WENDY BOWLES AND NARELLE PATTON

12. EXPECTATIONS AND RESPONSIBILITIES

EXPECTATIONS AND SERVICE QUALITY

It is increasingly recognised that expectations are integral in determining the quality of health services, because expectations strongly affect people's experiences of health services (AIHW, 2012, p. 32). The New South Wales Ombudsman is an independent body charged with watching over public sector and many private sector organisations and their staff to make sure that they "do their jobs properly and meet their responsibilities to the community" (NSW Ombudsman, 2014). This body offers a simple formula for calculating satisfaction with services (NSW Ombudsman, 2012, p. 1):

$$\textit{satisfaction} = (\textit{quality of service}) - (\textit{expectations})$$

The NSW Ombudsman notes that "consumers will only be satisfied with a quality of service that is equal to or exceeds their expectations. Quality service therefore comes from continuously improving the service and knowing and managing the expectations of your consumers" (NSW Ombudsman, 2012, p. 1).

How often has a health practitioner clarified what you can expect from them or asked about your expectations? If you are a health practitioner, what strategies do you use to ensure that your expectations align with those of the people you are serving? While it may seem obvious that people's expectations are related to their satisfaction with services, research findings reveal that understanding and working with expectations is complex, with expectations affecting health practices and outcomes in multiple ways.

In their comprehensive literature review and study of expectations of people using general practices and hospitals in the UK, Bowling et al. (2012) highlighted that not only do expectations influence satisfaction with services, but they also affect recovery. Expectations have been found to influence health behaviours in older adults (Meisner & Baker, 2013), the ways families choose interventions for hearing impaired children (Oshima, Suchert, Blevins, & Heller, 2010), family-centred health services in Ireland (Coyne, 2013) and young people's engagement and outcomes in mental health services (Watsford, Rickwood, & Vanags, 2013). Clearly, understanding and clarifying expectations should be an important focus for health practitioners and health services.

J. Higgs et al. (Eds.), Health Practice Relationships, 101–108.

EXPECTATIONS AND RESPONSIBILITIES – THE IMPORTANCE OF CONTEXT

As populations become more diverse so do public expectations of health systems (AIHW, 2012). “Expectations are shaped by the experiences of each individual, which are in turn shaped by such things as age, gender, locality and cultural background” (AIHW, 2012, p. 17). In this landscape of increasing diversity, if we are to understand and engage with expectations, we need to take the context of the individual and the service into account.

Context has become so important in how we understand health that it is included in definitions of health and disability, and in tools for assessing the health of individuals as well as the performance of practitioners and health services. Since 2001, the World Health Organization’s (WHO, 2014a) International Classification of Functioning, Disability and Health (ICF), which measures health and disability, has included contextual factors such as participation restriction and activity in the definition of health and disability. Assessing the health and disability levels of individuals and populations as well as the quality of health service delivery now includes, in addition to body structure and function, six domains of “cognition, mobility, self-care, getting along, life activities and participation” (WHO, 2014b). The role of environment or context in causing ill health and restricting people’s ability to participate is much better recognised. The responsibility for “recovery” has also shifted.

Instead of health and disability being seen as solely located in “sick” individuals who are expected to do all they can to follow the instructions of expert medical staff (usually doctors) to regain full health and return to a “normal” state of being fully able-bodied, it is now understood that environmental barriers to participation and functioning (both physical and attitudes/expectations) are just as important. The sociopolitical model of health and disability (Smart & Smart, 2012), which views disability as an issue of rights and, among other things, calls for people in the “patient” role to be included in decision making about their treatment as equal citizens rather than passive collections of symptoms with no voice, is the name given to the newest model or paradigm for understanding disability. Practising within this model creates very different expectations from those within the traditional biomedical model.

