

Professional Service Relationships in Chronic Illness: The Client's Perspective

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Attestation of Authorship

I hereby declare that this submission is my own work and that, to the best of my knowledge and belief, it contains no material previously published or written by another person (except where explicitly defined in the acknowledgements), nor material which to a substantial extent has been submitted for the reward of any other degree or diploma of a university or other institute of higher learning.

Signature.....

Date.....

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Ethical Approval

AUT University Ethics Committee (AUTEC) approved my ethics application for this research study on 28 July 2008. Application Number 08/90 (see Appendix – D)

Abstract

The relationship between professional service providers and their clients is of great importance to many service industries including educational, financial, consulting and healthcare services. The aim of this research enquiry is to identify, generate and describe a theoretical explanation of how a client engages in and manages their relationship with their health professional over a period of time.

Fifteen participants living with chronic medical conditions were interviewed over a period of four months with data collected via unstructured in-depth interview sessions, and analysed using thematic analysis. The analysis reveals three major themes, nature of relationship, degree of control and service satisfaction. Of central concern is the longevity of the relationship between the healthcare client and his/her service provider. If the service provider is willing to share their authority and relinquish some of the control to the client, the client feels empowered. The client is then willing to provide information and effort to co-create effective service episodes. This sharing of authority enables the client to have better control on their service consumption. The sharing of authority also has an impact on the client's propensity to remain engaged with their service provider.

The findings of this study have implications for our knowledge and understanding of professional service delivery and how it differs from the delivery of consumer services. The study clearly indicates a shift in the role of a client as an empowered entity who wants to be part of, not just the service consumption, but service production as well. The key lessons from this study may inform other types of services including financial, educational and consulting services.

CHAPTER ONE- Introduction

1.0 Research Enquiry

This research enquiry is concerned with exploring the relationship shared by professional service providers and their clients over a period of time. Professional services are defined as “complex services, customized and delivered over a continuous stream of transactions” (Lovelock, 1983). These services are characterized by an inability of the client to confidently evaluate the quality of services provided post consumption. This research study will specifically focus on medical services as a type of professional services. Medical services are distinctly different from other types of professional services such as educational, legal or even financial services because the outcome of failed service provision could be lifelong disability or even death of the client.

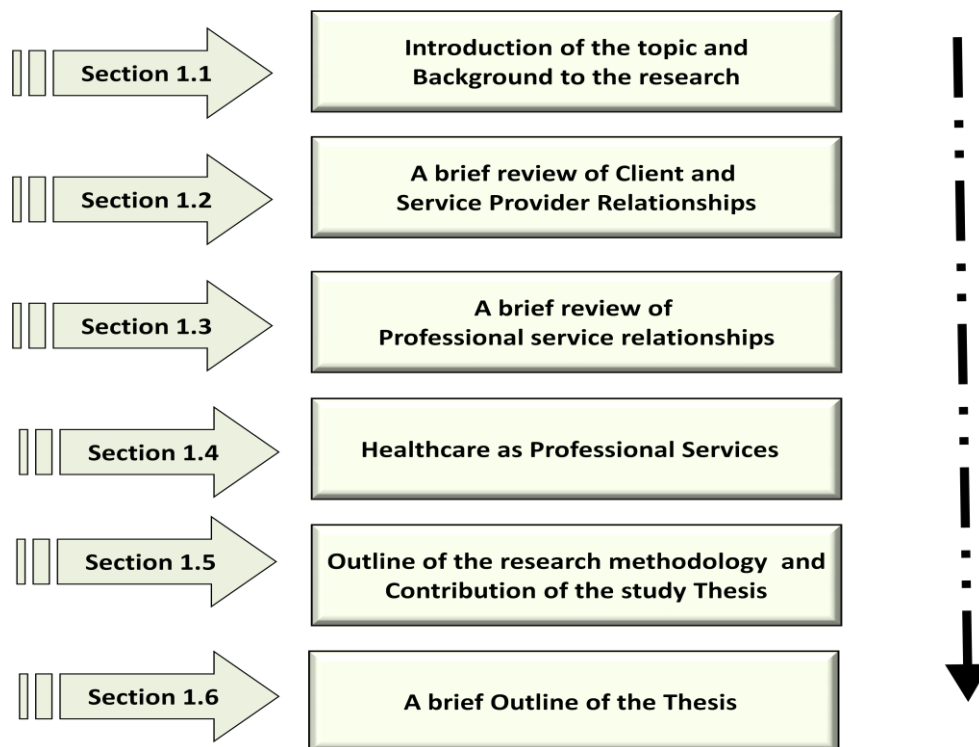


Figure 1.1 - Chapter One Outline

1.1 Background to the Research

A clients' choice of service provider largely depends on the ability of the service provider to instil trust and confidence that the client is getting the best service possible (Morgan and Hunt, 1994). The ability of service providers to instil confidence becomes even more important when trained professionals deliver these services over a period of time (Berry, 1995; Gundlach and Murphy, 1997).

Professional service providers rely upon credibility of the services provided to instil confidence in their clients. These professionals have undergone years of training and have practiced their skills within the field of their expertise. With this rigorous training and years of practice comes experience which is the key determinant of their ability to provide services to clients (Gundlach and Murphy, 1997).

Looking through the previous literature it is also evident that professional services have been researched for more than three decades (Gummesson, 1978; Kotler and Bloom, 1984; Crosby, Lawrence and Stephens, 1987; Brown and Swartz, 1989; Lovelock et al, 1998, Hirvonen and Helander, 2001; Hogg and Laing, 2003).

The relationship between a professional service provider and their client is of great importance to many service industries such as educational (Guskey, 2000; Richard and Lussier, 2006), medical (Kaba and Sooriyakumarn, 2007), legal (Gupta, Gantz, Sreecharana and Kreyling, 2008), financial (Aga and Safakli, 2007) and consulting services (Aharoni, 1993; Lowendahl, Revang and Fosstenlokken, 2001). There is also increasing evidence that most developed and progressive economies are turning into service-centric economies. Hence the importance of studying professional services will continue to grow (Aharoni, 1993; Lowendahl, 1992, 1997).

1.2 Client – Service Provider Relationships

Service relationships can be classified into two types. The first type is purely transactional and characterized by a one-time event that brings parties together for a short period of time untill complete delivery is achieved. The second type evolves over

a period of time and is characterized by an on-going, chain of encounters between the parties. This type of relationship development has facets of routine service delivery and formation of social bonds shared by both the parties (Grönroos, 1982; Bitner et al., 1990; Crosby et al., 1990; Price et al., 1995). As both parties engage in frequent encounters there is the possibility of formation of a social bond within the dyad and with time this appears to grow stronger (Liljander and Strandvik, 1995).

Organizations usually employ socialization processes to familiarize clients with norms and procedures to be followed during a routine encounter and this helps with calibrating service delivery expectations for the client (Kelley et al., 1990). During the service delivery process organizations develop mechanisms for managing client behaviour for a successful outcome, and to do this they usually employ socialization or familiarization processes. The socialization process helps the service clients learn what their role will be in the service encounter. In this process of socialization the clients engage in sense-making activities that help build their perceptions about organizational climate and possible service delivery outcomes (Kelley et al., 1990). This socialization process further leads to fostering bonds between service providers and clients that in turn lead to heightened motivations for clients to participate in service co-production (Feldman, 1981; Mills et al., 1983). Van Raaij and Pruyn (1998) suggest that clients may perceive more or less sense of control in each of the three stages of the service relationship: input, throughput and output. It is also evident that the greater the sense of control assumed by the client in co-production of services, the greater are the chances of reported satisfaction with the services (Ouschan et al., 2006)

One has to also consider the issues of self-serving bias when encouraging clients to participate in co-production processes (Bendapudi and Leone, 2003). A self-serving bias refers to an individual's tendency to claim all the credit for success, and less credit for failed outcome, where an outcome is jointly produced by both parties. Research has shown that when a client has a close and ongoing relationship with a provider, he/she is less likely to demonstrate this self-serving bias, especially when there exists a level of trust between the parties (Bendapudi and Leone, 2003; Wind and Ramaswamy, 2000). In simple terms, the client is more inclined to share the credit as well as the blame for service delivery outcomes. Organizations in the past have successfully used client participation as a means of differentiation and development of competitive advantage,

but also for cost savings to improve bottom line performance (Fitzsimmons, 1985; Prahalad and Ramaswamy, 2000).

Until the early days of the 21st century, the focus for understanding the service provider – client relationship was the domain of services and relationship marketing. This focus of evaluating service relationships took a new turn with the introduction of the “New Dominant Logic of Marketing” by Vargo and Lusch (2004), also known as the theory of Service Dominant Logic (SDL) (Vargo and Lusch, 2004, 2006). One of the key propositions of SDL theory “the customer is always a co-producer “(FP6) has been vigorously debated (Ballantyne and Varey, 2006; Grönroos, 2008; Gummesson, 2007; Payne et al., 2008). The theory of SDL proposes that service providers and clients engaged in an episode have to contribute towards co-creation of value. Vargo and Lusch (2004) have proposed that a service provider is merely a proposer of value and the client has to decide if they wish to engage with the provider and consume the services provided to them. This process of service production and consumption is driven in parts by both the parties and each has to share resources and effort to co-create value and the ultimate service experience. The co-creation of value in this relationship is experiential or phenomenological (Prahalad, 2004) and thus makes its measurement using existing scales and frameworks a little difficult (Payne et al., 2008). This co-creation of value in an episode appears to be the key driver for service quality evaluation by the clients. There are no existing models, conceptual or empirical that could test the validity and reliability of this process of co-creation of value in an episode (Grönroos, 2008).

There is a gap in our understanding of the process by which a client co-creates value in an episode (Payne et al., 2008). There is general agreement that a service provider is a proposer of value, and if the client finds this opportunity appealing then he/she will engage in value co-creation by consuming the proposed product or service (Vargo and Lusch, 2004, 2006). However this does not mean that both the parties hold equal power and are engaging in an episode to get an equal share of the value being created (Payne et al., 2008). From the current discussion it is evident that there are gaps in our knowledge of value co-creation processes in service encounters between a client and his/her service provider.

1.3 Professional Service Relationships

A unique characteristic of professional services is that clients are often part of the production and delivery processes. This means the clients have to take part in the delivery process via the sharing of information and effort (Kelly et al., 1990). In effect the client is providing the resources to enable a service episode and its delivery. The clients may not view this provision of resources as anything special but service providers may view such clients as members of the organization and are sometimes called ‘partial employees’ (Barnard, 1938; Lovelock and Young, 1979). Increasingly the focus of service organizations is shifting from “What can we do for you?” to “What can you do with us?” (Wind and Ramaswamy, 2000).

In a typical episode of professionally delivered services the client is not able to judge the technical aspects of the service provision and usually relies on the functional aspects of the service to judge service quality (Grönroos, 1984). In such services the client is usually dealing with a provider whose technical expertise is far superior to their own; hence the client’s contribution towards co-production of technical aspects of the service is limited. There is a gap in our knowledge of level of contribution of both parties for a successful service delivery outcome, in professionally delivered services.

1.4 Healthcare as a Professional Service

Healthcare Services as professionally delivered services are very complex. This complex service provision has long term implications for an individual, his or her quality of life, personal and social aspirations and has an ongoing impact on the many social and professional relationships that individual shares within the community (Baker, 1997). The key is acknowledging the importance of both mind and soul in the patient’s experiences of health, and of the social context in which health is situated (Cant and Sharma, 2000). This is a service that is socially and politically embedded within the community. It also shares all the facets of a typical service episode that has elements of intangibility, inseparability, heterogeneity, perishability and most important physical evidence and formality (Kang and James, 2004). Unlike consumer services a

healthcare client seeking services from a health professional expects the provider to look the part, dress and behave in a very formal way. The solutions or treatment choices offered by health professional can take longer to achieve a desired outcome in the health status of a client. This physical evidence that a therapy is effective has implications for the client's perception of service quality. It is a service that sometimes lasts for a limited duration, known as acute care, and sometimes lasts for a long time, known as chronic care (Nadelson and Notman, 2002).

When it comes to providing effective healthcare services the onus is placed on the health professional to deliver and provide appropriate care (Garman et al., 2004). Sharma and Patterson (1999) have illustrated that effective communication has implications for perceived trust in a service provider, expected service quality and the level of commitment demonstrated by the client. The proximity and empathy demonstrated by the health professional with physical touch and other gestures, and the actual physical appearance of the professional, have an impact on credence quality and the perception of competence (Stearns et al., 2001).

Demographic profiles of clients also appear to have an implication for levels of satisfaction reported by the clients of healthcare services. Clients have often reported higher levels of satisfaction when they chose a health professional who is either from their own culture or ethnicity, and also when a professional from another ethnicity demonstrates sensitivity towards the client's cultural norms (Winsted, 2000). These findings are in-line with Grönroos' (1984) earlier work on levels of satisfaction reported by the client and client's own understanding of functional quality issues of a service provider. Gender also plays a role in perceptions of service quality and levels of satisfaction expressed by healthcare clients (Stearns et al., 2001). Males and females have demonstrated differing needs from service encounters. It is noted that women are more sensitive to the relational aspects of a service experience than men who appear to be more focussed on the core service delivery (Bendall-Lyon and Powers, 2002). Accesses to primary healthcare services driven by bottom line issues also appear to have major implications for the health of economically underprivileged community. There is evidence in literature to show that health professionals have a degree of variance in their approach and engagement with economically underprivileged clients in comparison to their wealthy clients (Flaskerud and Nyamathi, 2000; Curtis, 2004). This variance can become a source of resultant service satisfaction with the service provider.

There are various models of healthcare services, depending on the level of client involvement in decision making for their healthcare. The various models sit on a continuum starting with the bio-medical model where the health professional makes the diagnosis and offers solution-based treatment (Dew and Kirkman, 2002). At the other end of the continuum is the consumer model of holistic care where the mind and body are addressed while delivering healthcare services. There is evidence in literature that a client may not show all the physical symptoms of a disease yet feel very sick, and needs to be treated not just with medical intervention but also with psychological support systems (Cant and Sharma, 2000).

Health professionals offer services that have elements of intangibility, complexity and an emphasis on heavy customization, typically delivered over a long period of time (Crosby et al., 1990). In this ongoing relationship their technical skills and softer interpersonal skills become critical determinants of differentiation and client satisfaction, and resultant client relationship longevity. Often for the client to be able to evaluate the effectiveness of the professional service delivery the relationship has to endure over many months or sometimes years (Sharma and Patterson, 1999). Thus the service provider's attempt at proposing value, the actual value delivered, and its co-creation and consumption, have to happen over a period of time in order for the client to evaluate its effectiveness. It is evident that healthcare services are complex services. This makes them a target for research enquiry. The key issue to address is how these clients of a professionally delivered service manage their relationship with their service provider and what impact this has on their overall well-being.

1.5 Aim of the Study

The aim of this research enquiry is to identify, generate and describe a theoretical explanation of how a client engages in and manages their relationship with their health professional over a period of time.

1.5.1 Research Contribution

This research seeks to provide a theoretical explanation of consumer behavior in professional service relationships. This research will add to our understanding of the

delivery of high credence services such as legal services, financial services, counseling, chronic care, nursing and mental health services. The outcome of the research will inform the daily practice of professional service providers.

1.5.2 Methodology

Researchers have shown a keen interest in studying professional service relationships (PSR) over the years. Some of the topics investigated have included the GAP analysis in PSR (Gummesson, 1978; Brown and Swartz, 1989) the typology of PSR (Kotler and Bloom, 1984; Crosby, Lawrence and Stephens, 1987; Hogg and Laing, 2003), value creation processes in PSR (Hirvonen and Helander, 2001), service quality issues in PSR (Sharma and Patterson, 1999; Bell, Auh and Smalley, 2005) and client empowerment in PSR (Ouschan, Sweeny and Johnson, 2006; Bell and Eisingerich, 2007).

Most of this research has adopted the positivist / post positivist paradigm. This research seeks to investigate the complexities of managing relationships with professional service providers within the naturalistic paradigm. Review of the literature indicates a lack of research using naturalistic techniques to investigate professional service relationships. The focus of this research is to comprehend personal experiences of the participants engaging in a professionally delivered service rather than achieve statistical power and generalization to a larger population. Clearly there is a gap in knowledge and in our understanding of the practical realities of clients involved in professional service relationships.

Naturalistic enquiry is the most appropriate paradigm to govern this enquiry (Lincoln and Guba, 1985). Naturalistic enquiry suggests that “realities are multiple, constructed and holistic” and unfold through the interaction between the researcher and his/her participants. It further states that the knower (researcher) and the known (knowledge) are interactive and inseparable; reality is in a state of multiple simultaneous shaping, so there can not be causality in a relationship that is, it is impossible to distinguish a cause and effect type relationship in the phenomena under investigation (Lincoln and Guba, 1985). This argument itself leads us to using qualitative research methodology for this research enquiry. This qualitative approach has both advantages and disadvantages (Miles and Huberman, 1994). It relies on a smaller number of respondents that are chosen through non-random sampling procedures that cannot be used further for generalization purposes (Patton, 1990). Miles and Huberman (1994, pg.) suggest that

“words especially organized into incidents or stories have a concrete and meaningful flavour that often proves far more convincing to a reader, another researcher, policy maker, or practitioner than pages of summarized numbers”.

1.5.3 Limitations and Key Assumptions

The research aims to understand the practical realities of the clients of healthcare services (patients) and not that of the service providers (healthcare professionals). This may give a one-sided perspective to the research issues. A key assumption is the participants will be able to articulate their experiences and communicate them within a research interview.

1.6 Thesis Outline

Chapter One Introduction - This chapter has introduced the aim of the research. It has detailed the scope of the research enquiry.

Chapter Two Literature Review - The Literature Review represents the conceptual, empirical and methodological foundation of this thesis. Chapter two is split into four parts: A comprehensive review of the state of knowledge of service marketing literature, relationship marketing literature and professional services literature within the context of this research healthcare service.

Chapter Three Methodology – The methodology chapter is a description of the qualitative methodology used in this thesis and issues of research design used for this research enquiry.

Chapter Four Findings – The findings chapter provides a detailed data analysis and interpretation of major themes as a result of data analysis.

Chapter Five Discussion and Implications - This chapter provides a detailed discussion of results and their place within the broader theory of professional services and later a general discussion of the results and their implications for marketing theory and key limitations of this research.

CHAPTER TWO - Literature Review

2.0 Introduction

This chapter aims to build the theoretical foundation by reviewing current literature and identify research issues or gaps. This chapter will review the literature on consumer participation in service encounters, then move on to discussing the relationship marketing and professional services literature. Finally the review will also elaborate on some of the contextual issues arising out of healthcare services as a type of professionally delivered service (see Figure 2.1).

This chapter is divided in four sections starting with a review of literature on notion of value delivery in a typical service encounter. Later the chapter explores marketing theory's progression from a transactional (co-production) to a relational (co-creation) approach to value delivery in an encounter based on the service dominant logic (SDL). This progression also documents the role of a typical client as a co-producer and as a co-creator of value in an encounter.

The second section of this chapter explores issues of service delivery, service quality and its implication for client satisfaction, loyalty, word of mouth, re-patronage and the role of client in managing effective service quality. This section will also explore issues of service quality and its impact on client relationship management and relationship longevity.

The third section of this chapter evaluates the evolution of modern marketing from a transactional to a relational paradigm called Relationship Marketing. This section also explores the process of relationship development and issues of structural and social bonding between clients and service providers with an emphasis on role of trust in relationships. The final section covers issues of Professional Service Relationships and integrates key concepts of service quality, relationship marketing and the role of the client and contextual issues of this research 'healthcare services'.

This literature review will help in exploring the current conceptual gaps in our knowledge around professional service delivery and set the tone for this research enquiry. Some of the key issues discussed in this literature review will focus on value

co-creation in service episodes, managing client expectations in an encounter, client empowerment in consumption processes and lastly factors affecting relationships longevity.

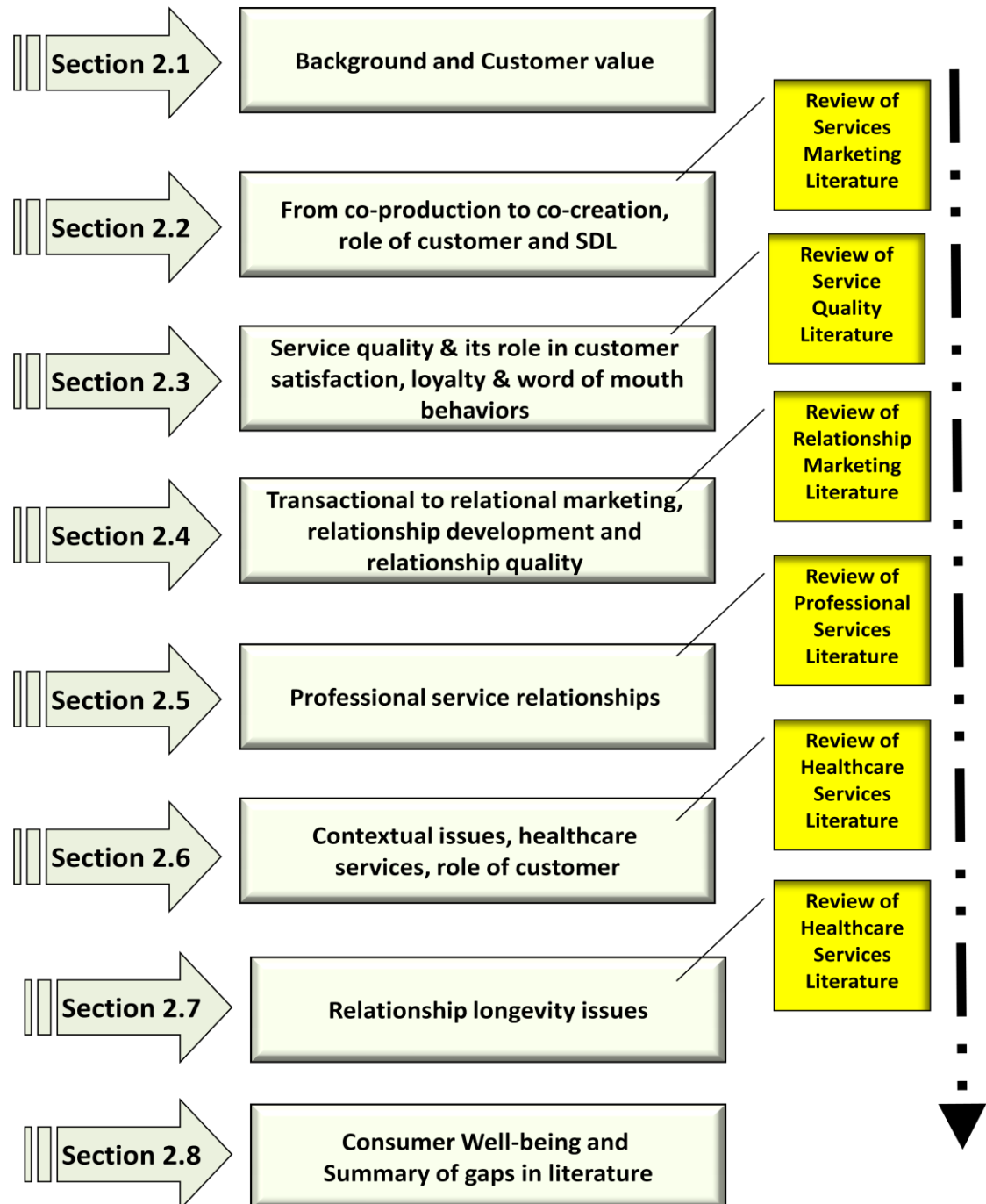


Figure 2.1 - Chapter Two Outline

2.1 Background

In today's global business environment, with deregulation within industries and intense competition within domestic and international markets, the point of differentiation for many businesses seems to be mode of service delivery. In every service encounter the client engages in he/she constantly grapples with the idea of getting the best value from that encounter. The notion of value is a multifaceted concept and marketing scholars have studied the concept of value for years.

