improved staff morale but also enhanced organisational reputation and bottom line economics.

Measurement of patient satisfaction is commonly based on the disconfirmation paradigm, where satisfaction is defined as the gap between expectations and perceptions (Sitzia & Wood 1997). As an attitudinal construct, patient satisfaction is discussed by Woodside, Frey and Daly (1989) as a post-purchase phenomenon that is not related to any one single interaction or episode but rather results from a series of activities and interactions. However, health care practitioners and medical professionals are increasingly recognising the need to accommodate patient views and are consequently becoming more open to a management and marketing approach (for example, Kenagy, Berwick & Shore 1999; Mayer & Cates 1999), as is evidenced by the shift towards a patient-centred approach. While customer satisfaction is a fundamental principle of marketing as is the prioritisation of consumer views, its place in professional services such as health care is yet to be established (Laing & McKee 2001; Stratemeyer & Hampton 2001). Applied to the health care context however, Gill and White (2009) argue that patient satisfaction as an indicator of quality is seriously flawed. More than that, Gill and White (2009) advocate perceived service quality as a superior approach to quality management within health care services.

Service Quality theory

There are several service quality models that have been widely applied as per the review presented by Seth, Deshmukh and Vrat (2005). During the 1980's, it became evident that service quality was poorly defined, sparking an avalanche of research (Brown & Swartz 1989; Grönroos 1984; Klaus 1985; Lewis & Booms 1983; Parasuraman et al. 1988, 1985; Takeuchi & Quelch 1983). This dedication to service quality research continued into the 1990's from which three dominant models of service quality emerged: Grönroos' (1984) perceived service quality approach; Parasuraman et al.'s (1988, 1985) gap analysis approach; and Boulding et al.'s (1993) dynamic process model of service quality. The general consensus within this literature is that service quality is a superordinate, multidimensional attitudinal construct; with each dimension comprising a number of attributes or service aspects.

In seeking to understand consumer evaluation of service quality, contemporary service quality researchers focus on delineating dimensions of service quality, identifying the attributes that comprise those dimensions and the appropriate point of reference for service quality measurement. As a prominent example, the perceived service quality approach (Grönroos 1984) is a theory based on the notion that understanding service quality must begin with defining what consumers are looking for and evaluating. Grönroos (1984) argues that service quality assessment involves two dimensions: functional quality and technical quality. For Grönroos, functional quality encompasses the process of service delivery, while the technical quality entails the outcome of the service received with functional quality considered to impact technical quality because it is the process by which the outcome is determined. However, while some support this approach (see for example, Brown & Swartz 1989), others challenge this approach (see for example, Carman 2000). Like Grönroos' (1984) perceived service quality model, Parasuraman et al. (1985, 1988) developed the SERVQUAL model based on the disconfirmation paradigm. Unlike the perceived service quality model however, Parasuraman et al. (1985, 1988) conceptualise the SERVQUAL model as five dimensions: reliability, assurance, tangibles, empathy and responsiveness. As a widely accepted and applied instrument, Ladhari (2009) presents a review of 20

