

OUTPATIENTS' EXPERIENCES OF QUALITY SERVICE DELIVERY AT A TEACHING HOSPITAL IN GAUTENG

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ABSTRACT

Quality service delivery to the consumer of health is a legal reality as it is emphasised in the White Paper on the Transformation of Public Service delivery (South Africa, 1997). The guiding philosophy adopted within this framework is that of Batho Pele, which means placing the consumer at the centre of healthcare service delivery. Increasing attention has been paid to hospital processes from a quality perspective. By analogy, outpatient departments can be viewed as industrial plants where technological know-how is transferred to patients through service delivery, which is a cornerstone of a hospital's business. Outpatients, as consumers of healthcare, draw conclusions about the quality of service delivery based on their experiences of such services. In this vein, an outpatient's experience of a particular service is an indicator of his/her level of satisfaction with the quality of that service. No South African study can be found in the literature on out-patients' experiences of quality service delivery. This study's purpose is to explore and describe outpatients' experiences of the quality of service delivery at a teaching hospital in Gauteng. A qualitative, explorative, descriptive study that was contextual in nature was conducted to achieve this aim. Focus group interviews were conducted with outpatients who met the selection criteria. Open coding was used to analyse the contents from the transcripts and field notes typed verbatim. Strategies for trustworthiness, namely co-coding, prolonged engagement, triangulation and adequate referencing, were employed to ensure the credibility of the study and research findings. The results reflect themes that were reduced into two main categories, namely positive and negative experiences. The positive experiences reflect outpatients' experience of their relationship with medical staff and their satisfaction with the quality of medical care. Negative experiences relate predominantly to a lack of service commitments, unethical context, and inter-personal relationship difficulties that render them powerless and dehumanised. Recommendations are made to improve the quality of service delivery at outpatient departments.

OPSOMMING

Gehalte dienslewering aan die verbruiker van gesondheidsorg is 'n wetlike realiteit wat in die Witskrif op die Transformasie van die Openbare Dienste (South Africa, 1997) beklemtoon word. Die rigtinggewende filosofie wat in hierdie raamwerk aangeneem word is die van Batho Pele, wat beteken dat die verbruiker van gesondheidsorg op die voorgrond geplaas word. Vanuit 'n gehalte perspektief word daar toenemend aandag aan hospitaalprosesse gegee. Analogies, kan 'n buite-pasiëntdepartement gesien word as 'n industriële area waar die tegnologiese kennis aan pasiënte oorgedra word deur dienslewering, wat 'n hoeksteen van die besigheid van 'n hospitaal is. Buitepasiënte as verbruikers van gesondheidsorg maak gevolgtrekkings oor gehaltdienslewering op die basis van hulle belewenisse van sodanige dienste. In dié opsig, is 'n pasiënt se belewenis van 'n bepaalde diens 'n aanwysing van sy/haar vlak van tevredenheid met die gehalte van daardie diens. Geen Suid-Afrikaanse studie oor buite-pasiënte se belewenisse van gehaltdienslewering kon in die literatuur gevind word nie. Die doelstelling van die studie is om buite-pasiënte se belewenisse van die gehalte van dienslewering by 'n opleidingshospitaal te verken en te beskryf. 'n Kwalitatiewe,

verkennde, beskrywende studie wat binne 'n spesifieke konteks plaasvind, is uitgevoer. Fokusgroeponderhoude is gevoer met buite-pasiënte wat aan die seleksie-kriteria voldoen het. Oop-kodering is gebruik om die inhoud van die verbatim getranskribeerde transkripsies en veldnotas te analiseer. Strategieë vir vertrouenswaardigheid, naamlik mede-kodering, verlengde betrokkenheid, kruisvalidasie en voldoende verwysing is toegepas om die geloofwaardigheid van die studie en navorsingsbevindinge te verseker. Resultate reflekteer temas wat binne twee hoofkategorieë gereduseer is, naamlik positiewe en negatiewe belewenisse. Positiewe belewenisse reflekteer buite-pasiënte se belewenisse van hulle verhoudings met mediese personeel asook hulle tevredenheid met die gehalte van mediesesorg. Negatiewe belewenisse hou hoofsaaklik verband met 'n gebrek aan diensleweringverbintenisse, 'n onetiese konteks, asook interpersoonlike verhoudingsprobleme wat hulle magteloos en verontmenslik laat voel. Aanbevelings word gemaak om die gehalte van dienslewering binne buite-pasiënte-afdelings te verbeter.

INTRODUCTION AND PROBLEM STATEMENT

There is no doubt that quality service delivery has become an increasingly important topic in the discourse on healthcare. Kersbergen (1996:169) for instance, mentions that the healthcare system of the 21st century is changing as a result of healthcare reforms focusing on cost, quality and access. The healthcare industry now finds itself with the challenge of safeguarding the integrity of high quality healthcare in a financially restricted environment. Therefore, concerns with the delivery of quality healthcare services and the continuity thereof have become a feature of healthcare policies in many health organisations worldwide (James, 2005:2). This situation is no different in South Africa as a developing country with a total population of about 42 million people, and whose current healthcare system is undergoing transformation. Kilian (1995:419-420), in support of the aforementioned argument, states that decreased resources and budget restrictions are a reality for healthcare institutions in South Africa. Therefore, the quality of service delivery has also become an issue for these institutions.