2.1.1 Customer value

In its simplest form the concept of value is defined as:

“Perceived value is the customer's overall assessment of the utility of the product based on a perception of what is received and what is given” (Zeithaml, 1988)

“Customer perceived value as the ratio between perceived benefits and perceived sacrifices the customer has to make” (Monroe, 1991)

Experts say value can be added via improving or adding to the product's features, production processes or even the delivery processes (Christopher et al., 1991). Monroe (1991) also suggests that two processes can help in value creation, either by increasing benefits or by reducing customer-perceived sacrifices. The assumption is that this value addition will eventually lead to client satisfaction and will foster client loyalty (Ravald and Grönroos, 1996). Strobacka et al. (1994) have suggested this co-creation of value has obvious implications for client's evaluation of service quality, which has implications for client satisfaction, which leads to relationship strength and further leads to relationship longevity. Grönroos (1994) goes further and adds a relational dimension to the value creation process by saying “firm's offerings should be seen as value carrier” and the client should be able to deduce the net-value vis-à-vis competitors based on their own personal value chain.

So far it is evident that most of the discussion has focussed on value addition and value delivery in the context of the goods-centric view of marketing. The focus of modern marketing is that of value distribution and not that of value creation (Vargo and Lusch, 2004). The next section will discuss two points of view namely co-production of value versus the co-creation of value in a service episode.

2.2 From Co-production to Co-creation

The marketing literature demonstrates that clients are encouraged to take on active role in production of goods and services alike (Bendapudi and Leone, 2003; Prahalad and Ramaswamy, 2000). One of the best examples of this is the self-service photo printing machines used at shopping malls, where clients are encouraged to select, edit and choose the size of their photos and then print them and pay for them using a credit card. Encouraging client as co-producers of goods and services is not a new concept. Client participation has been defined as “the degree to which the customer is involved in producing and delivering the service” (Dabholkar, 1990, p.484). Firat and Venkatesh (1995) even suggest that clients have been actively demanding a role in co-production and marketers must open up organizational processes and systems to allow for active participation by customer groups.

2.2.1 Client Participation

Meuter and Bitner (1998) have suggested three types of service production based on level of client participation: firm production, joint production and customer production. This is a continuum where at one end firm production has almost no client participation and at the other end the client carries out all the necessary effort to produce the service for him/her self. When discussing the client participating in co-production of services one has to also consider the ability of the client to share information and exert the effort required for successful co-production.

Wright, Newman and Dennis (2006) also suggest empowering the client to take more proactive role during the service encounter as the means of gaining control on their consumption process. When clients feel empowered they are able to enjoy the process of consumption as they are able to effectively participate in the experience of consumption. The onus then is on the service provider to facilitate processes that will lead to client empowerment.

From the review of literature it is evident that organizations try to use sense-making socialization processes to familiarize clients with the organizational climate, norms, roles and behaviours during product/service delivery (Kelly et al., 1990). These processes are meant to set the bar for client expectations around service delivery and if an enterprise is able to deliver in line with the client expectations then the reported

outcome is usually post-purchase satisfaction or dissatisfaction if the set client expectations are not met. Further these socialization processes are also geared up to bring about goal congruence between the enterprise and its clients so as to enhance client participation in the service delivery processes (Kelly et al., 1990). These socialization processes lead to affective involvement with an enterprise and also lead to increased motivation on the part of clients to willingly participate in service delivery processes thereby co-producing an experience for themselves. The theory of self-serving bias plays a role in this co-production process and clients report high levels of satisfaction with service encounters if they are able to share and contribute towards the outcome of an episode and share the blame if the outcome is not in line with prior expectations (Bendapudi and Leone, 2003).

The client has expectations associated with every service episode and has expectations around the role play of the service provider (technical quality), the behaviour demonstrated by the provider (functional quality) and also their own role in an encounter. The service provider also has expectations around the role of the client in an episode (technical quality); how the client should behave (functional quality) and the role of the service provider in an encounter (Kelly et al., 1990). It is evident each party has to bring resources and effort to each encounter to co-produce a certain experience for themselves. This view is still very much cantered around the goods-dominant logic of marketing where the aim is value delivery and not of value-creation processes.

2.2.2 Co-creation of value

So far the discussion has focussed on issues of co-production. There has been a lot of research done to understand the issues involving clients as co-producers. Marketing theory has always relied upon usage of terms such as markets, clients, production, value chain, suppliers, buyers, value addition, distribution that seem to suggest the dominance of good-centric view of the world of marketing (Vargo and Lusch, 2008). There has been much debate about the use of goods-centric view by Vargo and Lusch (2004) while elaborating on the theory of service dominant logic (SDL) (Kohli, 2006; Ballantyne and Varey, 2006). With the evolution towards the new dominant logic of marketing proposed by Vargo and Lusch (2004, 2006) there seems to be a subtle move away from the goods-centric view of marketing to more of service-centric view of marketing processes.

2.2.3 Service Dominant Logic

For the purpose of this research enquiry let us keep the discussion around the Fundamental Proposition No 6- “the customer is always a co-creator of value” (Vargo and Lusch, 2006) which clearly shows that it has its roots in the co-production of products and services alike. This is clearly a good-centric view of value creation in a service episode (Ballantyne and Varey, 2006). This good-centric view of co-production clearly ignores the notion of value, which is ongoing, interactive and reliant upon a network of relationships (Achrol and Kotler, 2006; Grönroos, 2006; Gummesson, 2006). This research enquiry seeks to explore the complexities of a typical relationship shared by a client and his/her professional service provider. Every client choosing to engage with a service provider is seeking the best value for their effort and contribution to each episode. This research will attempt to explore the processes of co-creation of value in an episode; hence, ongoing delivery of professional services is a perfect target for exploring the interactive nature of value delivery. Next we shall discuss the notion of co-creation of value in a service episode.

The entire process of co-creation of value depends on the supplier proposing superior value and the client determining the value when the good or the service is consumed. Payne et al. (2008) suggest three different processes that are working together to co-create value between suppliers and clients: customer value-creating processes, supplier value-creating processes and encounter processes. The framework suggests that co-creation depends on what each party brings to the table and includes various resources and practices that both parties use to manage the relationship with each other. The actual exchange encounter is also important as it presents opportunities for co-creation of value. Storbacka and Lehtinen (2001) suggest that the client in this encounter could assume one or many roles of a buyer, consumer, competence provider, controller of quality and co-producer or even a co-marketer. This phenomenon of co-creation of value is experiential and hence creating experiences is more about building relationship with the value provider and not about the provision of a product or service (Grönroos, 2008). Put it simply it is about “value in use” and not about the product features or core and supplementary service provision itself.

This argument that a client is a co-creator of value does not sit well with some scholars of marketing and they argue if the client is able to co-create value by themselves then what is the role of the enterprise (service provider) in this relationship (Sheth and

Usley,2007; Grönroos, 2008). Grönroos (2008) further suggests that there is a marginal distinction between the clients' ability to co-create value when using goods away from the enterprise; and when the client decides to use services for co-creating value. The enterprise can play a much bigger role in proposing, delivering and co-creating value in use. This discussion on who creates and who co-creates is far from over and further research is needed to understand value co-creation processes and roles of providers and receivers of value. The discussion on who creates and who co-creates value is far from over and an added challenge is that of exploring client's value co-creation processes when consuming products and when consuming services. This offers a unique opportunity to research value co-creation processes in service episodes.

2.3 Service Delivery Outcomes

Another issue that has given rise to much debate and scholarly research is that of the outcome quality of a service encounter. Further to this is the client's interpretation of each encounter and subsequent reported satisfaction with each encounter. Service quality has been a frequently studied topic for the last three decades and a dominant theme widely researched has been that of measuring service quality and its subsequent link with satisfaction, re-patronage, word of mouth referral and loyalty and purchase intention behaviours. Service quality is an abstract concept because of the very nature of services being intangible and the associated concomitant production and consumption of all service encounters.

Service quality is defined as;

“The degree of discrepancy between clients' normative expectations for the service and their perceptions of the service performance” (Parasuraman et al., 1988, p.17).

“The outcome of an evaluation process where the consumer compares his expectations with the service he perceived he has received” (Grönroos, 1982, p.37)

2.3.1 Conceptualization and Measurement

One of the major issues for service providers is that of managing the expectations of clients during a service episode. An expectation is defined as “subjective probability

that behaviour will be followed by particular outcome” and is often used interchangeably with expectancy. Bitner and Hubbert (1994) have noted three distinct concepts for service delivery encounter satisfaction, overall service satisfaction and the resultant service quality evaluation by the customer. The service quality literature holds that these normative expectations are expressions of what a client believes a service provider should offer rather than would offer and these expectations are implicit in nature (Coye, 2004).

Ojasalo (2001) proposes that expectations can be of three different kinds fuzzy, implicit and unrealistic. The onus is placed on the service provider to make these expectations precise, explicit and realistic for better service quality outcomes. Ojasalo further proposes a model (see Figure 2.2) to illustrate how to manage expectations during a service encounter and to achieve client satisfaction and relationship longevity.

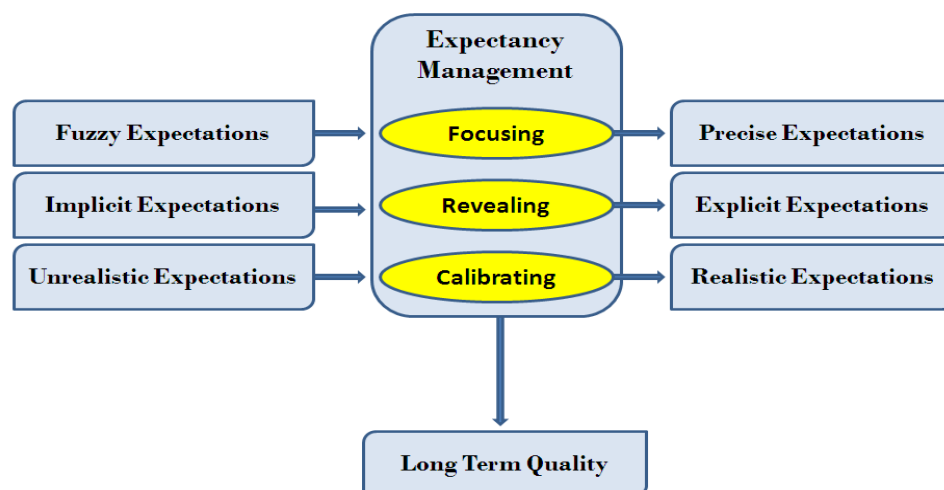


Figure 2.2 – A Framework of Expectancy Management (Ojasalo 2001)

Ojasalo (2001) illustrates that sometimes clients do not know what they want from their service provider, and this confusion makes expectations very fuzzy in nature and difficult to deliver on. When clients routinely engage the same service provider they expect a similar type and level of service to be provided at each encounter making these

expectations implicit in nature. Sometimes clients come up with totally unrealistic expectations that are outside of the scope of the standard service provision. In all of these cases of fuzzy, implicit and unrealistic expectations it is very difficult for the service provider to offer appropriate solutions to clients and the probability of resultant client satisfaction is very low.

Ojasalo (2001) proposes the only way the service provider can achieve a better service quality outcome is by making fuzzy expectations precise and setting boundaries around service delivery thereby making the outcome very explicit and realistic for the customer.

2.3.2 Service Quality Evaluation

There seems to be two major schools of thought on what service quality is and how to measure it. There is the European or Nordic school perspective (Grönroos, 1982) to service quality and the North American perspective (Parasuraman et al., 1985; Rust and Oliver, 1994).

There are a few issues to be considered when measuring service quality, starting with what is it that we need to measure? With the model of expectations versus performance we need to be sure what to measure i.e. types of expectations, performance of the service provider alone or both client and provider. The second issue is that of identifying whose perception we measure; the service provider, the personnel involved, the organization or the combination of all. The third issue is that of the client's prior learning and perception with the service provider and the actual process of service delivery. The final issue raised by Grönroos (1982) is that of what is delivered (technical quality) and then how (functional quality) the service is delivered and its effect on the client's evaluation of service quality.

Based on the European or Nordic school perspective Grönroos (1984) has proposed that service quality can be divided into two components based on: functional quality (how) and technical quality (what) provided in an episode. So far the research on service quality has primarily focussed attention on the functional and technical aspects of employees or providers of services (Bendapudi and Leone, 2003). Kelley, Donnelly and Skinner (1990) also proposed that one has to look at the technical and functional abilities of the clients before they engage in the service delivery processes. The technical ability of the client to perform a task is important which includes sharing

useful information with the service provider. The functional aspects such as friendliness, voice modulation non-verbal cues demonstrated during a service encounter are also equally important for a successful outcome. This clearly shows that the technical and functional aspects offered by both service providers and clients are important and can determine the success of co-production of services and the delivery.

Ever since the introduction of the SERVQUAL instrument (Parasuraman et al., 1985) many scholars have attempted to replicate or challenge its validity and reliability within multiple service settings (Cronin and Taylor, 1992; Teas, 1993). One of the key arguments has been that the SERVQUAL instrument mainly focuses on service delivery processes (Grönroos, 1990; Mangold and Babakus, 1991). The North American perspective proposed by Parasuraman (1985) is received as more of a functional quality perspective, i.e. the SERVQUAL instrument focuses on the service delivery processes and does not address the service encounter outcomes. This instrument has five dimensions to it viz. Reliability, Assurance, Tangible, Empathy and Responsiveness. This instrument does not include any measures of the technical quality dimension; almost all the studies done using this instrument have focussed on various service provider settings and tried to measure the functional aspects of service quality. Further to this Brady et al. (2002) developed a competing model called SERVPERF which focuses only on the performance measure of the service delivery rather than the client expectation model proposed by Parasuraman et al. (1985). Further to this a more recent conceptualization of the service quality dimensions was proposed by Rust and Oliver (1994) as a three component model driven by the client's evaluation of three aspects of service delivery viz. customer-employee interaction (functional quality), service environment and the outcome (technical quality).

One of the shortcomings of SERVQUAL is its inability to measure the technical service quality of an episode. Measuring technical quality is not an easy feat either and scholars have generally used qualitative methods such as open ended surveys (Brady and Cronin, 2001) and also using in-depth interviews with participants (Richard and Allaway, 1993). The findings so far suggest that there is no single underlying latent variable associated with technical quality. The debate is open to the nature and the content of the service quality dimension and it is thought to be a multi-dimensional, multi-attribute construct (Brady and Cronin, 2001).

The discussion will now progress towards issues associated with service quality as an outcome of an encounter viz. service satisfaction, loyalty, commitment, word of mouth referral and issues of trusting behaviour of clients and overall consumer well-being.

2.3.3 Client Satisfaction

The first factor that has strong linkages with service quality is the client's notion of post-purchase /encounter satisfaction, perceived value received from the service provider and its impact on loyalty. This link between service quality-satisfaction and subsequent loyalty has been widely studied by many scholars (Sweeney et al., 1997; Parasuraman and Grewal, 2000). The concept of client satisfaction has drawn the interest of academics and practitioners for more than three decades and a satisfied client is a necessary precondition for client loyalty which in turn drives profitability for the enterprise. Ueltschy et al. (2007) have suggested that satisfaction or dissatisfaction is not intrinsic to a product or a service but is dependant on the client's perceptions of the product or service attributes and its link with the client's individual needs.

Rust and Oliver (1994, p26) define customer satisfaction as “an emotional response that results from the cognitive process of evaluating the service received against the costs of obtaining the service”.

Our discussion is centred on service quality and resultant satisfaction with the service delivery. Ravald and Grönroos (1996) have suggested that perceived service quality is an antecedent of customer satisfaction. Patterson and Johnson (1993) on the contrary have propagated the notion that satisfaction precedes service quality. Teas (1993) explains that the source of this confusion lies in the operationalisation of two different constructs i.e. service quality and satisfaction. Carrillat, Jaramillo and Mulki (2009) have proposed that in fact service quality leads to customer satisfaction as quality of services is a cognitive state and the subsequent satisfaction is an affective (emotional) state of mind. The foundation lies in the casual chain of psychological processes where cognition precedes emotions in our lives and hence service quality precedes client satisfaction (Oliver, 1997).

This link between service quality-satisfaction and perceived value and post-purchase behaviour was tested by Tam (2004). The study showed that client satisfaction and perceived value are equally important determinants of post-purchase behaviour, demonstrated by the client's word of mouth, loyalty and re-patronage. This claim is

further supported by Hellier et al. (2003) where perceived value and satisfaction were the drivers of brand preference and re-purchase intention. Clearly service quality is important antecedent to perceived value in services received, client satisfaction and the subsequent behaviours with regards to word of mouth, loyalty and re-patronage. Ranaweera and Prabhu (2003) have taken this argument further and studied the importance of not just satisfaction but also the presence of trust between the service provider and client as a contributing factor that drives client loyalty and word of mouth behaviour.

2.3.4 Service Loyalty Behaviour

Levitt (1981) proposed the idea of customer retention as a source of competitive advantage since it is lot more expensive to win new clients than to keep the existing client-base satisfied and loyal. The service provider has to play an important role in keeping this client in the loop long-term and one way of achieving this is by offering something unique that stands out vis-à-vis the competitor. Service loyalty is most often viewed as a cognitive process and an outcome to effective service delivery (Pritchard et al., 1999). Client loyalty is also noted as an attitude that reflects a long-term commitment of the client to the organization (Shankar, Smith and Rangaswamy, 2003). There is debate around what is loyalty and one of the frequently used terms is attitudinal loyalty defined as “a deep commitment to the service provider” (Shankar, Smith and Rangaswamy, 2003).

One concept that can help explore this possibility of retaining loyal client is the “affect theory of social exchange” as proposed by Lawler (2001). He proposes the concept of shared responsibility between the service provider and his/her client as a source of emotional involvement between the dyadic relationships that further raises the possibility of client demonstrating loyalty behaviour. Lawler (2001) proposes that when service provider and client interact they are actors in an episode of social exchange where success or failure produces an emotional response and a positive emotion becomes the object of value in such relationships. When the act of service delivery is performed the success or failure of the outcome becomes the shared responsibility of the actors involved i.e. the provider and the receiver of service. Lawler (2001) proposes that, the greater the shared responsibility and stronger the emotional involvement between the parties, the greater are the chances of successful outcome to that episode.

These findings are in line with the ones proposed by Bendapudi and Leone (2003) based on the “theory of self serving bias” that client participation in service delivery leads to sharing of success and failure alike. Carrillat, Jaramillo and Mulki (2009) have also found support for this argument that enhancing the client’s psychological attachment to the service provider actually leads to stronger attitudinal loyalty and subsequent purchase intention. Johnson, Herrmann and Huber (2006) have also demonstrated that attitudinal loyalty-purchase intention relationship becomes stronger with the passage of time. Carrillat, Jaramillo and Mulki (2009) meta-analysed 86 studies on service quality and were able to demonstrate a strong linkage between service quality, client satisfaction, attitudinal loyalty and purchase intention.

2.3.5 Service Quality and Relationship Longevity

There is a wide array of research available on the chain reaction that starts with service quality to client satisfaction to client retention, loyalty, re-purchase intention and profitability (Beaton and Beaton, 1995; Berry1995; Grönroos 1994; Rust and Zahorika, 1993). A typical service encounter can be of two different types i.e. a one off short-term episode or a series of many episodes linked together that represents an ongoing relationship between the dyad (Grönroos 1984). Strobacka et al. (1994) suggest when evaluating issues of service quality and satisfaction one has to evaluate it not just at the level of an episode but also at the level of service relationship. Strobacka et al. (1994) proposed a model of relationship profitability (see Figure 2.3) where the underlying notion was that service quality leads to satisfaction, which in turn leads to fostering of the relationship, which ultimately leads to loyalty and subsequent profitability.

Strobacka et al. (1994) also propose that this model of relationship profitability has few conceptual gaps in it. The first suggested by Liljander and Strandvik (1994) that perceived service quality can be an “outsider’s perspective” and need not be self experienced by the customer. This clearly means the client can report on service quality issues purely based on word of mouth in spite of the fact they have never engaged with a particular provider. Satisfaction on the other hand is said to be an insider’s perspective as one has to experience the episode to report back on resultant satisfaction with that episode.

The second issue is of satisfaction leading to strengthening of the relationship between the parties. Scholars suggest this is too simplistic a view of relationships (Liljander and

Strandvik, 1993; Oliver 1989; Zeithaml et al., 1993). There is enough evidence to suggest that even dissatisfied clients remain in a relationship long-term owing to switching costs, structural or social bonds between the dyad, standardised offerings from competitor and even fear of changing providers. This is a clear indication that client satisfaction is not always based on positive attitudinal loyalty or even commitment and also challenges the link between satisfaction and relationship longevity.

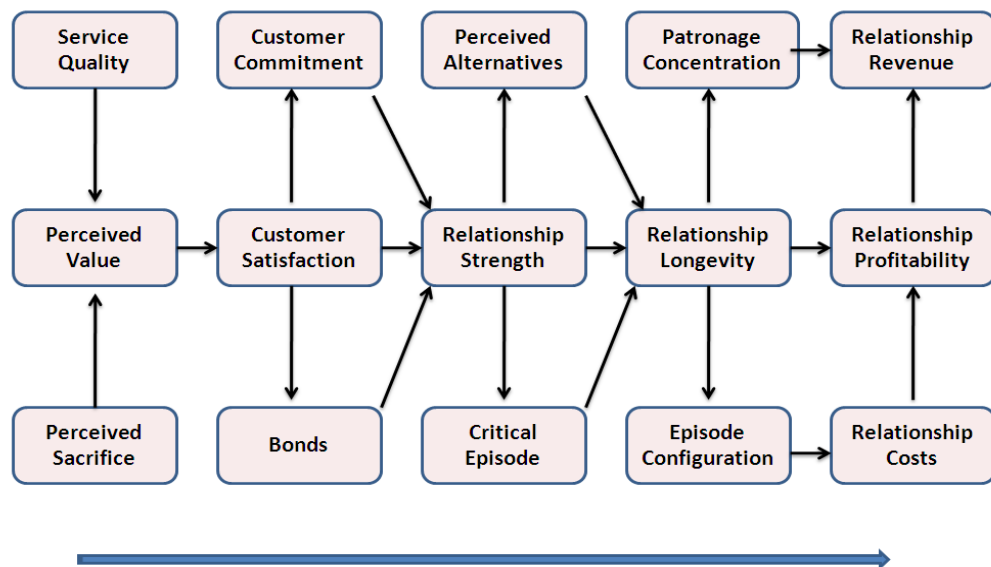


Figure 2.3 - Relationship Profitability Model (Storbacka et al., 1994)

The third assumption is that relationship strength will determine relationship longevity. Usually service episodes are a series of routine exchanges between service providers and clients and these at times could be punctured with what Bitner et al. (1990) calls “critical incidents”. A critical episode, as the name would suggest, is considered to be lot more important by the client and success or failure to deliver on such episodes can lead to fostering stronger relationships and improve the longevity of such relationships, or have the opposite effect. Handling of critical episode by the service provider will ultimately decide if the relationship survives or terminates (Bitner et al., 1990). It is evident that the link between service quality, satisfaction, loyalty and profitability is not as straight forward as thought by the marketing scholars. Further research is needed to

explore this link through the lens of relationship marketing. This offers a unique opportunity to research the link between service satisfaction and relationship longevity.