years of SERVQUAL research comprising of a meta-analysis of 30 SERVQUAL applications. This comprehensive review of SERVQUAL highlights some theoretical and empirical concerns but concludes overall that SERVQUAL is a useful instrument for service quality measurement. The question however, is how useful is SERVQUAL in a context as complex as health care. Following a review of service quality literature as applied in medicine and specifically plastic surgery, Fiala (2012) advocate a dissection of medical service quality into technical quality and functional quality measurements as per Grönroos' (1984). More broadly, this dissection is also advocated by other service quality researchers (see for example, Asubonteng et al. 1996; Babacus & Mangold 1992; Parasuraman et al. 1985, 1991). Although there is much diversity in what and how technical and function quality are defined, generally technical quality is considered as the actual medical procedure/outcome and/or the hospital facilities, whereas functional quality is considered as the process by which a health care service is delivered. However, as Fiala (2012) highlights, the medical profession has typically focused on technical aspects of medical service provision whereas consumers typically focus on functional aspects as a proxy in evaluating the quality of the medical service received. In other words functional quality assessment will be used by consumers to judge the service overall and in contrast the medicos typically rate their performance purely on technical quality. In terms of SERVQUAL dimensions, one of critiques of SERVQUAL is that there is an over-emphasis on process (Ladhari 2009) or functional quality with four of the five noted dimensions relating to functional quality and just one dimension, tangibles, relating to technical quality (Schembri & Sandberg 2002, 2011). The problem with using an adaptation on SERVQUAL in health care therefore is that the medicos providing the service are aiming to deliver technical quality whereas consumers are inept at judging technical quality and therefore evaluate functional quality as a proxy and then the health care service providers measuring service quality via SERVQUAL are measuring four dimensions of functional quality and only one dimension on technical quality. This point alone indicates an issue with the application of SERVQUAL in the context of health care and yet the practice continues.

SERVQUAL measures perceived quality not objective quality (Rashid & Jusoff 2009). A step further towards a patient-centred approach is to look at the evaluation of health care services through the eyes of the patient.

Patient experience

Patient experience of health care services is becoming increasingly central to assessing the performance of health care systems. The medical profession is now commonly judging quality of care by not only by measuring clinical quality and safety but also by gathering the views of patients. This information is valuable in terms of monitoring the performance of health care organisations, for informing patient choice and informing policy development, However, investigating patient experience is beyond the quantitative measurement of patient satisfaction and/or health care service quality. As Tsianakas et al. (2012) highlight, an in-depth qualitative investigation of patient experience can provide a detailed understanding of the meaning(s) individuals attach in the evaluation of health care service quality. Similarly Goodrich and Cornwell (2008) suggest that the 'what' (or transactional, technical) aspects along with the 'how' (or relational, functional) aspects of the health care service each hold meaning for the patient. A more comprehensively argument towards emphasising the patient experience is provided by Schembri and Sandberg (2011). By considering the patient experience of service quality as the initial point of reference, Schembri and Sandberg (2011) demonstrate that the experiential meaning of health care service quality varies according to what and how the patient understands the constitution of quality. The usefulness of patient stories therefore lies in the ability to vividly communicate the layered depth and complexity of a health care service experience. However, while patient narratives may be an effective means of investigating the experiential meaning of health care service quality, the collection of patient narratives can be a time-consuming endeavour. In seeking to overcome this shortcoming in the collection of patient stories, the methodology as outlined below entails accessing publicly available information.

Method

This research project employed narrative analysis as per Riessman (1993) and Riessman, Huberman and Miles (2002) to a collection of more than 300 unsolicited patient stories of their health care service experiences. The collection of patient stories were drawn from publicly available information published by PatientOpinion.org.au. Founded in the UK in 2005, Patient Opinion is driven by the mission of offering a feedback service between health care service organisations and the community. Organisations subscribe (usually) for a fee and this subscription enables Patient Opinion to provide real time feedback. The feedback provided is generated in an unsolicited manner by patients and their significant others, who voluntarily write stories related to their health care experiences. Patient Opinion then takes the feedback received back to the relevant organisation with the intention of improving the health care system at a fundamental level. In this way, Patient Opinion acts a neutral and effective feedback hub between patients and health care providers. As a localised version of Patient Opinion, Patient Opinion Australia (PatientOpinion.org.au) was established in 2012 and like the UK parent organisation, is structured as an independent not-for-profit organisation focused on the goal of improving health care services. The process works by patients and carers posting stories on the Patient Opinion website. Relevant health service personnel receive notice of a posted story related to their services, to which they choose to respond to online and/or make the required adjustments to their service as considered appropriate. The patient is alerted to that response and any organisational system change made as a result of their story. Anyone visiting the website is able to read all feedback. Effectively, in being part of Patient Opinion feedback system, organisations are generating publicly available evidence on how they are using patient feedback to improve services. Patient Opinion has received more than 300 patient stories which have had over 120,000 viewings.