Quality service delivery to the patient as the consumer of healthcare is emphasised in the White Paper on the Transformation of Public Services (South Africa, 1997). The guiding philosophy adopted within this legal framework is that of Batho Pele, a Sotho translation for "People First", implying that the consumer of healthcare is placed at the centre of healthcare service delivery and also that healthcare delivery be transformed in such a way that consumers are satisfied with it. The underlying belief that captures the Batho Pele culture is one of belonging, caring and service. In so doing, healthcare service needs to be transformed by a vision which is

representative, coherent, transparent, efficient, effective, accountable and responsive to the needs of patients/ clients as consumers of healthcare. Therefore, healthcare institutions ought to create a people-centered and people-driven service that is characterised by equity, quality, timeousness and a strong code of ethics. The latter principles amongst others serve as an acceptable legislative framework by which excellence in healthcare service delivery ought to be achieved. The initiative of Batho Pele emanated from an increasing awareness of social change, the community's need for self-expression as well as environmental, economic and political issues affecting health and healthcare delivery in South Africa. On the level of society, the consumer of healthcare shows an increased interest in the planning and decision-making in healthcare services, by demanding increased accessibility (Lazarus & Butler, 2001:22; Williams, 1998:264). Furthermore, the consumers of healthcare have become increasingly aware of their right to access to quality healthcare and participation in healthcare decisions that impact on their health. Thus, developments in education, as well as the need to improve and promote health in general have contributed to the revisiting of the quality issue in service delivery in healthcare (Muller, 1996:68-69). In this vein, James (2005:3) mentioned that the healthcare industry is shifting from competition based on price to competition based on quality and performance. The traditional concept that value is a function of cost and quality is expanding to include a third dimension, satisfaction (Bell, Krivich & Boyd, 1997:22).

Hiidenhovi, Nojonen and Laippala (2002:59) state that the consumer's satisfaction with a service or product is the main aim of product design in the field of commodities and trade. This opinion is based on the notion that consumer satisfaction has an effect on busi-

ness success. As a result, the perspective of the consumer of healthcare, insofar as the quality of the product and service is concerned, has become increasingly important in quality circles (James, 2005:3). Hiidenhovi, Nojonen and Laippala (2002:59-60) mention for instance, that increasing attention has been paid to hospital processes from a quality perspective with the aim of achieving improved productivity and cost-effectiveness.

Outpatient departments can be viewed as industrial plants where technological know-how is transferred to patients through service delivery. Service delivery could therefore be seen as a cornerstone of a healthcare system's business. Outpatients, as consumers of healthcare, draw conclusions about the quality of service delivery on the basis of their experiences of such services. A patient's experience of a particular service can therefore be regarded as an indicator to health practitioners about his/her level of satisfaction with the quality of a particular service (Carey, 2000:43; Bell, Krivich & Boyd, 1997:22). Quality service delivery is a multiphase interactive action, which coincides with the characteristic of excellence (Hiidenhovi, Nojonen & Laippala, 2002:60). Thus, to meet the needs of both consumer and healthcare practitioner in a way that adds valuable meaning to the healthcare experiences of outpatients, can be seen as a critical dimension of quality service delivery. However, whether this was the case insofar the outpatients' experiences of the quality of service delivery at a teaching hospital in Gauteng were concerned, had to be established. No South African study can be found in the literature on outpatients' experiences of quality service delivery.

PURPOSE OF THE ARTICLE

The purpose of this article is to describe outpatients' experiences of the quality of service delivery at a teaching hospital in Gauteng.

DEFINITION OF TERMS

Outpatient: In this article an outpatient refers to a formally registered patient at a particular hospital, and who received healthcare services in the outpatient department of that hospital.

Experience refers to the life events of an individual, which either the individual or another person acknowl-

edges happened, as ascertained through an interview with that individual.

Quality within healthcare service delivery refers to services that coincide with pre-determined standards, reflects the characteristics of excellence, and meets the needs of both consumers and health-care practitioners in a way that adds valuable meaning to both parties' healthcare experiences (Becker, 2006:12).

Quality service delivery in the context of healthcare refers to an act or multiphase interactive action carried out by staff in one moment or situation, the dimensions of which are assurance of competence, active attentiveness, dissemination of information, polite manners by staff and flexible helpfulness, which add valuable meaning to outpatients' health-care experiences (Hiidenhovi, Nojonen & Laippala, 2002:60).

RESEARCH DESIGN AND METHODS

A qualitative, explorative, descriptive study (Creswell, 1994:145) that was contextual in nature was conducted. Qualitative studies aim to explore the depth, richness and complexity inherent in the meaning of interaction among people.

Selection criteria

The selection criteria for participants included those patients:

- aged between 18-70 years;
- who could speak Afrikaans or English;
- who had been admitted to the outpatient department; and
- who agreed to share their experiences willingly.