2.4 Transactional to Relational Marketing

It seems modern marketing in the recent times has slowly evolved towards a new paradigm called Relationship Marketing. There is a clear distinction between two kinds of marketing exchanges. The first one is called transactional and involves single exchange of short duration (Gundlach and Murphy, 1993; Bagozzi, 1979). The second type is called the relational exchange which is characterised by a series of exchanges between parties over a period of time and offers a perfect opportunity to foster both economic and social bonds between the dyad (Lehtinen and Mittila, 1995).

There are many different definitions of relationship marketing. Two key definitions are:

“Establish, maintain and enhance relationships with the clients and other partners, at a profit, so that the objectives of the parties involved are met” (Grönroos, 1990, p.63)

“Relationship marketing refers to all marketing activities directed towards establishing, developing, and maintaining successful relational exchanges” (Morgan and Hunt, 1994, p.23)

2.4.1 Process of Relationship Development

There is also considerable debate about how this relationship develops over time but researchers agree it has two major components, i.e., structural bonds and social bonds. Structural bonds are usually seen in typical business to business type exchanges and may comprise product or process alignment, financial commitment between parties or even sharing of intellectual property for economic gains (Johanson and Mattsson, 1987; Pelton et al., 1997). The social bonds on the other hand are more personal and usually comprise of the presence of trust, commitment, interdependence and loyalty between the parties or even individuals in a relationship over a period of time (Berry, 1995; Morgan and Hunt, 1994; Wilson and Jantrannia, 1994).

The third factor is the process of relationship development itself. Two different schools of thoughts on this evolution process are stages versus states theory (Bell, 1995; Ford,

1980, 1986; Dwyer et al., 1987). The stages theory proposes that a relationship development happens in stages that are interlinked, progressive and irreversible. There is a considerable debate about the stages model; it is perceived to be too simplistic a representation of a complex phenomenon (Bell, 1995). The states theory proposes that relationship development goes through unstructured and unpredictable states and that relationship development can move backwards or forwards or remain static for long periods of time (Anderson et al., 1994; Bell, 1995). In a typical service relationship a 'critical incidence' has the power to determine if the relationship will get stronger or face immediate termination (Strobacka et al., 1994). For a typical client in a service relationship the service providers' handling of critical episodes seems more important than the length of the relationship and successful handling of routine exchanges in the past. This argument lends clear support to the states theory as an appropriate model of relationship development between parties.

Marketing scholars have further studied this process of relationship development and demonstrated that it is a continuum where at one end the relationship can be of a purely professional nature and on the other end it can evolve towards the likes of a social bond between friends (Arnould and Price, 1993, 1999; Beatty et al., 1996; Coulter and Ligas, 2004). In fact Coulter and Ligas (2004) have suggested a typology of relationship that comprises of four different types of relationships that can exist between a dyad: pure professional, casual acquaintance, personal acquaintance and close friendship. Their exploratory study suggests that this evolution from a purely professional to a friendly relationship between the parties may not happen overnight. Hence time spent in such relationships is important. This evolution also seems to follow a model proposed under the states theory of relationship development (Bell, 1995). Coulter and Ligas (2004) have noted the need for investigating two key questions, "How do professional relationships evolve in friendship?" and "Why do professional relationships remain professional even after long periods of time?" This supports the need to explore the relationship development process in a professional service encounter.

2.5 Professional Service Relationships

In the past three decades the importance of services and service delivery in a nation's economy has grown manyfold. One of the key growth areas has been in the realm of professional services. A trend in research within the domain of relationship marketing has been the transition of research from consumer services to professional services (PS) (Eisingerich and Bell, 2007, Karantinou and Hogg, 2007; Laing and Lian, 2005; Ouschan, Sweeny and Johnson, 2006). These services are distinctly different from consumer services with respect to their complexity and the years of training undergone by the personnel who deliver these services (Lowendahl, Revang and Fosstenlokken, 2001).

Professional services are defined as:

“Complex services, customized and delivered over a continuous stream of transactions” (Lovelock, 1983, p.18)

There are a few key issues worthy of discussion when professional services are put under the lens. Some of the major issues revolve around the link between PS and relationship marketing, issues of rapport and client empowerment within PS and its impact on key marketing constructs like satisfaction, loyalty, trust and word of mouth behaviour. Professional services are very complex in nature and this complexity is due to the number of intricate steps performed during an encounter and the executional latitude i.e. the preferred mode of delivery which can be different for different service provider.

Professional service providers share years of rigorous training and practice in the field of their expertise and years of experience can be a major determinant of their ability (Hausman, 2003). Grönroos (1982) noted a key difference between consumer and professional services is that of core service provision which is far more important than the supplementary service provided in an episode. The professional's ability to provide the core service is a major driver of choice by clients. Hill, Garner and Hanna (1989) conducted an exploratory study and proposed three different criteria that drive the client's choice of a professional service provider: competency, soft skills and punctuality. The difficulty though comes when the client is not able to distinguish between core and supplementary service provision and also the ability of the client to

evaluate the quality of core service provided (Lovelock, 1996). The client then puts a lot more emphasis on the components of the service provision that they can confidently evaluate i.e. ambiance of the place of service, interpersonal skills of the provider, communication verbal and non-verbal and gestures. These features then become surrogates or replacements for technical quality of the episode (Grönroos, 1982; Hausman, 2003).

The nature of service delivery that happens in professional services is distinctly different from that of client services. The nature of consulting allows the professional an access to confidential information about the client; the client has no choice but to share intimate knowledge and information during an encounter to receive an appropriate service (Churchill and Surprenant, 1982). This access to intimate information makes the client very vulnerable if the provider chooses to use this information to their advantage. On the other hand these intimate encounters also present an opportunity for the dyad to build a trusting relationship based on open communication and reciprocity. This can lead to loyalty, commitment and relationship longevity (Patterson, 1993; Lovelock, 1996; Eisingerich and Bell, 2007).

The theory of relationship marketing has emphasized the importance of structural and social bonds between the client and service provider as a key to successful service delivery. Macintosh (2009) has proposed interpersonal rapport between the dyad engaged in a professional service episode as a key antecedent to successful service delivery and the resultant satisfaction and word of mouth behaviour demonstrated by the customer. The four key drivers of this rapport building process are familiarity between the parties, propensity of mutual self-disclosure, uncommon or extra attention offered to the client, and common grounding, which signifies social bonding beyond the boundaries of professional service setting.

Client empowerment in the professional service encounter seems to be one more construct that has received much attention in recent times (Anderson, 1996; Jayawardhena and Foley, 2000; MacStravic, 2000). Client empowerment is defined as the “process by which individuals gain mastery or control over their own lives and democratic participation in the life of their community” (Zimmerman and Rappaport, 1988, p.726). Researchers have noted several benefits from empowering clients in a service encounter namely cost and efficiency gains, service quality improvement, and

also letting clients take charge of their own consumption which in turn leads to reduction in unnecessary overhead costs (Hjalager, 2001; MacStravic, 2000).

Client contribution to service delivery is not a new concept and was initially suggested as part of the continuum by Van Raaji and Pruyn (1998). What is different though is the complexity of professional service delivery and the ability and the competency of the client to co-create a desired experience in service encounter. Most research on empowerment has focussed on how an individual becomes empowered through involvement with community and organizations. Client empowerment research needs to be extended to one-on-one or customer-service provider dyad. This lack of research offers an opportunity to explore the process of empowerment in a professional service setting. Researchers studying relationship development processes have emphasized the importance of service quality, satisfaction and trust as mediators of loyalty, word of mouth and re-patronage but there is a lack of research on if and how client empowerment has a role to play in this relationship. This offers an opportunity to explore the link between client empowerment the resultant service outcomes.

2.6 Professional Services and Contextual Issues (Healthcare Services)

Our discussion now warrants a linkage between the purpose of the study and the choice of context. Health professionals are in the business of providing services and are striving for bottom-line driven objectives besides serving the wider community. The sheer nature of medical services makes them very personal where there is an element of power, authority and ongoing relationship between the provider and receiver (Gundlach and Murphy, 1997). Clients prefer to deal with the same provider over a period of time for reasons of familiarity and as means of reducing vulnerability (Berry, 1995).

In a typical professional services episode the client is not able to judge the technical aspects of the service provision and usually relies on the functional aspects to judge the service quality (Grönroos, 1984). In such services the client usually is dealing with a provider whose technical expertises are far superior to the customer, hence the client's contribution towards co-production of the technical aspects of a service is limited. There

is a gap in our knowledge of the level of contribution made by each the parties for successful service delivery in professional services.

2.6.1 Evolving Model of Healthcare

Across the world the healthcare model is constantly under evolution. This evolution is characterized by criticism of the old bio-medical model of health, development of information technology, the role of policymakers in healthcare delivery and also trends in materialism, individualism and consumerism (Albrecht, Fitzpatrick and Scrimshaw, 2000; Samson, 1999). The bio-medical model used by many health professionals is characterized by physician-centeredness, male-centeredness, giving due importance to credentials and not tolerant of any form of alternative therapy (Miller and Crabtree, 2000).

The bio-medical model believes that the body is a machine with its own anatomical spare parts and physiological processes that when out of sync can be fixed and treated by a health professional with sufficient knowledge and expertise. This model of health seems to have worked for decades and has lead to advances in treatments. This model though focuses too much on the physical expression of illness by a client and ignores the psychological expression of illness that may never physically manifest itself. The development of the sociology of emotions (James and Gabe, 1996) gives us the underpinning explanation of how our body connects with social relations, psychological processes and the biological processes. The disconnect between the body and mind in the bio-medical model has lead to clients seeking alternative/complimentary therapies for controlling their lives and subsequent well being.

The setting up of the Health and Disability Commissioner lead to a big shift of power from the treating physician to the receiver of his/her care the client. The client seems to have a choice of healthcare options and hence is able to control their own quality of life and subsequent well being. The bio-medical model still remains the dominant force but alternative/ complementary therapies are also gaining ground and clients choose between the two based on their individual needs. The discussion now considers the healthcare services client and discusses his/her role while engaging in professional service episodes.

2.6.2 The Client's Perspective

The current literature shows various theories developed in understanding the relationships between a client and health professional and also the roles assumed by the client in a healthcare encounter. The theories range from dominance of biomedicine, the feminist viewpoint of male-centred healthcare services and the care vs. cure debate by the nursing profession.

The various models sit on a continuum starting with a disease-centred model where the health professional makes the diagnosis and offers solution based on the bio-medical model of health (Dew and Kirkman, 2002). On the other end of the continuum is the client-cantered model of holistic care where the mind and body are addressed while delivering healthcare services (Cant and Sharma, 2000).

One of the reasons for alternative/complementary therapy gaining popularity is the attention paid to the mind's involvement in ailment, and the individualised care offered during a consultation. The actual fact is that all the consultation episodes are somewhere on this disease-centred to client-centred continuum and their nature can change based on type i.e. acute vs. chronic care and the length of time spent with a health professional. This length of relationships also affects client's individual perceptions of quality of life and attainment of well-being. Following is a brief summary of both models.

2.6.3 The Bio-medical Model

This role makes the client a lot more passive and a lot less assertive and compliant to the medical treatment and advice given by the health professional. This role puts the onus of getting better on the client and seeks the client to demonstrate a compliant and sick-behaviour which is appropriate in a societal context. This also gives rise to the power-authority issues in this relationship where the health professional assumes power due to his/her ability to offer healthcare solutions based on specialized skills, knowledge. This role prescribed by the bio-medical model still remains the dominant role played by clients in the current context (Cant and Sharma, 2000; Lupton, 2002).

2.6.4 The Consumer Model

This role makes the client a lot more involved in his/her healthcare choices. This role also makes the client think and behave like a client who is well informed, resists power exerted by the health professional, a lot more assertive and questioning of the motives and modalities of the health professional (Lewis and Bridger, 2000). These clients seem

to demonstrate a parallel between choosing between a restaurant, supermarket and a health professional (Lupton, 2000). Coile (2001) also notes these clients to be better connected to technology and can drive the demand for better drugs and treatments available across the globe. These clients are well informed of their healthcare choices and also discuss treatment options with treating professionals after having read expert opinions from various sources. They also seem to demonstrate a deeper understanding of their healthcare rights, also have the ability and willingness to engage more than one health professional and more than one type of therapy for treatment (Thakur and Perkel, 2002).

2.7 Factors Affecting Relationship Longevity

There are several issues that have a role to play when it comes to providing an appropriate service to a client and the onus is placed more on the health professional than the client (Garman et al., 2004). Health professionals get trained as scientists for many years and are expected to change orientation and start thinking like a service provider the moment they start consulting. Some health professionals find it difficult to switch into this new mode that may have implications for establishment of trust between the parties with obvious implications for perceptions of quality, commitment, propensity of re-patronage and positive word of mouth behaviour (Shah et al., 2003; Stearns et al., 2001).

Trust is recognized as a key mediator of successful relationship building but has received very little attention in the context of client-health professional relationships (Leisen and Hyman, 2004). Trust becomes a key component of this relationship as risk of unfavourable outcomes could be fatal, and clients have to assume the health professional has their best interest at heart (Swan et al., 1998). This perceived ability of trust to reduce uncertainty is very important and evident in high credence services, including professional services (Laing and Lian, 2005). It is obvious that trust plays an important role in building and sustaining long-term relationships.

Another issue is the outlook of the health professional with regards to a client's physical and demographic characteristics. Health professionals are likely to have a bias with

regards to obese clients (Stearns et al., 2001). Obese clients are not looked on as clients with metabolic anomalies but instead as individuals with low self-esteem, low self-respect and without any regard for disciplined life (Braunsberger and Gates, 2002). This can significantly impact the level of empathy demonstrated by the health professional and the allied staff members in an encounter (Braunsberger and Gates, 2002).

Ethnicity and culture also plays a role in the level and type of service expected by clients and the actual delivery in an episode (Saha et al., 2003). Clients reported higher levels of satisfaction when they chose a health professional who was either from their own culture or ethnicity and also when a professional from another ethnicity demonstrated a sound understanding of cultural safety issues (Winsted, 2000). These are in-line with the earlier findings of Grönroos' (1984) levels of satisfaction reported by the client and client's own understanding of functional quality issues of a service episode.

Gender also plays a role in perceptions of service quality and levels of satisfaction expressed by clients (Stearns et al., 2001). It is noted that women are more sensitive to the relational aspects of the service experience unlike men who are more focussed on the core service delivery (Bendall-Lyon and Powers, 2002). Research has also demonstrated that even the gender of the health professional has an impact on functional quality of the service experience. Female health professionals have shown to spend more time with their clients compared to their male counterparts with an obvious implication on the aspects of patient's service experience (Arora et al., 2004).

Economic inequalities also are a major determinant of quality of care received by the clients (Curtis, 2004). Social class, access to primary healthcare and healthcare services driven by bottom line issues have major implications for the health of a society (Flaskerud and Nyamathi, 2000). Health research policy commonly identifies gender, social class and ethnicity as major challenges facing the health of a nation. The primary care givers i.e. health professional have a major role to play in this type of relationship where the inequalities should not become the cause of a lack of quality healthcare.

Sharma and Patterson (1999) have demonstrated that communication effectiveness has obvious implications for perceived trust in a service provider, expected service quality and level of commitment shown to the relationship. We all learn the dual modes of communication viz. verbal and non-verbal from early childhood days (Littlejohn, 2001).

Clients utilise verbal communication for sharing of information and also put equal emphasis on the non-verbal cues in an encounter (Sundaram and Webster, 2000). The non-verbal cues include body language, posture, and tone of the voice, voice modulation and genuine interest in a client's condition exhibited by the health professional during standard consultation. The proximity and empathy demonstrated by the health professional with physical touch and other gestures and their actual physical appearance have an impact on credence quality and perception of competence (Stearns et al., 2001).

The healthcare professional's adherence to a conventional bio-medical model of disease can sometimes lead to a breakdown of communication within the dyadic relationship. The health professional may find there is no room for social, psychological and behavioural issues in a typical consultation encounter (Baker, 1997). This plausible breakdown in communication between the two parties may have subsequent implications for their relationship. There are a number of psychological issues that can lead to a breakdown of communication between the client and the healthcare professional (Shah, 2003). These issues are prominent in clients seeking help for chronic diseases (Baker, 1997). Living with a chronic and sometimes life threatening disease the clients go through a 'Dialectic Self' phase (Charmaz, 1991) where they think they know more about their own disease than the healthcare professional. This can be frustrating for the health professional with implications for ongoing communication within the dyadic relationship. It is a tough balancing act expected out of the client where one has to be both dependant on and at the same time be independent of the treating professional and this can lead to a sense of helplessness for the client (Baker, 1997).

Frank, open and empowering communication between the health professional and his/her clients has a much wider role to play within the healthcare sector. Studies have shown when a health professional uses communication as a means of empowering the client to share and co-create an appropriate experience they report higher levels of service satisfaction and also resultant quality of life and self reported well-being (Michie, Miles and Weinman, 2003). When clients feel empowered they are likely to take charge of their treatment choices and also are likely to demonstrate loyalty behaviour (Ouschan, Sweeney and Johnson, 2006).

2.8 Consumer Well-being

Scholars of psychology have also shown a keen interest in the issue of well-being and quality of life and have researched the issues for many years. For this research enquiry healthcare service has been chosen as context. Within the context of this study an issue that seems to take a centre stage is the client's subjective evaluation of well being (Deci and Ryan, 1991, Diener et al., 1999, 2000; Gibbs, 2004; Ryan and Deci, 2000) and its subsequent implication for quality of life. Sergey and Lee (2007, p.28) define "Consumer well-being as a state in which consumers' experiences with goods and services—experiences related to acquisition, preparation, consumption, ownership, maintenance, and disposal of specific categories of goods and services in the context of their local environment are judged to be beneficial to both consumers and society at large".

Research on well-being tends to fall into two general groups based on what is meant by well-being. The first one also called as the hedonic view point focuses on subjective well being (SWB), which is frequently equated to happiness and is defined as "more positive affect, less negative affect and greater life satisfaction" (Diener et al., 1999, p.278). In contrast the second viewpoint also called the eudemonic view focuses on psychological well being (PWB), captured by dimensions of an individual's perception of happiness, meaningfulness, wellness, self actualisation and vitality (Ryan and Deci, 2000). In spite of their definitional and philosophical differences these two view points do seem to show some degree of overlapping (Ring et al, 2006).

The most widely used definition for subjective well being is:

"Subjective well being is a broad category of phenomena that includes people's emotional responses, domain satisfactions and global judgement of life satisfaction" (Diener et al., 1999, p.279)

2.8.1 Theory of Well-being

The theory of well-being is broadly divided on the differences in points of view. There are two different views held by scholars when it comes to defining well-being namely the Eudemonic and the Hedonic view.

The Eudemonic view Point - “ between those needs (desires) that are only subjectively felt and whose satisfaction leads to momentary pleasure, and those needs that are rooted in human nature and whose realization is conducive to human growth and produces eudemonia i.e. well being ” Aristotle

The Hedonic View Point - “the goal of life is to experience the maximum amount of pleasure, and that happiness is the totality of one’s hedonic moments” Aristippus, 4th century B.C.

Although there are various ways to evaluate the pleasure versus pain continuum, most scholars of hedonic psychology assess subjective well being (SWB) as a key construct (Diener et al., 1999). By a broader definition SWB consists of three parts; life satisfaction, the presence of positive mood and the absence of negative mood, together often summarized as happiness (Diener et al., 1999). There is a plethora of research done on various antecedents to well being in the field of psychology, personality, mental health, economics and social sciences. Some of the prominent ones are trusting relationships, social class and wealth as predictors of well being (Diener et al., 1999; Diener and Lucas, 2002; Ring et al., 2006).

2.8.2 Trusting Relationships and Well-being

The second issue is that of social attachments and relatedness and its impact on well-being. Evidence shows that warm, trusting and supportive relationships are the key to enhanced well-being and quality of life (Deci and Ryan, 1991). The importance of relatedness is so huge that some scholars have even classified it as a basic human need (Deci and Ryan, 1991). Studies show that people experience greater relatedness when they felt understood, trusted and engaged in a dialogue and had fun while engaging in the relationships (Ryan and Deci, 2001).

Trust has emerged as a key component in successful relationship building and hence there is a lot of interest shown by researchers in understanding trust and especially evolution of trust in a service episode (Ranaweera and Prabhu, 2003). Trust plays an important role when it comes to choosing between providers, the overall commitment shown by the parties and also the cooperation that exists between parties in a service episode (Berry, 1995; Doney and Cannon, 1997; Morgan and Hunt, 1994; Palmer, 1995; Young and Wilkinson, 1989). Thus break down of trust conversely will have a detrimental effect on the scope of relationship building process (Fitzpatrick et al., 2001).

Trust between the parties seems to be an important issue for fostering long-term relationships (Halliday, 2004; Hausman, 2003; Kang and James, 2004; Patterson and Sharma, 1999; Rao and Perry, 2002; Ravald and Grönroos, 1996; Wong and Sohal, 2002). The evidence of trust as a mediator in relationship longevity is overwhelming.

One of the commonly cited definitions of trust is:

“Trust exists when one party has confidence in an exchange partner’s reliability and integrity” (Morgan and Hunt, 1994, p.27)

The final and the most important issue that seems to be intuitively linked is the association between health status of an individual and their perception of subjective well being (SWB). Sickness by its virtue is closely associated with displeasure and this leads to increased negative affect and further chronic illness may lead to decreased life satisfaction with subsequent effect on decreased (SWB) subjective well being and their quality of life (Ryan and Deci, 2001). This link between chronic illness and life satisfaction and the need for warm trusting relationships needs to be explored further within the context of healthcare services. In this context, there is an opportunity to explore dyadic relationship between a professional and his/her clients. This research can also explore issues of service quality, satisfaction, loyalty, re-patronage, word of mouth and relationship longevity in professionally delivered services.

2.9 Chapter Summary

The literature shows a clear link between some of the key issues: the notion of value, co-creation of this value in high credence services, client's dependence on trust in a relationship and its impact on client well-being and subsequent quality of life evaluation. Looking at the discussion so far it is evident there are gaps in our knowledge with regards to professionally delivered services (see Table 2.1).