As a narrative analysis, this research project has taken the initial 300 posted stories from the PatientOpinion.org.au site and analysed the text in terms of health care service evaluation through the patient's eyes. In the first instance, the stories were dissected in terms of negative or positive

comments. Identifying 165 positive stories and 132 negative stories, three themes emerged from the positive stories and three themes emerged from the negative stories. The positive themes entailed attentive and considerate service stories (61), effective treatment stories (66) and timely service stories (37). The negative themes entailed ongoing problem stories (43), service failure stories (88) and slow and unresponsive service stories (22). Notably, some stories comprised both positive and negative aspects and hence some stories are included in both positive and negative themes. More complexly, some positive stories included aspects of attentive and considerate service as well as effective treatment and/or timely service stories. Similarly, some negative stories included aspects of ongoing problems as well as service failures and/or slow and unresponsive service stories. The following preliminary analysis demonstrates this evident gestaltism within consumer evaluation of health care services.

Findings

The findings of this narrative analysis are presented as six identified themes; three positive and three negative themes. Illustrative quotes from these various themes are included to demonstrate the essence of the theme. Prior to presenting illustrative quotes from each of these six themes, stories are presented that show both positive and negative aspects within a single story; where the foreground is essentially positive and the background negative and vice versa, where the foreground is essentially negative and the background positive. This gestalt of positive and negative begins to show the complexities involved in the consumer's experience and evaluation of health care services. In effect, the stories presented in Table 1 show both positive and negative parts of the functional whole, as per Koffka's (1935) theory of gestalt. More specifically, Patient Story #1 about a dental patient and his *"fear and horror of dental appointments"* as described by his wife, shows how the negative experience(s) fade into the background and the positive story forms the foreground whereas Patient Story #2 is the opposite; the positive story forms the background and the negative story forms the foreground. To

further analyse the patient's perspective, both positive and negative stories are dissected into variant themes. Beginning with the positive themes of considerate, effective and timely patient stories, the negative themes of on-going problems, service failure and untimely service issues follow with illustrative quote presented in Table 1.

Positive stories

Positive patient stories ranged from stories about attentive and considerate service stories (61) to effective treatment stories (67) and timely service stories (37). While many stories were only a few lines, others were quite detailed and lengthy extending over several pages. Illustrative quotes for each of these three themes are presented in Table 1 as Patient Stories #3-8. Positive stories about attentive and considerate services included many instances of quality health care and excellent patient outcomes. Patient Story #3 is reflective of these myriad stories about attentive and considerate service. The patient describes being treated *"…with the utmost courtesy and respect"* during transition from a Royal Flying Doctors (RFD) service into a private hospital. This positive experience is reinforced at several levels of the health care service experience; from the RFD service to a private hospital surgery, intensive care unit and rehabilitation. Similarly, Patient Story #4 illustrates the gratitude a surrounding family holds for the care of their elderly mother. Beyond attentive and considerate service, positive patient stories also included descriptions of effective treatment as per Patient Story #5 of effective care in an emergency department and an excellent patient outcome and Patient Story #6 heaps praise for hospital staff. While the health system in Australia is regularly on the receiving end of negative publicity laced with difficult and confounding even horrendous patient stories, each of these stories provide experiential evidence of a health system that works at least to some extent. More than stories about attentive and considerate service as well as effective treatment, some positive patient stories included combinations of these service aspects, such as the Patient Story #7 from Western Australia where the patient describes both the attentive and considerate service provided by his GP as well as the excellent short term and long

term treatment of a chronic condition. *"What a gem"* the patient declares! As well as attentive and considerate service along with effective treatment stories, positive patient stories further included time oriented stories. Patient Story #8 for example, contrasts a poor service experience with a highly responsive service experience in an emergency room. The patient describes the experience as prompt, appropriate and effective and impressively occurring within two hours to boot. More than that, the positive experience was repeated with a later unrelated visit. Such timely service experience is repeatedly reported within this set of stories and patients express gratitude of the prompt and punctual service they receive.