A case from one of the authors’ practice illustrates how these different expectations can affect interventions. Tim is a young man with a deteriorating neurological condition who has marked tremors that affect gross motor and fine motor coordination and who uses a wheelchair full time. He enrols in a residential rehabilitation setting, with the stated aim of learning to “live independently”, working with a range of health practitioners. One day, while preparing his dinner under the supervision of residential staff, he spills a packet of frozen peas onto the floor of his kitchen. Despite the instructions of the staff he refuses to pick up the peas. The next day the social worker and occupational therapist are called. He still refuses to pick up the peas. The stand-off between Tim and the staff continues for some days. Now that Tim is labelled a “behaviour problem”, the psychologist is asked to intervene. Following a lengthy consultation with Tim, she calls a staff meeting. “Do you realise how humiliating it is, and how long it would take, for this young man to have to crawl around and pick up these peas?” she asks. “It is more efficient and appropriate for a person with the physical capacity to pick them up, to be asked to do so”. The gathered staff look at each other. We realise that we have fallen into the biomedical model – which sees the solution to impairment as modifying the behaviour of the individual to more closely approximate that of an “able-bodied” ideal, rather than stay with our professed sociopolitical model – which sees independence as the ability to make the decisions and organise the support needed to live independently, rather than having the physical capacity to perform specific tasks.

This absurd but real-life example illustrates the power of the biomedical model to influence health practitioners’ expectations and behaviour, even in situations where the rhetoric of the sociopolitical model is articulated. Despite ongoing calls for its inclusion in health professionals’ practice, e.g. in nursing (Scullion, 2010), in social work (Beaulaurier & Taylor, 2012) and in counselling (Smart & Smart, 2012), the expectations of the biomedical model continue inappropriately to dominate many of the interactions between health practitioners and people who use health services.

HEALTH CONSUMER EXPECTATIONS

An important aspect of context, which is not always taken into account but which strongly influences expectations, is the level of emotional, behavioural and cognitive functioning of the person seeking a health service. Often people needing health services are in crisis – a technical term used by health practitioners to mean that a person is overwhelmed by a situation such that their usual coping mechanisms no longer work. James and Gilliland (2005) pointed out that people presenting to a service in crisis vary along a continuum of decision-making capacity. At one end of the continuum the person is totally immobilised by the crisis, requiring health practitioners to “take over” for a time and make direct interventions for the good of the person. Around the middle of the continuum the person is partially mobile and the practitioner works collaboratively with the person. At the other end of the continuum, the person requiring a health service is fully mobile. In this situation the health practitioner offers information and options, and the person is fully in charge of the decisions affecting his or her life. These authors argue that health practitioners need to constantly assess people’s emotional, behavioural and cognitive mobility and adjust their expectations and behaviour accordingly. Mirroring this, the expectations of the person seeking health service will vary according to their position on this continuum at any point in time.

With the rise of the sociopolitical model, also known as the “consumer rights movement”, introduced in the previous section, and with increasing recognition of the importance of expectations in assessing the quality of healthcare and health outcomes, general standards of expectations of people who use health and other services have been enshrined in legislation and policy in most First World nations.

To implement these policies, organisations have been established to deal with the complaints that arise when expectations are not met.

The NSW Ombudsman (2012, p. 1), quoted in the introduction to this chapter, lists five key dimensions of consumers' expectations of services. While taking care to clarify that this does not mean that services should always give consumers what they want, the Ombudsman argues that if services perform well on these five dimensions of consumer expectations they will maximise consumer satisfaction with services. The five dimensions are:

- The physical appearance of offices, staff and communications (termed tangibles)
- The ability to perform the promised service dependably and accurately (reliability)
- Knowledge, courtesy and credibility of staff and ability to convey trust and confidence (assurance)
- Willingness to help and provide prompt service (responsiveness)
- Willingness to provide caring, individualised attention (empathy).