Table 2.1 - Knowledge Gaps Professional Service Relationships

Section/Topic	Knowledge Contribution	Gap in Literature
2.1 Services Marketing	Thorough discussion on client's role plays in production of goods and services (Prahalad and Ranmaswamy, 2000). Empowering clients to take more active role in consumption process (Wright et al., 2006). Conceptualization of value co-creation processes in product and service delivery (Grönroos, 2008; Payne et al., 2008; Vargo and Lusch, 2004).	Limited empirical research on the how to let clients take such an active role in production and consumption of products and services alike. No empirical research on who creates value and who co-creates the experience and the role of the enterprise in these co-creation processes.
2.2 Service Quality	Conceptualization of managing client expectations in service delivery (Ojasalo, 2001). Importance of managing 'critical incidents' in service encounters and Their impact on relationship longevity (Bitner, 1990).	No empirical research on how to manage fuzzy, implicit and unrealistic client expectations during service delivery. Limited empirical research on various processes used by the service providers to manage critical incidents.

2.3 Relationship Marketing	Proposed typology of relationship development from pure professional to close friendship (Coulter and Ligas, 2004).	No empirical research on processes that lead to this transition from professional to friendly relationship between a service provider and his/her clients.
2.4 Professional Service Relationships	<p>Opportunities offered by proximity and continuity of professional service relationships between a provider and receiver of services that can lead to relationship longevity (Eisingerich and Bell, 2007; Lovelock, 1996).</p> <p>The role of enterprise in client empowerment in consumption of products and services and its implications for service quality perceptions (Hjalager, 2001; MacStravic, 2000).</p>	<p>Limited research on what factors contributes to this relationship development and its impact on relationship quality.</p> <p>Limited empirical research on various processes of empowering clients in a service encounter.</p>
2.5 Healthcare Services	Multifaceted conceptualization of client well-being and its relative impact on quality of life indicators (Ryan and Deci, 2001).	Link between chronic illness and life satisfaction and the need for warm trusting relationships need to be explored further

One of the shortcoming of all the studies so far is that they try to extend or link service quality with service satisfaction, loyalty, trust, empowerment, commitment and word of mouth through a positivist paradigm within the context of healthcare services. There are two kinds of chronic illness client. The first type is the client who can be managed by the health professional. The second type is the client who holds the view that death is a better outcome compared to ongoing service delivery. None of the research completed so far has focussed on inclusion of all kinds of respondents irrespective of whether the illness can or can not be managed. This research enquiry explores the practical realities of respondents who are engaged with a health professional over a period of time.

CHAPTER THREE – Methodology

3.0 Introduction

The aim of this study is to identify, generate and describe a theoretical explanation of how a client engages in and manages their relationship with their health professional over a period of time. This chapter will justify the use of qualitative research methods for this enquiry. It will discuss the role of naturalistic enquiry as a paradigm governing the ontology and epistemology of this research, and will further elaborate on using unstructured interviews as a preferred methodology for data collection (see Figure 3.1). The second part of this chapter will examine thematic analysis as a preferred method of data analysis. The third section of this chapter will discuss the issues of access to the field, selection of research participants, confidentiality, accuracy and Treaty of Waitangi obligations in research.

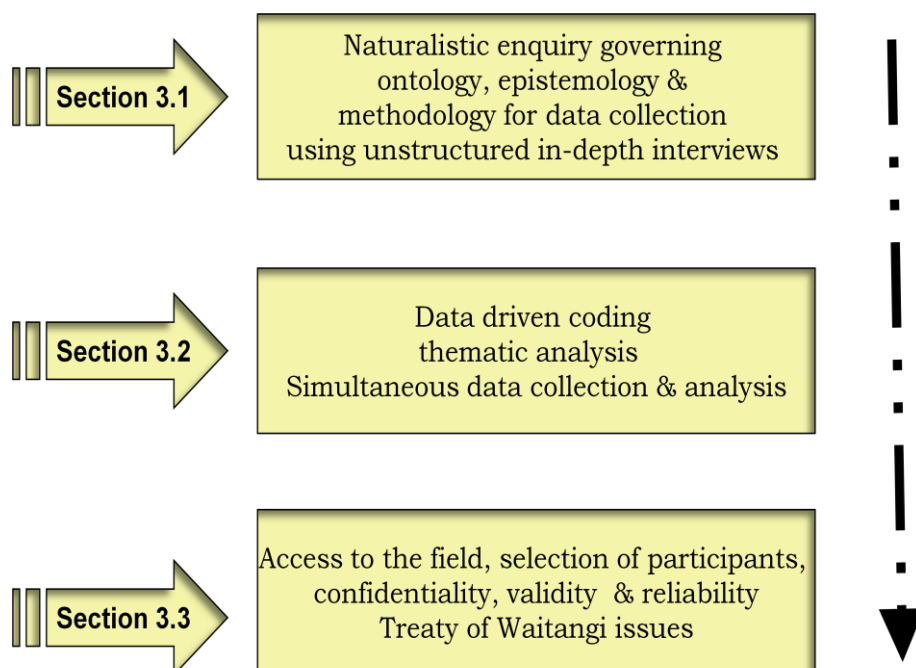


Figure 3.1 – Chapter Three Outline

3.1 Qualitative Research

This research seeks to explore the practical realities of clients engaged with a professional service provider over a period of time. The aim of this research is in line with the commitment shared by qualitative researchers of understanding lived human experience in its most natural setting (Lincoln and Guba, 1985). Qualitative research methods are appropriate when researchers want to study a phenomenon in its natural setting and interpret that phenomenon in terms of the meaning assigned by each participant under study (Lincoln and Denzin, 2000). The aim of qualitative research is to understand and illustrate the experiences and actions of people as they live through life's situations. Exploring the practical realities of chronically ill patients when they engage with a healthcare provider is a complex phenomenon and this very complexity of shared relationship lends itself to qualitative research enquiry.

Qualitative research begins by accepting that there are various ways of making sense of the world. The goal of qualitative researcher is to explore the world view of research participants rather than their own (Crotty, 1998). There are various approaches used by qualitative researchers which have their own tradition of rigor and work within different implicit and explicit philosophies. The one common theme that governs all qualitative research is its ability to contribute to the process of revision and enrichment of understanding, rather than pure verification of theory (Denzin and Lincoln, 1994). There is considerable overlap in terms of procedures and techniques in different approaches to qualitative research. These approaches have a number of features in common such as person-centeredness and an open-ended starting point. Qualitative researchers adopt a critical stance towards positivist perspectives and usually search for meanings in the accounts and actions of the participants under study (Lincoln and Guba, 1985).

3.1.1 Philosophical assumptions

One of the key questions a researcher has to ask when choosing a qualitative pathway for his/her enquiry is "what philosophical assumptions are being implicitly acknowledged?" (Creswell, 2007) These philosophical assumptions consist of the stance a researcher has taken towards the ontology, epistemology, and methodology of the research. Guba (1990) has further suggested a qualitative researcher has to answer three key questions when choosing a qualitative pathway to enquiry: "what is the nature

of reality?” (Ontology), “what is the relationship between the researcher and knowledge?” (Epistemology) and “how the researcher should go about finding out knowledge?” (Methodology). The paradigm guiding this research enquiry is naturalistic enquiry (Lincoln and Guba, 1985).

Table 3.1- Naturalistic Enquiry (Lincoln and Guba, 1985)

Axiom	Naturalist Version
Ontology	Multiple constructed realities that can be studied only holistically; prediction and control are unlikely but some level of understanding (verstehen) can be achieved.
Epistemology	The enquirer and the “object” (participant) of enquiry are interactive and inseparable.
Generalization	The aim of the enquiry is to develop an idiographic body of knowledge in the form of “working hypotheses” that describe individual cases.
Causality	All entities are in mutual simultaneous shaping so it is impossible to distinguish causes from effects.
Role of Values	Every enquiry is “value-bound”, influenced by the values of the enquirer, choice of investigation paradigm, choice of substantive theory and the context of enquiry.

Ontology – Naturalistic enquiry states that an individual’s life is socially constructed and heavily networked; though sharing of experiences help build one’s reality and give a sense of cohesiveness and meaning to life (Lincoln and Guba, 1985; Goulding, 1999). Humans give their actions meaning relative both to the events and to the people they share their lives with. Thus there are many constructed realities that are heavily entrenched within one’s fabric of social and cultural boundaries (Schwandt, 1994). This thesis adopts the position that there are multiple realities and they are dynamic, complex and multi-faceted (see Table 3.1).

Epistemology – The epistemology adopted is the position that researchers and their participants are interactive and inseparable. No one individual is privileged in the inquiry process. Naturalistic enquiry suggests the researcher and participants work collectively and equally to co-create “findings” via interacting (Lincoln and Guba,

1985). This epistemology favours interaction between the researcher and participants in which participants can tell stories about how they enact and construct meaning in their daily lives (Lincoln & Denzin, 2000). This research enquiry will seek to engage with participants through an interactive method of data gathering.

3.1.2 Situating the researcher

IN naturalistic enquiry the researcher elects to carry out research in its most natural setting possible within the context of the enquiry, as realities can not be understood in isolation and one has to immerse oneself within the context of the research (Lincoln and Guba, 1985). The only instrument the naturalist researcher chooses to use is the power of observation and interaction with other humans to evaluate the meaning in these interactions and sometimes interpret the meaning behind these interactions.

3.2 Data Collection Method – Unstructured Interviews

An interview is a widely used tool within the domains of sociology, psychology and anthropology as a means of accessing people's experiences, perceptions, attitudes and more importantly their individualistic world-view (Kvale and Brinkmann, 2009; Patton, 1990). Interviews can be further divided into three types: structured, semi-structured and unstructured interviews (Fontana and Frey, 2005). Lincoln and Guba (1985, p.37) suggest "all entities are in mutual simultaneous shaping so it is impossible to distinguish causes from effects; the enquirer and the 'object' of enquiry are interactive and inseparable" This idea of inseparability between the interviewer and his/her "object" (participant) lends itself to in-depth interview as a suitable method for data collection. An in-depth interview is defined as an unstructured, direct personal interview in which a single respondent is probed to uncover underlying motivations, beliefs, attitudes and feelings about a phenomenon (Malhotra and Peterson, 2006). The current research adopts unstructured, depth interviews as its method of data collection.

Naturalistic enquiry proposes multiple realities that can not be controlled but can only be holistically studied such that some level of understanding (*verstehen*) can be achieved. This ontology lends itself to one type of data collection method, the unstructured interview, as the most suitable method for the research. An unstructured

interview is a type of interview in which neither the questions nor the answers are pre-determined. This method relies on the social interaction between the interviewer and the participant. The course of the questions and the discussion is at times guided by the participant. Patton (1990) regards the unstructured interview as a natural extension to participant observation where questions and their answers are spontaneously generated by the actors in the dyad i.e. the interviewer and the interviewee. The merit of the unstructured interview lies in its conversational nature, which allows the interviewer to be readily responsive to each participant's constructed realities and guides the discussion to aid the process of understanding the participant's world-view (Patton, 1990).

In an unstructured interview the role of the researcher is to enter the field keeping aside all preconceived ideas about the phenomena under investigation. The intention of an unstructured interview is to expose the researcher to unanticipated themes and patterns within the data and shape his/her understanding of the social reality of the research participant (Briggs, 2000). This does not mean that an interviewer does not undertake pre-interview preparation. It is normal practice to have a format of questions ready before the interview is started so there is some degree of control over the conversation. This pre-determined format or list of questions is usually an aide memoire that helps the researcher stay on topic during the interview session and also bring in some degree of consistency across different interview sessions (Briggs, 2000).

One further technique commonly used while conducting an unstructured interview is the writing up of memos. A memo is a note to oneself. It is usually a note written by the researcher when he/she thinks of an hypothesis about a code or minor theme, or more importantly, when he/she identifies a link between the minor themes that make up the major theme (Strauss and Corbin, 1994). Scholars recommend this as a good habit that helps the process of coding and establishing a relationship between various codes, minor and major themes.

3.3 Data Analysis Method – Thematic Analysis

Creswell (2007) suggests that a researcher's choice of research methodology is dependant on the research problem on hand. The purpose of this enquiry is to identify, generate and describe a theoretical explanation of how a client engages in and manages their relationship with their health professional over a period of time. Braun and Clarke (2006) suggest that by using thematic analysis a researcher may be able to identify a general framework to explain how people are experiencing an event in their lives. Given the scope of this research, thematic analysis is an appropriate methodology for this enquiry.

Braun and Clarke (2006, p.79) propose thematic analysis as a method for “identifying, analysing and reporting on patterns (themes) within the data that helps to minimally organize the data and describe it in rich detail” Thematic analysis is regularly used by many researchers in a variety of disciplines (Boyatzis, 1998; Frith and Gleeson, 2004; Powell and Ennis, 2007). This section outlines the background and application of thematic analysis and then discusses why this method is appropriate for exploring the practical realities of clients engaging with healthcare professionals.

3.3.1 Key Issues in Thematic Analysis

The most commonly used methods for data collection in thematic analysis are in-depth interviews, note taking and theoretical memos that describe events, feelings and interaction patterns (Powell and Ennis, 2007). This methodology has a built in flexibility as it allows the researcher to draw upon prior knowledge but not feel bound by it.

Thematic analysis involves systematic steps of data collection; coding and analysis. The process is initiated with reading and re-reading each transcript and looking for a pattern within the data and using coloured pens to highlight each time a pattern is observed in the transcript (see Table 3.2). This initiates the process of coding and then each pattern of data is given a label or name and a brief description to elaborate that code. As more transcripts are generated with ongoing data collection the process of coding continues and the researcher is likely to start refining each code to make sure they are mutually exclusive. The next stage is to look for pattern and interdependencies between each

code and collapsing codes into themes. Towards the final stages each of the themes is discussed and then given a name or label and later defined.

Table 3.2 - Thematic Analysis – Step by Step Guide (Braun and Clarke, 2006)

Phase	Description
Familiarization with the data	Data transcription, reading and re-reading and noting down initial ideas
Generating initial codes	Initiating the process of coding using data management software NVivo 8
Searching for minor themes	Collating codes into minor themes and gathering more data for enriching the minor themes
Reviewing all themes	Reviewing all the minor themes and collapsing them into major themes with simultaneous memo writing and generating a cohesive thematic map
Defining and naming major themes	Ongoing analysis and refinement of major themes with thorough discussion utilizing the thematic map, naming and defining major themes
Providing description for major themes	Final discussion on major themes with the help of exemplars from the original transcripts that help build a descriptive storyline for the research

When conducting thematic analysis each piece of data is continuously compared with each piece of relevant data so as to generate open codes, and then these codes are further compared with all other data in order to generate interrelationships and theoretical constructs (Roulston, 2001). This constant process of collecting, analysing and then collecting more data allows the researcher the flexibility to code the themes, refine them and even extend these minor themes into major overarching themes. These major themes are later grouped together into a conceptual model (thematic map) which describes all the issues and concerns of the research participants under study.

Philosophical Position – Thematic analysis can be used as a realist method that reports on experiences, meanings and realities of the participants under study (Boyatzis, 1998). On the other hand it can be a constructionist method that illustrates how participants create meaning from their experiences within the broader social context (Willig, 1999).

During data analysis, themes can be identified via two different ways, deductive (Boyatzis, 1998) or inductive (Frith and Gleeson, 2004) pathways.

Deductive versus Inductive Reasoning - There are two different approaches to knowledge creation, deductive and inductive reasoning (Crotty, 1998; Hyde, 2000), which is theory driven (deductive) versus data driven (inductive) approaches. Thematic analysis can be used in both forms for the purpose of acquiring new knowledge. The deductive pathway starts by hypothesizing about an issue and then testing if the theory applies or holds true within a specific context. Thematic analysis can be used to seek patterns in the data and then prove or disprove some of the hypothesized causal relationships between variables (Boyatzis, 1998).

Thematic analysis works just as well with inductive logic where the objective is not to test but to build theory (Braun and Clarke, 2006; Frith and Gleeson, 2004; Roulston, 2001). The data driven approach lets the researcher seek knowledge in a naturalistic setting. As each new piece of data is collected, coded and analysed the researcher is able to provide a rich description of the data and the emergent themes within the data. This pathway of inductive coding helps with generating substantive theory (Strauss and Corbin, 1994). Substantive theory is a low level theory that is applicable to an immediate situation or a phenomenon situated in a particular context (Creswell, 2007).

This research enquiry followed an inductive coding pathway for thematic analysis (Frith and Gleeson, 2004). Inductive analysis as a process follows a pathway of coding the data without trying to fit the data into an existing coding frame and is not driven by the researcher's preconceived ideas about the analytical framework. This style of coding is usually data-driven and lets the data drive the initial codes, and later on, minor themes and resultant major themes. This research seeks to understand how individuals react to and reflect upon different situations, with respect to their chronic illness.

Coding – Coding is a process of transforming raw data into theoretical constructs appropriate to the underlying phenomenon under study. Usually coding evolves as raw data is analysed line-by-line and word-by-word. Roulston (2001) describes this process of emergence as generation of codes and minor themes from the raw data. This process initiates the process of theme development. When reading through the transcripts each time one gets a sense of consistent patterns in the data; these patterns get coded as chunks and are later given labels to help distinguish them from other codes. These

patterns are initially called open-codes and represent the process of examining the data, comparing the data with similar chunks within the same piece of transcript or transcripts from other interviews (see Figure 3.2). Later the data is conceptualized and categorized as open codes (Strauss and Corbin, 1990). Figure 3.2 depicts three such open codes that emerged out of a sample piece of transcript namely: trust, communication and power & authority.

Snapshot of Data & Coding

"To be able to trust your health professional is crucial with all the information that you give them and with making the right decision for you but with me so she will give me options about my treatment but also allow me to make the decisions. So she allowed me to throw the medication out the window and then come back and say well I've done this" Gill –Tape4)

Open Codes >>> Trust Communication Power & Authority

11

Figure 3.2 - Coding the Transcript for Patterns of Data

3.3.2 Simultaneous Data Collection and Analysis

Usually in the first interview the researcher is asking questions such as “What is going on here?” and “How is the person managing the situation?” (Glaser and Strauss, 1967; Keyton, 2001) Based on the first interview, the coding begins. Later the second interview is conducted keeping the open-codes from the first interviews in mind. As more and more interviews are conducted, the emergent open-codes are compared to the existing codes on the file. The data is constantly analysed and codes are refined throughout the process of data collection. Thematic analysis involves systematic data collection, coding and analysis. Coding initiates the process of theme development and allows the researcher to transform raw data into theoretical constructs (Bailey, 1997;

Frith and Gleeson, 2004). As the interviews progress with time a list of open-codes are generated (see Figure 3.3). The interview process is terminated when theoretical saturation is achieved. Glaser and Strauss (1967, p. 61) define theoretical saturation as stage in data collection where “no additional data are being found where by the sociologist can develop properties of the category”. This is a stage in data collection beyond which no new codes emerge. Later each transcript is read and re-read several times and this helps with the process of sorting the data and the open codes so as to achieve a list of mutually exclusive codes. The next figure depicts the entire set of open codes and how four open codes were collapsed together to depict two minor themes.

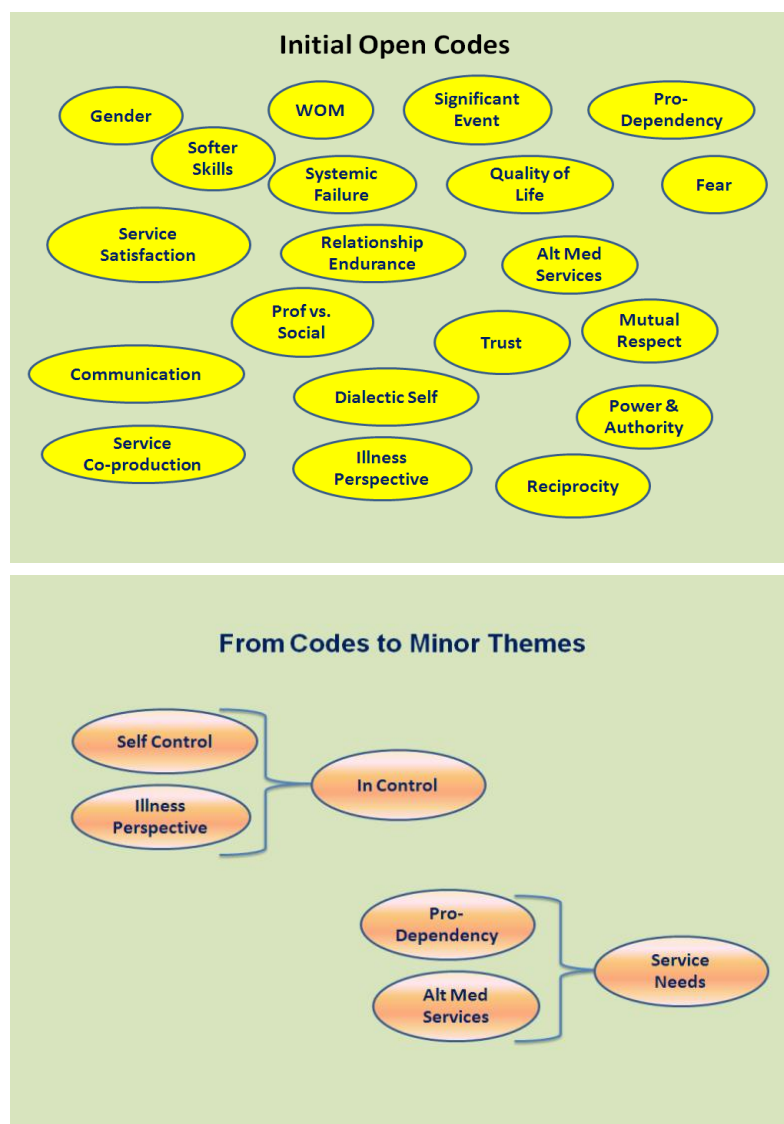


Figure 3.3 - From Open Codes to Minor Themes

Later on these codes are collapsed into minor themes and this initiates the process of description (Braun and Clarke, 2006). The aim is to look for interrelationships between the minor themes and build a theoretical explanation for the phenomena under investigation (see Figure 3.4). A total of five open codes were collapsed together which lead to emergence of major theme Degree of Control. The interrelationship between these five open codes will be discussed in detail in the next chapter.