Negative stories

Negative patient stories ranged from stories about service failure (43) to ongoing problems (88) and time issues (22). Illustrative quotes for each of these three themes are presented in Table 1 as Patient Stories #9-13. Negative stories about service failure included many instances where the system fails the patient and some more consequential than others. Patient Story #9 for example depicts the situation where the current system requires a patient to have to wait and pay to see a doctor for a life-long prescription renewal. The patient questions why the service is designed in this way and indeed poses an alternative design where the prescription renewal is reviewed and made available for a small fee. More cost efficient for the patient and the government and more time effective for the doctor. However, to make this small change in service design will entail a paradigmatic shift in the way doctors approach the task of health care. Patient Story #10 depicts a more abrupt service failure where the specialist is described as *"arrogant and dismissive."* Again, the patient questions the system and the possibility that continually negative feedback may be indicative of action needed, yet the current system does not hold this potential. More seriously, Patient Story #11 tells the story of a woman with a broken elbow that is misdiagnosed as a dislocation and sent home in plaster. As she tells it, *"12 months later, numerous OT sessions, and major out of pocket expenses, I still can't fully straighten my elbow and*

according to the Orthopedic Surgeon most likely never will." Effectively, service failures in health care compound the issues that remain unaddressed or misdiagnosed and yet, the patient is left to cope regardless. Patient #12 is the story of a mother with a chronic fatigued daughter who is shoved around unnecessarily in a system that fails the patient. What saves the daughter in this case is the mother persistence and information search. Involved and informed consumers are necessarily taking charge within a failing system. But unfortunately some do not find their way through the cumbersome experience as in the case of Patient Story #13. This patient has no answers after years of suffering and the problems are on-going; death is supposed as the way out! Similarly, Patient Story #14 is a story told by the husband who took his wife to emergency after she hit her head and was convulsing. On arrival at Mater Emergency, they waited 1.5hours for an examination, then another seven hours for a scan and three hours more before release. In this way, time also compounds quality of service issues in the context of health care.

Discussion

Analysis of patient stories has enabled a perspective of health care through the patient's eyes. What is evident from this analysis is that patient stories of their health care experiences can be both good and/or not so good; positive and/or negative in either or both foreground and background. This evidence of positive/background negative/foreground stories is found in Patient Story #1, which depicts someone with a condition that is managed quite fine locally but upon visiting a different facility experiences an extreme service failure. Considering health care from the perspective of that patient experience, the first two stories presented in Table 1 provide evidence of the complexity of issues as seen through the consumer's eyes. The complexity demonstrated is that positive stories sometimes have negative backgrounds and negative stories sometimes have positive backgrounds.

The quest to enhance quality of health care service must therefore aim to capture and manage this identified complexity. As discussed by Vuori (1991) patients *feel* the service quality they receive but

may not have the competence to assess the technical quality of medical care. Evidence to suggest the patient does indeed feel the service is found in Positive Patient Story #3 and 4 about attentive and considerate care as well as in Negative Patient Story #9 and 10. Yet, patients are expressively clear when effective treatment is received or not, as per Positive Patient Story #5 and 6 as well as Negative Patient Story #11, 12 and 13. These stories give clear evidence that technical competence has or has not been part of the patient experience. This narrative evidence therefore supports Vuori's (1991) suggestion that patients feel the service but does not support the suggested patient ineptitude in evaluating technical competence. This finding as summarised by the illustrative quotes presented in Table 1further indicates that patients are less focused on satisfaction and more concerned about satisfactory service standards. Experience of a system in crisis has many compounding factors as evident in Patient Story #13 and her forgiving sentiment that the people working in the system are stretched beyond what resources are available. Unmistakably however, service failures in health care can escalate to matters of life and death. More specifically and highly evident in these findings is that patients are not only assessing the functional quality of the service they experience but also the technical quality of the service they experience. By looking at the evaluation of health care services from the fundamental perspective through the patient's eyes, this work has shown that both functional and technical aspects of health care each hold meaning for the patient. This finding is in line with the both Goodrich and Cornwell's (2008) research as well as Schembri and Sandberg's (2011) research, which demonstrates that the experiential meaning of health care service quality varies in terms of what and how consumers understanding the question of (health care) quality.