The Ombudsman summarises worldwide research findings about what consumers expect from government services. According to the Ombudsman it is important to address these expectations, not only because many consumers have a sense of entitlement due to being taxpayers, but also because many other consumers have no choice or power about accessing these government services – they use these services because there is nowhere else they can go. Worldwide research findings about consumer expectations of government services are summarised as:

> People want to be treated like they are valued.
> They expect courtesy, respect, impartiality and honesty.
> They want processes that are easy to understand.
> They want timely and reliable advice and service and they don't want to be given the run-around.
> They want options for where and how the service is provided.
> They want clear advice in letters, forms, publications and verbal communications.
> They want fair and friendly treatment.
>
> NSW Ombudsman, 2012, p. 1

In 2008, Australian Health Ministers endorsed the *Australian Charter of Healthcare Rights* for use across the country (Australian Commission on Safety and Quality in Health Care, 2008). Other First World nations have similar charters. Echoing the more general consumer expectations summarised by the NSW Ombudsman, the *Australian Charter of Healthcare Rights* outlines seven key rights that apply to consumers, practitioners and healthcare organisations alike. These include access, respect, safety, communication, participation, privacy and comment (the right to complain about care and to have concerns dealt with properly and promptly).

While the rhetoric about meeting consumer expectations becomes ever more explicit, there is clearly huge variation in consumer expectations and whether they are met, as seen, for example, in the increasing diversity in expectations noted by the Australian Institute of Health and Welfare (AIHW, 2012). Two stories from the authors' recent experiences illustrate this variation. The mother of one of the authors was recently hospitalised for major surgery in another state. The night of the surgery this author was pleasantly surprised to receive a long and detailed phone call from the surgeon, explaining the outcome of the surgery and what could be expected post-operatively. Her expectations about healthcare were far exceeded. In contrast, the other author visited a colleague in hospital who had undergone a complicated hip replacement. During a ward round by a young registrar, the colleague was so offended at the registrar's attitude towards her that she exclaimed, "You arrogant little *** … just get out", which he did. In following ward rounds later in the week the woman explained to the registrar that she was a human being as was he, and that she expected to be treated with respect when he was talking to his students in her presence. Throughout the next week this woman received visits from young doctors thanking her for her intervention and for saying what they could not. The registrar has since been charming to this woman, but she wonders how he behaves with people who are not prepared to stand up for themselves.

HEALTH PRACTITONER AND ORGANISATIONAL EXPECTATIONS

As demonstrated in the examples above, health practitioner and organisational expectations are important because they powerfully shape health outcomes and experiences for health service users as well as expectations of the community more generally and of students or trainees more specifically. Berry, Gerry, Hayward, and Chandler (2010) provided a salient example of how health practitioners' low expectations and stigmatising views of health service users actively contribute to poor health outcomes and experiences. These authors found that pessimism about prognosis and attribution of negative characteristics to mental health service users were common among mental health practitioners. This in turn can lead practitioners to underestimate the ability of service users to be involved in decisions regarding their own care and medication, which could manifest as lack of collaboration between practitioner and service user. Moreover, these low expectations could be inadvertently conveyed to the general public (e.g. in interactions with carers, the media and personal acquaintances) and to students or trainees whom they teach or supervise. This inadvertent conveyance of low expectations or stigma is of particular concern as it perpetuates the conditions for poor health outcomes and experiences for service users. Health practitioners are therefore strongly encouraged to examine their individual values and beliefs in regard to those individuals with whom they work, to reveal the way in which those beliefs both shape their practice and are tacitly passed on to neophyte practitioners and the general community.