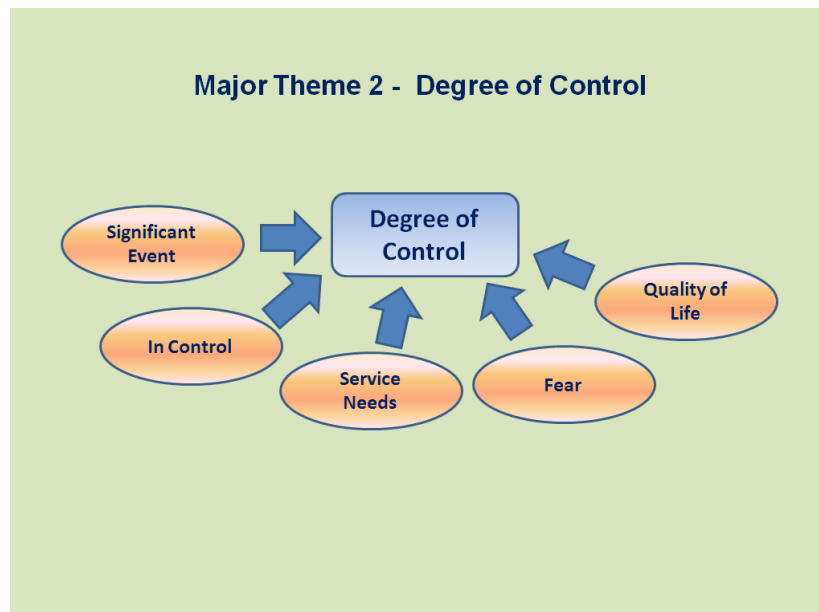


Figure 3.4 - From Minor Themes to a Major Theme

Theoretical Sampling - In this study the main source of data is unstructured in-depth interviews. The most popular approach is face-to-face interviews that could be one off or repeats with the same participants, and involves conducting an in-depth discussion until theoretical saturation (Braun and Clarke, 2006) is achieved. Theoretical saturation is a stage in data collection where no new information can be found with any additional data being collected (Creswell, 2007). In thematic analysis research participants are chosen because they have certain types of life experiences and they can discuss and elaborate on the phenomenon under study. The researcher will not set a limit on the number of participants, but rather be guided by the principle of achieving theoretical saturation and will rely upon network sampling at the beginning of the enquiry. Network sampling is a procedure developed by Sirken (1970) for the measurement of

characteristics or a phenomenon in rare populations. Burns (2003, p. 256) defines network sampling as a “sampling process that holds promise for locating subjects who would be difficult or impossible to obtain in other ways or who had not been previously identified for study”

In undertaking inductive thematic analysis, data collection is guided by the need for more data that is relevant to emerging codes. Once the initial codes emerge the researcher has to work towards getting additional data for substantiating existing codes. Hence the participant selection process is guided by the initial interviews and further data collection continues until all the codes are saturated. Sampling in thematic analysis is therefore described as theoretical rather than purposeful and is driven by emergence of theory (Braun and Clarke, 2006).

3.4 Research Design

This section outlines the various issues relating to the actual research conducted in the field: access to the field, profile of participants, ethical behaviour and lastly Treaty of Waitangi issues.

Access to the field - Access to the field was initiated with gaining ethics approval from the Auckland University of Technology Ethics Committee. The researcher used his professional network at Manukau Institute of Technology to recruit participants for this research. The institute runs a quarterly research seminar series. The researcher presented his research proposal at one of the seminars and invited participation for the research from the audience and from their personal and professional network.

Care was taken not to use any form of persuasion or persuasive language while extending an invitation to join the study. The Komatua of the institute was consulted with regards to involving Maori participants in the study. The Komatua also agreed to act as a contact person for inviting Maori participants for this study. To continue the process of consultation with Maori groups within the greater Auckland region, Mr. Tony Spelman of iwi Ngati Hikairo was consulted on a regular basis. Mr Spelman guided the researcher with regards to issue of a Kupapa Maori approach to research (Lincoln & Denzin, 2000). Issues of cultural safety while engaging with Maori

participants were discussed and the researcher was provided with procedural guidelines for conducting depth interviews with Maori participants.

Informed Consent - Once potential participants were located they were contacted and invited for an initial discussion and provided with a participant information sheet (Appendix – A). Participants were then contacted after a week to seek consent and discuss a mutually agreed time and venue for the interview. Before each of the interviews was conducted the researcher asked each participant to complete a participation consent form (Appendix – B).

Participants - This research enquiry actively sought two social groups within New Zealand, namely New Zealand Europeans and Maori communities around the greater Auckland region. All the participants were actively seeking medical advice and treatment for the management of a chronic illness. The intention was to study the kind of relationships shared by these individuals with their health professional over a period of time. Adults living with chronic illness and within the age group of 20 – 70 years were selected for the research. One of the pre-conditions for participant selection was that participants were willing to engage and participate in a dialogue and were able to articulate their experiences with their health professional, and able to express their experiences in English.

In total 17 participants volunteered for the research study from different walks of life but with one underlying commonality, they were all receivers of chronic healthcare services. The participants were mostly residents of the Auckland region; some resided in Hamilton, Te Awamutu and Wellsford. In all the cases the researcher travelled to a mutually agreed venue at an agreed time for each interview. Most of the interview sessions were conducted in the participants' homes usually sitting at the dinner table or on the deck. These venues were mostly selected by the participants themselves where they felt most comfortable discussing their chronic medical condition.

At the beginning of each interview the researcher attempted to make the participants comfortable by discussing general topics such as sports, movies, food choices. After each interview the participants were given an opportunity to decline the researcher's use of whole or parts of the audio tape from the session. Table 3.3 provides a profile of the 15 research participants whose interviews form the dataset for the research. There were two participants who volunteered for the interview but did not open up to the enquiry

and the sessions lasted for only ten minutes. These two sessions were not transcribed due to the lack of data, and were not included in the data analysis.

Table 3.3 - A Brief Summary of Research Participants

Participant No & Pseudonym	Age	Gender	Occupation	Nature of Illness	Length of Illness
Tape 1 - Aryan	52	Male	Education	Kidney Stones	20 years
Tape 2- Bala	42	Male	Education	Asthma	15 years
Tape 3- Aria	45	Female	Secretarial	Asthma	30 years
Tape 4- Gill	52	Female	Nursing	Hypertension	8 years
Tape 5- Bill	55	Male	Hospitality	Depression	12 years
Tape 6 - Ana	62	Female	Retired	Diabetes	15 years
Tape 7- Baba	71	Male	Retired	Diabetes	30 years
Tape 8- Jane	68	Female	Retired	Hypertension	30 years
Tape 9- Etha	72	Female	Retired	Angina	14 years
Tape 10- Pike	65	Male	Priest	Infarction	16 years
Tape 11- Tami	60	Female	Retired	Angina	26 years
Tape 12- John	62	Male	Business	Cardiac	9 years
Tape 13- Sam	65	Male	Retired	Renal	12 years
Tape 14- Eian	55	Male	Accounting	Asthma	15 years
Tape 15- Joe	55	Male	Education	Asthma	33 years

Transcription - Each interview session typically lasted for 45 minutes to an hour. All the sessions were audio-taped. After each interview the tapes were sent to an independent transcription agent who returned them within two working days. All the tapes were transcribed verbatim so as to not miss any of the pauses, coughs, sneezes, laughs or other sounds made by the researcher and the participants during the session (see Appendix – C). After the transcripts were printed each tape was played and checked against the transcript to look for omissions and alterations. This listening to tapes and

simultaneous reading of the transcript helped with the initial coding and also helped with cross checking memos written while in session.

An entire transcript of one interview is included in appendices (Appendix – C).

Deception - The researcher made all possible attempts to make the participants feel safe and protected during the entire time of participating in the research. All the participants were informed of the reasons for conducting the interview before the session began. They were instructed that they did not have to answer any particular question if they did not feel comfortable discussing it and that they could withdraw from the research anytime they wished. They were told that it was within their right to contact both the supervisors for verification using the details provided on the consent form.

Accuracy - Accuracy of the data is of prime importance and one of the ways of keeping control on accuracy was to allow the participants an opportunity to check the interview transcripts. Only two participants used this opportunity to review if their views were expressed in an appropriate manner and that cultural safety was maintained.

Treaty of Waitangi - In accordance with the Health Research Council (HRC) criteria, which are in turn guided by the Treaty of Waitangi, the three principles of partnership, participation and protection were adhered to while conducting the research. All the participants were allowed sufficient time to consult with their respective whanau, hapu and iwi before any consent was signed for the research interview. This enabled a partnership between the researcher and each participant.

The researcher offered protection by providing an environment that was open, welcoming and supportive in nature. All the participants were kept informed at all stages of the study and had an equal opportunity to take part in the research. All the participants were given an opportunity to review transcriptions to ensure that their cultural values are reflected appropriately. This collaborative process helped adherence to the principles of Treaty of Waitangi.

3.5 Issues of Reliability and Validity

The reliability and validity of the data collection technique and the processes used for data analysis are crucial to qualitative research (Keyton, 2001). To assess the reliability and validity of this research the guidelines proposed by Horsburgh (2003) were utilized. Horsburgh (2003) proposes the following set of criteria: subjective meaning, participant validation, description of the context, lay knowledge, flexibility of design, sampling design and generalizability of the findings.

3.5.1 Reliability of Research Data

As a reliability check two independent judges were appointed and were provided with an entire transcript for one interview for the purpose of independent coding. Both the judges were asked to report back on their independent coding with a list of open codes. Open codes conceived by the judges were compared line by line with that of the open codes generated by the researcher using NVivo 8 software. In the case of the first judge a total of 80 % of codes came back as matching with that of the researcher's codes and 90 % with that of the second judge. These scores were re-assuring with regards to the reliability of coding process. The discrepancies between the judges' coding and the researcher's coding were discussed and amendments were made to the final list of codes.

3.5.2 Validity of Research Data

When conducting qualitative research the researcher has to be mindful of obtaining logically consistent accounts of human experiences. The entire research process relies upon the assumption of logical consistency within the actual process of conducting research. This consistency should hold true for the data collection, interpretation and analysis processes.

Subjective meaning and Participant validation – The key question that needs to be addressed when conducting qualitative research is “does the research illuminate the subjective meaning, actions and the context of those being researched?” To validate if the research had captured the subjective meaning of the participants, each participant was given the option of reading the transcript. Two participants chose to take up the offer.

Lay knowledge - Towards the end of thematic analysis all the three major themes were discussed and cross checked with two more participants. This was done to make sure that the final analysis was consistent with the common / lay knowledge of the participants. This was also done to make sure that emphasis is given to the interpretations of those being researched rather than the value-laden interpretation of the researcher.

Description of context - One of the key features of qualitative enquiry is its ability to provide in-depth description also called thick description (Denzin and Lincoln, 1994). A key question is not that this type of research produces thick description but what is the purpose of this description. The question that guides this purpose of enquiry is “is the description provided detailed enough to allow the researcher or the reader to interpret the meaning of what is being researched?” Denzin and Lincoln (1994) have noted that thick description makes interpretation possible. Chapter Four is dedicated to providing the reader with thick description of the phenomena under study. Chapter Four provides a trail illustrating how transcripts were used to conceive open-codes which were later used to conceptualize three major themes.

Flexibility - Another validity check is the operationalisation of the method chosen for data collection and the method of data analysis. A key feature of valid qualitative methodology is its flexibility, rather than a rigid or standardised approach to research, and its capacity to fit the context of the study. Unstructured in-depth interview of all fifteen participants was the best method to capture the description of the context. Care was taken to let the participants use medical terminology while discussing their health concerns. Each participant brought different issues to the table and hence each interview was different in its flow of ideas.

Purposive sampling - A purposive sample is selected by the researcher subjectively and the researcher attempts to obtain a sample that appears to him/her to be representative of the population under study (Patton, 1990). A key question while choosing respondents for the study was “will the sample produce the type of knowledge necessary to understand the structures and processes within which the individuals are located?” the underlying purpose is to pick a subject that would give the most information and would have an impact on knowledge development. Patton (1990) calls them “information rich cases” that are able to offer an in-depth understanding about the phenomena under study

rather than empirical generalizations. All fifteen participants were purposefully chosen through the method of network sampling. Each participant had a history of chronic illness and were living and managing their condition over a period of time. During this time these participants were regularly engaging with various health professionals for seeking advice and treatment.

Generalizability - It is often argued that the aim of qualitative research methods is not to generalize to a wider population. In a qualitative enquiry the aim is to make some degree of generalization to our theoretical understanding of a phenomena or cases more than seeking probabilistic generalization to the population. The aim of this research is to understand the practical realities of chronic health sufferers when engaging with their health professional.

3.6 Chapter Summary

This chapter has outlined the background to the qualitative research paradigm with a detailed discussion on using the unstructured interview method for data collection and using thematic analysis as the method for data analysis. All the issues pertaining to research design, ethical behaviour and procedural issue of Treaty of Waitangi were discussed in detail. The validity and reliability issue of this research were properly addressed. The next chapter will discuss the major findings of this study and demonstrate the process of theme development in detail with the help of relevant samples of transcripts.

CHAPTER FOUR- Findings

4.0 Introduction

The purpose of this research is to generate theoretical explanation of how a client engages in and manages their relationship with their health professional over a period of time. This chapter presents the results of thematic analysis completed on the primary data collected during in-depth interview sessions with the research participants (see Figure 4.1). Later the chapter explores the issues and practical realities of these participants as they engage with their professional service providers over a period of time. Typical of any qualitative research, this study was an iterative inquiry process, and data collection involved moving in and out of a series of interrelated activities with the ultimate goal of gathering good information (Creswell, 2007).

The data analysis reveals three major themes Nature of Relationship, Degree of Control and Service Satisfaction (see Figure 4.2). The chapter gives the reader insights into the sub-themes and open codes that have helped shape these three major themes.

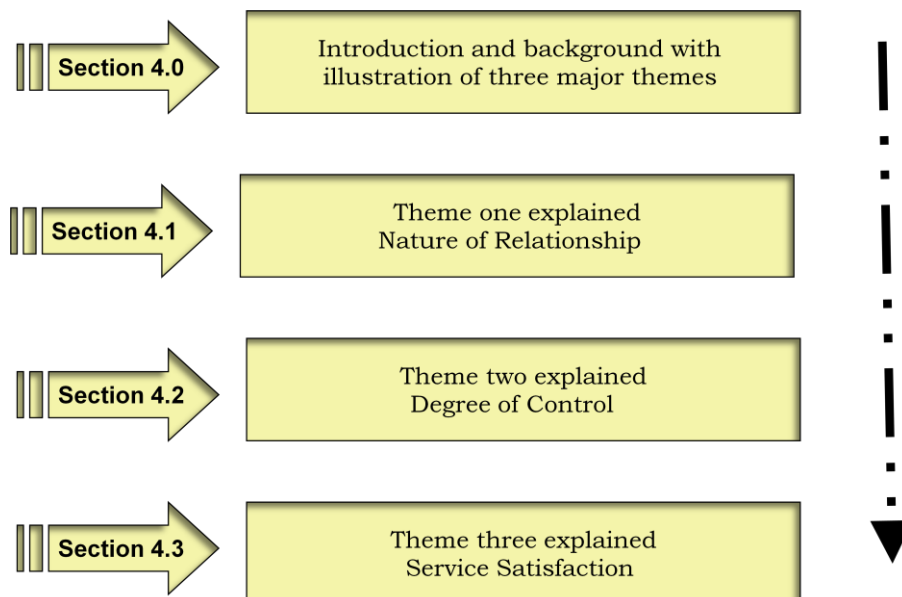


Figure 4.1 – Chapter Four Outline

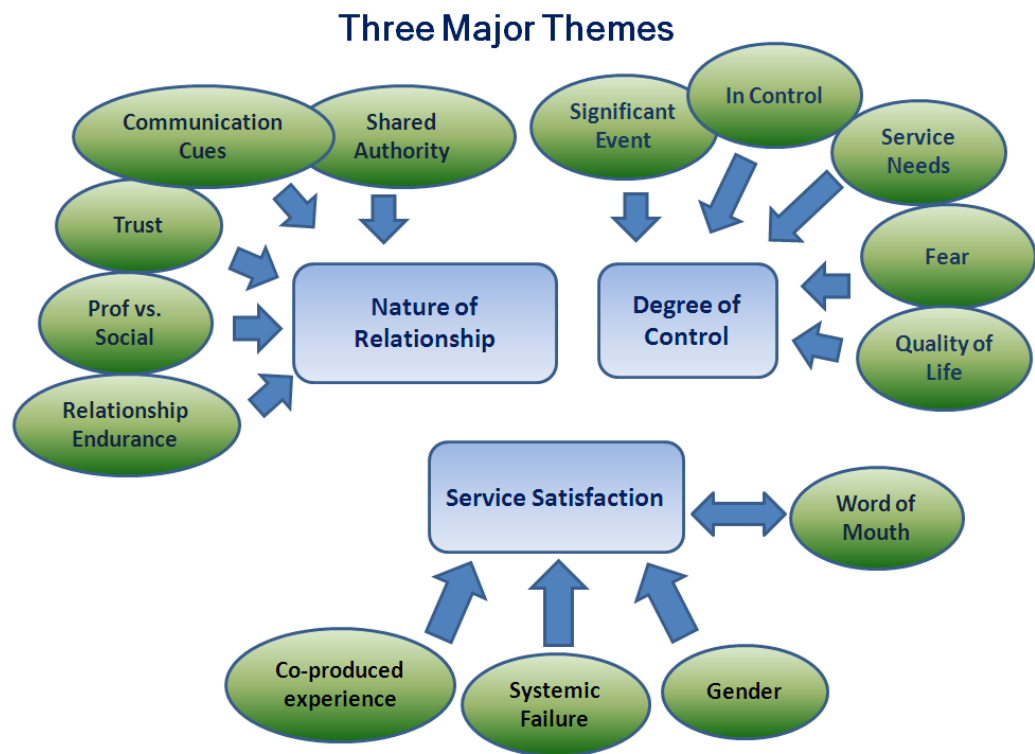


Figure 4.2 - Three Major themes illustrated

These major themes provide insight into the complexities of the relationship shared by a client and his/her professional service provider. These themes illustrate how clients of professionally-delivered services engage with their providers over a period of time and how this shared relationship may undergo various intricate and evolutionary changes. Throughout this evolutionary phase this relationship gets complex and embedded within the social and psychological fabric of the client's life.

The context of this study (i.e. healthcare service and the client's vulnerability when engaging with these services) is very different compared to other types of professionally delivered services such as accounting, educational and legal services. One of the key issues uncovered during this discovery process is that of client's overall satisfaction with the services received and its implications for the longevity of this relationship.

4.1 Theme One - Nature of Relationship

The first theme identified in the data, Nature of relationship (see Figure 4.3) has six different facets, the sub-themes that make up the overarching theme. This theme illustrates how clients of healthcare services engage with their provider and how this relationship evolves with time. This evolution is affected by various interpersonal factors such as locus of power, communication within the dyad, trust and social aspects that go beyond the consulting chamber of the health professional. Further discussion is warranted to illustrate how each of sub-themes fits within the overall theme.

Theme -1 Nature of Relationship

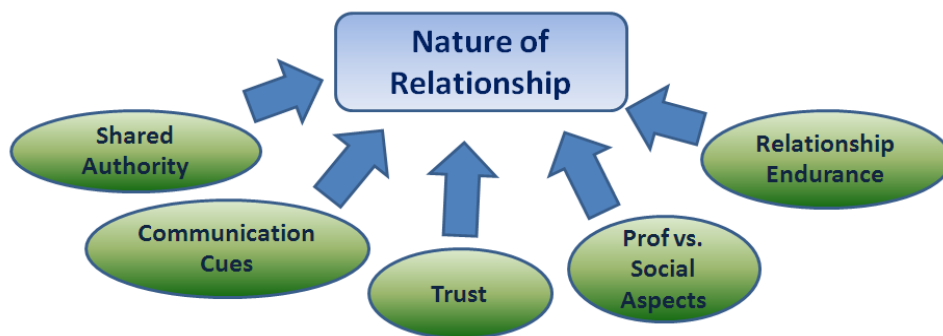


Figure 4.3 - Nature of Relationship

The first and one of the key aspects of this relationship is the notion of shared authority between the health professional and his/her clients. This shared authority, as the title suggests, is the sharing of power by the parties in the dyadic relationship. This sub-theme is composed of three open codes that emerged during the initial stages of coding viz. power and authority, mutual respect and reciprocity (see Table 4.1).

Professional relationships are typically looked upon as relationships where one of the parties commands authority when dealing with the other. Most often that party who commands this authority is the professional service provider. This inequality in relationship may stem from the professional service provider's ability to render services with years of training and practice. Another contributing factor to this inequality is the client's lack of knowledge and appropriate training. The client at times submits to this situation and learns not to question this authority vested in their health professional, as is evident from the following excerpt of transcript.

"Well they are in control, they make the final decision as to how they treat you and what they treat you with so as a patient you can't take control, you can't insist" Aryan-Tape1

Table 4.1- Construction of Theme One – Nature of Relationship

Major Theme	Sub-Themes	Open Codes
Nature of Relationship	Shared Authority	Power and authority Mutual respect Reciprocity
	Communication Cues	Communication Softer skills
	Trust	Trust
	Professional vs. Social	Relational aspects
	Relationship Endurance	Relationship endurance

This inequality does get resolved with time as both the parties engage with each other on a regular basis and a participative nature of service encounter starts to emerge. As time goes by these parties also show a natural progression towards a mutually respectful behaviour and they seem to value each other's opinions. This evolution was initially coded mutual respect, shown by both the parties when engaging with each other. This feeling of mutual respect leads to the client feeling in-charge of their life and treatment choices and he/she begins to share authority in the relationship as illustrated by two pieces of transcript taken from Gill's interview.

“With my GP it’s a therapeutic communication that she gives me enough rope to hang myself but will stop me hanging myself in the end if you know what I mean so that the communication is she talks to me like a peer, um but I know that she knows more than I do in terms of my own health and I don’t want her to tell me what to do but I also don’t want her to give me all the power to make my own decisions” Gill-Tape4

“I really got on very well with the locum person but that might have been because we had similar tastes in clothes and that was a less professional relationship I suppose that she would say love what you’re wearing and where have you been shopping lately and your hair looks good and all that kind of thing which in turn boosts your morale but I was really there for the medical expertise” Gill-Tape4

This new found respect within the parties leads them to treat each other as equals and this relationship starts to evolve beyond just a professionally delivered service and begins to be a part of a social fabric for both of them. Tami was able to illustrate this pattern of evolution between her and her doctor who appears to have become a friend.

“Because I greet him with a hug and farewell with a hug but it also means I can talk to him about anything if it’s related or family or whatever. Because in my position as a priest it’s difficult because the image I think public have as a priest” Tami-Tape11

The next important aspect of this shared relationship is the level of communication between the parties engaged in a professional service encounter. The previous transcript discussed under shared authority (see Tami - Tape11) illustrates the importance of communication between the parties for their ability to share authority in a relationship. Open ended communication can lead to participative decision making during an encounter, but the converse is true as well and this apparent lack of or breakdown of communication between the parties can have detrimental effects for longevity of this dyadic relationship.

The health professional at times likes to hold on to their authority in the relationship, and uses language as the means to demonstrate their control in an episode. At times this is achieved by using medical jargon that the client is not familiar with and this jargon seems to work like a barrier within dyadic communication and can frustrate the client aptly described by Jane in the next piece of transcript.

"It's hard at the hospital to get out of the doctors or even to see a doctor or nurse. I mean I go over at seven o'clock some mornings and just wait but it's hard to understand what they're trying to tell you. They talk in their language" Jane-Tape8

It is no secret that an open ended and equilateral communication between the parties certainly leads to a stage where the health professional is willing to share authority and take instructions from the client for the best course of service delivery, as illustrated by the next item of transcript.