Conclusion

This research project begins with an overview of various patient-centred approaches to the evaluation of health care services. A basic critique of patient satisfaction and (health care) service quality literature is presented along with literature related to patient experience. In seeking to identify

and describe health care through the patient's eyes, the question of what and how patients evaluate health care services is addressed through a narrative analysis of a collection of 300 patient stories. The findings show evidence of patients evaluating health care services in terms of both functional quality and technical quality. Essentially, this research shows the usefulness of patient stories lies in the ability to vividly communicate the layered depth and complexity of a patient's health care service experience.

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Table 1: Patient stories

Patient story #	Evident theme	Illustrative quote
#1	Negative background; positive foreground	**"My husband the nervous dental patient (N.S.W)."** After having gone through literally years of fear and horror regarding dental appointments (even just a basic clean had him in tears) we finally found a dentist who really seemed to care and listen when my husband explained just how frightened he was. The dentist my husband now sees appears gentle and supportive and most of all she talks him through each and every step. After only one visit he seemed to be cured of his phobia (that was a few years ago but he continues, to this day, to be a loyal patient).
#2	Positive background; negative foreground	**"Severe Migraine & Vomiting, Royal Hobart Hospital ER"** Whilst holidaying in Hobart I was struck down with a severe migraine and uncontrollable vomiting. These attacks occur once every few months and at home I am able to attend the local 24 hour medical centre where I'm treated with Maxalon and Tramidol injections which provide almost immediate relief and I'm normally able to return home within an hour of the treatment and sleep it off. But in Hobart, I had to go to the ER at RHH around 3am and was admitted immediately as I was vomiting uncontrollably in the reception area....The nurses I saw were very caring and responsive. I was seen quite quickly and I explained my predicament and also let the doctor know it's something I've experienced many times and that Maxalon/Tramidol treatment was always very successful for me. He basically ignored this and told the nurse to give me intravenous Largactil and Maxalon. The Maxalon settled my nausea and the Largactil knocked me out but only appeared to have had a minor effect on the migraine headache. After a few hours I started to have a very strange reaction where I couldn't control my arms and legs and couldn't stop their repetitive involuntary flexing and unflexing. I told the nurse who must have gone to talk the doctor. Eventually I was taken off the IV and the problem subsided. After being there for approx. 8 hours, in out of consciousness, I seemed to be judged OK to leave. It took me another 24 hours before I felt normal again. I like to think I'm an articulate person with a better than average grasp of my condition, but I wish I knew the secret to get the doctor to listen!
#3	Positive – attentive and considerate service	**"Spinal surgery at St Andrew's War Memorial Hospital, QLD"** I was flown by RFD from Bundaberg to St Andrews. From the minute I arrived I felt I was treated with the utmost courtesy and respect. I underwent two major surgeries and spent seven weeks at St Andrews which included time in ICU and Rehabilitation. All the health care professionals I had contact with were extremely professional,

