STUDY OF THE HOSPITAL AS A SOCIAL INSTITUTION: A CASE STUDY OF RAM MANOHAR LOHIA HOSPITAL IN DELHI

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CERTIFICATE

This is to certify that the dissertation entitled - '**Study of the Hospital as a Social Institution: A Case Study of Ram Manohar Lohia Hospital in Delhi**', submitted by Amar Jeet Kaur is in partial fulfilment of the requirements for the award of the Degree of Master of Philosophy of this University. The dissertation has not been submitted for any other degree of this university or any other university, and is her own work.

We recommend that this dissertation be placed before the examiners for evaluation.

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AMAR JEET KAUR

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ABBREVIATIONS USED

1. A.M.S. - Additional Medical Superintendent
2. A.N.S. - Assistant Nursing Superintendent
3. C.A.O. - Chief Administration Officer
4. C.C.U. - Coronary Care Unit
5. C.G.H.S. - Central Government Health Scheme
6. C.M.O. - Chief Medical Officer
7. D.M.S. - Deputy Medical Superintendent
8. L.A.M.A. - Leave Against Medical Advice
9. M.S - Medical Superintendent
10. NIHAE - Now Known as NIHFW (National Institute of Health and Family Welfare)
11. N.S. - Nursing Superintendent
12. OPD - Out Patient Department
13. O.T. - Operation Theatre
14. R.M.L.H - Ram Manohar Lohia Hospital
15. V.I.Ps - Members of the Parliament, Freedom Fighters and their Dependents

CHAPTER I

INTRODUCTION

Conceptualization of Institutional Study :

Even at its most progressive limits, the paradigm of clinical medicine which is currently the universally recognized model of medical-science persists as an individualistic, class-biased, and ideological mode of diagnosis, treating and preventing illness. This is evident from the development of health services, historically, and the concepts of health and disease.

From this proposition follows the theory that contemporary medical definitions of health and disease are inadequate because they are abstraction derived, for specific historical reasons, from the clinical study of an individual. The definitions are inadequate expressions of the relations of medical states (illness) to reality, since individuals are not clinical entities. In reality the human essence is the product of an ensemble of social relations. The clinical model does not encompass the social relations of the individuals, even at its most progressive limits.

The proximate source of the clinical paradigm was the hospital base of the medical perception of reality. During the 19th century, the hospital became the place where diseased people were housed, diseases were identified and census of diseases were kept. Along with sickness, health acquired a clinical status, becoming the absence of clinical symptoms.

Initially, the clinical paradigm appeared in association with disease, but eventually it came to dominate the entire spectrum. One way to approach the spread of the clinical medical paradigm-a phenomenon sometime referred to as the medicalisation of society-is to arrange various medical disciplines on a continuum extending from death at one end to health at the other.

The overwhelming concern with individual is a major limitation of the paradigm of clinical medicine. No medical discipline can evolve on the basis of this paradigm to study holistically the total interaction of groups of people with their economic, political and social circumstances. Yet, life and reproduction of human life, are viable only within the context of an economic structure, social organisation and political system. A medical paradigm that is not holistic and collective produces only an inexact and inadequate body of medical knowledge.

This suggests an additional proposition : that medicine failure to develop a positive definition of health results fro the individualistic and ideological bias that pervades medica research and medical practice, structures relations betwee practitioners and patients, shapes the approaches selected fo treatment (e.g. clinical or surgical intervention) and th technology employed and rejects the initiation of collectiv social action by communities.

Health services are one of the main factors influencing th health status of a population. Health of a population is als influencing, sometimes even more significantly, by such social economic factors as nutrition, housing, education, income and it distribution, employment, communication and transportation an the social structure. Morecver, as are the other factor influencing the health status, the health services of a communit is usually a function of its political system. Political force play a dominant role in the shaping of the health services of community, through decisions on resource allocation, man-powe policy, choice of technology and also the degree to which th health services are to be available and accessible to th population.

The entire way of life of a community (i. e. its culture including social and economic conditions, form a major categor

of factors, which along with biological and environmental factors, determine the nature, size and distribution of health problems in a community. Again the cultural response in a community to the health problems confronted by it determines the health practices. The culture of a community determines the way individual members perceive different ways of dealing with health problems, and health behaviour of a community are also determined by its culture. Indeed, all these elements form an interacting sub-system within the overall cultural system.

The growth of these public health institutions in India have been guided by the value system of the colonels of the Indian Medical Service, the British trained bureaucrats of Indian Civil Service and above all the political leadership of free India. The political leadership of independent India also laid emphasis on the old colonial tradition of giving supremacy to the western system, i.e., the establishment of hospitals.

The approach has increasingly been to establish a number of hospitals, for providing intensive care services, open heart surgery, brain surgery and cancer therapy services leading to overspecialisation without taking into consideration the felt needs of the community.

Hospital and its inter-linkages with the community have not been realized leading to the health service development without the prime concern for the community. The wider social system of which hospital is a sub-system, with a complex network of sub-systems interacting have not been visualized, i.e., the OPD, indoor wards, the various category of personnel working and their interactions, the patient population as a category and its interactions with hospital staff and so on.

Increasingly, the social scientists have been hired to solve the problems commonly found in the hospital because of westernized institutional culture. The approach has been unidimensional, not adequate to understand the problem holistically.

Health Care - Towards an Understanding

A major amount of research endeavour has been directed towards the study of various social institutions forming the foundation of any society or culture. Although sociologists have long and frequently spoken of 'social institutions', the term has no precise and uniform usage. It is generally applied to aspects of social behaviour regulated by well established, easily recognized and relatively stable norms, values and laws. Indeed some sociologists have used it to designate the complexes of

norms, values or laws rather than the patterns of actual behaviour. Various institutions of the society such as family and kinship, economic, political, and cultural institutions are seen as linked to the functional prerequisites of a society. The health care institution (in this case a hospital) is guided by the socio-cultural milieu in which it is operating. In other words, it creates the notion of the hospital as a replica of the wider social system of which it is a part and parcel.

The hospitals are introduced in the process of social evolution as a purposive intervention to cater to the needs of the people in relation to health. Health institutions are one of the means to achieve a good health status in a society but the notion that 'hospital as an apex health institution has contributed to the better health institution has contributed to the better health status'needs an epidemiological enquiry; or in other words, a holistic approach to study these health care provisions.

The entire range of health care institutions starting from the Primary Health Centre at the block level to the hospitals with super-specialities is headed by an apex body of a 'hospital' itself. Hospital as a social organisation enjoys the maximum financial and economic resources, the issue henceforth which is raised ..... whether these institutions as the health care

providers are really catering to the needs of the population whom they are supposed to. Here, another pertinent issue should not be overlooked i.e., the aspect of the 'patient satisfaction'. In other words, are the health policies, plans and consequently the health case delivery system in consonance with the "satisfaction" of the "passive patients" who are left at the mercy of the doctors? The "patient" who enters the hospital, i.e., when engrossed in the "patient role" is accompanied by many shades of stresses and anxiety which is reflected in his behaviour. He has certain preconceived notions about the medical functionaries which when unsatisfied leads to his dissatisfaction.[1]

Satisfaction is primarily a psychological phenomenon concerning the subjective world. It is at the same time a product of the social situations of interactions with 'alter'. The satisfaction of the "Patient" (i.e. a person who suffers patiently; from the physicians point of view, one who is sick and requires treatment)[2] thus, has to be seen as a resultant of the fulfilment of expectations focused around situational needs and social needs. Some other scholars (Edward J. Speedling and David

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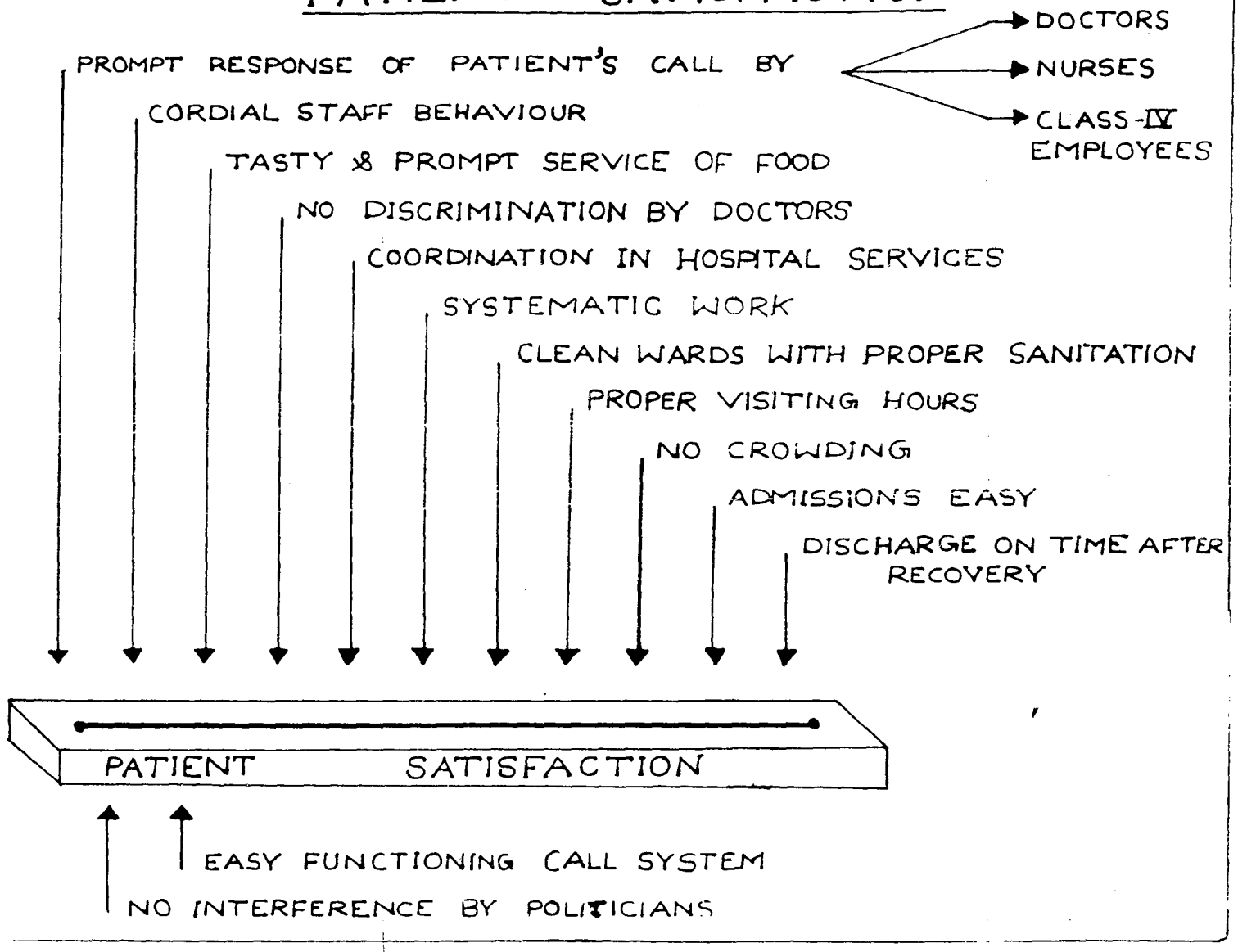
1. Advani, M.(1987), Dimensions of Patient Satisfaction, in S.K.Lal and A. Chandani(eds.),*Medical Care:Reading in Medical Sociology*, New Delhi, Jainsons Publishers, p. 84.

2. Webster, New Twentieth Dictionary of Social Sciences vol. 7.

FLOW CHART-1
PATIENT - SATISFACTION



N. Rose, 1985)[3] argue that in addition to patient satisfaction, patient participation should be encouraged in order to build an effective doctor-patient relationship.

The other issue pertains to the extent to which the hospital is a community institution, i.e., how the hospital came into being, process of linkages between the hospital and community, the role of the hospital in developing new linkages. In other words, 'the social and economic forces which shape the formulation of these technological institutions, interactions between these institutions and the community and the social relations within these institutions are the issues to be looked at while examining the relationship between hospital and community'.[4]

Medical Care in India : A Historical Perspective

Hospitals of the modern day society are in no way similar to that of earlier ones when they were established. In India, the history of hospital can be traced far back to the times of Ashoka, who not only built hospitals for men but also for

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3. Speedling, E.J.,& Rose, D.N.,(1985), Building an effective doctor-patient relationship: from patient satisfaction to patient participation Social Science and Medicine, vol. 21, no. 2.

4. Banerji, D.(1981), 'Hospitals and Promotion of Community Participation in PHC,' Karachi, CIDA.

animals, guiding motive behind the act being the Buddhist ideal of sympathy for the sick. The modern hospital is totally different than the 'tiggichya/chikitsala bhaisjaya graha' or 'arogya sala' of the first and second century B.C. Basham[5] quotes that these hospitals were built with different notions than that of present day hospitals. Entry of the Islamic rulers also did not bring much changes. A new era was ushered in the second half of the nineteenth century in the history of hospitals though in the early phase the motivational forces remained social, religious and ethical and hospital remained a charitable institution meant for the poor.(Mathur 1975)[6] It was the progress of medicine and surgery which called for the emergence of a new modern type of hospital organization. Increasingly the hospital served as a base for the training of the therapist and treatment of the sick. The present day hospital owes its legacy to the portuguese invasion, later French and eventually British East India Company. The first portuguese hospital was set up in 1506 in Goa. By the end of eighteenth century hospitals were built up in all the presidencies of Calcutta, Bombay and Madras but till 1792 natives could never get the treatment and it was only in 1835 that the so called 'Black Doctors' got scientific training.

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5. Basham, A.L.(1976),'The practice of medicine in ancient and medieval India', Charles Leslie (ed), *Asian Medical Systems,* ,California, University of California.

6. Mathur, I(1975), *Interrelations in an Organisation,* Jaipur, Aalekh.

Thus, the hospitals of the present day are a modification of the western hospitals.