There was a total of thirty ($n = 30$) outpatients in this study, of which 17 were women and 13 men. In terms of race four of the participants were White, nine classified themselves as Coloured and the rest ($n = 17$) as Black. The participants were predominantly treated for chronic medical health problems.

Ethics

The study was approved by the University's Academic and Ethics Committee and the Ethics Committee of the Hospital (letters dated 18/03/2003) where the study was conducted. The researchers provided both com-

mittees with a research proposal of the study in which the aim, design and methods were described and justified. Written informed consent was sought and obtained from each participant who met the inclusion criteria. The participants were guaranteed strict confidentiality and anonymity, and were allowed to withdraw from the study at any time.

Data collection

Three focus group interviews (Krueger, 1994:6) were conducted on different days with outpatients who met the selection criteria. Interviews were conducted after the patients' appointments while they had to wait for their prescribed treatment. Arrangements had been made with the pharmacy to process those patients' prescription charts, while the interviews were conducted. The researcher invited participants to an assigned meeting room and conducted a focus group interview. A central open-ended question, probing how participants experienced the quality of service delivery in the out-patient department, was asked. The question asked was: How is the quality of service delivery in the outpatient department for you? A recording of the conversations was made and field notes on the participants' body language, such as facial expressions, tone of voice and reactions, were noted, to be used as a reference for data analysis. The interview lasted 50 minutes, and the data collection and analysis were conducted immediately after the focus group interviews. Field notes of the tone of voice and non-verbal communication behaviour by participants were kept by the researcher.

Data analysis

The open coding method (Tesch, 1990) was used to identify and analyse the content of the transcripts and field notes were typed verbatim for themes. Transcripts were read through carefully to obtain an idea of the whole, while ideas were jotted down as they emerged from the text. During the analysis, the researcher asked himself "what is the interview about?" and "what is the underlying meaning?" and wrote notes in the margin. Similar themes that emerged were clustered together, by arranging them into major, unique and leftover themes. These themes were coded. With the coded themes, the researcher went back to the data collected and read through it again, this time writing the codes

next to the appropriate segments in the text. With this organising scheme, new sub-categories emerged, which were then grouped into two main categories. Data saturation was accomplished after the third set of transcripts was analysed.

Methods of trustworthiness

In this study, trustworthiness was ensured by means of the strategies for trustworthiness as devised by Lincoln and Guba (1985:289-331), namely co-coding, prolonged engagement, triangulation and adequate referencing.

Co-coding was conducted by an independent coder. A full set of verbatim transcripts was given to the independent coder, together with the purpose of the study. After both the independent coder and the two researchers had coded the transcripts and identified the themes and categories, a consensus discussion was held. The aim of the discussion was to compare and justify how both parties arrived at the themes and sub-categories, and to achieve consensus on the final categories of experiences. The researchers' previous knowledge and experience of an outpatient department and of qualitative research, and the literature that was consulted enabled them to satisfy the criteria of being knowledgeable and prolonged engagement with the phenomena under investigation. Triangulation of both national and international literature sources was carried out during the conceptualisation of the categories. For audit-trail purposes, adequate reference is made to the literature sources used during the conceptualisation of the categories.

DISCUSSION OF THE RESULTS

The emerging themes describe outpatients' experience of the quality of service delivery at a teaching hospital in Gauteng. Themes were clustered into two main categories, namely positive and negative experiences. The positive experiences reflect outpatients' experiences of their relationship with medical staff and their satisfaction with the quality of medical care. Negative experiences relate predominantly to a lack of service commitments, ethical cultural context, and interpersonal relationship difficulties that render them powerless and dehumanised.

For a discussion on the experiences of outpatients regarding the quality of service delivery at a teaching hospital in Gauteng, the reader's attention is drawn to Table 1, which reflects the themes, sub-categories and main categories.

Positive experiences of quality service delivery

The outpatients expressed their satisfaction with the medical management they received from the doctors. Therefore, satisfaction with medical management related to helpful doctors, was identified as the first theme to be discussed.

Satisfaction with medical management related to caring doctors

Service delivery in an outpatient department reflects the work of a multi-disciplinary team of doctors, nurses, physiotherapists, laboratory technicians and pharmacists. The multi-disciplinary health team is broadly classified by the outpatients in two categories: the medical team (that include ancillary medical staff, for example, physiotherapists, pharmacists and laboratory technicians) on the one hand and the nursing team on the other. The interaction of these teams with

the outpatients during service delivery can either have a positive or negative impact on their experience of such a service. Outpatients unanimously expressed their satisfaction with the management they received from the medical team, and described them as "helpful". One outpatient verbalised this as follows "[the] doctors and the physio [physiotherapist] went out of their way to help me ...". Another patient verbalised something that might be disturbing to nurses that claim to be caring professionals: "... the doctors in this place is much more considered and helpful ... he even took my hand and tells me that everything will be all right ... I feel so special, and yet I would have expect this from the nurses, but I didn't ...".