		supportive and showed great empathy. I thought the surgical team lead by Dr Steven Yang were amazing, caring, kind and not the least bit patronising. The accommodation, facilities, catering and housekeeping that I saw were all of a very high standard. In my opinion it is indeed a very special place where patients are treated as individuals and very well cared for.
#4	Positive – attentive and considerate service	**"The staff have been truly wonderful at Wynnum Hospital"** My 90 year old mother has been in Wynnum Hospital for almost 2 weeks. I have been absolutely amazed by the care and kindness she has received there. She has been a very tough case with really trying behaviour, but the staff that I saw (of all levels) have been truly wonderful. Every night when we visit we feel as if we are greeted by members of family, not medical staff. We are so lucky that Mum has ended up at Wynnum. A big thank you from us.
#5	Positive – effective treatment	**"Ipswich Hospital (Emergency Department) Care"** I attended Ipswich ED for ongoing treatment after seeing the GP. From the minute I entered the department the experience was nothing short of positive. The staff were professional and thorough and the new layout (even if some only interim) streamlined the flow from a patient experience compared to previous ED encounters I have had. The staff accompanied me through to the Sub Acute Care area after only a short wait time in the temporary wait area and the care and attention I received in the SAC is to be commended. Of particular note, was the ED Dr - Thomas who was the treating Dr, I would like to thank him for his attention to detail and rapid diagnosis and effective treatment.
#6	Positive – effective treatment	**"Praise for RBWH staff: Hand vs broken wine glass"** I have nothing but praise for the staff I saw at the Royal Brisbane and Women's Hospital. A few months ago I was on the losing end of an encounter with a broken wine glass. I was seen promptly and given 10 stitches by an ED resident. The scar is barely noticeable and I cannot thank the staff I saw enough for looking after me. I believe we are very lucky to have the public health care system that we do!
#7	Positive – considerate and attentive service; effective treatment	**"Great GP at the Kaamunda Surgery WA"** I got an appointment with a GP I didn't know at the practice I was going to on the day I was to fly overseas. He was quite good and I saw him again. He seems to listen as though I am the only patient for the day, shows genuine concern about my symptoms and has provided excellent short and long-term care for a chronic disease I have. What a gem!.
#8	Positive – Time	**"Good ER experience at Royal Adelaide Hospital"**

		After a poor ER experience at another Adelaide hospital we went to Royal Adelaide Hospital. The attention we received at the RAH was a contrast to our previous experience at the other hospital. The RAH staff that we saw were professional, triaged my partner appropriately, and dressed the wound with a sterile dressing. He saw the doctor within 20 minutes and received 13 stitches in his forehead and a tetanus injection. We were seen, treated and went home from the hospital within 2 hours. We were both impressed with the level of professionalism, care and actions of staff who came into contact with us. Later that week my son was admitted with an acute asthma attack and again the staff that we saw at the RAH showed their professional and caring approach, we all had every confidence in the RAH ER department. Well done to RAH ER.
#9	Negative – service failure	**"seeing my doctor for repeat prescriptions"** I am on cholesterol tablets and my doctor says I have to stay on them permanently, I find it most annoying that I have to wait to see my doctor, sometimes up to 4 days to get a prescription renewed. I think it would be much better for me and the government if the doctor could write out a script and leave it at the desk for a small fee instead of a visit which costs me nothing but Medicare a doctors fee.
#10	Negative – service failure	**"Arrogant and dismissive Orthopedic specialist"** I had a small fracture and I was referred to a specialist. No introduction, no pleasantries. I had to ask him to show me where the fracture was on the x-ray which he seemed to do with poor grace! There was no discussion about any relief or simple remedies. I was told surgery was one option. I had to ask what surgery entailed and was told screws, plate, and a piece of bone out of my hip. I replied I had only recently had an operation and really didn't fancy jeopardising that very successful procedure with possible infection complications etc. end of consult. I was in and out in less than 5 minutes with a very large gap after Medicare and feeling very let down and annoyed. When I related my experience to the GP clinic that referred me they said they had stopped referring patients to this doctor because of the negative feed-back they were getting. I don't think that is good enough!
#11	Negative – service failure	**"Broken elbow treated at Redcliffe Hospital"** I attended Redcliffe Hospital after falling off a bicycle. When I arrived the nurses I saw seemed to see I was in a lot of pain and sent me straight through for an x-ray to see what damage had been done. The radiologist was very abrupt, rude and unsympathetic and told me to straighten my elbow so that he could take pictures properly. As I was in a lot of pain I tried my best but was unable to straighten my elbow as it was obviously out of shape. He seemed to get very frustrated with me and …not surprisingly the x-rays did not reveal any breaks but showed dislocation. My arm was placed in a plaster on a 90-degree angle and I was sent home. Four weeks later the plaster was taken off and I was