"I have to lead them through the process saying well hang on a minute, yes x-rays don't necessarily show them, well not often but on occasion I find I'm leading the urologist through the process and saying well this test might not necessarily tell you what you need to know" Aryan-Tape1

The literature recognises that people use dual modes of communication, both verbal and non-verbal (Sundaram and Webster, 2000). Participative decision making in an episode is also partly driven by the non-verbal cues sent by both the parties. This non-verbal communication seems to follow the lead from the verbal cues in an episode. These non-verbal cues were initially coded as softer skills as these are usually called the bedside manners of health professionals. There are times when the health professional may use non-verbal communication to show that he/she is still in control. This further demonstrates that he/she does not wish to relinquish their authority by having open ended and welcoming communication, as illustrated by the following items of transcripts from Bala's and Tami's interview.

"My GP no totally different relationship to the guy I saw once, I think he was very competent but I didn't warm to him if you know what I mean, you know there was no humane element, I think" Bala-Tape2

"A lot of doctors that they go to see don't look at them the patient, they're looking at the screen to see the symptoms or whatever, the drugs and things and I've had a number in the last few years saying but he doesn't see me personally. He's just got this screen and hardly ever swivels his chair around to look at me" Tami-Tape11

The third aspect of this shared relationship is the evidence of trust between the parties and its role within the major theme Nature of relationship. When a client decides to engage a service provider they rely upon word of mouth referral from their social network to recommend a service provider. The underlying rationale is the trustworthiness of such recommendation. Later trust between the parties takes a similar evolutionary

path as that of shared authority. During the initial encounters both the parties are not sure of the intentions of the other and with time and with multiple encounters both learn to respect each other. With time both parties start trusting each other to make an appropriate decision for service delivery. This is evident from Gill's interview.

"Well trust is huge in my life and I think even more so at the age I am now. To be able to trust your health professional is crucial with all the information that you give them and with making the right decision for you but with me so she will give me options about my treatment but also allow me to make the decisions. So she allowed me to throw the medication out the window and then come back and say well I've done this" Gill-Tape4

The relationship marketing literature has provides a typology for professional services that suggests a continuum from a purely professional relationship to a purely social relationship between a service provider and a client (Hogg and Laing, 2003). The fourth dimension of the nature of relationship is that of professional vs. social aspects.

During the initial encounter when a client needs to engage with a health professional the relationship will normally exhibit a purely professional character. This professional boundary between the client and his/her service provider starts to get blurry and with time starts to turn into social contact similar to a friendship. This evolution towards a social bond has its basis in the amount of time spent in such a relationship, trust between the parties and the mutual respect that helps foster a social bond as described by Tami in the next piece of transcript.

"We go there for their occasions like 21st birthdays or whatever, give them a Christmas present, they give me one. That sort of thing" Tami-Tape11

This evolution towards a social bond is not always true and a few clients like to keep their relationship as a purely professional contact and nothing beyond as illustrated by the next item of transcript.

"Purely professional but I respected her because she is my age and she would ask me about my work and I would ask her about hers so we had a professional boundary around our relationship" Gill-Tape4

The fifth and the final aspect of this relationship is relationship endurance described as the willingness of the client to engage and stay in a relationship with their health professional. It is a culmination of all other sub-themes of nature of relationship such as willingness to share authority, mutual respect shown thorough communication, the trust

between the parties and finally the natural evolution towards a social bond between the parties. If the client feels like an equal in a relationship, has a trusting relationship with their health professional and also able to have a dialogue with their professional on social aspects then he/she is more than likely to stay in such a relationship, as illustrated by Aria and Tami in their interviews.

“I have a GP now and she is really good and I have had her for the last 4 years and she is good. We talk a lot and we do talk about my personal life issues and also about my health and overall social issues. She is very friendly and I trust her” Aria-Tape3

“Oh I always trust my doctor implicitly. The doctor I have now is one I’ve had since 1989 and his practice is at Tuakau which is a half hour journey for me from my home and I go there. He’s become a personal friend”Tami-Tape11

4.1.1 Theme summary

The discussion so far indicates presence of a major theme, the nature of relationship between health professionals and their clients. This major theme illustrates a continuum, where at one end the clients and their health professionals share an equal relationship, use communication cues to demonstrate a level of mutual respect, where there is evidence of trust between the parties and where both the parties may gravitate towards greater social contact. This also has implications for the longevity of the relationship, and the client may willingly decide to stay in such a relationship. The next theme is called Degree of Control. This second theme is linked to the first theme, Nature of relationship.

4.2 Theme Two – Degree of Control

The second theme identified in the data is the degree of control (see Figure 4.4). This theme is composed of five sub-themes and looks at how unfolding events in the client’s life have an impact on their relationship with the health professional and subsequently the client’s self-reported well-being. Data analysis uncovered five different facets for this theme that are intertwined with each other. Further discussion is needed to elaborate on these five sub-themes significant event; in-control, service needs, fear and quality of life (see Table 4.2).

The first sub-theme, significant event, refers to an event that occurs in the client's life that changes the course of things for them. Most of the data describes how clients accidentally found out about their chronic illness and how this revelation came as a shock and surprise. Such sudden and significant events are reported throughout the data. Such a discovery makes the client feel that they are losing control of the status quo and Pike certainly felt vulnerable faced with such situation back in 1995.

"In 1995 I had a myocardial infarction in the lower left, underneath the muscle there. I had an angiogram about six months later and it couldn't really get through. My doctor I asked for a printout and about 60% was blocked and I ended up in Greenlane and I ended up in coronary care" Pike-Tape10

Major Theme 2 - Degree of Control

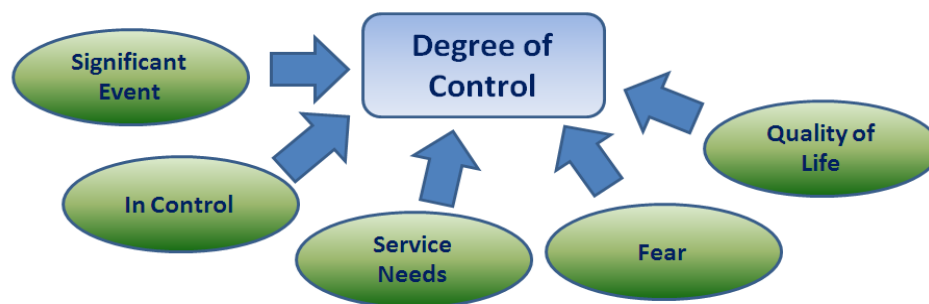


Figure 4.4 - Degree of Control

The second aspect of degree on control is called in-control and is described as the level of control exercised by the client over his/her life circumstances. The data talks about individuals who pathologically understand their body and their medical condition and know how to self-manage their condition. Some clients are able to predict the onset of

an emergency and know how to manage such an incident. Aryan certainly spoke highly of his ability to self manage his illness.

“It’s based solely on the severity of the pain. If I know I’m about to pass a kidney stone or have passed one and the pain is really extremely bad then I’ll go straight to hospital. If its just niggling, grinding pain or I get a sharp stab of pain and it goes away and I’m out of pain occasionally I’ll just go to the GP for a repeat prescription of medication” Aryan-Tape1

These clients know they are responsible for their life and like being in control at all times and do not like it when the health professional wants to take charge and decide the course of optimum service delivery. This sense of loss of control frustrates them, as depicted by the next item of transcript from Aria’s interview.

“Sometime the doctor will listen sometimes they keep trying stuff to see it does not work and then give you what they should have at the beginning” Aria-Tape-3

These are individuals who are aware that they are living with a medical condition but do not consider it to be a major impediment and don’t think of themselves as chronic sufferers, as illustrated by the next item of transcript excerpt.

“I don’t consider myself chronically ill, if chronic is defined in terms of severity of illness, but if chronic is defined as an ongoing perpetual thing then yes it’s a chronic and because its ongoing and um I guess.....”Aryan-Tape1

Table 4.2 - Construction of Theme Two - Degree of Control

Major Theme	Sub-Themes	Open Codes
Degree of control	Significant Event	Significant event
	In Control	Self in control Illness perspective
	Service Needs	Professional Dependency Alternative Medical Services
	Fear	Fear
	Quality of Life	Quality of life

The third facet of degree of control is service needs and is the level of dependency shown by the client on professional services provided by a health professional as depicted in the next excerpt of transcript from Eian's interview.

"I mean I go to the doctor on a regular basis now because the doctor says you are a high'ish risk candidate asthma-wise and I want to keep it controlled so I have to go to the doctor for treatment every three months"Eian-Tape14

Sometimes the clients do not have a choice hence are heavily dependent on professional services. If the clients are able to take back some of this control it makes them less dependant and less vulnerable which has an obvious impact on their self-reported well-being.

This sub-theme of service needs is a continuum where at one end a client is completely dependant on professional service providers. On the other end when the clients feel they are in-charge, they are more likely to behave like clients who willingly engage in professional services. Etha talked about her need as a consumer when engaging with health professionals and her want of control on her consumption process.

"I mean I go to this chiropractor once a month or sometimes twice may be and it makes me feel energised for the rest of the week and my GP knows I do this and he is ok with it, I guess. I do it for myself I want to feel good and relaxed" Etha-Tape9

The fourth aspect of degree of control is the fear experienced by the clients of professional services. This sense of fear arises from the chain of events that occurred in their life, starting with a significant event that led to the change in status quo and the subsequent loss of control of life circumstances. All of these events make the client fearful for their own life and the possible outcomes of failed service delivery. The next transcript excerpt puts this fear in perspective and documents how a client is fearful of the outcome and is hiding it from loved ones.

"Privately frightening, not publicly, not to show your wife, yeah it is but for me it was a mixture of that and I guess because I am who I am, a Christian priest that its almost like what will be will be you know so it was a mixture really" Tami-Tape11

The extent of how fearful a client is has a lot to do with the apparent loss of control on one's well-being. This feeling of being vulnerable has much to do with the fear of consequences of failed treatment. Sometimes this loss of control is more of a

psychological trauma clients suffer when dealing with health professionals and institutional setups like hospitals.

The final aspect of this degree of control is that of client's self-reported quality of life. The data shows evidence of how a significant event in the client's life leads to significant changes in life circumstances and an overall decline in self-reported well-being. More than anything this declining quality of life has to do with how vulnerable the client feels and how they despise this lack of control over life circumstances, as depicted in the next item of transcript from Jane's interview.

"My quality of life is not the same, definitely not the same, see I was very active before I had the leg off and it was good but since I've had this leg off and what have the quality of life has gone down to nothing" Jane-Tape8

4.2.1 Theme summary

The data suggests that the occurrence of a significant medical event in the client's life comes as a shock that sometimes needs urgent intervention from a professional service provider. This sudden event makes the client feel that they are losing control over life circumstances and the event also unwittingly makes them dependant on professional service providers. This loss of control also makes the client fearful of the situation and generally has an impact on their self-reported wellbeing and quality of life in general. The converse is true, as well when a client is in control of their life circumstances, and is able to manage their medical condition and hence is less likely to be dependant on professional services is less fearful of the personal situation and has a positive outlook towards their quality of life.

4.3 Theme Three – Service Satisfaction

The third and the final theme identified in the data is that of Service Satisfaction and is composed of four sub-themes, co-produced experience, systemic failure, gender and word of mouth (see Figure 4.5). This theme deals with the client's self-reported satisfaction with the services provided by their health professionals over a period of time. Service satisfaction and the issues of service quality are widely researched topics

and an attempt is made to discuss this major theme within the framework of professional services (see Table 4.3).

Theme -3 Service Satisfaction (outcome)

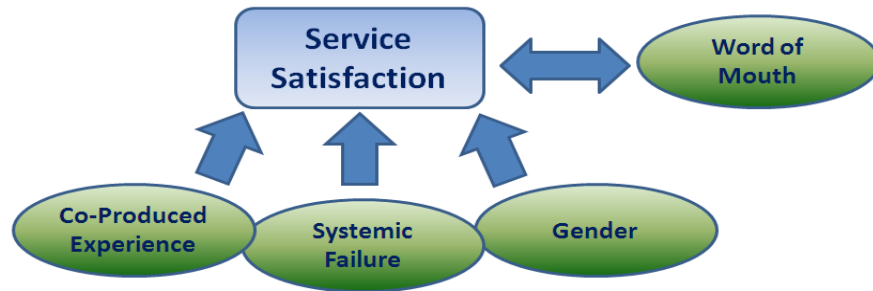


Figure 4.5 -Service Satisfaction

The first facet of this major theme is co-produced experience in an encounter, described as how the client and his/her health professional co-produce a service experience during their repeat encounters. The onus of co-producing an experience lies equally on the client and his/her health professional. This co-produced experience is dependant on both the parties sharing operant resources (sharing information); the failure to share these resources has obvious implications for service delivery outcomes. In his interview Bill talks about holding back operant resource and wanting the health professional to reach out and provide an appropriate solution to the problem.

“I used to go into him and not give him the full picture of what I was experiencing because I wanted him to think about things and figure things out because I’m an intelligent guy, I can figure a few things out and would propose things and he said yes it could be that, it probably is that but that was an excuse for him not to think a little bit laterally and challenge himself” Bill-Tape5

In a typical service encounter, service providers use socialization processes to make the client aware of the role they have to play during an encounter (Kelley et al., 1990). In the next excerpt of transcript the client seems to understand the role they have to play in an encounter and is using an analogy to justify their role.

“You know what its like, there’s no point in just going along and like telling your teacher, I’m no good at maths and they say well why aren’t you good at maths, well I don’t like it. But in actual fact you’re not doing any homework so you’re not practising, so they don’t get the whole picture” Gill-Tape4

Table 4.3 - Construction of Theme Three – Service Satisfaction

Major Theme	Sub-Theme	Open Codes
Service Satisfaction	Co-produced Experience	Service Co-production
	Systemic Failure	Systemic frustrations
	Gender	Gender issues
	Word of Mouth	Word of mouth referral

This sharing of operant resources seems to be the driver for successful service delivery. The willingness to engage in such sharing of resources certainly has an impact on the client’s perception of service quality outcomes, that is, if they are satisfied or dissatisfied with the services provided to them.

The next facet of the major theme is systemic failure and is described as individual and or institutional systemic failure. These failures are not always under the control of health professional but these failures have a serious impact on service delivery and reported satisfaction with the delivery. The clients are usually aware of these institutional systemic failures which are a source of frustration for them, as illustrated by the next excerpt of transcript from Bill’s interview.

“I had to go to hospital to have radioactive iodine, it comes over from Melbourne and I jumped the queue because we made a lot of noise and complaints about how unwell and in fact how unwell I was going and that’s the only reason we managed to queue jump” Bill-Tape5

Sometimes the source of systemic failure is the service provider themselves. This has to do with the health professional's approach towards dealing with clients in an encounter. A total lack of personal touch and time spent in an encounter can frustrate clients, as depicted by the next item of transcript. The real issue is that of systemic failures leading to client dissatisfaction with the services provided.

"I think 15 minutes maybe 20 if you're lucky and really its like a conveyor belt and I sometimes feel like even with my GP you know if you're coming in and they have a little chat um they give you a quick diagnosis, they're under time pressure" Bala-Tape2

The third aspect of service satisfaction is the issue of gender bias and the subsequent reporting of service satisfaction. The data shows an interesting observation that some clients are particular about the gender of health professional they engage as service provider. Conversely, the data shows other clients don't seem to care about the gender of their health professional, as long as the health professional is able to provide appropriate services. Gill illustrated this gender bias in her interview.

"She was recommended and I don't remember who by right now but she came with ah women's health at the fore and someone who will make sure that you get all your checks as a woman but also she was very good with children" Gill-Tape 4

The literature on service quality has noted that different genders have different expectations from their service providers and report different levels of satisfaction post-delivery. Some of the interview participants claim that gender of the service provider has an impact on the nature of services received and their reported service satisfaction. The same data also points out cases where the gender of the service provider and the nature of services received show a bias and impact on subsequent satisfaction with the service delivery. Tami certainly got a first hand experience of this in her stay at the hospital.

"It's a men's ward overflow and they resented me, the women thing and I got no attention from the staff. I didn't even get a wash except when my husband came in and did it whereas I noticed the men were washed and I wasn't" Tami-Tape11

The fourth and the final aspect of service satisfaction is the ongoing word of mouth behaviour of clients. The transcripts show evidence that clients both utilise word of mouth and generate word of mouth. This is a two way relationship where a client relies on referral while choosing a health professional.

“We have heard from someone that this was a really good practice to be in and its very close and convenient which is important if you have a child because you know you might be doing a few unexpected runs to the doctor early in the morning” Bala-Tape2

Secondly, in a post consumption scenario, the client may generate word of mouth. The propensity of a client to engage in positive or negative word of mouth behaviour depends on the level of satisfaction with the services rendered as illustrated by Bill’s transcript.

“I’m taking myself off them so these are the same health professionals who are treating my daughter and I just said to her look if you would like to go to another doctor, I can recommend a good doctor, different doctors, they have women doctors da-de-da” Bill-Tape5

4.3.1 Theme summary

Service satisfaction is an important facet of health professional – client relationship. Satisfaction has implications for the client’s propensity to stay in a relationship. The client understands that he/she needs to co-create an experience during an encounter by sharing resources and this has a bearing on perceived satisfaction with the service provider. There are two external issues that also affect reported satisfaction with the service provider; they are the gender of the service provider and the institutional failures that accounts for substandard service delivery.

4.4 Summary - Relationship between themes

Finally, we seek to explore how these major themes may come together in a single framework.

The issue at the heart of this study seems to be the longevity of the shared relationship between the client and his/her service provider. If the client feels they have a voice in the relationship, then there is an implicit trust and respect between the parties. The client is able to bond with their health professional and appears more than happy to remain in the relationship. Similarly if the service provider is able to relinquish some control to the client then the client is more than likely to share operant resources, co-create a desired experience with their provider. This sharing of authority will make the client remain in such a relationship. These clients will also report higher level of satisfaction with their service provider with obvious implications for longevity of the relationship.

CHAPTER FIVE – Discussion and Implications

5.0 Introduction

The aim of this research enquiry is to identify, generate and describe a theoretical explanation of how a client engages in and manages their relationship with their health professional over a period of time. The thematic analysis (Chapter Four) revealed three major themes viz. degree of control, service satisfaction and nature of relationship respectively. This chapter explores each of these theme and its sub-themes with respect to the parent theories introduced in chapter two. These findings are further divided in two categories of knowledge as follows:

- a) A priori theme (s) - confirming previously established constructs and
- b) Emergent theme – original contribution of this study to the body of knowledge

5.1 Discussion

Theme identification is one of the most fundamental tasks in qualitative research. Opler (1945) proposed three principles for thematic analysis. Principle one, the themes are only visible and thus discoverable through the manifestation of expressions in the data. Principle number two, some expressions of a theme are obvious and agreed upon by scholars, or can also be subtle and symbolic in nature. Principle number three, themes can be interrelated and entrenched within the social fabric of a civilization. Themes come from both the data (emergent approach) and from the researcher's prior theoretical understanding of the phenomenon under investigation (a priori approach) (Ryan and Bernard, 2003). It is common to identify some themes in advance referred to as "a priori" themes. These themes are very obvious to the researcher as he/she has chosen a purposive sample with assumptions that the participants will be able to share information with regards to phenomena under investigation.

5.2 A Priori Themes

The importance of using a priori themes is evident when researching well-established phenomena. For example, a researcher investigating participant experiences of chronic illness may feel that "trust" can be readily used as an a priori theme because of its prominence within the literature (Suh, Janda and Seo, 2006). The next sub-sections discuss the link between each of the three major themes and their parent theories discussed in the literature review chapter of the thesis.

5.2.1 Major Theme Degree of Control

The first major theme that emerged after the thematic analysis was *degree of control* (see Table 5.1). This theme is composed of five sub-themes, *significant event*, *self in control*, *service needs*, *fear* and *quality of life*. The first sub-theme *significant event* is described as a sudden medical event that leads to life-changing circumstances for an individual. Such significant events are looked upon as turning points and are heavily embedded in the memory of the chronic sufferer. These events are generally of two types, positive and negative. They serve as pointers for progression of the illness over time. The positive events can reinforce the feeling of being in control of one's life. Negative events have the reverse effect. These findings are very much in line with earlier seminal work done by Charmaz (1991) and Denzin (1984). Living with chronic illness can be very intrusive and a sudden event has the power to alter the course of life for chronic sufferers.

The second sub-theme to emerge is called *in control*. This is characterized by the client's ability to self manage their medical condition and a refusal to accept that they may have to live with a pathological condition. This heightened awareness of one's body makes the client behave like a dialectic-self individual who likes to be independent of the disease condition and also not be dependant on the health professional. This ability of the individual to take charge of their life and also of treatment choices is well documented in the research by Charmaz (1991). This sense of control on one's life-situation makes it easy for these individuals to live a life independent of the disease. The third sub-theme, service need, is linked with the second sub-theme of in control. Even with the need for control in one's life, chronic sufferers need to consult their health professional on a regular basis to access prescription

medication and medical advice. They have to work closely with their service provider for better health outcomes (Anderson, 1995). The client's ability to self-manage their medical condition can diminish with time and this may be due to normal progression of the disease itself or due to a non-compliant attitude of the dialectic-self. This progression makes them dependant on the professional service provider. The client uses all the avenues possible to be independent and in control of their life as soon as possible. This finding is also in line with the work by Charmaz (1991).

Table 5.1 - Major Theme – Degree of Control

Sub- Theme	Evidence from Literature	A Priori / Emergent
Significant Event	Sudden events in ones life (e.g. medical emergency) has the power to alter the course of life ahead	A Priori theme identified in previous research by Charmaz ,1991; Denzin,1984
In Control	These sudden/ accidental events do bring about a sense of loss of control on ones status quo	A Priori theme identified in previous research by Charmaz ,1991
Service Needs	With time the medical condition can worsen and this forces the client to engage with the service provider on a long-term basis	A Priori theme identified in previous research by Anderson, 1995; Charmaz,1991
Fear	All these events make the client vulnerable and fearful of the service delivery outcomes especially with regards to professionally delivered services	A Priori theme identified in previous research by Grönroos, 1982; Patterson,1993; Lovelock,1996
Quality of Life	The altered lifestyle and long-term dependence on professional services does impact upon client's perception of quality of life	A Priori theme identified in previous research by Charmaz ,1991; Diener, 2000; Diener and Lucas,2002

The fourth sub-theme is that of *fear*, the feeling of vulnerability experienced by most clients when dealing with health professionals. This feeling of vulnerability stems from

the client's inability to confidently evaluate the services provided (Grönroos, 1982), the intimate nature of the relationship itself and the inability of the client to gauge the intentions of the service provider during initial encounters. This presence of fear or being fearful of this relationship is in line with the previous work done by Patterson (1993) and Lovelock (1996). Lovelock (1996) has clearly demonstrated the onus is on the service provider to make sure the client is able to distinguish between core and supplementary services so they are able to judge the quality of service provided and feel less vulnerable about the outcome.