Katz (1993:34) is of the opinion that good customer relations do not just happen automatically. They are the product of careful planning, close control and the ability to adapt to changing circumstances and needs. Helpfulness of the medical staff is, according to Katz and Seifer (1996:32), important in patient treatment as the patient is assisted to manage his/her own health by positive input made by staff through constructive suggestions and behaviour. Stemming from the aforementioned discussion, if nurses, who claim to be caring professionals, want to deliver quality healthcare service, they should be much more aware of the

Table 1: Outpatients' experiences of quality service

MAIN CATEGORY	SUB-CATEGORY	THEMES
Positive experience	Satisfaction with medical management	Helpful doctors
Negative experiences	Lack of service commitment and service orientation	Unresponsive and disorganised, untidy environment
	Experiences of a culture of non-caring and lack of hospitality	Impatient and distrustful nurses
	Powerlessness	Lack of information or choice
	Violence	Anger, aggression and frustration
	Non-enabling environment	Unfriendliness, lack of coordination, lack of safety
	Dehumanisation	Lack of consideration, respect for the person and professionalism

behaviour that they demonstrate towards other people and to their patients in particular.

In the next main category the negative experiences of outpatients regarding quality service delivery, by nurses in particular, the context within which such services are delivered and the feelings these experience brought on, are discussed.

Negative experiences of quality service delivery

The negative experiences of outpatients of the quality of service delivery include experiences of a lack of service commitment; a culture of non-caring and inhospitality; powerlessness related to a lack of information; violence as the language of aggression, frustration and uncertainty; and a non-enabling environment; an unfriendly, unsafe and non-enabling environment; dehumanisation and the lack of consideration for the person.

Lack of service commitment and service orientation

Healthcare is recognised as a service that healthcare providers and employees, delivers to the community, in terms of which the community grants such services certain legal rights and obligations to practise responsibly. However, what is sometimes expected is not necessarily realised. For instance, in the Nurses Pledge of Service (Searle & Pera, 1998), nurses promise to “serve the community with dignity and respect ...”. However, when expected to operationalise this promise in reality, it is clearly evident from outpatients’ responses that nurses often fail to comply with this promise. The following excerpt from one participant supports the aforementioned statement: *“I came quite early in the morning, so that I make sure to be helped early, [but] ... many of times you first find the nurse drinking tea while we [the patients] have to wait”*.

Abbott and Lewry (1999:82) are of the opinion that service is that part of the process that involves day-to-day contact between staff and the customer. This links up with the generally accepted view that services, in other words the products of “service industries”, like hospitals who deliver health services, differ from material goods in that they are far less tangible, more perishable, simultaneous and heterogeneous (Abbott & Lewry,

1999:82). In this vein, service in an outpatient experience is made up of both sensory and psychological experiences rather than objects that patients can take home and add to their permanent possessions.

Goods can be stockpiled but service cannot (Caceres & Paparoidamis, 2007:840). To this extent, it can be said that an opportunity missed by a healthcare practitioner to be of service to outpatients’ as consumers of healthcare services, is lost forever if he/she does not grasp it. The simultaneous nature of service implies that the customer has to be there when the service is delivered. Without the physical presence of both patient and healthcare professional, the entire concept of service experience becomes meaningless. What also needs to be considered from a service point of view is that the experience thereof is heterogeneous in nature (Becker, 2006:17). This implies that different customers have different needs, and sometimes it is even more difficult to ensure that service standards are met.

Of all the healthcare professionals, nurses have the most contact with patients in the healthcare delivery cycle. To this end, the way in which nurses behave and treat patients determines the service product being sold in an outpatient department. One might admire a finished artefact in a manufacturing industry without worrying about whether there might have been a bitter labour dispute during the manufacturing process, but a comparable event in an outpatient department would make a client’s experience rather unpleasant.

Service quality can be measured by reliability, responsiveness, courtesy, customer orientation, confidentiality and caring (Abbott & Lewry, 1999:83; Caceres & Paparoidamis, 2007:840). In other words, the value of commitment and service orientation is an important aspect of quality service delivery. From this perspective, the outpatient department can be compared with a front office at a hotel. Insofar as it concerns the outpatient department of a hospital, reliability means the avoidance of error in every single procedure, for example, filing that is normally carried out in an outpatient department. This includes from filing to a tidy waiting area to having the medication ready when an outpatient is ready to leave the outpatient department. The following two excerpts from the focus group interview summarises the contrary: *“... they send me off to the pharmacy with the wrong prescription*

chart" and "... *this place is so dirty ...*".

Responsiveness implies that each service should be available as and when an outpatient is supposed to have it, and not when it happens to suit the staff (Abbot & Lewry, 1999:83). It thus covers an important time dimension. In outpatient terms it means promptness in redirecting the patients to the appropriate service areas, answering their questions and not keeping a patient waiting while the nurse is finishing his/her conversation with a colleague or drinking tea outside scheduled tea-breaks, as reflected in the following excerpts: "... *many of times you first find the nurse drinking tea while we [the patients] have to wait*" and "... *they send me from one point to another just to tell me that I must go back where I start ...*".