		unable to bend my arm. It remained at the 90-degree angle no matter how much I tried to straighten it. I returned to Redcliffe Hospital and was told to just straighten it and that it was psychological; if I wanted me straighten my arm I could. I was absolutely shattered to be dismissed like that. After consulting an Orthopedic Surgeon, I was told that I would need extensive OT to straighten my arm as it was misdiagnosed and should never have been put in plaster. I, did in fact, have a broken elbow and should have had surgery to fix it. As some months had passed since my initial visit to the hospital there is now no chance of proper healing and it isn't a viable option to now go into surgery. **12 months later, numerous OT sessions, and major out of pocket expenses, I still can't fully straighten my elbow and according to the Orthopedic Surgeon most likely never will.** This could all have been avoided if a certain radiologist showed some empathy and understanding and listened to a woman who was trying to tell him that she could not straighten her arm and was in a lot of pain instead of treating her with disdain and contempt.
#12	Negative – ongoing problems	**"In office helicobactor pylori testing (Spring Hill)"** My daughter who has chronic fatigue was given an in-office test for HPylori. It showed a positive and she was prescribed a med, a three-fold approach using antibiotics and proton pump inhibitors. On the third day she became quite unwell. My online research showed this was not unusual. I advised the doctor who totally seemed to deny that it could have been the med. As she worsened to a state of constant unsettled stomach, reduced food intake and sleeping sitting up., it appeared to me that the doctor again and again failed to suggest any solution to this dilemma. I contacted the manufacturer of the med who were surprised that given her reaction she was not put on a follow up dose of another proton pump inhibitor to stop the acid reflux. Once we started that med it took quite some time for her to be able to eat comfortably, she continued to sleep sitting up for a period of 2 months....on top of chronic fatigue issues! Nows here is the rub...eventually we went in again to see the GP who performed yet another in office HPylori test which again showed positive and he dared suggest she may have to do the mess yet again. Two days later I had her in for an endoscopy with Prof. of gastroenterology who said there was no sign of HPylori present and no indication of previous presence of HPylori.
#13	Negative - ongoing problems	**"No information on how my treatment fits with my ability to work"** I have been given no real information about how my treatment fits in with my ability to work. There are a lot of times when I don't feel well and if I do any work (even cleaning up) I will sleep for 3-4 hours after. This isn't me. Antidepressants don't appear to improve things for me but pain meds do. I have been diagnosed with chronic pain syndrome and I think the problem may be the cyst. I have been waiting for 5 years to get my cyst fixed. From what I have read Epidemiological studies point to raised deep vein pressure as causing all kinds of vein

		damage. I can get no real answer to getting back to being productive. I don't blame the Charters Towers Hospital as I believe they are dangerously under resourced and in the present climate there may be little they can do. From what I have experienced there seem to be procedural problems which indicate to me that some people are working to an impossible schedule. Maybe I will have a pulmonary embolism and expire before they need to do anything.
#14	Negative – time issues	**"Waiting time at Mater Public Emergency"** Wife fell and knocked herself out in the middle of the night and starting convulsing. Once she came round took her to mater public emergency at around 1am. It took 1.5hrs before we actually got a bed and someone examined her. They then said they will have to do a scan before they release her. 7 hrs later scan was done. 3hrs later finally released. That is just not good enough, I think if it had been serious after 10hrs she could have been dead.