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Healthcare leadership and the ethics of managing expectations of caregivers and patients

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Abstract

Healthcare providers and patients are often disappointed by the level of care public hospitals can deliver. The remedy is to lower expectations. Providers should be brought to see their obligations as only to give the best care resources allow. The public should be clearly told what care hospitals can and cannot provide and involved in decision-making. Healthcare leaders can play innovative roles in both these remedies.

Introduction

In any healthcare system in which demand for care exceeds the supply, patients cannot always receive the care they want or need when they want or need it. Throughout Canada, there are long waits for tests and admission to hospitals; once admitted, there may be four patients to a room, sometimes of mixed sexes; pain medication can be slow in coming, discharge accelerated, and what is called discharge to alternative levels of care may turn out to be discharge to inferior levels of care; early discharge home may put additional burdens of care on families not covered by home care, and discharge to long-term care will often be to the first bed available in the community, which could take patients from their friends and familiar neighbourhood.

I am not criticizing any of this. It is only what we should expect in any public hospital. But it is not what the public typically expects, and reality often only comes home when individuals encounter the system. It is also a situation that causes healthcare providers distress, as they cannot give their patients the care they think they should. How should healthcare leadership manage these disappointed expectations? I will first address the case of healthcare providers and then that of the public.

Healthcare providers

Since the problem of disappointed expectations comes from a scarcity of resources, one solution would be to make the supply meet the demand. But even if substantial increases to the budget, cost-saving measures, or opening a second tier could ease the problem, it is hard to see how it would eliminate it. Thus, the rationing of resources, and quality of care that inevitably goes with that, seems to be the foreseeable future of public healthcare. The first step in managing the expectations of healthcare providers is to lower their expectations. They have to come to see their job as not to give patients the best care possible but the best care possible in conditions of scarcity. This, in turn, means coming to see rules of rationing as their friends.

Rules of rationing are designed to regulate the delivery of healthcare so as to harmonize three goals: responsible cost-containment, an equitable distribution of resources, and hippocratic loyalty to patients whereby physicians can look patients in the eye and tell them that they are doing all they can for them—all they can, that is, within the rules. Nothing other than rules of rationing can do these things and that is why those rules are so important. However, the best rules of rationing will be of no avail if healthcare providers do not cooperate with them, and one central question is how to motivate such cooperation. It is here that there is scope for innovation by healthcare leaders.

It is common to seek cooperation by carefully monitoring compliance and penalizing violations. But such sanctions are costly and (as no one likes to be told what to do) alienating. It would be better to take a page from the literature on the management of common pool resources[1] and see if there is another way. That literature yields two key ideas for our purposes. The first is that there should be a shift from the question "What should *I* (as an individual) do?" to "What should *we* (as a group) do?" The second is that this shift can be most easily made if the individuals identify themselves as members of a group with a common purpose. Once they so identify themselves, what is in the interest of the group becomes what is in the interest of the individual and cooperation can be secured.

This model is a natural one for motivating cooperation with rules of rationing. Healthcare providers are used to thinking that they are members of a team, that the team has a common goal—the good of patients—and that achieving that goal requires the actions of many. This primes "we" thinking, and all that is then needed for effective action is a clear rationale for cooperation. In the case of rules of rationing, understanding that cooperation with such rules will produce the best system of delivering healthcare available in an economy of scarcity, and

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that general non-cooperation means disaster, will predictably stimulate healthcare providers to cooperate with them.

Cooperation brought about in this way can also be expected to be largely self-enforcing. Acting contrary to what healthcare providers as a group should do, while identifying with that group, is sure to produce feelings of guilt and shame. And physicians who push patients ahead of those of others can expect the professional and social censure of their colleagues. These sanctions will not eliminate the need for monitoring and formal punishment altogether but should reduce the need for it and promote better relations between healthcare providers and management. The challenge for healthcare leaders is to nurture the sense of group identity and understanding of the importance of rules of rationing on which all this rests.

Patients

The recipe for managing the expectations of the public is similar; this is to lower its expectations by accurately disclosing what the healthcare system and hospitals can and cannot offer and involve the public in the decision-making.

In response to requests from senior managers and board members across Canada for advice about priority setting and resource allocation, the University of Toronto Joint Centre for Bioethics (JCB) has developed a framework which it calls ''Accountability for Reasonableness.''[2] This identifies the following five conditions for a successful priority setting process:

1. *Relevance:* Decisions should be made on the basis of reasons (ie, evidence, principles, values, and arguments) that people disposed to cooperate in finding mutually justifiable solutions can agree on.
2. *Publicity:* Decisions and their rationales should be transparent and made publicly accessible.
3. *Revision:* There should be opportunities to revisit and revise decisions in light of further evidence and mechanisms for challenge and dispute resolution.
4. *Enforcement:* There should be either voluntary or public regulation of the process to ensure the first three conditions are met.
5. *Empowerment:* There should be efforts to optimize effective opportunities for participation in priority settings and to minimize power differences in the decision-making context.

It is the publicity condition that chiefly concerns us here. That condition is important for two reasons. First, satisfying it will put the public in a better position to accept the need for priority setting, understand the alternatives between which a choice must be made, the arguments for and against each, and the rationale for the decision made. This, together with the conditions of revision and empowerment, will involve the public in the decision-making and thus help make hard choices more palatable. It will also allow the public to align its expectations with reality.

Second, and overlapping with this, is the demand of democracy. In a democracy, the people are the rulers, and the function of government is to carry out the will of the people. But the people can fulfill their role as rulers only if they have full information about matters of public policy—which healthcare surely is—and meaningful opportunities to participate. They thus need to be kept up-to-date on and involved in the care provided in public hospitals.

But such communications are not common. When matters of policy regarding town planning come up—when, for example, light rapid transit or zoning changes that affect residential neighbourhoods are considered—the public is brought into the deliberations. Detailed information goes out, public meetings are organized, and there are opportunities for input. But when hospitals decide on accelerated discharge or first-bed policies, nothing similar typically happens. After noting this, the JCB paper goes on to say that decision-makers often express their reticence to ''go public'' for fear of ''making noise'' for the Ministry of Health. Reticence on the part of both healthcare leaders and the government is understandable. Nonetheless, the advantages of satisfying the publicity condition are also clear, and the JCB cites some notable examples of such reaching out to the public. The challenge for healthcare leaders is to find a way to do more of this.

Seeking cooperation from healthcare providers and input from the public in the ways recommended earlier may also have the additional benefit of giving these parties a sense of ownership of the healthcare system under which they work and live. And feeling that it is *their* system, not merely a resource provided to them by others, may in turn give them reason to be proud of the system, use it judiciously, and work to improve it.

References

1. Wilson DS, Ostrom E, Cox ME. Generalizing the core design principles for the efficacy of groups. *J Econ Behav Organ*. 2013; 90S:S21-S32.
2. Gibson JL, Douglas KM, Singer PA. Evidence, economics and ethics: resource allocation in health service organizations. *Healthc Q*. 2005;8(2):50-59.