Putting the Care in Healthcare

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Bobby John focuses on ensuring health outcomes - equally at ease with processes of formulation and implementation of development policy and financing, strategic communications, or in the weeds of biomedical research, development and translation.

Bobby trained at the Armed Forces Medical College, Pune, but stepped out of a career with the Indian Army to work among the rural poor in village Kedgaon of Maharashtra, India. He subsequently worked as the Administrator for the NM Wadia Hospital in Pune, Maharashtra.

In 2004, he founded Global Health Advocates in Winterthur, Switzerland as a non-governmental organization focused on engaging all sections of society towards the formulation and implementation of effective public policies to fight disease and ill health. Today, Global Health Advocates is independently registered in the EU with offices in Paris and Brussels, as well as in Chennai, India.

Bobby also worked as the Advocacy and Public Affairs lead for the India office of the Bill & Melinda Gates Foundation between 2010-11 and as the HIV AIDS Coordinator for World Vision India between 2001-02.

In Indian clinical settings, consumer protection covers the delivery of specific clinical services and expected clinical outcomes, but not 'patient experience'. For instance, if a patient admitted into hospital for cataract surgery on the left eye is mistakenly operated on the right eye instead, the hospital is liable to pay damages for not delivering the expected clinical outcome. However, if the surgery is performed correctly, according to guidelines, but the patient has had to endure a time-consuming admissions process and rude bedside nursing care, the hospital is not liable for damages because the basic outcome was met. India's hospital operators do not see patients as consumers, and as a result, a positive consumer experience is mostly accidental, and not by institutional design.

In the early 90s, however, hospitals in India took a few small steps towards better patient experience. This was during the HIV epidemic, when hospital administrators began to discuss patients' rights, focusing on topics such as whether or not an infected individual should know their diagnosis, if an individual's consent was necessary prior to performing certain procedures, or if the individual should have the right to private counselling, etc. As a result, certain regulatory guidelines related to patient experience were introduced; however, this positive beginning did not lead to broader adoption across the healthcare sector. Today, most providers still lack focus on patient experience.

Challenges to achieving holistic healthcare

According to the preamble to the Constitution of the World Health Organization, "Health is a state of complete physical, mental and social well-being, and not merely the absence of disease and infirmity." Holistic healthcare must focus on providing for all these aspects, but there are serious discrepancies between what is and what should be. Any attempt to change the current state of healthcare in India must take into account the complex and interlinked underlying issues that need to be understood.

Social:
The absence or disregard for patient-centric care at hospitals is rooted in our collective social behaviour which is not grounded in respect for fellow humans but driven by an individual's financial and social standing. For example, patients who can pay will receive luxury stay experiences at hospitals, while patients who do not have the means often have to rely on family to bring them meals when they are in hospital. The same disregard is also common to other citizen services, such as police, emergency services, railways, clinical services and diagnostic services.

Economic:
Based on a recent survey, the average monthly salary in India is ₹32,800. However, if you examine median salaries, you get a different picture. The median salary in India is ₹16,000 month which means half the Indian population is earning less than ₹16,000 per month. This inequality has two significant implications. First, that half the population cannot access basic care, let alone good patient experience, which is only available to the privileged few who have the financial capacity. Second, with such low incomes, many individuals in the healthcare system are employed under exploitative work conditions with little training and guidance to deliver patient experience. A comparison of nurses' salaries offers a glimpse of this disparity: the salary of a staff nurse at All India Institute of Medical Sciences (AIIMS), Delhi's premiere medical institute, is approximately ₹50,000 per month, while many nurses at private hospitals earn just ₹7,000-8,000 a month.

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Performance measurement:
Most hospitals in India are overburdened by high volumes of patients due to the lack of primary healthcare infrastructure across the country, and patients self-referring to secondary and tertiary care specialists. As a result, hospitals have a consultation model that allows doctors very little time with patients. According to a study, it takes a doctor about an hour to note down a patient's medical history thoroughly. In contrast, another study has found that doctors in India typically interrupt patients an average of 12 seconds after they begin describing their symptoms. The dangerous implication is that doctors, pressured to see as many patients as they can, prescribe treatments without taking detailed patient history into consideration.