Modern medicine was first introduced into India on a very limited scale by the portuguese in the 16th century. Francisco De Almendia built a hospital in 1506 at Cochin. The first portuguese, settlement in India. Royal Hospital at Goa was built for portuguese soldiers in India and other Europeans in 1510. By 1842 it was turned into the school of medicine and surgery. Modern medical facilities as well as medical training was introduced on a vast scale on a firmer footing by British[7]. During the British rule, the chief architects of medical policy were doctors of the IMS which was primarily a military service, maintaining the health of the fighting forces. It also provided services for the European civil and military servants to maintain their morale and their strength in a hostile environment. The provisions of health for the masses was used to forestall and respond to the demands for some tangible benefits of the British rule.[8]

Hospitals began to be opened for the servants of the British army in the 17th century at Madras (1664), Bombay (1676), and

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7. Joseph & Others (1969), *Health Care in India*

8. Jeffery, R.(1988), *Politics of Health in India*, Berkley, University of California, California Press.

Calcutta (1707-8). A hospital for Indians was provided at Calcutta by the end of 1792; 115 in-patient and 101 out-patients were treated there in 1974, and their number rose to 218 and 4,443 respectively in 1803. During the 19th century more hospitals were opened for Indians in Bombay, Madras and other places. The first mofussil hospital was established at Dacca around 1804 and by 1840, a dozen more in different parts of the country.

The British doctors in-charge of the hospitals employed a few Indians for technical help and gave the elementary training in some aspects of modern medicine. In 1740 a medical department of the Company comprising the British military surgeons and their Indian assistants was created. Indian assistants came to be known as 'native doctors' and 'black doctors' attached to a battalion of sepoys. However no systematic training was given.

It was a beginning of a systematic training in 1824, when the Native Medical Institution was established at Calcutta, where medicine was taught according to both Ayurvedic and the Modern systems. At the same time classes were also attached to the Calcutta Sanskrit College and Calcutta Madarasa to impart instruction through Sanskrit and Urdu respectively, in Muslim and Hindu systems of medicine in combination with some aspects of modern medicine.

In 1833, the viceroy Lord William Bentinck appointed a committee to report on the conditions in the existing medical institutions and on medical education imparted at the Native Medical Institution. Report of the committee was presented on Oct 20, 1834. The members directed on the question of the medium of instruction, Orientalists headed by Dr. Tyler, Superintendent of Native Medical Institution held that the medium of instruction should be native language and the Anglicists crowned by Dr. Duff, head of the Free Church of Scotland's Mission stressed that medium of education should be English. The committee recommended the immediate abolition of native medical institution, Calcutta as well as the medical class at sanskrit college and Madarasa. Suggestion was made to establish a medical college for the education of Indians.[9]

The medical college was established in June 1835 containing 500 beds and 24 wards and it catered to the needs of the patient belonging both to European and native patients. In 1835, another medical school named as the Madras Military Medical School was established at Madras.

By the end of 1901-1902 there were 4 medical colleges in India, at Calcutta, Madras, Bombay and Lahore. There were 1,466

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9. Minocha, A.(1974), *Some Aspects of Social System of an Indian Hospital,* Ph.D.Thesis, Delhi, University of Delhi.

students in medical colleges & 2, 727 in medical schools. Of these 242 were women.[10]. Once the skepticism of the British about the aptitude of the 'native intellect' for modern medicine was overcome it was possible for them to open more medical colleges and schools.

The foregoing discussion shows that modern medicine was introduced into India initially for the benefits of the employees of the East India Company. Later, as the work of the East India Company expanded and as Indians too started resorting to the new system of medicine, it was considered necessary to extend medical facilities further. The British were, however, quite skeptical about how the Indian students would respond to western medicine but the Indians demonstrated their aptitude to study an alien system of medicine. Subsequently medical institutions were established all over the country.

A Theoretical Perspective:-

Hospital as an institution has been defined by Rodney M. Coe[11] as " ... the modern hospital is a very large and complex

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10. Raina,'Medical Services', in B.P. Bishewar Prasad(ed), *Official History of IAF Forces in II War*, 1963.

11. Coe, R.M.(1970), *Sociology of Medicine*, New York Mc.Graw Hill Company, p. 233.

organization in the sociological sense of a recognizable hierarchy of statuses and roles, rights and obligations, attitudes, values and goals". This definition gives a picture of a modern bureaucratic organization with superordination and subordination built into the system for proper allocation of duties and efficient performance by the personnel. (A. Ramanamma and Usha Bambawale)[12]. While on the one hand we have a comprehensive definition by R. Coe, on the other hand we have a very general one of Eliot Friedson[13] who defined hospital as " ... it is a place where people sleep and receive care. It implicates that hospital has distinct division of people, the one who provide care and those who are receivers of care; those who assume responsibility and for those whom responsibility is assumed and those who keep house". Mary E. W. Goss[14] has defined hospital in terms of an organisation with specific goals which are essential for the hospital's very existence.

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12. Ramanamma, A.,and Bambawale,U.(1987),'Doctor-nurse-patient relationship in a hospital setting', in S.K.lal & A.Chandani(eds.), *Medical Care:Readings in Medical Sociology*, New Delhi , Jainsons.

13. Friedson, Eliot (1970), *Profession of Medicine, A study of the sociology of applied knowledge*, Harper and Row, New York.

14. Goss, M.E.W.(1973),'Staff-patient relationship' in Eliot Friedson (ed.), *The Hospital in Modern Society*, New York, Harper and Row.

Pointing at the features of a modern hospital as distinct from the traditional ones (as pointed out by Benjamin, Paul,[15]) and looking at the hospital with a socio-cultural framework Lyle Saunders[16] highlights that " ... hospital is in some sense neutral ground of physician and patient. Both are a guest of an institution which has its own organisation and its own corporate life. The purity of the patient practitioner relationship is inevitably adulterated by the presence of host of ancillary personnel and by the bureaucratic imperatives of multipurpose organisations. For the doctors environment well attuned to all technical requisites of medical care, it affords him an ideal therapeutic facility in terms of scientific amateurism and the resource of supporting members of the medical team. It requires him to do a highly specialised bureaucratic role subject to administrative and collaborative desiderate - which in certain important respects is at variance with the traditional healer and characteristic generalist".

In a general sense, hospital is essentially an establishment intended for the treatment of diseases and injuries arising in the community; it ensures that persons suffering from

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15. Paul, Benjamin(ed)(1955), *Health Culture and Community,* New York, Russell Sage Foundation.

16. Saunders, L.(1954), Cultural differences and medical care, New York, Russell Sage Foundation.

degenerative diseases and incapacitated by senility find shelter and receive attention and it may also provide maternity care (WHO technical report on the role of hospital, no.176, 1959).[17] More specifically, World Health Organisation in their technical report on the role of hospitals in the programmes of community health protection have defined hospital as, "The hospital is an integral part of a social and medical organization the function of which is to provide for the population complete health care, both curative and preventive and whose out-patient services reach out to the family in its home environment; the hospital is also a centre for the training of health workers and for bio-medical research." (W.H.O, 1957, p.4).[18] These definitions by WHO give a picture of a general hospital. The above definitions have tried to trace the relationship of the society and the hospital mainly in the western context. The Indian hospitals have also been seen through the western parameters. The need therefore is to study the 'health culture'[19] of Indian society and then see its implications on the health status of the country.

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17. W.H.O.,(1959), Technical Report Series. no. 176, Geneva, W.H.O.

18. W.H.O., (1957), *Technical Report Series*. no. 122, Geneva, W.H.O.

19. Banerji, D.(1968), 'Role of Social Science in Hospital

Hospital as a Social System

Hospital is a sub-system of society. It is influenced by the society and in turn influences the entire society. In other words, hospital being the sub-system of the social system is on one hand influenced by the main system and on the other, influences it. Recruited personnel and students, patient population and other visitors carry with them the cultural and social values of the larger system and affect the culture and functioning of the organisation. Stressing this view, Cockerham[20] states that regardless of a society's level of medical knowledge and technology, the structure of medical science still functions within the context of the values, beliefs and attitudes of the people comprising that society.

Studies on hospital as a social system describes hospital as an elaborately structured, rigidly stratified, tightly disciplined bureaucratic organization, which have repercussions on the patients; the patients become habituated to a predictable amount of daily activities and a clearly delineated set of duties, rights of privileges that any alteration in them causes tension. Hence, hospital when viewed as a social system evokes

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Administration,' *Hospital Administration.*

20. Cockerham W.C.(1978), *Medical Sociology,* Prentice Hall, Engle

the issue of patient being the most important part of it, and the relations between the staff and patient, hence, should be conducive towards creating an environment where the health of the patient promotes.[21]

Profession of Medicine in India : Some Issues:

The study of the profession of medicine raises basically two issues : the issues of the sociology of professions on one hand, and that of the sociology of hospital as a health care institution. In the field of profession of medicine in India considerable emphasis has been laid on the study of the allopathic practitioners and nurses, their social background, recruitment pattern, role-perception, role set, role expectation and role performance. There is an attempt to examine into doctor-patient relationship and doctor-nurse relationship. The study of the professions have followed two distinct approaches : the structure- functional approach and the Marxist approach. The adherents of the structure-functional approach consider profession as "a form of the division of labour based on code of ethics and work autonomy "as an" occupational group based on specialised knowledge, primary orientation to the community interest internalised. Code of ethics, towards which primarily

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Wood Cliffs, New Jersey .

21. International *Encyclopedia of Social Sciences*, New York,

symbolise work - achievement" and as a "group performing rational, functionally specific and universalistic roles". The other approach is influenced by Marxism, though it recognises the basic elements of professions such as specialized knowledge, length of training and work autonomy, yet, stresses more on power, resource, privilege, profit motive, market orientation, monopoly and exchange relationship of professions.

Hospitals are the most visible elements of the western medicine which influences its 'culture' through education and training of the health professionals consequently influencing the socialisation of these workers into the 'culture' of various hospitals and directing the medical knowledge through research conducted in these apex bodies. The interrelations between the community and the hospital necessitates the community to perceive it as a source of getting cured from the diseases and as an alien institution.[22]

Indepth analysis of these facts, i.e., the issues regarding the sociology of hospitals indicate the involvement of the social scientists in the health fields in ensuring the acceptance of the package of health technology by the people. Further, it highlights the role of the market forces influencing the social

scientists to direct the efforts towards "selling" the product manufactured by them. In addition to these a very major aspect of the sociology of hospitals is the access of the different segments of a community to these institutions. The efforts of the social scientists in this field have been guided by certain socio-political forces prevailing in a society. The issues of accessibility and availability are the ones influencing the quality and kind of health care provided to the majority of the population.

It may be pointed out that obviously social sciences form an important dimension in the process of understanding the complex functioning of the hospital. Relating social science issues to the overall functioning of the hospital is basically different from usual hospital studies conducted by the hospital administration. The social sciences deal with community (patients) and the professionals vis-a-vis the semi-professionals and major areas in organisation and management. The social sciences are also of considerable relevance in relating functions of a hospital to the wider systems of medical care administration, primarily health care and overall health services. Social sciences are also of help in understanding how some of the socio-economic forces influence political decisions concerning hospitals, medical care and health services.

In the next chapter the studies conducted earlier by the social scientists as well as the health administrators on different hospitals, have opened up a lot of inter-disciplinary issues. But these inter-disciplinary dimensions have not been fully studied keeping in view wide range of patients who form the central pivot around which all activities of the hospital revolve.

Variation among the Hospitals :

Hospital is one of the significant institutional structures of modern medicine. A lot of variation is now found not only among hospitals in various countries, but also among hospitals in the same country. These differences are in terms of buildings, size, complexity, availability of resources and provision of facilities-- in respect of both men & materials and social environment and experiences they provide to the patients and the staff. The variation is to take into account the cross-comparison of hospitals.

The hospital in India are not the true replica of its western counterparts.

A sharp stratification exists among community hospitals, in terms of levels of technology and such basic amenities as

hygiene, food, linen, floor space, furniture, quality of equipment and so on. At one hand, there are highly sophisticated hospitals built by contractors from western countries on a turnkey basis and at the other hand are the utterly overcrowded "filthy and grossly mismanaged" and ill-equipped hospitals in the "mofussil" areas, and in district headquarters, where the privileged few among the underprivileged manage to get admission for treatment of such conditions as intestinal perforation, typhoid fevers, ante-partum and post partum haemorrhages of various forms of malignant growths. In between, there are the expensive teaching hospitals the big general hospitals and those of smaller sizes in smaller cities.[23]

The hospital with superspecialities in India, forms an apex of the rest of the elements of the health care delivery system. The recommendation for the building of All India Institute of Medical Sciences was formulated by the Bhore Committee in 1946. The aim was to bring together, in one place, educational facilities of the highest order for the training of important medical professionals, promote research activities and coordinate it with training, provide post graduate education with the professionals developing a community outlook. This institute was to be seen as a reference model in all respects of health care

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Participation in PHC", Sept 27, 1981.

and medical education in this country. (H.S.D.C. ; 1946, vol II, 431).[24] This resembles Johns Hopkins Medical School, Baltimore, U.S.A., which serves as a model of medical education in that country. On the same lines the Post Graduate Institute of Medical Research and Education was established at Chandigarh.

Besides these hospitals, there are hospitals run by private organizations which include those built by different business magnates as TATA, BIRLA and others. Other highly expensive hospitals privately owned exist in the metropolitan cities of Bombay (Jaslok), Rotary Club hospitals of Calcutta, Bombay, Delhi and Madras, the access to which is almost extinct for the majority of the masses. Moolchand Hospital, Ganga Ram and Apollo Hospitals in Delhi are examples of these well managed, highly equipped hospitals providing services to the upper crusts of the population.

Though there are hospitals and dispensaries run by the government in the public sector i.e., general hospitals as well as the super-specialities hospitals, we have hospitals in the private sector too, (the access to which is limited for the commons), there are others run on an voluntary basis by certain christian missionaries and other social welfare organisations.

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23. Banerji, D. (1981), *Ibid*

24. Govt.of India (1946), *Health Survey and Development Committee*

These run on a non-profit basis and are approachable for the poor people. The quality of care provided to the patient in these hospitals is generally standardized. Most popular of them are the Christian Medical College and Hospital, Ludhiana (Punjab) and Vellore (Tamilnadu), Holy Family Hospital (Delhi) and another one also run by Christian Association (Voluntary Health Association of India). So far as the management and treatment of patient is concerned, these hospitals are few of the best ones.