Lastly, courtesy, as an important aspect of service commitment and orientation in an outpatient department, is every individual staff member's responsibility towards his/her patients. It means being polite even when the outpatient, viewed as a guest, is overbearing, inconsiderate or downright offensive. This requirement can sometimes conflict with other requirements, such as responsiveness, for it can mean being willing to explain things clearly and patiently even though there is a long queue waiting. It can also mean being friendly and reassuring, though it is sometimes difficult to draw the line between being coldly polite on the one hand and too familiar on the other. Customer-oriented service means placing the outpatient before the institution, a notion also reflected in the phrase: "Batho Pele", the latter being the guiding philosophy of public service delivery (Abbot & Lewry, 1999:83; South Africa, 1997). Any suspicion on the part of the outpatient that the priorities in terms of service delivery are the other way round is likely to be counter-productive, and is not facilitative in creating a caring and ethical service delivery environment.

Experiences of a culture of non-caring and lack of hospitality related to impatient and distrustful nurses

Service delivery takes place in a particular culture. Therefore, it can be argued that the dominant factor in healthcare delivery and health promotion practices within a context of transformation is that of culture. Drennan (1992:233) defines culture as "the way things are done around here", which suggests that culture creates the

context within which health service delivery occurs. Kitson, Harvey and Hyndman (1998:151) are of the opinion that context includes "the forces at work which give the physical environment a character and feel". This remark suggests a direct relationship between culture and context. The following remark by Bate (1994:12) emphasises the slippage between culture and context: "Culture is not something that an organization has but something an organization is ... It is a label or metaphor for, not a component of, the total work organization". Outpatients verbalised their experience of how things are done around the outpatient department. One patient expressed this as follows: "*I don't like the way they neglect the old people ... and some of the nurses ... I'm not happy with. They have an attitude ... you ask them something ... it's like they're doing you a favour*". An old woman with a chronic respiratory problem in one of the groups narrated her experience of impatient nurses as follows: "*The nurse in my room were in a hurry ... she asks me questions, but do not wait for me to answer ... and you know I get short of breath easily with my problem ...*". Another participant said "*I wanted to know from the nurse where the X-ray [department] is, she just tell me to ask someone outside to show me ... you know I don't know this hospital*".

Several diverse and sometimes conflicting cultures can operate in an organisation or institution and different cultural norms reflect implicitly different values or world views (Kennedy, 2001:16). Clashes between cultures in an organisation often lead to dysfunctional or sub-optimal working relationships (McCormack, Kitson, Harvey, Rycroft-Malone & Seers, 2002:97). Bate (1994:11) suggests that the way organisational culture is understood in the context of practice is essential to understanding how best to bring about changes in practice and cultural change (if needed). Therefore, it can be argued that if one wants to improve on the quality of service delivery in an organisation through creating changes within the context or environment within which such services are delivered, then changing the prevailing culture may cause this to happen (Ledger & Shufflebotham, 2006:22).

Caring means that staff must make every effort to appreciate the individual outpatient's needs. This might differ from outpatient to outpatient and even from time-to-time, but recognising them is a key feature of the

service concept. However, the following excerpt demonstrates just the opposite: "... he even took my hand and tells me that everything will be all right ... I feel so special, and yet I would have expected this from the nurses, but I didn't ...". Outpatients are individuals and should not be treated as if they were identical, and staff need to be able to differentiate between the changes. According to Abbott and Lewry (1999:83) it is this need to combine individuality of treatment with the maintenance of a consistent overall standard that provides much of the challenge in hospitality or service-orientated work. Trust in a relationship impacts on the generation of a particular climate, which in turn is affected by the culture that exists. However, the behaviour of some of the staff contributed to distrust, not only in the healthcare system, but also in terms of the confidentiality of care delivered by health professionals. As one outpatient responded: "*I overheard a nurse telling one patient what was wrong with one of the patients ... you know, how can one tell them [nurses] your personal stuff if it is broadcast to other people ...*".

Powerlessness related to a lack of information or choice and respect

The purpose of healthcare is to promote the health of the individual, group or community, in other words, moving them from one given state of health to another. Health promotion can be conceptualised as concerns about the creation of living conditions or an enabling environment in which a person's experience of health is increased (Mitra & Alexander, 2003:383; Hartrick, 1998:219; Brown, 1991:441-442). According to the Joint Commission on Accreditation of Healthcare Organizations, quality of patient care is defined as the degree to which patient-care services increase the probability of desired patient outcomes and reduce the probability of undesired outcomes, given the current state of knowledge (Accreditation Manual for Hospitals, 1990:2). According to the World Health Organization (WHO, 1986:1), health is defined as: "... a resource for living ... a positive concept ... the extent to which an individual or group (or community) is able to realize aspirations, to satisfy needs, and to change or cope with the environment". This implies empowering the individual with the necessary information and skills to make autonomous decisions and to manage his/her own health. Empowerment is regarded as a process of enabling people to increase control over, and to improve

their health (Mokwena, 1997:67). Power therefore correlates positively with health status.