The final sub-theme from the major theme degree of control is *quality of life*. This is the client's self-reported evaluation of their quality of life. Philosophers of the present and past centuries have pondered the question "what is the good life?" The focus has been on things such as love and loving others, pleasure seeking and insight that help define the bigger picture called Quality of Life (Diener, 2000). Subjective evaluation of individual health status offers an opportunity to decide whether his or her life is worthwhile living and also gives an insight into the individual's perception of their Individual Quality of Life (IQoL). Chronically ill individuals have varying degrees of response when asked about their quality of life. This self reported quality of life is dependant on how vulnerable they feel due to the severity of their illness. These findings are in line with the work by Charmaz (1991), Diener (2000) and Diener and Lucas (2002). The next section will discuss the second major theme called *service satisfaction*.

5.2.2 Major Theme Service Satisfaction

The second major theme that emerged from thematic analysis is *service satisfaction* (see Table 5.2). This theme has four sub-themes, *co-produced experience*, *systemic failure*, *gender* and *word of mouth*. The first sub theme *co-produced experience* is characterized by the sharing of resources and effort by the service provider and his/her clients to co-produce an experience. The role of the service provider remains as proposer of value and the client has to perform an effort to evaluate if he/she may want to engage and consume the proposed value offered by the provider (Grönroos, 2008). If either party in this relationship hesitates to share resources and/or effort, this can have an effect on service satisfaction. These findings confirm earlier research by Carrillat et al. (2009) and Johanson et al. (2006). The client and the service provider have to share

responsibility of co-creating a desired experience that leads to a favourable outcome for both parties.

Table 5.2 - Major Theme – Service Satisfaction

Sub- Theme	Evidence from Literature	A Priori / Emergent
Co-Produced Experience	The service provider can only propose an experience and the client has to make an effort to co-create the experience they wish	A Priori theme identified in previous research by Carrillat et al. , 2009 ; Johanson et al., 2006
Systemic Failure	Medical institutions and health professional's inability to offer customized solutions to each client can have an impact on service quality evaluation and satisfaction	A Priori theme identified in previous research by Charmaz, 1991; Flaskerud and Nyamathi, 2000; Miller and Crabtree, 2000
Word of Mouth	Utility of WOM is very evident once when choosing a provider and later in post-consumption mode to share delight or dissatisfaction	A Priori theme identified in previous research by Stearns et al., 2001; Shah et al., 2003
Gender	Different genders have shown different attitudes towards service quality evaluation and post consumption satisfaction, loyalty and word of mouth behaviour	A Priori theme identified in previous research by Bendall-Lyon and Powers, 2002; Flaskerud and Nyamathi, 2000

The second sub-theme is *systemic failure*. This is characterized by the client's expressed frustration with institutional protocols and procedures. Healthcare institutions are tasked with providing services while also accountable for bottom-line financial performance. These institutions follow programmes that expect clients to be in charge of their treatment, and only intervene when the client needs attention. These systems that want the client to take charge of their life and treatment choices have an impact on the client's perception of service quality and resultant satisfaction. This research is in line with the work by Charmaz (1991) and Flaskerud and Nyamathi (2000). The client finds it hard to be in charge of their own treatment and then don't appreciate when

treatment failure is attributed to their lack of self discipline. The second source of systemic failure can be the health professionals themselves and even their clients. Post-episodic dissatisfaction has its roots in two different issues. Chronic health sufferers sometimes raise problems for which the health professional may have no solution to offer, problems such as a need for funds to pay for rent, food and clothing. The second issue is the health professional's adherence to the sick role assumed by the client. Such health professionals do not like it when clients ask too many probing questions about treatment choices. These findings are in line with the previous research by Fitzpatrick and Scrimshaw (2000) and Miller and Crabtree (2000). The dissatisfaction with service provider is attributed to the client having fuzzy or unrealistic expectations from the service provider and service provider's refusal to let client participate in treatment choices.

The next sub-theme, *word-of-mouth*, is the only theme that demonstrates a two-way relationship with post-encounter service satisfaction. The data analysis revealed two aspects of word-of-mouth utilized by participants. The first type is evident when most participants use WOM to choose an appropriate professional service provider. This WOM communicated by someone in the participant's social network was an important driver of choice and usually took the form of a personal recommendation. The second type of WOM was usually the WOM initiated by the participant's themselves. This WOM could be positive or negative depending on how satisfied or dissatisfied they were with their health professional. This two-way relationship between service satisfaction and resultant word-of-mouth behaviour of clients is consistent with previous research (Shah et al., 2003; Stearns et al., 2001).

The next sub-theme is *gender*, that is, the gender of the service provider and the impact of gender on expected service quality and post-encounter satisfaction. Past research suggests that males and female have different expectations of their service providers with regards to functional and technical quality provided in a typical service episode (Bendall-Lyon and Powers, 2002; Flaskerud and Nyamathi, 2000). These differing expectations alone can be a source of service dissatisfaction. The data collected for this research enquiry only lends partial support to the concept of gender bias in service delivery. This lack of support for past research could be due to the context of the chosen services, i.e. professional services, and it could also be due to the sample size of 17

participants. The next section will detail the third and the final major theme *nature of relationship*.

5.2.3 Major Theme Nature of Relationship

The third major theme that emerged from the data was *nature of relationship* which is composed of five sub-themes, i.e. *communication cues*; *trust*, *professional vs. social aspects*; *relationship endurance* and finally *shared authority* (see Table 5.3). *Communication cues* refer to the use of verbal and non-verbal body language by the parties engaging in a professional service episode. Past research has studied the role of communication in consumer and professional service episodes (Sundaram and Webster, 2000; Stearns et al., 2001). In a professionally delivered service the client puts a lot more emphasis on the components of the service provision that they can confidently evaluate, and the interpersonal skills of the provider; communication verbal and non-verbal gestures then becomes a replacement for core service delivery in an episode (Grönroos, 1982). This study confirms earlier findings that communication between the parties has obvious implications for perceived service quality, evolution of trust and the level of commitment demonstrated by the client to stay in the relationship. This is in line with earlier research on communication effectiveness by Sharma and Patterson (1999). Effective communication can be used as a driver for empowering clients in a service episode and build trusting relationships.

The second sub-theme that emerged was *trust* between the parties when engaging with each other. Trust is an extensively researched topic in consumer and professional services alike. The current research was able to document the effects of the evolution of trust within the dyadic relationships over a period of time, in line with the research by Ranaweera and Prabhu (2003). There are two major antecedents of trust in a relationship, vulnerability and perceived risk associated with a service episode (Sitkin and Weingert, 1995). It is said that if either is missing from the episode clients do not seem to have the need to be able to trust the service provider. Trust is not so important in consumer services where the client is in control of their choice of provider and also their service consumption. Other antecedents impacting trust in a relationship are frequency of interaction, social similarity and communication between the parties (Morgan and Hunt, 1994). Eisingerich and Bell (2007) have even demonstrated trust between service providers and their clients as a key driver of longevity of the

relationship in high credence services. The current research was able to confirm the role of trust as a mediator of relationship longevity.

The third sub-theme identified was *professional versus social aspects* of the relationship. The decision to keep a purely professional relationship in the dyadic engagement was at times made by both the parties but more so by the professionals themselves. The professionals, time and again, demonstrated use of a socialization process to set the norm of a purely professional relationship with their respective clients. Using these sense-making socialization processes to familiarize clients with the norms, roles and behaviours during service delivery is in line with research by Kelly et al. (1990). These processes are designed to regulate client expectations around service delivery, and also act as a barrier for the evolutionary process of social bond formation between the service provider and the receiver. Some of these relationships do evolve towards a more social engagement as that is seen between friends. This evolution is also in line with the previously proposed relationship typology framework of Coulter and Ligas (2004). The length of the relationship, honest communication and the presence of trust between the parties can result in the professional relationship evolving into social bonding.

The fourth sub-theme to emerge was *relationship endurance* which signifies the duration or the length of the relationship between the professional service provider and his/her clients. The longevity of relationship between the client and his/her professional follows the path proposed by Berry (1995), based on the formation of social bonds between the service provider and his/her client. The relationship develops over time and the formation of social bonds makes the relationship more personal. It is usually comprised of the presence of trust, commitment, interdependence and loyalty between the parties. This evolutionary pattern of the relationship, and the client's propensity to stay in such a relationship, is in line with the relationship development pathway proposed by Lawler (2001) and Morgan and Hunt (1994). Another issue that is linked with relationship endurance is the ability of the professional to manage a critical episode in between the sequence of routine episodes. The impact of critical incidence management on relationship longevity as proposed Storbacka (1994) is supported by this research enquiry. It does not matter how long the client was engaged with the service provider for routine service delivery. If the service provider is not able to

competently manage a critical incidence the client may decide to terminate that relationship based on the failed outcome of one critical service episode.

5.3 Emergent Theme

The final theme shared authority emerged as a sub-theme within the major theme nature of relationship. The following discussion substantiates the claim of this theme as an emergent theme of this research enquiry. Shared authority is characterised as a process that begins with the first encounter between the health professional and his client. Healthcare services by nature are a very complex set of services provided by trained professionals. As a result, client contribution during the service encounter can be and is very limited. During initial encounters the process of communication and service delivery very much follows a one-way path where the health professional takes charge and asserts authority over service delivery i.e. treatment choices. With time and repeat encounters this unilateral decision making and effort start to undergo moderate changes. The relationship moves from an authoritarian to a mutually respectful relationship that has elements of reciprocity.

There is evidence in the literature of the positive impact of client participation on client commitment to the relationship and increased trust in the service provider (Moorman et al., 1992; Roth, 1994). There is also evidence in the literature on the link between trust, commitment and satisfaction, most often referred to as relationship quality (Roberts et al., 2003). This sub-theme of shared authority is a process that starts with a unilateral relationship, proceeds through a sequence of service encounters, and ends up being a more reciprocal relationship. This evolution towards a respectful, equal and reciprocal relationship appears to be a process or a pathway that has the potential to empower clients to take an active part in consumption.

This process then is very similar to the psychological construct of empowerment (Feste and Anderson, 1995). Gibson (1991, p. 359) defines empowerment as “...a social process of recognizing, promoting, and enhancing people’s abilities to meet their own needs, solve their own problems and mobilize the necessary resources in order to control their lives”. It is very evident that customer’s motivation to contribute to service episode is driven by their need for empowerment. Services marketing literature so far

appears to have neglected the concept of client empowerment in encounters. This research identifies shared authority in service encounters as a process that can lead to client empowerment. There is a need for further research to explore the empowerment framework in one-on-one dyadic relationships in service encounters and more so within the domain of the professional services literature.

Table 5.3 - Major Theme – Nature of Relationship

Sub- Theme	Evidence from Literature	A Priori / Emergent
Communication Cues	Communication between the dyadic relationship does have an impact on the service quality evaluation , post- episodic satisfaction and propensity to stay in a relationship	A Priori theme identified in previous research by Grönroos, 1982; Sundaram and Webster, 2000; ; Sharma and Patterson,1999; Stearns et al., 2001
Trust	Building of a trusting relationship between the client and his/her service provider is a key driver for relationship longevity	A Priori theme identified in previous research by Morgan and Hunt, 1994; Eisingerich and Bell , 2007; Sitkin and Weingert, 1995; Ranaweera and Prabhu , 2003
Professional vs. Social Aspects	Time spent in a relationship, honesty in communication and presence of trust between the dyad can lead to formation of social bonds in a dyad	A Priori theme identified in previous research by Coulter and Ligas , 2004; Kelly et al., 1990
Relationship Endurance	A process that builds reciprocal relationship based on trust and mutual respect and certainly affects client's propensity to stay in such relationships longer	A Priori theme identified in previous research by Berry ,1995 ; Lawler , 2001; Morgan and Hunt, 1994; Storbacka , 1994
Shared Authority	A process that builds reciprocity between the client and his/her professional service provider and is proposed as a pathway that leads to client empowerment	Emergent Theme not identified in the literature

5.4 Discussion Summary

It is evident that professional service relationships have been a widely studied topic. What makes the context of current research on chronic illness unique is the vulnerability of the client engaging in such service relationships. Professional services are distinctly different compared to consumer services with regards to their complexity of delivery and the service provider's personal preferences towards what counts for optimum delivery. These services are very hierarchical in nature and owing to the years of training and practice undergone by the professional the locus of power is usually tilted towards the service provider. With time there seems to be a shift in this orientation and service providers are inclined to relinquish some of this authority and clients are willing to take back control on their service consumption. The current research has demonstrated that the sharing of authority in the service relationships has an impact on client empowerment and relationship longevity.

The conclusions drawn from this study appear credible within the context of the participant's lived experiences shared with the researcher and the researcher's interpretation of the data gathered via the interviews. The study does not present an exhaustive summary of all the practical realities of the participants under investigation but rather is an attempt to explore relationship management strategies used by chronic illness sufferers engaging in professionally delivered services. Another researcher with a different research strategy can very well compose a different set of findings within the context of this enquiry. There are however valuable lessons learned from this research enquiry. The next section indicates how the research findings inform our understanding of professional service relationship and its management.

5.5 Implications for Theory

The findings of this study have relevance to the marketing literature. These research documents key differences between consumer and professional services and the role clients have to play in co-producing the experience they want. The services literature has not paid enough attention to the concept of customer empowerment and the

processes that lead to customer feeling empowered. This research is able to illustrate the process that leads to customer feeling in charge of their consumption and the customer's willingness to engage with providers that facilitate this empowerment. This research also illustrates that the sharing of resources, open and welcoming communication, and client empowerment can have favourable outcomes not only for the client but also for the service provider by way of recommendation that comes through positive word of mouth.

5.6 Further research

This research enquiry offers an opportunity to explore the practical realities of chronic health sufferers and how they manage their relationship with their health professional. Many of the sub-themes that emerged from this research are consistent with previous research and help confirm existing knowledge. More research needs to be done within the healthcare services industry to explore if gender of the service provider and gender of the client have implications for service quality and satisfaction. The emergent sub-theme of shared authority as a process needs to be explored further. There is also an opportunity to explore if shared authority as a process is affected by the concomitant presence of other constructs such as trust between the parties, length of time in a relationship, formation of social and structural bonds and the context of research, i.e. professional versus consumer services.

5.7 Limitations of this study

A limitation of this research is the low number of participants that were recruited for the research within the finite time given to complete the thesis. The research enquiry only recruited participants from one region of the country, the upper North Island. Having access to nationwide participants or even Australasian participants would have enriched the findings of the study. Each country has a different approach to healthcare policy and various ways of funding public healthcare systems. These variations in the healthcare

policy, service delivery, access to resources and funding regimes understandably have an impact on the client's experiences of service quality and satisfaction. In addition, as there are a significant proportion of chronic sufferers who mistrust conventional or allopathic medicines and choose to use alternative medical treatments, having access to such participants could have provided additional insights into the practical realities of chronic health sufferers. This research enquiry only recruited the clients of healthcare services and not the service providers themselves. Inclusion of service providers could have resulted in a more holistic picture of health care service delivery and the issues associated with managing chronic healthcare delivery.

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Participant Information Sheet



Date Information Sheet Produced:

22 June 2008

Project Title

Professional Service Relationship in Chronic Illness– The Client’s Perspective

An Invitation

Hello my name is Milind and I am a postgraduate student at AUT University. You are invited to take part in this study about how you manage your relationship with health professionals and how this affects your management of chronic illness. Your health advisor could be a health professional you consult on regular basis, such as a physician, a nurse, and even a physiotherapist. Your participation is voluntary and you can withdraw from this research without penalty at any stage. This research will contribute towards my formal qualification of Master of Philosophy through AUT University.

What is the purpose of this research?

I want to talk to someone like you who is managing chronic illness and seeking medical advice and treatment for a period of time. I want to find out about the relationship you share with your health professional you see on a regular basis. This research will help the health professionals to understand how to improve their services for chronically ill individuals such as you. The results of this research will also be published in academic journals.

How was I chosen for this invitation?

You have either answered a newspaper advertisement or your name was suggested to me from my network of colleagues, friends and family members. I have asked people if they knew someone who was living with chronic illness who might like to be part of my research. Once that person confirmed your interest your details were passed on to me for sending you a formal invitation for joining this study.

What will happen in this research?

Once you have read this Participant Information Sheet you will have a couple of weeks to think about joining this research. I will then contact you again after two weeks to seek your approval for participation and you can again ask me any questions and you will be given sufficient time to consult your whanau, hapu and iwi before you give written consent to join the research.

We will organize an interview at a time and place to suit you. This could be at your home, my office at Manukau Institute of Technology, or a place in the community that suits you either a café in the mall or public library.

At the time of the interview with me you will be asked to sign a written consent form to confirm your agreement to be a research participant. The interview will be an in-depth discussion session that could last up to an hour. Early in the interview you will be asked:

“ I understand you have chronic illness and that you need regular medical advice. I am interested in understanding more about the relationship you have with your health professional. Perhaps you could begin by telling me a bit more about your condition...”

You will be encouraged to discuss how chronic illness affects your daily life and the relationship you share with your health professional. The session will be audio taped and if you wish you will get an opportunity to read through the transcript once it is available.

What are the discomforts and risks?

It is possible that the discussion about your experience with your health professional may raise uncomfortable issues for you. If that happens I will stop the interview. The interview can be discontinued all together, continued after a break or continued at some other time. The choice is yours.

How will these discomforts and risks be alleviated?

If the interview leads to emotional discomfort you will be offered an appropriate counselling support via the AUT University counselling services.

What are the benefits?

There may not be any immediate benefit to you participating in this research.

Your contribution though may help others to understand what it means to live with a chronic disease and how you cope with it on a daily basis. Understanding your lived experiences with health professional will help decision makers to improve their service delivery for chronically ill individuals like yourself.

How will my privacy be protected?

To ensure your privacy is protected and the information you shared remains confidential the taped sessions will be transcribed and absolute care will be taken that the transcription does not identify you, your personal details and any other third party. I will ask you to assume a pseudonym that will be your research identity. I will be the only one who knows your true identity. The consent form you sign and the information you share with me will be kept apart in a locked cabinet at AUT during the research and after the study. The only people who will have access to the data will be me, and my supervisor Professor Mark Glynn. When the study is complete the data will be stored in a locked cabinet, secure and safe until it is destroyed after six years.

What are the costs of participating in this research?

The only cost to you will be the interview time. You may be interested in having a second or a third interview but that will be negotiated later. There is no expectation that you need to speak to me more than one time, the choice is yours.

What opportunity do I have to consider this invitation?

Once you have read all the information provided about the research I will contact you in two weeks time, and will follow-up and complete the consent process. If you have any questions in the meantime about the research you can always contact me at work on 09-9688000 Ext – 7433 or 09-8326556

Via email milind.mandlik@manukau.ac.nz

How do I agree to participate in this research?

You need to complete a consent form to be included as a participant for this research. I will ask you to complete the consent form before the interview is initiated.

Will I receive feedback on the results of this research?

Yes a summary of findings will be made available to you on request.

What do I do if I have concerns about this research?

Any concerns regarding the nature of this project should be notified in the first instance to the Project Supervisor, Dr. Mark Glynn, mark.glynn@aut.ac.nz , Tel: 64-9-921-9999, Ext. 5813

Concerns regarding the conduct of the research should be notified to the Executive Secretary, AUTECH, Madeline Banda, madeline.banda@aut.ac.nz, 921 9999 ext 8044.

Whom do I contact for further information about this research?

Researcher Contact Details:

Researcher Contact Details:

Milind Mandlik (Interviewer)
Senior Lecturer
Faculty Of Business
Manukau Institute Of Technology
Auckland, New Zealand
Tel: - 09 - 968-8000, Ext: 7433
milind.mandlik@manukau.ac.nz

Project Supervisor Contact Details:

Dr. Mark Glynn
Faculty of Business
Auckland University of Technology
Auckland 1142, New Zealand
Tel: 64-9-921-9999, Ext. 5813
mark.glynn@aut.ac.nz

Approved by the Auckland University of Technology Ethics Committee on 28 July 2008, AUTECH
Reference number 08/90.

Appendix – B – Consent Form

Consent Form



Project title: Professional Service Relationship in Chronic Illness – The Client’s Perspective

Project Supervisor: Dr. Mark Glynn

Researcher: Milind Mandlik

- ☐ I have read and understood the information provided about this research project in the Information Sheet dated 20/04/2008.
- ☐ I have had an opportunity to ask questions and to have them answered.
- ☐ I understand that notes will be taken during the interviews and that they will also be audio-taped and transcribed.
- ☐ I understand that I may withdraw myself or any information that I have provided for this project at any time prior to completion of data collection, without being disadvantaged in any way.
- ☐ If I withdraw, I understand that all relevant information including tapes and transcripts, or parts thereof, will be destroyed.
- ☐ I agree to take part in this research.
- ☐ I wish to receive a copy of the report from the research (please tick one):

Yes ☐ No ☐

Participant’s signature:

.....

Participant’s Name:.....

Participant’s Contact Details (optional).....

Date:

Approved by the Auckland University of Technology Ethics Committee on 28th of July 2008 AUTECH
Reference number 08/90

Note: The Participant should retain a copy of this form.

Interview transcript for interview number two - BL-Tape 2

Interviewer:

Would you like to start with telling me a bit about the sort of condition that you have and what has your experience been living with this condition?

Response:

Okay. I'm a severe asthmatic and I've got a lot of allergies that basically culminate in a runny nose and feeling lethargic and getting asthma which is the worst symptom of it. I've had it for about, I'm 41 now so probably had really not knowingly I've had it for at least 30 years. When I was very young I had it and never sort of knew what it was and the first incident that I can remember that totally got out of hand was back in Germany 20 years ago for the basically I was driving around in a convertible with a friend and the roof was off and we were driving around in summer and there was a lot of pollen and stuff and at night I was lying in my bed and I couldn't get air and it was absolutely frightening and that night I went to the hospital in my home town, you know emergency sort of thing you know and I could obviously still breathe but it was very restricted and I got an injection there so that was the first incident I've ever had for it and now 20 years later I'm managing it well basically.

Interviewer:

Okay what do you mean by managing it well?

Response:

Okay now I know when, at that time I didn't really know what I had um but then (inaudible) years ago back at home, back to New Zealand and now I know what I've got and now I know how to treat it so what I do I have regular medication that I take every single day. I used to (inaudible) which is a tablet basically. Um I take a nasal spray and I take an asthma preventative inhaler that I just had now. I get it from my GP and so I manage it and I really don't get any asthma at all because I take preventative medicine.

Interviewer:

Okay besides medication would you like to tell me more about what sort of prevention strategies you have?

Response:

Basically avoiding the allergen, so basically avoiding the things that I'm allergic so I know that I'm highly allergic to horses and things like that so I would never go horse riding because its just, it would kill me basically. Not kill me really literally but you

know it would be very uncomfortable. Um so when I did maybe about 10 years ago I did an allergy test here in New Zealand with a doctor (inaudible) whatever it was and we did a test and he showed me all the things that I'm allergic to and he said the easiest thing you can do is just avoid the allergens and some you can avoid like horses. You know you don't go horse riding. Other things you can't avoid so you have to do something (inaudible).

Interviewer:

Okay in terms of um a relationship with your GP um all the (inaudible) practices that you would have had to be with in the last 15-20 years what you like to tell me? What sort of relationship you have?