There is growing recognition that the emerging health practitioner workforce has very different professional expectations from those of earlier generations (Gallagher, Clarke, Eaton, & Wilson, 2007). For example, a group of vocational dental practitioners in the UK chose dentistry because they perceived dentistry as a financially lucrative, contained career in healthcare, with professional status, job security and the opportunity to work flexibly (Gallagher, Clarke, Eaton, & Wilson, 2007). This vision of a favourable work/life balance is in stark contrast to the view of Hanlon, Halseth, and Ostry (2011) of "stealth volunteerism", those acts of volunteerism undertaken by professionals over and above their formal responsibilities. Hanlon et al. used that term in recognition of the fact that the activities themselves are not easily identifiable, and also because the underlying systemic conditions that create the need for this type of volunteerism are often masked behind personal and professional commitments to help. Such volunteerism is more common in rural contexts where healthcare access is typically restricted and health practitioner workloads are consequently very high. Examples of stealth volunteerism include assisting support groups and helping clients and their caregivers to navigate health and social care systems. Significantly, Hanlon et al. found that these extraordinary efforts were not rewarded or acknowledged in any official sense and came at significant personal and professional cost to health practitioners. Continued acts of volunteerism place health practitioners at greater risk of burnout from role overload. These two examples highlight significant differences in health practitioners' expectations of their role and commitment to achieving positive health outcomes for health service users. From these two examples it may be inferred that younger generation health practitioners may be more focused on a positive work/life balance and therefore may be less susceptible to the burnout inherent in the undertaking of stealth volunteerism activities than their older colleagues. If this is indeed the case it raises a critical question for the future provision of quality healthcare: How will healthcare organisations bridge the gap between organisational provision of services and healthcare users' service needs?

Organisational expectations strongly shape health practitioners' practice and consequently the health experiences and outcomes of health service users. Organisational expectations are broadly visible in the organisational culture (vision and mission statements as well as staff attitudes and behaviours), practice models (e.g. adherence to treatment protocols and pathways) and articulation of goals and outcomes. Dubois et al. (2013) demonstrated that four distinct unit-level nursing care organisational models, characterised by contrasting staffing, professional practice environment and innovation characteristics, were associated with different levels of risk of adverse outcomes for patients. Their findings highlight the significant influence of organisational expectations viewed as practice models on healthcare practice and consequently on health outcomes. The setting of health service targets and reporting requirements against achievement of those targets reveals what is most valued at an organisational level. For example, an organisational focus on reporting of occasions of service and patient turnaround times reveals privileging of efficiency over quality of care and perhaps service user experiences. This privileging of efficiency may create a tension between organisational expectations and health practitioners' moral or professional responsibility to provide the best treatment for individuals in given circumstances.

Strategies for balancing expectations and responsibilities should start at the very beginning, that is, with the ethos and values of the practitioners and the service for which they work. It is important that health practitioners become aware of their own values, beliefs and practices (the models or paradigms within which they operate) as well as those of the organisations within which they work and the professions they represent, so that cultures, attitudes and beliefs that are not inclusive of health service users' expectations, values and beliefs are identified and eradicated. In this way, more inclusive cultures can be constructed that nurture the wellbeing of all stakeholders.

CONCLUSION

While documents such as the *Australian Charter of Healthcare Rights* take great care to align consumer, practitioner and healthcare organisation expectations and responsibilities, such efforts will remain at the level of empty rhetoric unless they are known about and practised by the three groups of people they are meant to assist: people who use health services, healthcare practitioners, and the organisations that deliver healthcare. Thorough understanding of health user expectations, combined with understanding of how organisational and professional expectations shape practice, will empower individual health practitioners to construct effective and enjoyable health practice experiences with and for health service users to achieve meaningful health outcomes.

This chapter began with the provocative formula proposed by the NSW Ombudsman, revealing that satisfaction with services, quality of service and expectations are closely related. The first step in working with people's expectations is to understand your own. Once practitioners clarify which models they work within, including their own values, perspectives and philosophies of healthcare, they will be much better prepared to ask the people who use their health services what they in turn expect. Similarly, people using health services will be better prepared if they can articulate their expectations to health practitioners. In this way, realistic partnerships will develop that can lead to improved health and higher quality health services for everyone.

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Wendy Bowles PhD
School of Humanities and Social Sciences
Charles Sturt University, Australia

Narelle Patton BAppSc(Phty), MHSc, PhD
The Education For Practice Institute
Charles Sturt University, Australia