Powerlessness refers to a lack of power. Webster's dictionary (1986) defines powerlessness as being helpless and without authority. This implies a lack of personal control over events or a situation. The environment of the outpatient department as experienced by the outpatient contributes to his/her feelings of powerlessness. The environment of the outpatient department at an academic hospital, which handles almost eight hundred outpatients on a daily basis, has many factors that can lead to the outpatient feeling powerless. Three prominent factors described by the outpatients in the group are a lack of coordination, a lack of communication between different departments and a lack of information to the patient. These factors contribute to what the outpatients described as a "... *disorganised overwhelming environment*". One patient expressed this as follows: "*I came here at 06:00am and my appointment was at 08:00 ... between those two hours they [nurses] sent me from one point to another but eventually I end up with the first person [nurse] again... I don't know what is happening*". Outpatients express numerous examples that support the aforementioned quote.

Outpatients experienced healthcare services as disempowering to them. This feeling of powerlessness is related to a lack of healthcare information or choice concerning the individual outpatient. One patient described this as follows: "... *many of times I have to figure it out for myself what is happening ...*" and "*The nurse at the pharmacy gave me my tablets without looking at me ... before I could ask her a question she just called next*". Another participant alluded to the lack of information that exists with regard to treatment: "... *the nurse, when I ask her about my treatment, she scream on me and tell me that she does not repeat things twice ... and you know I cannot hear so well*".

Because of the outpatients' feelings of powerlessness, they respond in various ways. Powerlessness often results in feelings of frustration and anxiety. These feelings are related to the outpatient's experience of loss of control. Feelings of powerlessness related to frustration lead to anger and hostility, which ultimately lead to violence among fellow outpatients (Dunn, 1998:136). This phenomenon can be described as:

‘Violence as the language of anger, aggression and frustration’ related to feelings of powerlessness. Healthcare services may be modified in order to support outpatients’ desire for information, respect and relief from factors that contribute to powerlessness.

Violence as the language of anger, aggression and frustration related to feelings of powerlessness

Anger is an emotional defence to protect the individual’s integrity against a perceived threat and agent of harm (Roberts, 1986:259). Feelings of anger experienced by outpatients are derived from frustration and powerlessness. One patient described this as follows: *“I come here quite early this morning hoping to be helped soon as I also know that it can become quite busy in this place ... [but], then I had to wait here for hours without being helped ... most of the times I left the hospital being angry ...”*. Frustration frequently produces anger when one is blocked from achieving a goal. Powerlessness viewed as a threat to the outpatient, coupled with feelings of frustration, often makes the individual respond with anger. Anger internalised by the outpatient often results in hostile behaviour that leads to violence. One participant described his experience of aggression and violence by the nursing staff as follows: *“I remember one time when the nurse gets the porter to slap a patient who was confused ... and then they laugh afterwards ...”*.

The Oxford Dictionary (1994) defines violence as “an unlawful use of force ... involving a great physical force which is due to the intense experiences of vehemence in a particular situation” (Ferns, 2006:42). However, violence is a subjective phenomenon and therefore people interpret it in different ways. The participants in the focus group expressed numerous examples of violent moments they had had to endure as outpatients. One patient described this as *“... people [patients and nurses] are fighting down there [outpatient department]”*. Another participant alluded to the occurrence of anger against the nurse by a patient as follows: *“Shame, I feel so sorry for her ... the patient called the nurse a bitch when she ask him to wait while she was attending to another patient ... and then he slap the nurse ...”*. Kaplan and Sadock (1998:159) explain this phenomenon as follows: “Anger is the fight and flight response to anxiety. Anxiety occurs from the frustration of unmet expectations or loss of self-respect. The

anxiety is transformed into feelings or actions and relief is felt. Angry, hostile and destructive behaviour, thus being acts of aggression or violence is a primary response to frustration, and when the balance between impulse and internal control collapses, violence breaks out”.

The occurrence of violence as experienced by outpatients can be described as the language in which deep-rooted intra-personal and interpersonal conflicts express themselves (Krug, Mercy, Dahlberg & Zwi, 2002:1085). Outpatients attributed frustration that builds up into aggression as the underlying dynamic for this violence. Violence as a symptom is a message that something is out of balance between the internal and external environments of the individual. Violence as the language of aggression, frustration and feelings of powerlessness is laden with meaning. They ask for interpretation in order to be able to address it efficiently and effectively. Violence as a symptom points to something deeper, and if one simply eliminates the symptom, one is not solving the underlying problem (Gilmore, 2006:254; Krug *et al.* 2002:1085; Smith-Pittman & McKoy, 1999:5-6).

Violence experienced by patients or staff in the outpatient department violates two fundamental principles in ethical thought, that of Beneficence and Nonmaleficence, which implies the concept of doing good and preventing harm to patients respectively (Pera & Van Tonder, 2005:32). As such, violence in the workplace, irrespective of the form thereof, ought not to be tolerated and measures should be instituted to safeguard people, including patients against occurrences of violence (Ferns, 2006:44). In this regard Smith-Pittman and McKoy (1999:12) state that “... unless interventions are developed and appropriately applied, violence at work will increase in frequency and intensity”. Thus, the responsibility for a safe and healthy work environment rest on all stakeholders’ shoulders and therefore ought to be a shared responsibility of all. Strategies to counteract violence should take cognisance of the environment in which violence occurs. This relates to the next category of outpatients’ experiences of a non-enabling environment.