Response:

Maybe I'll go backwards. So I'll start with my GP, I've been with my GP for maybe about three or four years and they just basically prescribe the medicine that I need. They don't really do anything more sort of corrective um very occasionally if I need something, if I know I'm going somewhere where there's a lot of (inaudible) involved then I might ask them for extra medicine basically but we've got a good relationship because-

Interviewer:

What do you mean by you've got a good relationship?

Response:

I think we've got a good relationship because I see him relatively regular so to me a good relationship isn't necessarily (inaudible) but regular contact but I think having regular contact facilitates a good relationship um because you get to know the person beyond just what they're doing professionally, you get to know them a little bit (inaudible) well because after you see them so I know for example my doctor or my practice there are generally two doctors I go to and (inaudible) and more often I would see the guy, that's just the way it turns out but I don't have a problem. Um and I also (inaudible) so there is a particular (inaudible) you don't know it works but (inaudible) I used to be like to this, so you know we talk about that sometimes a little bit and a little bit of fun I have with them because it's all money of course. I've met him outside coincidentally and next door and while I was buying an iPod he was getting his laptop serviced and you know we were talking a bit so it's nice to know a little bit about (inaudible) relationship.

Interviewer:

I've sort of related this, why is it nice to know somebody in a social context, somebody that's a professional looking after you?

Response:

Because it makes it more meaningful because it gives you more connections, more layers for relationship and also I think it levels the playing field a little bit because basically they sit there, not in a white coat but you know you're clearly in a power relationship. You know they know a lot and you know probably very little about medicine in general and about what you might be having, what's your service and by

making, if you know a little bit about them I think it just makes them more humane, which they are all, they're just you know, they go to the toilet, they (inaudible) other normal things you know but they can be for certain people I guess intimidating. I'm not intimidated but I enjoy knowing a little bit about them because it just makes them more interesting.

Interviewer:

Okay you have just said um that (inaudible) and you don't really have a (inaudible), can you tell me more about that?

Response:

Mm I was quick to add that because I think in New Zealand often guys will often prefer a male doctor or a female would prefer a female doctor and I guess what I was signalling is that I'm totally open either way. I have a very good chat and relationship and I feel competent from a male doctor and I feel equally so though it's a slightly different relationship with the female doctor.

Interviewer:

Can you elaborate on the slightly different relationship?

Response:

Okay slightly different it is just because male and female, if you have a mixed gender relationship and a professional relationship its just different. I think there's um nothing sexual going on but I think its and she's I don't know 55 or something you know and happily married but um women have a different way of interacting with people, not just with males but with females as well so I guess automatically they have a different, a slightly different relationship perhaps slightly more nurturing um slightly different way of interacting, facial expressions, gestures, they have all sorts of soft little interpersonal things. Women may be slightly more adaptive than I think male doctors even though they're still trying to find you (inaudible), male doctors particularly see them more specialised, they become specialists, they can be a bit uppity themselves and they really (inaudible) they got.

Interviewer: Okay have you had an experience like that?

Response:

Um I've seen doctors, specialists who were very good in relation to this actually. I've only seen one um he was very good and he made a couple of very astute observations immediately when I came in about my posture, about me puffing, about a couple of little things that I thought oh this guy knows what he's talking about but he was also carrying himself in a body way and the way that he dressed, in a reasonably formal way and seemed quite, it seemed quite important to him to be well respected by the things that he said, how he said them, the shirts that he wore, where his practice was um there was a more of a hierarchy. It seemed to be yes you're a customer but you know um I'm the doctor, you know. He was negative at all, he was very good at what he did but I felt as if this guy, the specialist was more, yeah more of a, (inaudible)

Interviewer:

Okay what would you like in terms of your perception of the GP, (inaudible)

Response:

My GP no totally different relationship to the guy I saw once, I think he was very competent but I didn't warm to him if you know what I mean, you know there was no humane element, I think not too much of it. My GP I think is competent in the field that he practices in and I think he would be smart enough and brave enough to acknowledge that maybe I need to see a specialist, and not competent anymore but because of the number of times I've seen him, um I'm really guess, let's say half a dozen times a year, quite easily so I'm a fairly regular customer of him just because of that and because my wife goes there and my daughter goes there to the same practice, its not just me but its three of us and sometimes like says how's Sarah, how's my daughter and we might have a quick chat, it might just be you know 15/30 seconds but its just an acknowledgement that he knows about me and knows about my family and since care about them because they ask about them.

Interviewer:

Okay now onto your family going there as a group to this particular consultant, in terms of your illness would you like to tell me more about the impact it has had on your social life as such?

Response:

Ah yes at the moment I would say my social has not had an impact by my asthma and by my allergies because I am on regular medication and I know what to avoid um but it has in the past um on my sociability if you like and so maybe about six or seven years ago at the height of summer um driving from place to another place with the windows wound down I would have asthma again and that (inaudible) for many years and you know I was just a total write off. I was lying in bed that night and you know it was 31st December and I was basically arrived at the hotel and I basically went to bed and just you know had the curtains closed and just I was quite anti-social. So its not treated even though asthma and allergies seem like a fairly basic sort of thing it can actually have quite a big impact on your life if its not treated.

Interviewer:

Okay and does your relationship with um your social and your um wider professional network does it have an impact there?

Response:

It doesn't have anymore um no I would say now if you said had it in the last year has it made an impact on me I would say very marginally, a little bit sort of sleepy and it might be due to medication or it might be due to not taking the medication, I'm not sure um but I would say now I feel quite in control of it, so it hasn't really impacted on my professional ability to act.

Interviewer:

Earlier you talked about you know how to sort of manage your condition and how to work on prevent as well. Is it because of number of years of experience that you have or um is it beyond that?

Response:

I think its number of years. Yeah definitely and I think it's the consultations that I've had initially when it was first declared when I was say 20 years old I had no idea what I had so I ran literally into the open night, I drove in a convertible with the roof down all day in the summer which is a killer for anybody with asthma um because I was diagnosed, I think that was the most important thing I was diagnosed twice with hayfever and (inaudible) allergens that I had with tree pollen and dogs and cats and all sorts of stuff, um the first diagnosis was in Germany and from that moment onwards I kind of knew well maybe I ought to avoid all sorts of, so going to the zoo for example um, going to the circus you know I would keep well away from those, I mean a hundred metres away um going to the races at Ellerslie for example, I know what to do because I was diagnosed with it. So its number of years that I've had it for which have cemented the importance into that its important to avoid the allergens but its also impacted that I was actually diagnosed with it because otherwise I wouldn't have known what to avoid. So it's a double whammy I think.

Interviewer:

In terms of when you talked about managing your condition by yourself, what sort of input do you think your social life has um on your self-management?

Response:

I don't understand that, sorry.

Interviewer:

Do you think your social circle, your family's social circle, what sort of support do you get from them and what sort of input do you get from them when it comes to managing your relationships?

Response:

Ah managing my relationship?

Interviewer:

With the context that you have a condition like this?

Response:

I think they have very little to do with it. I mean my wife would possibly say oh have you taken your medicine in the morning but that's probably the extent of it because at the moment I feel quite in control and haven't really impacted much on it, on my social life. Many years ago it had, occasionally it will have an impact, (inaudible) we can holiday and they rent a bach by the beach, a really old bach and the bach is probably very dusty and you know I wasn't in terrible shape but basically I was sneezing and my eyes were running the whole weekend you know, they said oh we're really sorry, I said

don't worry you know, you couldn't know that the bach was dirty you know that's bad luck you know and there was nothing I could do. I mean I couldn't storm out and say I'll sleep in a hotel, that's antisocial, so you know I suffered for a bit, for two days but um it hasn't really impacted.

Interviewer:

Going back to um your prevention strategy. How much reading do you do about the condition you have, over the years how much reading have you done and does it really matter?

Response:

Very, very little because it's a well known condition to have, its not complicated. The treatment, I mean you avoid developing and taking preventative medicines for it so the allergens you try and avoid um I've honestly no interest in reading up more and that's just purely because I feel its well managed. If I took my preventative inhaler and I would still have asthma every second week I would be doing some reading but I can honestly say have I ever looked online, no. Why? Its just unnecessary.

Interviewer:

Okay um so in terms of information so who would you categorise as a major source of information?

Response:

Well the diagnosis first given by the doctor in Germany that was the first big eye opener and I still remember them, I remember them very well, they said this is a very wide spectrum which they were excited about because they hadn't seen that. For me it meant I was allergic to a lot of things which is not a good thing and that's you know it's the doctor that is particularly when the allergen, the allergy test is done, they know what you're allergic to and then you know once you're off to specialist and they sort of hand over to a GP um you know its just the GP you get your source of information and really I don't need any information because I know how to use the inhaler, its not rocket science and my nasal spray does the trick but I think its purely function of being, feeling in control. If I wasn't feeling in control I would be talking to more people, I would be clearly switching my doctor, all that sort of thing.

Interviewer:

Okay, in terms of um, in terms of some of the other issues that um anecdotal evidence, is how much do you think trust is important um and sort of trust that I talk is the sort of trust that you meet and you (inaudible) and trust between you and your social circle around you?

Response:

Social circle around me trust for my condition is quite unimportant because its not a big thing. It doesn't inconvenience anybody. When it did so let's say go back to that

weekend where we were away with friends you know its sort of important that they know that I'm not faking to be sick or something you know so where there is actually a bit of a reason why I'm not feeling that great and its not just the running nose and running eyes but its actually how you feel, you know also, so I think trust is um, I don't think trust is actually the right word but it's appreciation of your condition you know its empathy maybe. Empathy, appreciation of the condition and saying yeah this guy has actually something and oh I feel sorry for you but can't really help me and that's fine. So that's trust on the social side. Trust in the doctor relationship or medical relationship I think is important but again because my condition is not rocket science, its not you know, do I trust the doctor, yes absolutely um because its not such a difficult thing to diagnose. You know you do a few blood samples and things like that so its not hard. I do trust him. Again purely a function of my condition now because I feel in control, I trust him. If they gave me the regular medicine and had been doing this for four years then I would be feeling really bad and it might last a month I probably wouldn't trust them very much I'd think gee they must be missing something, but I fee in control, I guess there's trust. Its just based on the treatment.

Interviewer:

In terms of, you did sort of mention that earlier you have a good working relationship with your GP and um hospital wide team (inaudible) you might have a different type of relationship with them um how does that translate into two things then, for the rest of your family?

Response:

We all signed up together and where we live its really hard to get basically on to the register of the GP practice and we have heard through word of mouth that this was a really good practice to be in and its very close and convenient which is important if you have a child because you know you might be doing a few unexpected runs to the doctor early in the morning and trust wasn't that important because at the beginning it was just word of mouth we heard this person was meant to be good and then the community know that and the trust has developed since.

Interviewer:

Okay would you like to tell me a bit more about word of mouth?

Response:

I can't remember who but somebody told me, probably my wife Sarah about the practice, I can't remember who it was, it might have been a friendly probably, might have said oh this is a good one, a good practice to be in, you know we've gone there for a while or whatever and because it was a friend we would have trusted their judgement. Actually on the topic of trust I've had two diagnoses, one in Germany about 20 years ago, the other one was in New Zealand and because in New Zealand my hayfever got worse again, my asthma and it was done by somebody who was a specialist in electrolysis and their practice on Remuera Road and I had a little trust issue there I guess because he was um, a typical specialist well dressed and the flash car and the flash practice so that always doesn't pee me off but it signals something to me that they're quite desperate to signal to everybody else that they must be worthy of attention and good treatment basically and I remember doing an allergy test at this place and it sort of confirmed what we knew from Germany but it was good to redo it and then

basically he said oh well we should do (inaudible) so basically he picked up on a treatment that is (inaudible) lasted for, I think I did it for four years. You know what I did basically at the beginning of every week, you do it every month and then you do it every couple of months I think go to nurses and basically pricked with the allergy that I'm allergic to. I did this for four years, that is a long time, did this for four years and then at the end we were about to go overseas and I thought oh let's do another test to see what the increase was and do you know what it was, nothing and I was really quite pissed off for starters because here was somebody who was a total specialist in their field who had the flash car and the flash shirt and this and that and glasses and you know all the awards and certificates on the wall behind, all the stereotypes were there and you know he suggested something and it didn't make a pinch of a difference and so because his treatment wasn't effective and although I said before when I first started the treatment I visited his practice so basically I went to his practice and the nurses pricked every month or whatever and it was quite expensive. It was 50 bucks I think a trip sort of thing, so 50 bucks every visit and it took 10 minutes and it was literally just a little nip with a needle and I thought gee that's a bit expensive and then I, after it was inconvenient (inaudible) so I went to the university because I was working there at the time and the university nurses did it and they did it for \$15 and I thought well bloody hell, here's somebody who more than three times as much so basically he was ripping people off plus the treatment was ineffective because we went overseas I couldn't even continue the relationship but the trust was (inaudible)

Interviewer:

Has the frequency of your visits even partially, did you have (inaudible)

Response:

Yeah.

Interviewer:

So you had some

Response:

Yes because I don't know how close these people are, their little things on the wall behind them don't mean anything to me, they're just paper what matters is that they actually (inaudible) well I can't judge if they're effective unless I can see the outcome of the treatment well in this case I could see the outcome of the treatment and I was no better off after four years of you know every week, every month going to the nurses for the prick. (inaudible) it would be ridiculous. So very inconvenient for me and expensive for my insurance company but you know it was the level of trust that basically mainly due to inefficiency of the effectiveness of the treatment and overpriced services.

Interviewer:

Did you try and discuss that with your GP?

Response:

No because then I went overseas, and overseas I didn't have the problem basically. The whole issue fell away and then when I came back I didn't even contact the electrologist, um I even know his name still, I know he's moved his practice to Ponsonby because he

(inaudible) shifted, um I would never go back. I just get that sort of impression you know that you're just a number um, you're just you know doctors are (inaudible) like that. I think 15 minutes maybe 20 if you're lucky and really its like a conveyor belt and I sometimes feel like even with my GP you know if you're coming in and they have a little chat um they give you a quick diagnosis, they're under time pressure but they put themselves under time pressure because they want to earn a lot of money and that has impacted a little on my trust sometimes. I know these people are fatalists you know they're not there, they're there to help you but they're most there to help themselves.

Interviewer:

Why would you say that?

Response:

Because you get the sense that if you see a note from their, when you come into the practice and there's a little note on the reception desk saying our charges have gone up and you think gee they've gone up again but it's a fairly expensive practice anyway and they've gone up again and I'm not even paying for it I shouldn't care about it, but I do care because when I think about it sort of stuff and you think well its gone up again, that's a lot of money and you know you get 15 minutes of time with the doctor, it does feel like a process, very much like a process and yeah its, you don't get that sense of a doctor actually wanting to help or a GP wanting to help you beyond a certain time limit because you're sort of fitting into a slot, you're a bit like a matrix you're a little container you know and you fit your little thing you know and you get your little number and that's what you get you know and if you can't just hang around chatting you know, as our customers would do here you know, they stand around chatting and some of us are happy to do that and engage in that, I'm quite happy to do that um but the doctor you just have the feeling that you know move on, next one, next one and you're sort of, you're the dollar coming into the office.

Interviewer:

Okay, what would you rather see (inaudible)

Response:

Um very general time is money you have to make sure that people don't ramble on and you have to charge for your services but I do think that some of the medical charges are fairly steep um and you get a sense that, I think its just the way the medical system deals with people, you know with their customers, (inaudible) you make an appointment, if you can make one in the first place so its not always convenient for you (inaudible) which is kind of weird and you say well hang on I'm paying for this you know, (inaudible) to be fixed admit that, I'm sick in the morning, I want to see somebody now, well you can't and that's what happens, but um I don't know it's a sense that you get that you are a number and that its mainly about money.

Interviewer:

Anything else that you would like to see as a customer?

Response:

I guess what I do think about it is how much remuneration doctors get compared to other people who work you know who might be highly qualified and I think our line of work is a great example you know, we help people, we help them not with their health but you know with getting a job and getting a (inaudible) you know it's a huge impact, has a much bigger impact than health probably um we get paid very little in comparison. We don't have a receptionist so sometimes I compare things, I compare the different industries and I think how come these guys can milk customers kind of, not for all they're worth but you know they've got a lot of wealth, when they charge \$50 for 15 minutes, that's \$400 an hour, they've got a practice, they've got a receptionist to pay, I understand that um I think it's the level of remuneration sometimes that you think mm how can they get away with it.

Interviewer:

Um have you had any dealings with a public doctor within the (inaudible) as such?

Response:

Yes I have. The birth of our daughter by sheer accident, through my cycling, yes I have.

Interviewer: Not particularly for your condition?

Response:

A couple, you know mm the last one was many years ago um it was basically out of town in the Hawke's Bay, it was a typical scenario, eight years ago or something like that and we'd driven all day with the windows down from one place to another and I was in terrible shape and that was the thing that I mentioned earlier in the interview and I was really not as bad that but the next day we went to the public hospital and I got an injection, a cortisone injection, a steroid injection and it sorted it out in literally half an hour and I have experience of other health systems for my condition but not very much of it. More sort of (inaudible)

Interviewer:

What is your perception of that one particular incident that you had done that with the public health system?

Response:

Yeah it seems to work find, in fine I have to correct myself, I have had it twice, once in Auckland as well so exactly the same scenario, going to (inaudible) clinic, you know talking to the doctor, getting an injection in the bum and um rushed, um generally feeling people, in particular the nurses for some reason, rushed basically I think, and certainly competent I think but sometimes more customer focused in the sense that

END OF SIDE A

To wait in the waiting room, they give you a little form to fill out so that keeps you busy. There's all sorts of things they do to shorten the perceived waiting time but basically sometimes you sit around a lot. This is taking a long time and again its supply and demand, they don't know when the customers are coming in but as a result it sort of seems rushed. Rushed in the attention that you get because it sometimes seems like once over lightly kind of thing. You know the nurse kind of basically does 90% of it, the

doctor comes in um asks you a couple of questions and then says yeah this is what we need to do and you sort of that anyway and you think far out you know. That was just so superficial, very superficial and its because they're rushing off to the next person who's been waiting for 20 minutes.

Interviewer:

Did you remember getting in, you knew exactly what was happening and then because of the prior experience and you knew what needs to happen now, did you actually mention to people when they talk to you, I know what I want and this is what I want?

Response:

Yeah very much so. I keep a little file of, like a little medical file, all my sort of allergy issues and the treatments I've received so the last time I went to my GP for example I said to him oh the last time I had this injection was in that year and I said is that a good treatment to continue and he said no we should switch to something else so I would have done exactly in the hospital basically saying, hey I've had this type of injection five years ago or whatever um I would like to have that sort of thing again and then they might say yeah that's great but we might change to something slightly different today.

Interviewer:

How do they respond to somebody saying I know what I want?

Response:

I think quite good. I think its all about how you make (inaudible) and if you say I've been treated with this before and its worked, then I think they're grateful for that because it just decreases the diagnosis time um and it gives them immediately a number of possible treatments and decreases the uncertainty for them.

Interviewer:

So now deliberately asking a question, um tell me your, could be your perception about your GP, the allergy specialist that you were dealing with, and the public health system, how do you put them ah in terms of what sort of perceptions do you have with these three different type of services?

Response:

All very different. The allergy specialists um is clearly the most money hungry because they're in private practice for themselves, they act the way, you know they play a role, you know they have all the props. It's a bit like theatre, they have all the props to signal that they're worth a lot and that their time is very valued and that your time is not so valued, that's why you can wait in the waiting room. Um and they're competent but I think sometimes they certainly don't know what they're doing as in my case um I think I'm probably more sceptical of them sometimes in terms of their motives for actually being a doctor, are they actually doing it out of the goodness of their heart because they want to help humanity or are they just greedy. And I think often it's the latter, they're just greedy you know, they might have chosen to study medicine because they wanted to help people but now after so many years in practice its all about the cash.

Interviewer:

Okay, about the public health system?

Response:

The public health system quite different I think because I don't, or I have no idea whether this is true what I'm about to say but I don't think they are as well remunerated, I'm guessing. I've never seen the actual figures. I don't know what they earn um I would think that they're probably more in it because they actually want to help people so in some ways I would have, its funny I would have greater trust in them, I would have a better connection with them because I would think that they're in it for the right reasons, um but I wouldn't rate them less competent because then the public system competes with the specialist. GP, yeah good trust because I've seen so much, um because the treatments generally seem to work and because he knows my family so I've clearly got the deepest most meaningful relationship with him but calling it a relationship I guess is already nearly a stretch you know, you see somebody six times a year for 15 minutes is not exactly a hell of a lot. He's there to do business and I'm there to get a solution but um yeah I've got the strongest relationship with him.

Interviewer:

Anything else you would like to add to the whole discussion that we've had since the beginning?

Response:

No I think relationships, you know can be important but I think really the key is that the treatment works, that's the single most important thing um I would rather have someone who's competent who knows what they're talking about, who hits the nail on the head, who's a bit unpleasant than somebody who's pleasant who I have a nice relationship with who's not so competent and who takes three goes to sort it out so relationships are good and nice to have but I think much more important as the competence and getting the solution basically, treating the illness. Yeah.

Interviewer:

Thank you for that.

Appendix – D – Ethical Approval



MEMORANDUM

Auckland University of Technology Ethics Committee (AUTEC)

To: Cristel Russell

From: **Madeline Banda** Executive Secretary, AUTEC

Date: 28 July 2008

Subject: Ethics Application Number 08/90

Professional service relationships in chronic illness.

Dear Cristel

Thank you for your revised ethics application, which I am pleased to advise was approved by the Auckland University of Technology Ethics Committee (AUTEC) at their meeting of 14 July 2008. Your application is now approved for a period of three years until 14 July 2011.

I advise that as part of the ethics approval process, you are required to submit to AUTEC the following:

A brief annual progress report using form EA2, which is available online through <http://www.aut.ac.nz/about/ethics>. When necessary this form may also be used to request an extension of the approval at least one month prior to its expiry on 14 July 2011;

A brief report on the status of the project using form EA3, which is available online through <http://www.aut.ac.nz/about/ethics>. This report is to be submitted either when the approval expires on 14 July 2011 or on completion of the project, whichever comes sooner;

It is a condition of approval that AUTEC is notified of any adverse events or if the research does not commence. AUTEC approval needs to be sought for any alteration to the research, including any alteration of or addition to any documents that are provided to participants. You are reminded that, as applicant, you are responsible for ensuring that research undertaken under this approval occurs within the parameters outlined in the approved application.

Please note that AUTECH grants ethical approval only. If you require management approval from an institution or organisation for your research, then you will need to make the arrangements necessary to obtain this.

When communicating with us about this application, we ask that you use the application number and study title to enable us to provide you with prompt service. Should you have any further enquiries regarding this matter, you are welcome to contact Charles Grinter, Ethics Coordinator, by email at charles.grinter@aut.ac.nz or by telephone on 921 9999 at extension 8860.

On behalf of the AUTECH and myself, I wish you success with your research and look forward to reading about it in your reports.

Yours sincerely



Madeline Banda

Executive Secretary

Auckland University of Technology Ethics Committee

Cc: Milind Mandlik milind.mandlik@manukau.ac.nz