CHAPTER - II

REVIEW OF LITERATURE

Existing Literature on Hospital: Issues and perspectives

The development of Indian hospital and the social and economic forces shaping the formation of these technological institutions have drawn the attention of the social scientists to solve the problems faced by the hospital administrators from time to time. The major contributions of the social scientists in the study of the complex dimensions of the hospital from the conceptual and methodological view points, form the basic thrust of this study.. These studies have contributed in different areas of hospital viz., doctor-patient relationship, staff patient relationship, management and administration of hospital versus patient satisfaction etc.

The studies in relation to medical sociology as a discipline and in particular the hospital have been guided by the Western reference model, resultant of which the studies have highlighted the same conceptualization of the issues, hypothesis formation, methodology, data interpretation and derivation of conclusion. Most of the scholars have followed either the Parsonian model[1] or

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1. Parson, T.(1949), The system of social action. The use of the pattern variables to understand the social systems.

The studies related to doctor-patient interaction have been dealt with, in various ways by Indu mathur[3] , A.L. Srivastava[4] , S. Pathak[5] , Aneeta Minocha[6] , Advani[7] , Timmappaya[8] et. al., who considered one or more than two wards where doctors were either interviewed or observed regarding the patient treatment, patient behaviour, ward management, behaviour of the nurses and paramedical staff towards the doctors in terms of cooperation while treating patient, besides the facilities being provided to them for patient care. The patients were administered to a questionnaire comprising of patients' age, sex, income, religion, place of residence, educational proficiency, total number of the family members, eating behaviour of the patients, the feeling of the patient towards the general cleanliness of the wards, the behaviour of the doctors, nurses, paramedics, class IV employees along with enquiry into preferential treatment of a patient, his

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3. Indu mathur (1975), Interelations in an organisation, Jaipur, Aalekh.

4. Srivastava, A.L., (1980), A study of doctor patient relationship in Varnasi city hospital.

5. Pathak, S, (1979), Social Welfare Health & Family Planning in India, New Delhi, Marwah.

6. Minocha, A., (1974), Some aspects of the social system of an Indian hospital, Ph.D. thesis, Delhi, University of Delhi.

7. Advani, M. (1980), Doctor-patient relationship in Indian hospitals, conducted in 20 hospitals of Delhi, Jaipur, Sanghi.

8. Timmappaya, A. et al. (1973), Dimensions of hospital social system, hospital and its people, New Delhi, NIHAE.

feeling about the overall set-up of the hospital and care and cure of the ailment. But these studies remained unidimensional failing to depict a holistic account of the understanding of the institutional health care practices. Sincxe these studies give a partial understanding by highlighting one or two dimensions they cannot contribute to any epidemiological studies.

Studies on Indian Hospitals

The maximum number of studies conducted in India are mainly to assess the doctor-patient relationship in an organisational set-up. The study by Indu Mathur also highlights the same.

Indu Mathur's study was conducted in Jaipur at 'Sawai Man Singh Hospital" (SMS Hospital) in the years of 1967-68.[9] The sample comprised of 185 patients (both sexes), 52 doctors and 60 nurses who were interviewed. An observation was made equally regarding the patients as well as the staff of the hospital (mainly doctors). Major thrust of the study has been on formal position and informal control, situational and formal position and the degree of power, pattern of communication system and efficiency of the organisation, extra organisational factors and deviations both professional and non-professional in the

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9. Mathur, I.(1975), Ibid.

organisation, status groups both within and outside the organisation, and the ideologies and attitudes of the members, information control and therapeutic ends and interaction system and achievement of social goals by the organisation. Informations have been gathered on the deviance of "the role to be performed" versus "the role being performed".

This hospital is a teaching hospital with a medical college affiliated to it and hence provides practical experience both to the undergraduate & post-graduate students. Patients with peculiar illnesses are retained in the hospital for the learning of the students, though the hope of the patient getting cured may be very scanty. The study highlights the superior position of the male members in the family which is replicated in the hospital decision - making too. Patient population mainly comprises of the urban people yet the rural ones come only when they have lost hopes with a patient's treatment in their respective areas. A lot of communication gap exists between the patients and the doctors.

Another study by Minocha was carried out in Lady Hardinge Medical College (now Sucheta Kriplani Hospital), New Delhi in the years 1966-69.[10] For the purpose of the study only 280 female

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10. Minocha, A.(1974), Ibid.

patients were considered. The study basically highlighted the following aspects of the social system of the hospital : nature of the hospital set-up, its formal organisation, arrangement of personnel, patients view about the hospital set-up, their experience about traditional medicine, patients' expectations of the hospital staff and their observations about them during the course of interaction, patients' conceptualisation of the hospital and further interaction amongst the various patients within the wards & their considerations for ordering their relationships.

The scholar has put forth two major factors affecting the modern doctor-patient relationship: the growth of specialisation resulting in"Specialist" approach from the usual generalist approach making the relationships more impersonal: modern hospital with a different number of functionaries involved in the treatment process. Patients' interaction with the doctors has been analysed in the light of patients traditional role & norms. Further the scholar has highlighted the communication gap between the female patients and the male doctors, the messages being passed by their male members of the family. The study also mentions the patients being culturally alien to the hospital set-up; the treatment being expensive for many leading to many LAMA cases.

The scholar has recommended for a thorough understanding of the patient's response to modern medicine coloured by his ideas, norms, and values having an impact on their treatment process in the hospital. Further, she suggests that a homely atmosphere for the patient be generated to facilitate their stay in the hospital. (p. 279).

Both the studies though highlight the hospital social system focussing mainly on doctor-patient relationship, yet both tend to be unidimensional. Indu Mathur's study did not take up psychological factors in relation to other socio-cultural parameters. The category of patients considered also is inadequate as only the indoor patients are interviewed. Further the information was collected by the scholar from the functionaries of the hospital without any cross-checking or probings. The caste factor in a modern big sized hospital is not effective which has been emphasized by the scholar.The phenomenon of 'complacency' of patient satisfaction is questionable. Even in Minocha's study the OPD patients were hardly considered. The scholar though emphasizes on the 'ward culture' yet the sample taken is very less (3 wards only). Though the idea of communication gap has been raised by the scholar yet the fact remains that it is not only the fault of the patient but also the doctor who uses a technical jargon which the patient is unable to follow.

Another study by Advani can be considered to be a comprehensive one where he has consulted 20 small, medium and big size hospitals of Delhi, the sample size being 1031 patients. The study was carried out in 1980.[11]

This study primarily focussed on the doctor-patient relationship. Major issues tackled in this study comprised of the relationship between the size of the hospital and its effect on the doctors and patients; the socio-economic characteristics of the patients in general hospitals, process of doctor-patient interaction and levels of satisfaction evaluation of each other's role, analyse doctor-patient relationship in view of the present society, areas of improvement and finally to conceive a perspective for ideal doctor-patient relationships.

This study had used psychometric and psychological tests to validate or abandon the hypothesis/hypotheses that larger hospital would have better professional satisfaction, better functioning of the hospital would lead to better role performance, patients in community general hospital would tend to be from lower strata, patients using influence (ie. deviant behaviour designated as problem patients and larger the hospital - more mechanized the treatment by doctor yet rated high in their

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11. Advani,M.(1987), Ibid.

performance variation whereas move deviation on professional ethics in case of smaller hospital (page 10)

The major findings of Advani's study highlight the do's and don'ts regarding the doctor's behaviour in relation to the patients. The doctor should have sympathetic attitude, give moral support to the patient, enquire about disease and related problem during the treatment process and recovery, give instructions regarding disease, dietary precaution and help the patient who is getting difficulty in treatment. Further he is expected not to waste time with visitors and in writing on registers, names & giving medicine etc. On the whole, the doctor's attitude should be harmonious. Checking the same patients themselves don't ask for consultation or for orientation.

The index of patient satisfaction was however dealt with in relation to interference from patients, need for more equipment, medicine, additional beds, communication of diagnosis, need for public relation, community expectations, interdepartmental coordination, inefficiency of class IV staff, delay in getting treatment. These were also asked from the doctors who agreed with everything except that of communication of diagnosis towards which they had mixed feelings.

Advani emphasizes on the fact of changing of the "professional values, policies & medical care to be revived" in this light. The patient belonging to the lower strata is a passive recipient in most of the times. Further, he emphasizes on the fact that differential treatment should be avoided. He also puts forth the idea of interrelations of political system, economic structure and social & cultural changes in the society and the level of technology and scientific knowledge.

Another study on doctor-patient[12] relationship was carried out by Srivastava in Varnasi city hospital in 1981 whereby he has tried to explore whether patients approach the problems of health and disease on a rational and objective basis or they are governed by the prevailing socio-cultural norms and values. The sample comprised of both doctors, paramedicals as well as patients. The scholar took one hundred doctors, one hundred paramedics and two hundred patients.

The study tried to analyse the attitudes, behaviour orientations of the doctors, their role performance and behaviour. It had been hypothesized by the scholar that socio-economic status & influence affects, the doctor-patient relationship. The aspect of satisfaction of patient was also

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12. Srivastava, A.L.(1980), Attitude of patients towards doctors, medical norms and values.

looked into. Another study by Pathak also touched on the same aspect but he studied four Delhi hospitals i.e., Irwin, Safdarjung, Hindu Rao & Willingdon. This study tends to be more comprehensive and good for cross comparision.

Timmappaya et. al. in Delhi conducted a study on patient satisfaction and ward social system. The objective of the study was to identify, important in-hospital variables, influencing the three indices of hospital performance: length of stay, bed occupancy rate and patient satisfaction; further, to study the extent to which the in - hospital variables influence the indices of hospital performanance; and to develop and standardize instruments to measure patient satisfaction and several intra-organisational variables.

A study which was carried out in two hospitals revealed that in a missionary hospital, there was high job satisfaction amongst the doctors, more systematic work, better care of the patient leading to high recovery rates while the case was reverse in a municipality hospital. The results of this pilot study was used for preparing a hypothetical model concerning hospital performance. The model hypothesized a relationship between patient satisfaction, hospital status, employee satisfaction & service, leading to patient satisfaction and forming a vicious circle.

The study was divided into three phases:- Firstly, study of patient satisfaction and community image of the hospital using patients, visitors & doctor samples. Secondly, the study of the ward social system; and thirdly, a known "good" and "bad" hospital was selected on the basis of experts' opinion & patients' opinion. Hospitals were compared for the patient satisfaction, ward social system, community image of the hospital, inter role perceptions, interaction patterns, catering services etc.

The study revealed that medium sized hospital was 'good' and small one 'bad'. Ward social system has less integration. There is less work morale of the members. Further, there is a need for improving medical & hospital service system.

A study conducted by Venkataratnam[13] in two hospitals in Tamil Nadu. The hospital A and B are the names, given by the scholar, to government hospital Pingalur and Pingalur Medical College Hospital respectively. The objectives of the study were : to find out doctors' and nurses' roles in the hospital in terms of their role prescription, to find out their role expectation and actual role performanance of their own (doctors' and nurses') roles and of each other, to find out role satisfaction or

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13. Venkatratnam, R.(1979), Medical sociology in an Indian setting, Madras, Macmillan.

dissatisfaction in terms of the difference between role expectation & role performance and their causes and to explore the sociological truths that emerge from an analysis of the role play of doctors and nurses in a hospital.

The study comprised of 324 samples (184 doctors and 140 nurses). The study was conducted in two stages using survey and the participant observation techniques. The first preliminary stage was carried out between Dec. 1968 and March 1969 while the second stage was carried out from Aug. 1969 to March 1970. The data collected was first analysed in order to understand the social background of the two occupational groups so as to have an idea of its influence in fulfilment of their roles in the hospital. Four distinguished types of authority and power were existing - the medical line, the nursing line, the lay service line and the miscellaneous service line. The structure of authority was paramedical, with heads in medical line. (page 249)

The scholar has applied Levi-Strauss conscious models - this attempt indicated the existence of ideological, immediate and internal observer's models in the professional, academic, bureaucratic and welfare dimensions of doctor's role. Similar models were also used in the context of the nurses' role. (page 249)

The study highlighted that the doctors and nurses didn't perform their roles properly, due to improper socialization of professional qualities. Nurses' non-acceptance by other technical & non-technical groups as status groups and the demands on them by bureaucracy led to work sub-optimally many a times. Doctor's and nurses have made their own models, legitimizing the same by themselves. Two functions have been identified by the scholar-essential and supplementary. The essential functions of cure are being carried out yet supplementary function of care and teaching is not followed by the doctor and nurses. The rules laid down by the government thus become secondary.

Organisational status of the members of certain groups makes it difficult for them to go their own way since their activities are watched and supervised in order that they do not pose a threat to their superiors (p. 252). The scholar thus points out that the attributes attached to the medical profession as ideal type are yet to become realities in the hospital situation. Henceforth, need for through change in philosophic approach to the problems of economic and social life of which doctors and nurses are part.

A study by Madan[14] in the All India Institute of Medical Sciences, in the year 1975, focussed on the personal attributes, the social background, educational attainments and career patterns of 100 doctors, who were the samples sending the questionaires (filled), supplied by the scholar. All these were the members of the faculty. The objective of the study was to know, how these people relate to their work, the place of their work (i.e. AIIMS) and their society in the course of the discharge of their professional roles. (p. 65)

The questions related to doctors' zeal and tenacity to work to stay back in the country and serve the country and to help the patients relentlessly. The tendency to fulfil the individual and the institutional/professional goals, towards research versus patient treatment. These questions comprised of the main ones, in the questionaire supplied to the doctors.

Further, Oommen's study on the doctors and nurses, in the year 1979, in Delhi, highlighted the dominance of doctors over nurses. Lack of role specificity led to low degree of skill required in it. Certain role performance would lower them in the eyes of their patients. Further, the scholar pointed out the over-bureacratization of roles, which is dysfunctional in patient

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14. Madan, T.N.(1980), Doctors and Society.

care. Nurses give preferential treatment as that of doctors. The relations of the doctors and nurses being antagonistic leading to a latent class conflict between doctors and nurses and nurses mostly sensitive to even minor issues.

All these studies can be put in the category of studying the staff of the hospitals besides training of the medical students of different years. Scholars like Madan,, Oommen and Venkataratnam have dealt with the category of staff of the hospital but the patients were not studied carefully to get a picture of the hospital care system. These studies though are important yet are not comprehensive and tend to be unidemensional.