Experience of a non-enabling environment related to unfriendly staff, lack of coordination and unsafe circumstances

The outpatient department of the hospital where the study was conducted is large and can accommodate about 300 sitting people. Chairs are positioned in rows in front of cubicles or service points where patients have to wait. Chairs are sometimes placed outside in the corridors. The participants complained that the air-conditioning in the areas where they were seated was not good and the room was very hot. Many complained that they had to use sheets of paper to fan themselves. These physically uncomfortable circumstances contribute to a non-enabling environment, as the following excerpt from the data demonstrated: *"It was very crowded and I felt like collapsing ... it was too hot. You know I am here since half past six, by now it is ten ... The doctor have seen me but now I have to wait for my medication, and do you know how long that is going to take ... plus the place is so dirty"*. The experiences of unfriendly staff and a lack of coordination of services further contributed to experiences of a non-enabling environment. The following excerpt demonstrates this: *"They send me back to the Casualty Department to find the doctor to complete a specific form for me ... I mean ... don't they kept these forms here [outpatient department] then to make me to run around like that ..."*. One patient described the safety of the circumstances in the out-patient department as follows: *"You know, we sit here for the whole day ... in these uncomfortable chairs ... and sometimes rubbish overflow in the rubbish bins, plus you often find needles lying around ... We can get prick by it ... I don't want to get AIDS"*.

Creating a therapeutic environment is a legal requirement in terms of the Scope of Practice of the Nurse (South African Nursing Council, 1984:2). Lin and Liang (2007:20) are of the opinion that patient safety is a compelling concern in the healthcare system. However, patients who narrated their experiences of such an environment indicated otherwise. By modernising the "nursing system", Lin and Liang (2007:20) are of the view that patient safety can be improved. They conclude that improving the nursing environment requires a broad approach to patient safety. Such an approach will require that the nursing care environment be treated as a complex system, which can result in greater nurse professionalism, empowerment and patient safety. In this vein, Kalisch and Aebersold (2006:143) propose measures for facilitating patient safety such as clarifying values,

encouraging and rewarding the reporting of mistakes, consistently analysing mistakes and near misses, looking for the unexpected, simplifying work, minimising interruptions, commitment to resilience, encouraging deference to expertise, and promoting team work.

Besides a non-enabling environment, many outpatients experienced that the nurses were disrespectful and not very considerate, and this results in feelings of being dehumanised.

Dehumanisation and a non-ethical climate related to a lack of consideration, professionalism and respect for the person

Agulair and Stokes (1996:4) write that good customer service means meeting one's patients' needs in a sense that has value and meaning to them. Because outpatients as customers experience service delivery in a outpatient department one moment at a time, Agulair and Stokes are of the opinion that providing a service that meets individual needs and adds value to each patient's experience makes them as customers feel valued and respected. However, the participants were of the opinion that they experienced the opposite of what Agulair and Stokes mention. Outpatients recalled moments in which nurses referred to them as *"... a number"*. One participant who worked in a factory relates his experience to goods on a production belt in a factory. He described it as follows: *"You know, like in the morning you receive a number ... they call you on that number ... [Nurses] rarely call you on your name ... which make you feel like just another can of coke passing through the production belt ..."*.

Nursing as a profession values the right of the patient to be treated with respect and dignity, regardless of race, gender or social standing (Muller, 1996:13). But, nursing is foremost a profession that promises "to do no harm". Respect for patients incorporates at least two ethical convictions: first that individuals' should be treated as autonomous agents, and secondly, those people with diminished autonomy are entitled to protection. This implies protection from harm, which relates to the ethical principles of non-maleficence. In this vein, Katz and Green (1992:18) write that patients have certain basic expectations of a particular service and expect to be "served in a respectful and meaningful way". This implies the right to be treated in a dignified

way and not to be dehumanised to a mere number. Referring to outpatients as “numbers”, strips them of their identity, thereby dehumanising them. Outpatients often related their experience of being dehumanised to the lack of professionalism demonstrated by the nursing staff. One participant verbalised that: *“When the nurse talk to me, she barely look at me ... or call me on my name”*. Another participant mentioned that: *“they [nurses] are so loud [talking loud] ... the one nurse talk to the other from across the passage, but it is almost as if she scream ...”*. One patient told of a situation where he had complained about a nurse and how the nurse punishes him for that: *“she [the nurse] went to put my file just underneath the pile of files ... that make me have to wait there [outpatient department] for the whole day, only to be told that I should come back the next day”*.

The latter two themes both allude to the necessity of creating an ethical climate. An ethical climate refers to the stable, psychologically meaningful perceptions members of organisations hold concerning ethical procedures and policies existing in their organisations and organisational subunits (Wimbush, Shephard & Markham, 1997:1705). In this vein, an ethical organisation or out-patient department refers to one that has a strong ethical value orientation, and in which employees (nurses, doctors and members of the healthcare team) live these values and practice them when engaging with patients. An ethical value orientation according to Van Vuuren (2004:123), is inextricably linked to the practice of good corporate governance that aims to satisfy the needs of all stakeholders. Thus, creating an ethical climate in the outpatient department is a critical dimension of quality service delivery that will facilitate positive experiences of the patients of such services. Creating an ethical climate alludes to the concept of professionalism. LaSala and Nelson (2005:63) are of the opinion that appearance, behaviour, dress and communication skills play an important role in the image that a nurse projects. As a nurse interacts with patients, families, community members, corporate personnel, and policymakers, he/she must reflect a professional image. The nurse should reflect a high degree of professionalism to patients, the public and other professionals, which is important for him/her to self-actualise as a practitioner and as a person and to enable him/her to facilitate professionalism amongst student nurses (Fetzer, 2003:139; Secrest, Norwood

& Keatly, 2003:81).