The success of surgeons in the hospital system is also measured by metrics such as the number of procedures or surgeries they have performed, rather than how happy their patients are with them.
This creates a cult of personality with patients lining up to meet these doctors regardless of how they are treated. In the absence of patient satisfaction survey metrics, the procedure metric has become a gold standard for hospitals everywhere, and even the new generation of medical professionals end up pursuing the same success formula.

Education:
In Europe and North America, the medical education curriculum puts emphasis on developing soft skills such as empathy and compassion, as they are known to significantly contribute to enhancing the therapeutic experience of patients who can share their anxieties and feel heard. In India, however, developing these soft skills is not part of the education curriculum.
The focus of Indian medical schools is solely to teach clinical aspects, resulting in a lack of awareness that seriously limits a medical professional's ability to deliver holistic, patient-centric care.

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Creating a new, empathetic holistic care system

Given the complexity of India's healthcare system, a gradual approach to transforming healthcare could steer practitioners and institutions towards becoming more empathetic and compassionate, delivering positive patient-focused experiences along with clinical outcomes. This requires a concerted effort to build the following areas:

Build an inclusive framework:
The quality assurance framework that exists for clinical outcomes can be extended to incorporate patient experience, provide transparency in the healthcare delivery process, and recommend guidance and remedies for any lapses. Such a framework could also address the unhealthy dynamic that currently exists between providers who treat patients based on their ability to pay, and patients who are suspicious of the treatments prescribed by providers, especially when they include expensive diagnostic tests.

Reimagine medical education:
Today, the criteria for someone to enter medical school in India is purely academic, and restricted to those who have studied biology as part of their higher secondary education. Educators could consider taking new admissions criteria into account, including the applicant's character and intellectual traits, such as their views on being humane and considerate, and their emotional intelligence. In addition, applicants could have multidisciplinary educational backgrounds, including engineering and humanities. For example, a medical graduate with an undergraduate degree in computer science would think of a human-centric approach to designing AI solutions for healthcare. Lateral entries from other educational disciplines enrich the medical system by bringing fresh approaches to solve traditional problems.

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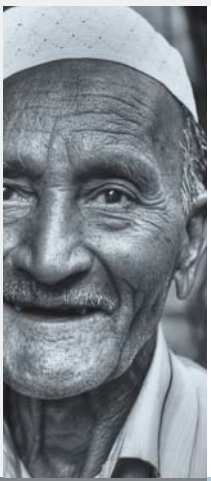

It is important that students in the medical education system understand human relations and feelings, and have the maturity and empathy to deal with them.
A first-year student who has joined right after senior secondary school might lack this maturity, understanding and experience, even if they are academically proficient.
By making undergraduate studies a mandatory prerequisite to medical studies, students will gain the maturity that gives them a better understanding of people, relationships, and of their own propensity for a care-oriented profession.

Apart from medical education itself, institutions should also offer certain foundational credits in the curriculum that are required for completion of the degree.
Courses on topics such as human

centred design, individual dignity, compassion, empathy, bedside behaviour, etc. should be offered for all disciplines of study. In addition, all course content should be revised to focus on patient experience by emphasizing human empathy.

Offer equitable compensation:
The paradox is that although healthcare is considered a collective effort, 80% of its workforce is disproportionately underpaid. A new payment mechanism would ensure equitable salaries and benefits that would go a long way in not only stemming attrition and extortionist behaviours, but giving dignity to underpaid workers who spend more hours on the hospital floor caring for patients.

Build a technology platform:
Although there is huge potential for the application of technology to improve the patient experience, adoption is limited and heterogenous, with highly localized systems that do not allow information sharing between providers. A universal technology platform can be enabled to address many critical challenges that are putting hospitals under such pressure today. For example, a national universal patient data platform can aggregate data across time and space with a single platform that captures their historical medical information, rather than patients and doctors having to spend their valuable time capturing this information again and again every time they change hospitals or doctors. This can also help doctors make informed decisions within the limited time available to meet the patient. A corollary to the lack of time is the issue of triage, i.e. examining the patient's history, identifying the potential issue, inputting the symptoms and diagnoss, and accordingly directing the patient to the right department, where care can be given in accordance with the system data provided.