Another study by Seal[15] in a Calcutta based hospital, (1971) has tried to see the relationship between hospital and the patient. The author interviewed 350 non-selected patients including some guardians of child patients in different wards of a very crowded hospital, to obtain their views regarding liking and disliking of doctors and nurses. The patients were not much interested in the intelligence, skill and training of the doctor but on the humane side of doctor's behaviour and results. Further, the expectations of the patients from the nurse included

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15. Seal, S.C.(1971), Hospital - Patient relationship, Calcutta, Nababharat

more humane nature, promptness of action, timely assistance on the side of intelligence, knowledge and skill. Further, the scholar has pointed out the errors taking place in a teaching hospital, the modes of conduct to be followed in senior-junior relationship, nurse-patient relationship besides talking about bridging the gap between the hospital and home. The scholar emphasizes on proper coordination between hospitals and the referral system to be maintained.

Further, a major amount of work has been done in relation to the utilization pattern of the government hospitals, factors affecting it etc. Most of these studies can be categorized on the basis of the approach they have followed:

ECONOMIC APPROACH In these type of studies major determinants of use of medical services can be found in the financial cost and the utilization behaviour exclusively in terms of financial resources which may be only one of the variable influencing the utilization of services.

SOCIO-DEMOGRAPHIC APPROACH This approach has been in relation to the utilisation behaviour of the patients understood in terms of failure of a certain programme. The studies conducted with this approach are only identificatory and have seldom been truly explanatory.

GEOGRAPHICAL APPROACH These are studies in in terms of accessibility showing relationship between domicilliary care and its acceptance by people. Among many other important variables, it is now recognized that accessibility of the service has a direct bearing on the level of utilisation of services, the concepts of availability and accessibility being inter-related.

SOCIO-PSYCHOLOGICAL APPROACH These are studies with insightful analysis of utilisation behaviour. This approach is increasingly been employed in the field of utilisation behaviour.

One study conducted in evening OPDs in hospitals in Delhi in 1977 was in relation to the utilization behaviour. The study was conducted in six hospitals[16] (government) where evening OPD were functioning -- namely Safdarjung Hospital, AIIMS, Irwin Hospital, Willingdon Hospital, Rajendra Prasad Centre for Opthalmology and Lady Hardinge Medical Hospital attempted to assess the working pattern of OPD, reactions of people and assessing services from the patient point of view of organizational inputs, i.e., in terms of manpower and input. The instruments used for the purpose included an interview schedule for assessing reactions, awareness of people regarding OPD (for morning and evening OPD patients separately). The sample included 155 evening OPD

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16. Sharma, S.C.(1977), Study of evening OPD in six hospitals of Delhi, Research Report no. 37, NIHAE.

patients and 470 morning OPD patients, wherein the selection was purposive in nature. A profile of OPD patients was collected i.e., age, sex, education, occupation marital status, distance from hospital to patient's home, distance from office to hospital. The study however, highlighted a very poor awareness regarding evening OPD, the source of awareness being the hospital staff, display boards, friends etc. Most of the patients in the evening OPD came to know about its existence only six months back. Further only 31.2% of the patients aware about the evening OPD actually utilize the services.

Another study was conducted by SIVA RAJU[17] regarding the factors influencing differential utilisation of government hospitals in two contrasting regions, namely Rayalaseema and Coastal Andhra in Andhra Pradesh. Socio-economic status of people, family planning adoption rate and infrastructural facilities are relatively low in Rayalaseema as compared to Coastal Andhra. In this paper, hospital utilisation variables like satisfaction derived from government hospitals, distance between house and the hospital, cost per trip to visit the hospital, time taken to visit the hospital and service acceptability factors are compared across the two regions.

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17. Raju, S.S.(1987), A study of the Factors Influencing different Utilization of Govt. Hospital, (Hospital Admn, vol. XXIV, no. 3 & 4.

Multi-stage random sampling was used - one district from each region selected, then one community development block, eight villages from each sub-centre, and lastly, three hundred households from each of these eight villages. Hence, the sample included six hundred respondents. Distance, transportation, doctor-patient ratio, type of service rendered etc., differ significantly between the two regions, which are major factors, for the exiting differences in the utilisation of government health care facilities. The region-wise disparities in the existing health service facilities and its utilisation by the public, henceforth, should be taken into account for the strengthening of infrastructural facilities.

The study highlighted regarding the service acceptability that the present pattern of health delivery at government hospitals is not satisfactory to a very large population of clients, leading to least importance given to the advice of the health personnel working at the government hospitals. Therefore, to increase the credibility of the service personnel and also to increase the influence of these persons among the clients, better amenities may be provided. The scholar, has propogated for research, essential henceforth, to improve the utilization of the existing facilities besides providing additional facilities.

ırther another study on the factors affecting utilization ;pital beds in the surgical department of Safdarjung ıl by Gupta[1] highlights the similar kinds of issues. The .ves of the study (p. 5) were as follows:

ıctors affecting the utilisation of beds, average length of f selected patients the factors affecting the length of a selected patient category.

ılationship between the factors and average length of stay ;an be affected by reducing or eliminating if possible some components of average length of stay.

ıe factors affecting the length of the stay as affirmed by ıdy included the patient characteristics (age, sex, marital , income, education, occupation, place of origin ie., rural or urban background, distance of hospital from home type of family) and disease characteristics, (diagnosis, tent disease, complication, severity of disease, type of nt or operation and number of investigations); hospital teristics (admission procedure and ward unit) as well as

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ta, J.P.(1975), Factors Affecting Utilization of Hospital A Study In Surgical Deptt. of Safdarjung Hospital, M.D. ation, New Delhi, NIHAE.

the physician characteristics (mean length of years in speciality).

In addition, there are few studies carried out in relation to the cost-analysis of patient care in hospital such as one by Sadananda[19] in Safdarjung hospital wherein he tried to -- identify the cost centres in the inpatient and outpatient services; estimate the output in respect of inpatient and outpatient services and to find out the total as well as unit costs in respect of inpatients and outpatients treated in the hospital.

A comparative study conducted by Anand in 1974[20] in three hospitals of Delhi regarding the emergency services came out with striking findings - the study conducted in the emergency department of Irwin hospital(A), Safdarjung hospital(B) and Willingdon hospital(C). Retrospective studies based on records, prospective studies on understanding of work situation and interviews with doctors, nurses and patients to find out their difficulties and reactions alone with questionnaires and on the spot' studies were used.

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19. Sadananda, B.(1987), A study of Cost Analysis of Patient Care In a Large Hospital in Delhi, M.D. thesis, New Delhi, NIHAE.

20. Anand, R.C.(1974), A Comparitive Study of Emergency Services in 3 large Delhi Hospitals, (M.D.thesis), New Delhi, NIHAE.

The findings of the study included:

Inadequacy of space in hospital A;

-- Absence of policies and procedures in B 7C hospitals;

-- Absence of death record/review committee in hospital C;

-- Poor system of maintaining records in hospital C;

-- Absence of social services by and large in all hospitals;

-- Long waiting time in hospital B because of distant location of emergency ward and supportive services;

-- Poor internal communication facilities in hospital B affecting immediate availability of specialists;

-- Complete absence of coordination between the three hospitals.

Basically, these studies in relation to hospital have looked towards the utilization of the services by the patients, cost analysis of patient care, staffing pattern and workload of nursing professionals. But hardly any cross-checking has been done from the patients. Further, these studies have overlooked many other aspects of utilization behaviour of the patients such as rude behaviour of the professionals in the hospitals, non-availability of services and so on. Comparative Studies such as one by 'Anand' and other conducted by NIHAE though contribute to the understanding.

In relation to these studies, it would be worth noting the objectives and problem areas highlighted by the National Workshop on Hospital Administration[21] conducted by the 'National Institute of Health and Family Welfare' in 1969. The objective of the workshop was to identify priority problem areas in the field of hospital administration. The major areas highlighted thus far were -

1. Development of precise norms and standards in regard to various aspects of hospital administration as staffing pattern, drugs, equipment and supplies, physical facilities, budgetary allocations, etc. The availability of such norms is considered a basic need for keeping a check on the performanance of hospitals improving their efficiency and regulating their development most effectively;

2. Problems in relation to economic aspects of hospital administration i.e., budgetary grants and local sources;

3. Training of hospital personnel;

4. Material management in hospitals with reference to procurement, storing,, distribution and accounting of drugs and equipment;

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21. National workshop on Hospital Administration (1969) NIHAE.

5. Communication gap between different categories of personnel within and outside the hospital;

6. Need for reducing load of non-professional work of trained nurses;

7. Decentralization of administration by suitable delegation of authority and responsibility;

8. Proper planning of hospitals and coordinating the hospital facilities in an area.

Cross-comparison of the hospital services have been of paramount importance in the evaluation of the health services health institutions. One such study was conducted in three hospitals of Delhi by Chakravarti[22] of the Army medical corps during his stay in the All India Institute of Medical Sciences. This study was conducted in three hospitals - Lok Nayak Jaya Prakash Narayan Hospital (A), Safdarjung Hospital (B) and the All India institute of Medical Sciences (C). This study was conducted with the following objectives: To study the organisational pattern, working, workload of cases in general and trauma cases in these three hospitals, physical facilities of

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22. Chakravarti,A.(1982), A study of the Accident & Emergency Services of Some of the Hospitals of Delhi, New Delhi, NIHAE.

casualty, ascertain the level of satisfaction of the users of services and to identify deficiencies in the emergency services and suggest measures for streamlining the services.

The study involved discussions with the functionaries of the casualty departments, retrospective study of records alongwith prospective study by observing patient arrivals during January to July 1981. Further direct observation study was carried out to review the physical facilities and functional relationships and the level of evolving a structured interview was ascertained by study though helps in understanding of the casualty services of three hospitals of Delhi yet the major emphasis has been laid on 'trauma' cases within the casualty services.

Further, there have been studies in relation to the communication pattern, and public relations in the hospitals as they form a very important part of the hospital set up, making the health services move meaningfully understood by the community at large. One such study conducted at AIIMS, though true in relation to this apex health institution only, it can seldom be applied to other hospitals; yet it gives an idea of the importance of public relations in a hospital.

This study conducted by Gupta[23] a medico, primarily with the

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23. Gupta, T.R.R.(1988), Study, Scope and Function of Public

objective to evaluate the effectiveness of the existing public relations systems in the OPD from the patients' point of view and administrators' point, to identify the inadequacies and to suggest remedial measures. The study was carried out for a period of three months, from 1.8.87 to 30.10.87. The existing system of public relations and the facilities connected with public relations in the OPD, central admission office, emergency services was studied by making direct observations & open interviews with the concerned function area. An interview schedule with structured questionnaire on 15 items was developed and pretested through pilot study. Sample of 100 patients, and 210 visitors was selected. Further a seperate questionaire was developed for functionaries like public relations officer, medical social worker, receptionist & welfare officer.

The observations revealed that there are inadequacies in public relations system - lack of organisation & coordination; functional integration amongst various functionaries connected with public relations in OPD is missing; different public relations working under different heads resulting in lack of coordination and duplication. Of the 100 samples interviewed, 70% expressed satisfaction in OPD services offered. The study revealed that the existing pattern of public relations officer system is inadequate to meet the needs of the public.

Relations in Hospitals with particular Reference to AIIMS. New Delhi.

The patients were critical of the overcrowding and large queues, choked corridors and packed lifts. Further, the questionnaire analysis, visitors interview, functionaries interview, public complaints analysis brings about very poignantly the inadequacy of public relations system and suggests a need for radical changes.

The above studies have revealed one or the other dimension of the hospital and the patients. But no scholar so far has attempted to study the hospital as a complex organisation. Furthermore, a hospital can be best understood when the complex system and sub-system of its various units are in a process of interaction as a social system. In a social system various units function in a coordinated way through its members with certain ways of norms, rules and principles and binding the society in one thread. Same is the case in a hospital if the different systems and sub-systems do not function in a well-coordinated manner. The clients of this system, "The Patients" get neglected. Hospital being a complex system has its own organisational culture and which has to conformed to the needs of the patients and their culture. It is an important issue to underline here that the earlier studies quoted above have by and large ignored the interaction pattern of the patients and the culture of the hospital and have gone to recommend other

organizational managerial issues. Keeping in view these points present study has been designed to explore the issues stated above and study a hospital as a social institution.

NEED FOR THE PRESENT STUDY

The study was conducted in Dr. Ram Monohar Lohia Hospital earlier known as Willingdon Hospital with a view to see the hospital as a comprehensive health care institution in the health care delivery system of the country. The hospital is seen as a social system with various sub-systems (comprising of OPD, indoor, operation theatre, casualty, laboratory services, laundry and linen service, dietetics, blood-bank, ambulatory services, workshop etc), constantly interacting with each other. The hospital is seen as the sub-system of wider social, economic and political milieu. The various categories and personnel involved in providing health services to the patients namely, the doctors, the nurses and the paramedics are seen as one category and the patient population as the other. The interactions of the hospital staff within themselves and with the patients, the inflow of patients from the out patient department to the indoors, difficulties faced by the patients, have been given basic impetus in the study.

Ram Monohar Lohia Hospital is an 800 beded hospital established by the Britishers in 1932 and its catchment area extends from Delhi and nearby areas to the whole of the country in general. The hospital is a government owned institution catering to the needs of the general population, central government employees and members of the parliament.

The study was conducted with the basic aim of looking at the apex health care delivery institution in its sociological dimensions. An attempt was made to look at the hospital as a social institution, viewing the professional staff and other supportive staff as well as their interaction on one hand and the patients on the other, i.e., a preliminary enquiry into the socio-economic background of the patients, their attitudes towards the hospital infrastructure, the treatment they receive and to see what it really means for the patient to be in the hospital. The patient was to be given pivotal importance, as the principles of community health stress, the patient forms a link in the delivery of the health care system in India. The basic assumption behind the study was that in reality, organisational structure, the various professional groups at work in the hospital setting, attract all the attention, the patient, however, does not receive its place of importance. The patient also, further, gets differential treatment depending on the

socio-economic background apart from hospital influence as in the case of this hospital titled as 'V.I.P.HOSPITAL'.

The study has tried to see the hospital as a more conclusive and comprehensive health care institution keeping in mind the larger perspective of health and hospital culture with an Indian socio-cultural milieu.