CONCLUSION

The need to measure quality and effectiveness is a dominant theme in healthcare. The relationship between the measurement of effectiveness and quality of care is widely debated in literature (Donabedian, 1988:1743). However, both Donabedian and Deming (1991:17) argue that measurement effectiveness is much more complex than just measuring it in number, and they illustrate this through the many ways in which medical quality can be defined, depending on the particular perspective adopted (doctor, service user, administrator, and others). While most “hard” data of cost-effectiveness and resource management provide a particular perspective on the quality of practice, a humanistic or person-centred culture of practice makes explicit the value of individual perceptions and feedback.

The results of this study seem somewhat disturbing, as it reflects quite the opposite values emphasised by the Batho Pele legislative framework as a guiding philosophy in healthcare service delivery. Furthermore, unprofessional conduct demonstrated by healthcare professionals is not conducive for the creation of an ethical health service delivery environment. Lastly, negative experiences of quality service delivery of patients in outpatient departments reflect also negatively on the image of that service on the one hand and on the other, can negatively affect the health of patients. Thus, thoughtful consideration is needed of the interventions needed to manage these negative experiences outpatients has about the quality of service delivery. To address the negative experiences, an ethical healthcare environment needs to be cultivated in the outpatient department. This ethical environment will promote quality service delivery experiences for outpatients and will make these experiences meaningful.

RECOMMENDATIONS

The following recommendations are made based on the findings of this study, which aimed to explore and describe outpatients' experiences of quality service.

1. Organisation management should demonstrate a commitment to improving the quality of service delivery

in the organisation by:

- Formulating new management policies that emphasise customer excellence. These policies should be designed in such a way that they are clear on providing specific customer excellence guidelines and behaviours for all employees, including medical personnel.
- Top-management should show an increased visibility in service-delivery settings through the development of rounding schedules that get them out to all service sites on a routine basis.
- Top management should provide written feedback reports following these rounds.

2. New customer service standards should not only be adopted, but evidence of the implementation of these service standards should also be collected.

3. These customer service standards should reflect statements of the following aspects:

- patient safety;
- professional conduct and presentation;
- courtesy;
- efficiency; and
- trust.

4. The above-mentioned service standards should be reflected in mission and vision statements that are visible to staff and patients.

5. A customer service contract should be formulated and all employees should be requested to sign the new customer excellence service contract in line with reasonable labour practices.

6. A new monthly employee orientation process/in-service education programme should be adopted to reflect:

- Sessions where top management are given a chance to demonstrate their commitment to the values and process of customer excellence and report on tangible measures that were undertaken to achieve this.
- Sessions where topics related to the improvement of customer excellence service and the customer service standards are addressed.

7. Job descriptions should be revised to include the new customer service standards with clear descriptions on corresponding required behaviours.

8. Recruiting and hiring policies and procedures should be re-formulated in line with reasonable labour relations practice that reflects at least the following:

- Screening of applicants by the human resources department for specific customer service skills.

- A customer service standard commitment that is signed by the employee as part of the application and employment process.

9. A customer service excellence committee should be established to help with the formulation of and revision of:

- customer service standards and contracts;
- development and steering of a customer service excellence training programme;
- development of generic benchmarks for customer services excellence in the organisation and assisted clinical units tailored as their own; and
- patient satisfaction surveys.

10. An aggressive customer grievance procedure in keeping with labour relations, patient rights and other relevant stakeholder expectations (South African Nursing Council (SANC), Medical and Dental Council) should be established.

11. A new rewards and recognition programme based on unit performance and continuous employee evaluation by customers should be developed.

12. Disciplinary procedures for employees who do not comply with the expected customer service excellence behaviours should be re-formulated.

13. Quality assurance programmes that embody more efficient reporting and working relationships between the customer service excellence committee, grievance committee, quality assurance committee, patient care committee and top management should be re-formulated.

14. The outpatient department should be re-decorated to facilitate a friendlier, safe environment:

- visibility of nurses in waiting rooms;
- visible signs indicating locations; and
- visuals giving information that is relevant.

LIMITATIONS

It is recognised that this study reflects only the experiences of out-patients in a particular context. The intention was to understand and gain more insight into how outpatients experience the quality service delivery at a particular teaching hospital. It is therefore recognised that the results reflected in this study might not be generalisable to other contexts. It is recommended that studies with a methodology that enable a larger sample group be conducted. However, findings in this study can serve as ground work for such a study. Secondly, that a longitudinal study be

conducted to determine how outpatients' perceptions/ experiences of the quality of service delivery may change over time.

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