The study has been divided into the following six chapters :

(1) Introduction

(ii) Review of literature

(iii) Design of the study

(IV) Ram Monohar Lohia Hospital - an overview

(V) Discussion

(VI) Issues and Perspectives.

In the first chapter, an attempt has been made to highlight the sociology of 'institution of hospital' and to give a clear and vivid picture of the formation of hospitals, their

development in India (their present status and various types) and their functions as assessed by the social scientists time and again. Hospital is seen as a social system with importance given to concepts such as 'patient satisfaction', services provided and the treatment received. Various issues like the origin of the hospital, its contemporary situation, its inter-linkages with other institutions of the society are touched upon in the first chapter.

In the second chapter, the different studies conducted by social scientists, medical professionals in the sociological understanding of the hospital, public administration scholar, independent and governmental organisation have been revealed; so as to find out how far these studies kept the 'preambles' of institutional health care and whether these studies have contributed to a holistic understanding of the 'hospital' as a health care institution.

In the following chapter, the focus is on methodology of the study -- a re-examination. The study comprised of data collected on the present functioning of the various subsystems of the hospital, the hospital functionaries, the patient population, as well as collecting secondary information through records of previous years apart from the development of a check list administred to a representative sample of the patients, medical

professionals & other ancillary staff. The fourth chapter, has been devoted to the case study of Ram Manohar Lohia Hospital - its historical background, the various sub-system (i.e., OPD, indoors, casualty, blood bank, dietetics, laboratory services, laundry and linen service, ambulatory services and workshop); facilities within the hospital, staffing pattern, administrative structure, recording of cases, provisions regarding complaints and grievances. A major amount of emphasis has been laid on the patient population, i.e.,socio-economic background, degree of illness, and the treatment they receive.

The fifth chapter has been directed towards a discussion based on the quantitative data collected and tabulated leading to inferences based on these regarding the kind of patients coming to the hospital; their placement in the hospital, their socio-economic background, period of hospitalization referral cases,difficulties faced at the hospital OPD, opinion regarding the services of the hospital, about general functioning of the hospital; thus trying to see the most vulnerable population needing health care and also the services actually received in the hospital.

The last chapter has been devoted to conclude the issues highlighted n the study, inadequacies of the earlier studies,

limitations of the present attempt and scope for further research.

CHAPTER -III

DESIGN OF THE STUDY

The present study was undertaken to analyse the problem on ıe basis of secondary information as well as to build up further ıalysis through the case study of R.M.L. Hospital. Infact, the udies referred in the earlier chapters have been designed to udy, according to their objectives. In this study the emphasis s given to examine whether a hospital is a social institution not. How does it function to cater to the needs of the tients and provide a scope of medical care for the other health stitution's referral cases as an apex organisation in the alth services hierarchy. The earlier studies by and large; re unidimensional in nature. They have not given adequate phasis in understanding the complexity of the hospital. reover patients were not given due place in the study design.

R.M.L. Hospital has been selected purposively considerin s bed strength, number of wards and average patient turnover the table number one, the hospitals located in Delhi have beer bulated according to their bed strength, number of wards, spital size, agency under which it functions, annual budget anc ar of its establishment. From this table, it is evident that n Manohar Lohia Hospital is one of the largest hospitals :ated in Delhi, and is directly under the control of Government

of India. Safdarjung and L.N.J.P. Hospital are the largest and are having maximum number of beds and wards. Considering the time constraint and source for the present study, R.M.L. Hospital was found to be suitable in all respects as per the data requirement of the present study.

TABLE-I: LIST OF HOSPITALS IN DELHI

S.No.	Name of the Hospital	Bed Strength	No.of Wards	Hospital Size	Agency	Annual Budget (in Rs.000)	When estd.
1.	AIIMS	750	23	Large	Autonomous	1,55,97	1956
2.	Safdarjung	1207	32	Large	Govt of India	1,84,28	1946
3.	Ram Manohar Lohia	730	10	Large	Govt of India	90,35	1954 (Govt took over)
4.	LNJP Hospital	1107	27	Large	Delhi Admn.	1,39,00	1936
5.	Hindu Rao	345	13	Large	M.C.D	35,25	1911
6.	Lady Hardinge	580	13	Large	Govt of India	1,21,52	-

G.B.Pant	258	8	Large	Delhi Admn.	37,50	1964
Victoria Zanana	215	11	Medium	M.C.D.	15,80	1905
Tirath Ram Charitable	125	6	Medium	Charitable	10,94	1955
Sir Ganga Ram	190	5	Medium	Charitable	10,00	1954
Holy Family	178	7	Medium	Mission	44,04	1956
St. Stephen's	170	-	Medium	Governing body	10,88	1834
Kalkaji	31	4	Small	M.C.D.	1,73	-
Balak Ram	30	2	Small	M.C.D.	1,92	Before 1900
Malviya Nagar	31	7	Small	M.C.D.	1,48	1952
Tilak Nagar	47	9	Small	M.C.D.	2,28	1954
Patel Nagar	15	5	Small	M.C.D.	1,72	1954
Lajpat Nagar	47	4	Small	M.C.D.	-	1948
Moti Nagar	31	3	Small	M.C.D.	1,56	1952
Civil Sha	12	1	Small	M.C.D.	1,76	1939
General-Hospital Shahdra	74	3	Small	M.C.D.	10,66	1963

The present study was conducted in Ram Manohar Lohia ital with a broad objective of trying to see whether the tal is a social institution; is it a replica of the wider

social system or not. This hospital was chosen with the primary aim, as it is a large government hospital (800 bedded) catering to the needs of the general population although known as a 'V.I.P. HOSPITAL'. The catchment area of the hospital includes the union territory of Delhi and nearby areas apart from patients from all over the country both from rural as well as urban background. The hospital though caters to the needs of the VIPs cases comprising of the members of the parliament, freedom fighters and their dependents as well as higher central government employees, yet this preference is only in case of the admissions to the Nursing Home. In the general wards, no such discrimination is made as per the policy issue. Attention has been put to the patients from the socially and economically deprived sections of the population and effort was made to see the hospital as a community institution.

Before undertaking the study in R.M.L. Hospital the investigator contacted the Medical Superintendent, Dr. Narendra Bihari and discussed the different objectives of the study and sought the permission to collect all possible documentary information. Dr. Bihari agreed readily to the proposal and gave permission to contact all the officials in the different units of the hospital

The investigator went around the hospital and visited different departments to get acquainted and to develop a rapport before collecting the required data for the study. With this informal meeting and discussion with the functionaries of the different departments the investigator could develop a confidence to gather all data from the records available in different departments and also from the functionaries. No difficulty was faced by the investigator in contacting the patients in various wards and units. After establishing the rapport, a considerable support and cooperation was provided to the investigator by all sections in the hospital right from M.S. to the class IV employees of the R.M.L.Hospital. Because of this, the investigator was able to complete the data collection within a duration of three months.

Data Required:

First of all, the organization of the hospital was understood in detailed way by drawing an organisational chart and discussing with the M.S. and H.O.D's of other units. Subsequently each department was studied in detail by direct observation, informal interview and discussions held with key functionaries. Over and above the patients were also contacted in the units and wards itself and frequent informal discussions with them created a favourable atmosphere in eliciting very vital

data regarding the functioning of the hospital and their difficulties of experiences in the hospital.

In carrying out the data collection, different techniques were used - direct observation and informal interview could bring home a lot of valuable qualitative data from the different units of the hospital. The case studies reported in this study has built up an indepth analysis of various units and moreover those case studies have revealed the malfunctioning of the hospital and negligence of the patient's treatment by the various functionaries. Finally, after collecting the qualitative data, two interview schedules were prepared carefully to quantity and cross check the qualitative data from the functionaries (doctors, nurses and paramedics) as well as from the patients. A representative number of functionaries and patients were administered with this interview schedule.

A total number of hundred doctors, nurses and paramedics from different units were administered with the interview schedule raising various questions about the hospital and patients. The patients interviewed were selected giving representation to the wards, units and out-patient department on the basis of random selection.

The data collected from various units were cross-checked and verified in all possible manner by checking the records and discussing with the higher authorities in the hospital.

DATA COLLECTED:

The data were collected from records relating to quantum of services provided during the last few years. Data were collected from the hospital records for the past five years regarding the bed-strength, bed occupancy percentage, admissions (to the indoor with a distinction made between general wards, casualty, nursing home, maternity nursing home), total discharges, total delivery, total deaths, total hospital attendance (including O.P.D, special clinics and emergency attendance), X-ray cases, laboratory tests, operations, medical legal cases, details of O.P.D. attendance and so on.

The data were collected about the existing staff, procedures of work, waiting time of the patients apart from other problems of the hospital. Information, was collected regarding the functioning of the various sub-systems of the hospital comprising of the O.P.D, indoor, casualty department, laboratory services, laundry and linen services, dietitics, blood-bank, ambulatory services and the workshop. Further an enquiry has been made regarding the socio-economic background of the patient, problems

a patient encounters while he is in the hospital and the whole process of the patient admitted to the hospital and getting treatment and discharged subsequently.

Apart from this qualitative data collected from the hospital with a few discussions with the functionaries of the hospital comprising of the doctors (of all grades), nurses and paramedics (of different specialities). This was however substantiated with observation and discussions with the ce the study lays the basic thrust on the patient ive sample of patients was selected on stratified om different wards, OPD, casualty as well as a ver ing Home, was administered with an interview sched of a set of questions). This interview schedule however, as a check-list and also to some extent ta collected qualitatively. The hospital function gory was also administered with such a check d for them separately.

To put it more clearly and discr y of Dr. Ram Manohar Lohia Hospital as a social ussed on the following methodological approach:

1. A Historical Account of the Hospital (R.M.L)

Data were collected regarding the history of the hospital, how it was established and the year when the hospital came into existence. For this purpose, a detailed study was made regarding the available literature on the beginning of the hospital, from the masterplan of R.M.L.Hospital apart from the annual reports published yearly, consequently.

2. Structure of R.M.L. Hospital - Complexity of a System

An enquiry was made into the structure of the hospital,i.e., OPD, indoor, blood bank, casualty, laboratories, laundry, dietitics, transport and ambulatory services. These sub-systems of the hospital were seen as a part of the wider social system. These were seen and understood as constantly interacting with one another. As there is a constant flow of patients from one department to another, the interactions of patients and of hospital functionaries were taken into account. Henceforth, the hospital was seen as a complex system with various sub-systems constantly interacting with one another, as the systems theorists put it.

3. Functioning of the Different Units/Subsystems

A detailed account of information was collected regarding the functioning of various sub-systems, i.e., OPD, Casualty, Indoor Wards and other supporting departments. The category of the hospital staff is seen in relation to the category of the patients. Information was collected regarding the staffing pattern, types of patients coming, the strength of the hospital staff as well the patients, the bed-patient ratio, nurse-patient ratio etc. apart from information regarding the coordination (inter-departmental and intra-departmental). The inflow of referral services were also accounted, thus for.

4. Follow-Up of the Patients from the OPD to the Indoor

The problem experienced by the patient himself indicating gross irregularities in the functioning of the hospital was studied. Informants included basically the patients yet the arguments were cross checked of substantiated with the statements by the hospital functionaries. The difficulties a patient encounters while he is referred from the OPD to the indoor have been noted. In other words, the whole procedure of the patient from the OPD with all formalities of getting the slip made, requisition slip for admission, admission to the particular unit

of a ward, getting treatment and thereby getting discharged, was studied in great depth.

5. A Detailed Account of Different Categories of Patients

After these preliminary stages of collecting data about history of the hospital, understanding the functioning of the hospital and its sub-systems, follow-up of the patients etc., an indepth analysis was made of the category of patients coming to the hospital, i.e., their socio-economic background, age, sex, period of stay in the hospital, whether they are from rural or urban background, education, occupation and type of disease. An approximate analysis was made regarding the class of patients getting the treatment in the hospital. This helped in the identification of a core group of patients needing the medical services to the optimum i.e., socially and economically deprived class of people coming to this complex hospital with high hopes.

6. A Few Case Studies - for Indepth Qualitative Data

The data were collected regarding the profile of the patients but for indepth qualitative analysis, cases were interviewed and observed in great depth. These cases were cited in order to highlight the malfunctioning of the hospital in general, the problems of inadequate staff and other problems a

patient faces, more specifically. Some cases such as a death of patient, resulting in chaos created by attendants and eventually the beating up of a staff nurse on night duty were revealed in the study.

7. Quantification and Cross-Checking

For the purposes of quantification and cross-checking, a set of checklist (comprising of a series of open-ended questions were posed). This checklist comprising of questions such as the socio-economic background of the patient, occupation, age, sex, problems he faced during admission to the wards, problems at the OPD, attitude towards nurses, doctors and paraprofessionals, the kind of services provided, i.e., linen, ambulatory services, diet, sanitation in the ward etc. along with questions regarding follow-up and treatment. This check list was administered to the various categories of patients selected on stratified random basis.

Another check-list developed was administered to the hospital staff including the doctors, nurses and paramedics. The questions relating to issues such as duration of their work in the hospital, to get an idea about the experience of the professional in the hospital, opinion regarding functioning of the branch/hospital, patients getting maximum attention in the

hospital, the level of cooperation at workplace, the cooperation from the patient in following the treatment procedure and suggestions, the state of the poor patients, referral cases, the measures to improve the functioning of the hospital, supplemented with their special experiences.

Limitations of the Study

The study conducted in R.M.L. Hospital though tried to take into consideration the various lacunae in other hospital based studies in order to evolve a comprehensive study of R.M.L.Hospital, yet certain limitations as well as the difficulties faced cannot be ignored. The patients at first did not reveal the facts, a rapport had to be developed with the patients to get the relevant information and sometimes the difficult cases took a long period of time. The situation was aggravated further by the presence of incomplete records, which had to be consulted to collect the data. Further the non-availability of the doctors for interview was another factor as they used to be busy and could be contacted only during their leisure hours, who sometimes discouraged the investigator. Further, sometimes the O.P.D and other units used to be very crowded and hence proved to be a hindrance in observation of the investigator.

The patients of serious nature could not be contacted as they used to come during night usually (i.e., the medico-legal cases such as road accident cases) and the investigator could not stay late to observe such cases. Further, the ratio of the doctors nurses per patient ratio could not be seen during right duties. Due to involvement of the police in the medico-legal cases, the investigator could get fewer opportunities to converse with them or observe them. Also other cases in the I.C.C.U. such as burns cases were not contacted due to the seriousness of the patient.

Inspite of the difficulties and limitations abovesaid, effort was made to study the R.M.L. Hospital in a comprehensive way taking into consideration all possible syb-systems and sub-systems of the hospital to examine it in a totality.

CHAPTER IV

A STUDY OF RAM MANOHAR LOHIA HOSPITAL

Historical Background

Originally known as Willingdon Hospital and Nursing Home and now known as Dr. Ram Manohar Lohia Hospital (changed the name in 1977) was established by the Britishers in 1932. Later on, its administrative control was transferred to New Delhi Municipal Committee. Nursing Home was constructed during the year 1933-35 out of donations of his excellency Marchioner of Willingdon. In 1954, this hospital was taken over by the central govt.servants due to the increasing need of the public. At the time of its taking over, this hospital had only 20 beds in the Nursing home and eight special wards and twenty two beds in the general wards.[1]

At present, the hospital has a bed strength of 800. But to meet the rush of patients, 101 additional beds have also been provided. The hospital has a nursing home which is the only nursing home run by the central government. There are 47 beds in

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1. Govt. of India, (1988), Performance budget, Ministry of Health & Family Welfare 1988-89.

ng home and 14 in the maternity nursing home. The hospital on its pay roll a sanctioned strength of 2058 consisting of al, non-medical, technical, non-technical, ministerial and staff. It provides free medical services to the central nment employees (CGHS beneficiaries), residents of central 'est Delhi, in particular, inhabitants of the adjoining s and the people of the union territory of Delhi, in al.

The nursing home caters to the needs of the members of ament, freedom fighters and other dependents, senior central nment employees eligible for this service. A limited number ds are allocated to the general public also (though it is on papers).

The hospital has 29 departments and provides services in all ajor specialities including medicine, surgery, orthopedics, & obstretics, dental and skin, psychiatry, physiotherapy, , neuro-surgery, plastic surgery, C.C.U. etc. It has al clinics for coronary heart diseases,, hypertension, logy, diabetes etc. It provides accident and emergency ces round the clock with specialist cover in medicine, ry pediatrics and orthopedics.

The hospital also provides post graduate education in various specialities like surgery, medicine, X-Ray, pediatrics, skin & E.N.T. Undergraduate students from Lady Hardinge Medical College are also trained in the hospital. Attached to the hospital, is a school of nursing for 75 nursing students coming from all over the country and also from neighbouring countries. The hospital is affiliated to the Delhi University for post-graduate students.

Facilities within the Hospital

O.P.D. services in all departments exist. Emergency service is available round the clock. Medicine & Medical services are rendered free to indoor patients and out-door patients except for the patients in the Nursing Home.[2]

TABLE -2

Distribution of the Bed Strength

S. No	Department	Number of Beds
1.	Medical	226
2.	Surgical	181

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2. R.M.L. Hospital, (1978), Master Plan, 1978-2003.

TABLE -2 (Contd..2)

S. No	Department	Number of Beds
3.	Pediatrics	63
4.	Eye	26
5.	Skin	26
6.	E.N.T.	26
7.	Gynecology and Obst.	26
8.	Nursing Home	47
9.	Special Wards	14
10.	Orthopedics	41
11.	Psychiatry	30
12.	Maternity Nursing Home	14
13.	Dental	4
14.	Nurses Sick Room	4
15.	Septic	2

SOURCE: Master Plan, R.M.L. Hospital (1978-2003).

Staffing Pattern of the Hospital

The orientation of the staff and patients towards their roles, formal and informal relationships amongst themselves is affected by the organization of the hospital. Basically the staff at R.M.L. Hospital has been divided on the basis of whether they belong to Group 'A' or 'B'.

TABLE NO. 3

STAFF STRENGTH

1) GROUP A OFFICERS	
(a) Medical	59
(b) Non-medical	6
2) GROUP B OFFICERS	
(a) Medical	4
(b) Non-medical	12
3) GROUP C STAFF	
(a) Medical	125
(b) Ministerial	75
(c) Nursing	286
(d) Non-ministerial	201
4) GROUP D STAFF	
Various categories	695

SOURCE: Annual Report of R.M.L. Hospital: Medical Records 1988.

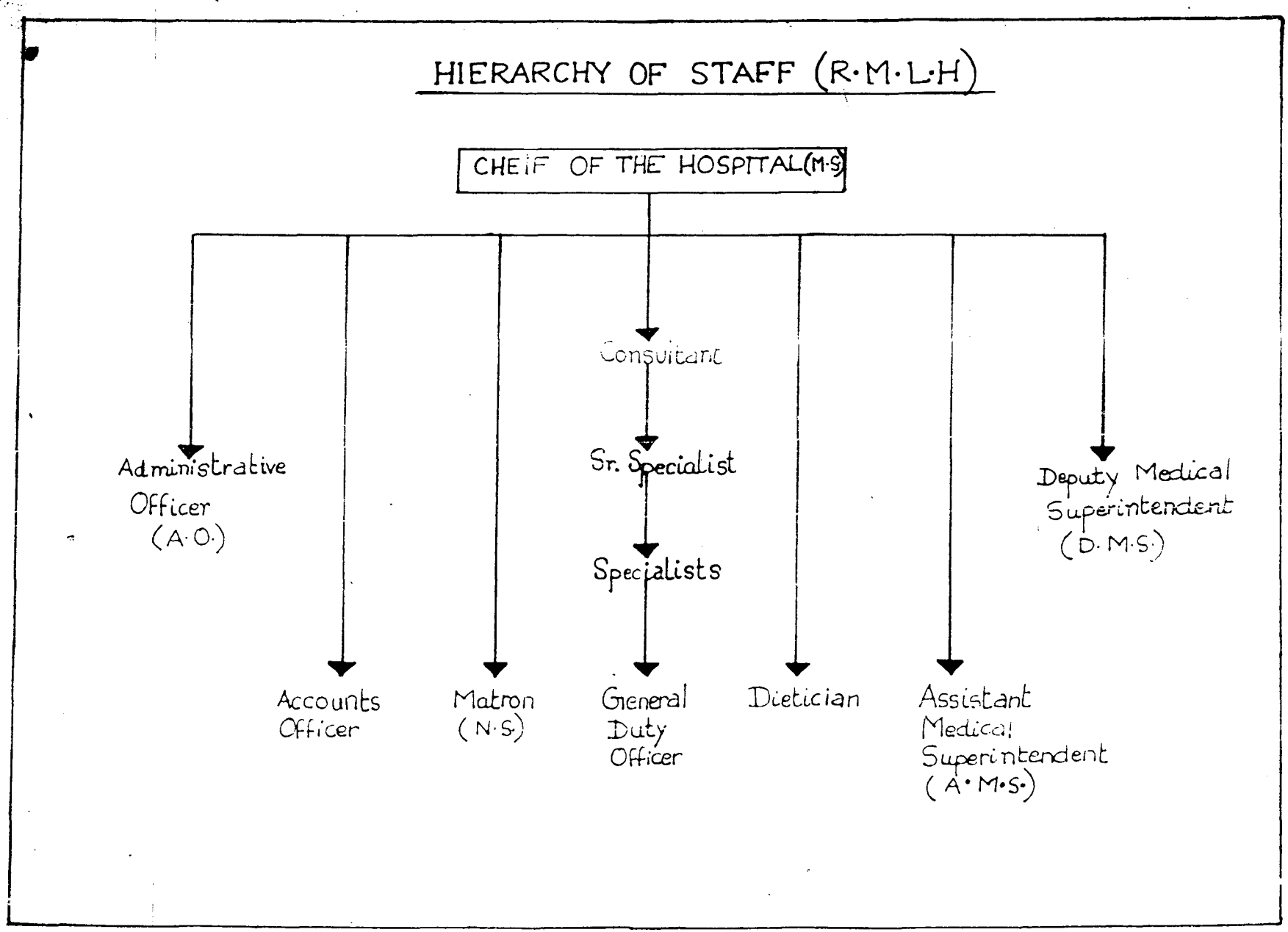
... addition to above, family welfare staff is attached with the hospital comprising of one medical officer, one family planning extension educator, one Public Health Nurse, two family Planning Workers, one storekeeper and one female attendant.

Further the following Central Government Health Scheme (CGHS) and Lady Hardinge Medical College staff are also working on the panel. The CGHS doctors comprise of supertime grade I, their number being one; seven specialist grade II, in addition to twenty Medical Officers and Junior Medical Officers. The Lady Hardinge Medical College staff includes two Professors; two Associate Professors; three Assistant Professors, one Lecturer, three Senior Residents & four Junior Resident Doctors.

The Nursing Staff mainly includes the Nursing Superintendent and Assistant Nursing Superintendent (ANS); Male nurses (compounders), Female nurses (sister in-charge & staff nurses), Nursing students. The technicians (labs, X-Rays, Dental etc.) also come under the same hierarchy. The office staff includes the administrative officer along with clerks (both lower division clerks and upper division clerks). The class-IV staff comprising of the wardboys, maids and safaiwalas, both females & males.

The hierarchy of the staff at R.M.L. Hospital can be diagramatically represented as :

HIERARCHY OF STAFF (R·M·L·H)



The medical superintendent holds the apex position in the hospital and delegates the responsibilities to other members of the hospital personnel, yet, not the administrative and financial functions as a matter of general principle & policy in hospital administration. In practice in R.M.L. Hospital, the M.S had delegated all administrative responsibilities to the Deputy Medical Superintendent who happens to look after everything. Only a medical superintendent with a super-scale can have an additional medical superintendent working under him, so, this position depends on the scale of the medical superintendent.

HOSPITAL ORGANISATION

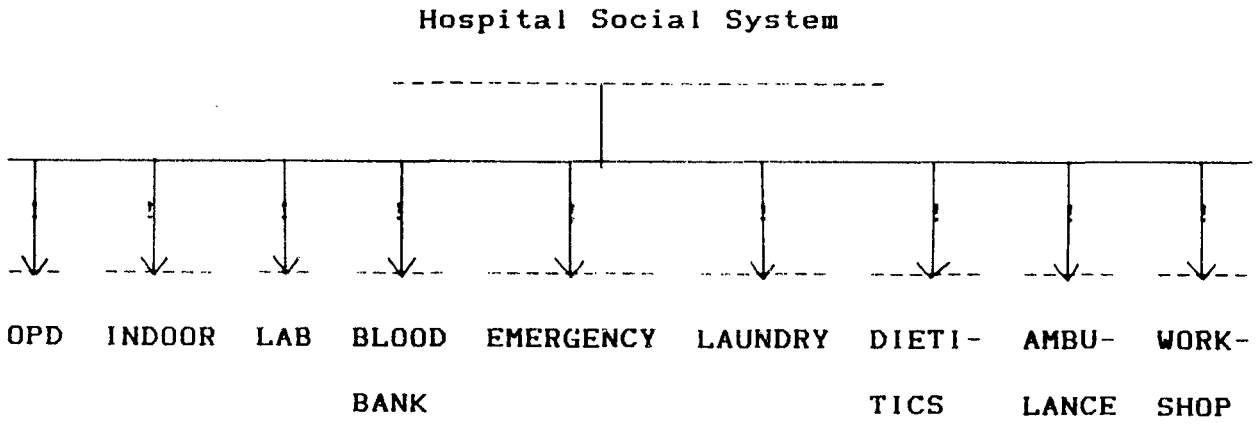
The term 'social system' has been used loosely as a synonym for social structure. The word 'system' means a complex whole, or a set of organized and connected things or parts, so 'social system' implies stable interconnections between institutional patterns within society. Many a times, the term has been used to denote a teleological or goal directed system, containing social mechanisms analogous to a thermostat, so that the system was self-regulating & self-maintaining.

The hospital being the sub-system of the social system is on the one hand influenced by the main system & on the other, influences it. Recruited personnel & students, patient population

and other visitors carry with them the cultural & social values of the larger system & affect the culture and functioning of the organisation.

To examine hospital social system, in other words, as a social institution would involve looking at the professional staff and the other supportive staff and their interactions on one hand and the patient population on the other, i.e., a preliminary enquiry into the socioeconomic background of the patients, their attitudes towards the hospital infrastructure, the treatment they receive and to see what it really means for the patient to be in the hospital.

The structure of the hospital (R.M.L) social system would require to look into its various components, to put it diagramatically:



OUT - PATIENT DEPARTMENT

Except in the cases of serious ailments, the patients come to the out-patient department for treatment. The nature of the patient population that seeks medical treatment every day, in R.M.L. Hospital, comprises mainly of three categories of patients - the Central Government employees (under CGHS scheme) either referred from their respective dispensaries or otherwise directly to the OPD, the members of the parliament i.e., the V.I.P's who either come to the emergency or the OPD, though, quickly get themselves transferred to the Nursing Home and the general patients, from all over the country - usually the nearby states. The people from the rural areas come to the hospital, only when they have lost hope in the case. Here again, most of the patient population comprise of the urbanites. The patients in the general category are usually from the lower, lower-middle class though sometimes middle class, also come.

THE DEPARTMENTS AND THE UNITS

The hospital (R.M.L.) comprises of various departments, the size of the department depending upon number of units each department has which in turn replicates the strength of the patient population coming to each of these. R.M.L.Hospital has medical, surgical, orthopedics, gynae and obstretics, neuro-

surgery, cardiology, E.N.T., opthalmic department, psychiatry, burns & plastic surgery, dermatology, dental and pediatrics. Each department is further divided into 'units', consisting of the consultant who is the head of the unit, senior physician, physician, chief medical officer, senior medical officer as well as junior residents and senior residents attached to it. The strength of these physicians may vary from department to department. Though administratively, it functions under the head of the department, clinically, it is an independent viable organisation capable of functioning without interference as far as treatment of a patient is concerned. Relations amongst the unit member tend to be formal. The junior subordinates always listen to the medical advice by their seniors.

Each unit is allocated beds, spread in one or two wards. Each unit requires certain female & male beds as both are kept separately and hence space required in both male & female wards. Every unit has to plan its work schedule according to the days allocated to it for outdoor clinics, operation theatres (in case of surgical units) or working in the wards.

Units of the same department though work independently yet maintain contacts with each other through occasional clinical meetings, consulting each other in professional matters or help in some way or the other. But the relationship depends on the

relationship of the unit heads. The member doctors of the unit effect the whole network of relationship. In most of the cases, the unit of the head of the department is higher in 'status' than other units but it varies from department to department.

PROCEDURE OF THE OPD

The patient entering the hospital is registered at the Reception counter at the main hall of the OPD building. The registration of the patients is done from 8.30 A.M to 11.30 A.M on a routine basis yet on Saturdays, the counter closes by 10.30 A.M. The patients coming here, to speak of the general category, face a lot of inconvenience as they are not even aware of the timings. On Sundays and Gazetted holidays, OPD remains closed and the patient has to wait for the next OPD day, yet, for very serious cases, emergency is open twenty four hours. For all practical purposes OPD provides medical services to the patients from 9 A.M to 4 P.M.

Though the enquiry office exists in the main hall of the OPD building apart from other such enquiry booths in various departments yet the patients faces a lot of difficulty in locating units due to the communication gap between the rural patient and hospital functionaries at the counter. Many a times these 'poor patients' wait in the corridor for some person

wearing 'a white coat' to come and then they run to ask the person who also tends to be busy and explains hurriedly, leaving the patient again without prcper guidance.

After the registration, the patient is given a slip, on which the days of the various unit are marked of is directed to the concerned OPD, where he gives in, his slip and waits for his number to come. Sometimes the 'poor rural patient' is sent back from the OPD counter without registration by the clerk sitting stating that either the timings are over or that the patient doesn't require any medication.

Usually a patient registered at one unit is not seen in the other unit and if so happens, the patient is not treated properly by the previous doctor. Management of the queues, maintenance of the sanitary conditions, provision of the wheel chairs and patient trolleys along with seating arrangement of the OPD patients is directly under the sister incharge OPD who decentralizes the job by the help of the staff nurses as well as the sanitary inspector. Though in actual, the sister incharge is so busy that she hardly takes rounds once or twice to see the management in the OPD.

A patient on his first visit is usually seen by the junior resident or at the most the senior resident, whatever the case

may be. Depending on the degree of the ailment, opinion of the specialist/consultant is taken on patient's subsequent visit and the treatment carried. But it solely depends on the discretion of the junior doctor. In cases where hospitalization is sought, requisition slip is made by the doctor incharge to the respective ward, where beds are allocated as per the units. The patient thereafter goes to the emergency Block and gets himself admitted. The patient is kept under observation for one or two days again, depending on the seriousness of the case and then shifted to wards if he has not recovered. If recovered, he is discharged. The patient not requiring hospitalization is sent back after the drugs are provided from the pharmacy (if available) free of cost. Hence a continuity of treatment to the patient from the outdoor to the indoor is maintained.

Services are provided, free of cost, to the patients irrespective of their income level, though in cases of Nursing Home and private wards, a certain amount of fees is charged at the registration counter. The patients though are charged by the hospital for the consultancy, yet for the laboratory tests, if the income of the patient is more than Rs 500 P.M., fees is charged. In case of specialised services such as Cat Scan, TMT, Holter, ECO Cardio, VCG, permission is sought from the medical superintendent and fees are charged ranging from Rs 50 to Rs 500, depending on the repetitive tests to be done. Smaller repetitive

tests are done in the laboratory attached to the emergency, yet for other OPD cases, laboratories exist in the OPD building, i.e., Haematology, Bio-chemistry, Bacteriology, Histo-pathology & Cytology. These laboratories work from 9 A.M. to 4 P.M for OPD cases yet for emergency cases it is open twenty four hours.

X-Ray services are available round the clock for the emergency cases, yet for the normal OPD cases one section works from 9 A.M. to 4 P.M. Another section of the X-ray services is for the emergency block and the remaining one for other indoor cases.

Drugs though not all, are dispensed through the dispensary, working during the OPD hours. Prescribed medicine if not available, the patients have to buy themselves or otherwise a substitute available is provided from the medical store.

SPECIAL CLINICS

Along with the usual OPD hours, some special clinics are run in the various OPD's for specialized services. The following special clinics run, the usual timings being 2 P.M. to 4 P.M., though the days are fixed according to the department:

TABLE NO. 4

LIST OF SPECIAL CLINICS

S.No	Departments	Special Clinic	Timings	Days
1.	Gynae	Antenatal	2-4 p.m	Mon, Tues, Wed
		Diabetes	2-4 p.m	Wed
2.	Medical	Respiratory	2-4 p.m	Tues
		Cardiac	2-4 p.m	Thursday
3.	Skin	Leprosy	2-4 p.m	Tuesday
		V. D Clinic	9-1 p.m	Daily
4.	Neuro-Surgery	Neuro	2-4 p.m	Tues, Fri
5.	Pediatrics	Well Baby Clinic	2-4 p.m	Tues, Fri
		Neuro Clinic	2-4 p.m	Mon
		Diabetes	2-4 p.m	Wed

SOURCE: Annual Report of R.M.L. Hospital 1988.

Staff on a Usual OPD Day

The strength of the physicians & surgeons varies form unit to unit in the various departments. The doctors are divided of each unit as a few of them are required for the morning routine rounds as well as the usual OPD clinics. In the major OPDs including medical, surgical E.N.T., Neuro-surgery, Radiology and Cardiology the number of doctors available are ten to fifteen, comprising the Consultant, Head of the department, unit head, G.D. M.O I, G.D.M.O II, Pool officer, Registrar, Senior Resident and junior residents.

The strength of the nursing staff also varies from department to department and also depends on the fact that whether it is the morning shift, the evening shift or the night shift. On the morning usually the proportion is 4:70, followed by 2:70 & 1:70 patients. Class IV employees including the aayas and the sweepers, the strength is at least two in each OPD.

Along with the usual laboratory services, X-ray sections, provision is made for minor operation theatre (One) in the OPD and one in the emergency block; one injection Room in the OPD, one dressing room in the emergency as well as surgical. The services of the physiotherapy, occupational therapy and social

welfare section are, however, provided in the OPD building itself.

The above description gives an account of the general OPD functioning, the nature of the patient population and the kind of services received by these patients whose per day attendance in the OPD is about 3000 to 4000 in addition to the 100-120 patients visiting emergency everyday (Medical records, R.M.L.Hospital).

Usually a patient in the general category has to spend the whole day in the hospital to get their treatment and tests done. Sometimes the timings are over, by the time their number comes in the queue, the patient therefore has to come next time again. But for the Patients who get reference letters from the members of the parliament, are dealt first by the doctor though this case is not always in each unit, yet is quite common. The other 'strict' doctors make it is point to see the patients in the queque only.

Indoor

The 'Indoor' department forms the core of any hospital. The basic work of the hospital is done here. The patients are received, cared for, diagnosed, treated and finally discharged. Practically all the facilities of the institution ranging from

technical services such as operation theatre, laboratory and X-ray to administrative services such as laundry, kitchen or the office, exist in order to cater to the needs of the staff and patients in the ward.

The 'indoor' department of R.M.L. Hospital comprises of the wards in the old building, wards in the new building and that of the nursing Home.

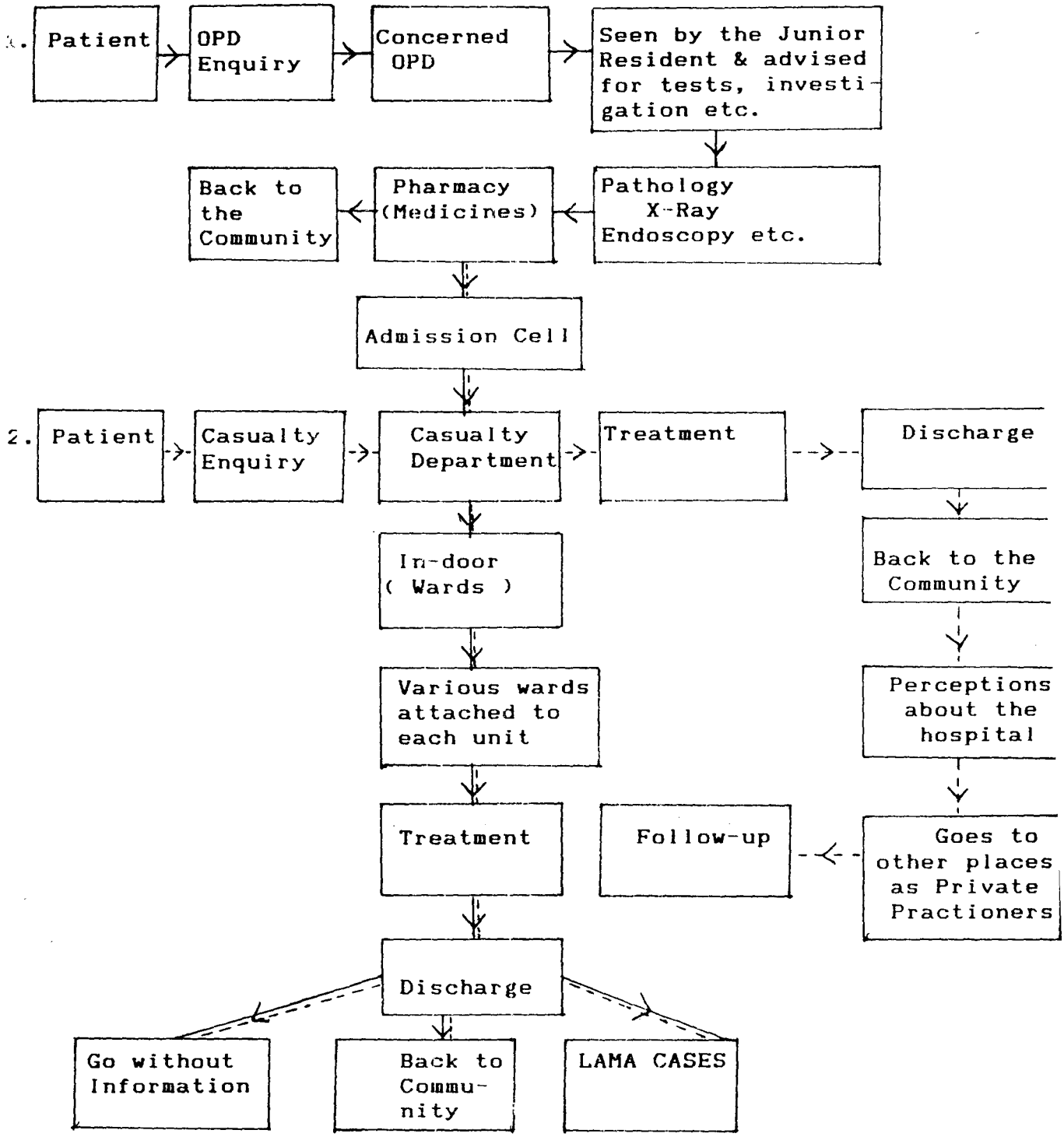
Procedural routine of Indoor-Admissions

The admission system to the general wards is centralised in this hospital where in the central Registration Room, the Chief Medical Officer examines the patient, initiates the medical case record & hence the patient is admitted to the wards depending on the category & degree of illness. For the emergency cases, the admissions are done round-the-clock yet in other routine case, timings are coinciding with the OPD.

In case of the admissions to the Nursing Home, a separate admission cell is situated in the Nursing Home. Usually a procedure of advance booking is followed in the hospital for the operation cases. For the maternity services, though, no maternity services exist for the general patients. Members of the parliament, higher CGHS employees are provided admission to the Nursing Home.

CHART NO.2

PROCESS OF TREATMENT OF THE PATIENT IN R.M.L.HOSPITAL



. Indicates the patients entering the hospital through the OPD.
. Indicates the patients entering the hospital through the casualty Department.

Payments In Case of Hospitalization

Usually the treatment is free of cost to all the patients, coming to the hospital, except, in the case of the Nursing Home, where the payments have to be made according to the income of the patient. Usually there are no payments in cases of laboratory tests, X-rays etc., except, in cases of some specialised services rendered by the hospital The provision of free-of-cost medicines in the hospital would generate "an aura of legitimacy' to the fact that health of the people is not only his individual concern but also a responsibility of state and society yet in practice, a very limited number of medicines are dispensed to the patient prescribed by their respective doctors. In most cases, hardly any local purchases are done to help the patients in the general category, though in the case of the patients in the Nursing Home, instant action is taken for the complaints made.

To get personalized attention, the patient has to appoint a private nurse/mid-wife to look after him, payments have to be made to them ranging, from Rs.50 to Rs.300/day.

Admissions to the general wards depends on whether the beds are available or not. Yet in cases of emergency, even two to four patients are put on a single bed, at peak hours, if needed.

Not only does the problem oi drugs (shortage) exists, but also non-availability of beds, hospital clothes (given only in operative cases) is persistent. Life saving drugs are dispensed depending on the degree of illness and the availability of the same in the drugs store.

The Ward

Incharge of a ward is sister-in-charge nurse who controls the routine business of the ward & supervises the nursing and non-technical works. The sister is responsible for the ward management including drugs, wheel chairs, oxygen cylinders, patient trolleys, suction machines, transfusion & infusion sets, linen etc. The nursing superintendent, who is the senior most nurse, is the administrative incharge of all the wards and supervises the working of ward incharges. She is expected to take rounds to inspect the cleanliness, order & proper functioning of the wards. Wards are divided on the basis of single unit versus multi-unit ward as well as on the basis of the age, sex (male & female). Patients from all wards can come to pediatrics though actually it is only the pediatrics department sending them to the ward.

The staff on duty in the ward, usually includes a senior resident, a sister incharge nurse, staff nurses (usually 2)

students nurses (usually 2), unskilled staff including Dais, ward boys & sweepers. But there are times, on gazetted holidays, during the time the relieving staff has to come to take charge, there is practically no doctor, no nurse except a wardboy in the ward.

Usually the senior resident doctor is present in the ward yet in cases of his absence, the sister-on-duty calls him. Even a specialist is called if the case turns out to be a serious one. Sometimes the situation has been quite problematic when the relatives of the patients had beaten up the nurse as there was no doctor available for the dying patient.

Requisition of the diet is made by the doctor attending the patient and is given to the dietician who looks after the diet supply to the wards. Though the nurse is required to orient the patient to the hospital rules yet practically it is not done, patients usually ask the other patients regarding where to go for food as it is not supplied on bed-side.

Attendants allowed in the ward is one per patient, in case of male patient a male attendant & in case of female patient, female attendant is allowed. In cases of patients in the children's ward, only female attendants are permitted. During the visiting hours however, there is no such restriction.

Usually there is overcrowding in the wards as more than one attendant per patient comes and there is no arrangement for them to stay.

Usually the routine of the ward begins at 9.00 a.m in the morning when the breakfast is served. The doctor's round is preceded by the collection of the information regarding treatment by the house officer who makes it available to the consultant or specialist as the case may be during the rounds. Usual routine jobs are done by the nurse with the doctor such as taking temperature, pulse etc. Provision is made for the segregation of the infectious & contagious cases from the general ones.

Case histories of the patients, the treatment plan has to be made by the senior resident/registrar who is expected to be present in the ward the whole day yet the medical records are most of the times defaulty with incomplete information. These case records are added with the treatment plan by the consultant or specialist attending the case. The discharge slip is also made by the doctor in-charge of the patient and the patient is usually discharged before 5 p.m. from the hospital.

The proportion of the nurses per the patient in the wards varies from 4:70 patients in the morning, followed by 2 : 70 in the evening and 1:70 for the night duty.

The proportion of the absconded cases from the ward is usually 2-3 per week. There is also a general trend of the patients to leave the hospital against medical advise leading to an increase in the 'LAMA' cases.

EMERGENCY DEPARTMENT

Emergency/casualty forms a very important part of the hospital set-up. It is maintained to treat the patients suffering from any surgical or medical condition requiring immediate care. The department deals with lacerations, septic conditions, sprains, fractures, dislocations, collapse shocks, haemorrhage, poison cases, extensive burns, multiple injuries, heart condition, acute abdominal conditions, acute severe pain or distress. dog bite, medico-legal cases and other emergency cases.

The emergency services are available round the clock with at least a pediatrician. neuro-surgeon, surgeon, orthopedic, physician available all the times and rest are on-call basis. In a ward in the emergency block, three doctors, three nurses, one sweeper, one wardboy is present at night. The usual procedure of getting registered at the reception of casualty and then transferred to the concerned ward, i.e., casualty pediatrics, casualty medical etc. as the case may be. If the patient after

being kept for observation doesn't require any more need for admission, the patient is discharged and is referred to the OPD.

Medico -Legal Cases, Major Accidents and Unknown Cases

When a patient comes to casualty with multiple injuries, bleeding profusely etc., the case if a medico legal one, an intimation is made to the sub-inspector appointed within the premises of the hospital and medical treatment is given simultaneously to the patients. The patient later is kept for observation and the police is allowed to talk to the patient only when he is in a condition, fit for a conversation.

Sometimes in case of an unknown patient, not known to anyone, is picked up and brought to the casualty, the patient is given treatment yet later-services are referred to the medico-social service department.

Availability of Medicines

Usually all medicines are available in the casualty yet in cases of non-availability/shortage, local purchase is made or the patient's attendant is asked to get the medicines immediately from the medical store in the premises. Usually, the clearance of the wards is done by morning 9 a.m., Yet, the cases may stay

on if they require further treatment while the cases requiring intensive therapy will be promptly admitted to the intensive care unit for immediate treatment. In cases of the death, the body is sent to a well maintained mortuary in the hospital and given to the patient's relative, when the doctor says so.

Laboratory Services

Apart from the X-ray services available free of cost to the general patients in the R.M.L.Hospital, a well maintained network of laboratories exist. The incharge of the laboratory division is Dr. Guha who is also the head of the pathology. The major divisions amongst the laboratory depends on the kind of the tests done in each of these namely clinical pathology, Bio-chemistry, Micro-biology, Histo-Pathology, Cytology, Blood bank, laboratory and the respiratory laboratory. The labs function round the clock for the emergency cases and otherwise for collection of specimens during the OPD hours. All the laboratories are located in the OPD building though for the repetitive non-time consuming tests clinical pathology and bio-chemistry lab exist in the emergency block also.

The staff in a laboratory comprises of a clinical head of department (who is a pathologist, bio-chemist, histo-pathologist

or as the case may be) along with technicians as well as the clerical staff.

Procedure to get the tests involve, the requisition slips sent by the doctor incharge along with the clinical note to the laboratory leading to the specimen being taken from the patient (in case of OPD patient) and the reports, thereafter, being sent to the concerned OPD. In case of the indoor patient, the messenger - boy takes the specimens from the wards and brings to the concerned laboratory. The reports are later dispensed by him, to the various wards again for further treatment of the patient.

In case of emergency, if the concerned technician is not available, call is given and he has to come and do the test immediately. In this case, usually the patient is accompanied by the doctor if the case is serious for giving the specimen. Reports are made available, quickly, in emergency cases.

Though there is well equipped laboratory system in the hospital yet the patient has to face difficulties as the reports get misplaced. The patient has to run from the concerned OPD to the laboratory many a times to get a duplicate made. Further the proportion of the staff and patient is very less, total

automation is not done, leading to constant delays in getting reports.

Laundry & Linen Service

Laundry & Linen Service forms an important of the hospital set-up as it is responsible for the provision of sterile clothes, clean linen to the patients as well as the doctors, nurses as well as para-medics to facilitate the treatment process, infection-free. Usually the laundry services are provided by lowest tenderer who has a reputation to wash hospital linen satisfactorily in case of contract washing but in R.M.L. Hospital, a proper well equipped laundry is attached.

The laundry is provided with modern mechanised equipment on American style but there is not adequate manpower to manage it. The incharge of the laundry, though is a medical person but is only involved with paper-work regarding laundry service, actual work, for all practical purposes is done by the laundry supervisor Mr. M.C. Varma. The staff includes two people to work on the boiler, twelve machine operators, eight helpers along with six casual labourers.

The linen is though on centralized distribution pattern yet it is supplied on exchange basis, i.e., to say for ten dirty bed

sheets given for washing, ten washed ones are supplied. At a time, four pairs of linen are available - two in laundry (washing, drying); one forward stock; one for central linen service and one for use in the ward.

Earlier, the washing of nursing home linen and general wards linen was done separately but now it is done together though the nursing home is provided with well-ironed linen and the general wards un-ironed ones. The linen from the nursing home & OPD is washed weekly though in case of wards it is on routine basis.

The blankets are not washed frequently as there is no operator in the laundry for blanket washing machine. Hence they are washed with ordinary clothes which leads to their being destroyed quite easily. No bacteriological tests are done to infection-free linen except for the clothes from operation theatre. Nothing is done to avoid pilferage of the linen except that, one old man is there to mend the linen. The soiled, fouled & infected linen is not given separately by the sister I/C of the wards due to which it is washed with ordinary clothes only.

The doctor's coats, pajamas etc are marked and are washed & ironed separately. Usually supervision is done by the laundry supervisor in that he takes rounds in the laundry many-a times in the day and maintains indents regarding the linen.

In case of shortage of linen, which is due to the fact that the linen is damaged in the ward only as are not given frequently for washing and is kept lying in the corner of the ward for days and then sent for washing, no alternative arrangements is made as no new linen is being provided except in cases of emergency. Sometimes during the period of the strike of the workers/doctors/staff as in 1980, whatever is available in the ward stock is used, otherwise nothing is done.

DIETITICS

Diet forms a very important component of the treatment process. The hospital has been provided with two dieticians, one attached to the nursing home and looking after the kitchen and the requisitions for the diet in the nursing home and the other for the general wards.

Incharge of the dietetics for the general wards is Miss Shikha Khanna who along with the matron (nursing superintendent) is expected to the rounds in the wards to check the distribution of food, particularly when special items are prepared and sent to the wards. They are also supposed to make surprise checks in the kitchen.

The strength of the staff in the kitchen as well as the subordinate staff includes two head cooks, two junior cooks as well as cook mates for the kitchen as ward boys for the distribution of food to the wards. The distribution pattern in the wards is partially decentralised. As a matter of principle, the ward boy is required to go to each patient's bed-side and provide food as per the sister incharge's order who reads it from the diet chart provided. Yet in routine, the ward boys get the food in the trolley to the ward & shouts for all the patients to run and take the food. The case is worst when the lift is out of order, the patient without an attendant has to sometimes remain without food since nobody can go & get his food.

The usual timings of the meals includes, the morning tea at 7 a.m., milk at 8 a.m., breakfast at 9.00a.m., lunch at 11.30 a.m.. evening tea at 3.30 p.m., and dinner at 6.30 p.m., though provision is made for making tea in the ward pantry.

The requisition for the diet is sent by the sister in-charge of each ward which then is calculated by the dietician and purchases are made regarding routine dry food items as well as daily food items. Usually one day is required between requisition of diets & actual requirement.

The menu planning for the general patient is done by the dietician keeping in view the availability of food items. Otherwise alternative arrangements are made. Dietetic interns are also given training in this department who help in the planning of diet charts.

Medical examination of the staff working in the kitchen is done every year though on papers it should be done every six month.

The lacunae in the dietitics department tend to be in the distribution and purchase. Distribution of food is not supervised properly and supply of food items is solely in the hands of the dietician which should also be decentralized to avoid corruption as well as to avoid pilferage.

BLOOD - BANK

Blood Bank is an important feature of hospital set-up. It stores blood of all possible groups and supplies it to patients needing blood transfusion. In case of R.M.L.Hospital, the blood bank is maintained, fully equipped with free of cost blood being given to the patient, round the clock, whenever needed.

The structure of the blood-bank includes eleven rooms including one grouping room, one cross-matching room, one for issue of blood, one for bleeding, hepatitis-laboratory, refreshing room for the patients, autoclave and distillation plant room, store as well as the incharge doctor's room.

The staffing pattern in the blood bank includes one doctor 1/C (regular), one adhoc medical officer, two staff nurses, one store officer, one senior technician (hepatitis lab), seven technicians, one lab assistant, one lab attendant, four nursing orderlies and one sweeper.

Procedure to get blood from the blood bank usually involves requisition from the doctor concerned, bleeding the relative of the patient and taking the blood followed by cross-matching of the patient's blood and issuing of the blood to the patient's relative who has to come with the ward boy for collection of the same. Secondly, blood is also issued to the close of the kin members who are voluntary donors of Red Cross Society. But barring all these, blood is issued instantly if there is an emergency case, however donations are taken later from the relatives.

In case of non-availability of the blood, it is taken from the Red Cross Society who has collaboration with other

laboratories all over Delhi. The blood bank of R.M.L.Hospital is associated with the Red Cross Society and routine procedure to collect blood is through Red Cross members. Techniques of the blood bank used here include grouping (slide test), cross matching, COOMBS test, hepatitis and HIVS (which is done at Red Cross only).

Professional donors are discouraged, they are caught if they come for donating blood by the staff. Sometimes the relatives of the patient brings a professional donor to give blood which is usually caught. To discourage such practices, no payment procedure is kept in the hospital. The figures for the relative donors for the year 1989 was 3722, 77 voluntary donors; Red Cross 1993, so, on an aggregate 5847 patients were issued blood from here.

AMBULATORY SERVICES

To facilitate the mobility of the doctors from the hospital, the patients to their respective homes or other places of rehabilitation after discharge of the patients, transport facilities are being provided by the hospital. The Chief Medical Officer (CMO) at casualty reception is the in-charge of all the ambulance services of R.M.L.Hospital. Though there are more than thirty ambulances in the hospital yet only three are in a working

condition. The ambulance services are provided free to all the patients who are sent home as per the doctor incharge's advice. in other cases if a patient needs ambulatory service unless he is very poor, he has to fill in a requisition form countersigned by the registrar attending him and has to pay Rs. 1.70 per kilometer.

Though ambulatory services are available yet to avail these is of great difficulty because of non-availability of same many a times, many of the patients are ignorant about this facility too. So in most of the cases, the patient comes and goes by his arrangements. It creates problem for the very poor ones who cannot afford private transport after discharge and thus have to travel by the public transport with great difficulty.

WORKSHOP

To maintain the general wear and tear a workshop is located within the premises of Ram Manohar Lohia Hospital. The usual divisions comprise of electrical section, air-conditioning, Instrumentation, Carpentry, Spray painting, Sheet metal section, Blacksmith section, depending on the specialized services provided by each of these. The staff comprises of the engineer who is the head along with the technicians.

THE PATIENT

Patient is the 'pivot' around which the whole hospital revolves, the facilities and services provided, thereof, are directed to serve the needy population with various degrees of ailments. The population however would be stratified on the basis of their socio-economic background and the seriousness of the ailment. But in practice, the patient is not considered to be a part of the social life of a ward/OPD/indoor. He is believed to be having very little interest in the problems of the hospital organisation and administration which is quite evident in the behaviour of the hospital staff in relation to the patient.

Usually, the patient coming to the hospital is categorized on the mode of his entry in the organizational set-up i.e., whether he is OPD patient or an indoor one. The number of sanctioned beds in R.M.L.Hospital are eight hundred with an additional one hundred and four mini-beds. The usual number of patients coming to the hospital for the year 1988 was 1072240 patients which is increasing day by day. (Annual report 1988 R.M.L.Hospital).

Patients coming to Ram Manohar Lohia Hospital usually belong to the lower, lower middle classes apart from CGHS employees and

VIP cases (member of parliament). The patients therefore can be categorized on the basis of whether they are CGHS employees, general category patients or VIP cases.

As it is evident from the general set up of Indian hospital, they tend to be situated in the urban areas, the population it serves, also tend to be from the urban areas 70% of the cases coming to the R.M.L.Hospital come from an urban background only 30% (approx) come from the rural areas (Medical Records. R.M.L.Hospital) and the remote peripheral ones even less in proportion. A rural patient comes to this hospital in most cases, when he has given all hopes and hospital is the last resort for him.

Though a lot of referral cases come from different hospitals, CGHS dispensaries, private clinics yet no preference is given to them. The others come directly to the OPD.

Though the patient is given admission to the hospital if he needs hospitalization, investigations are done, drugs are provided and after recovery the patient is sent back. But the pertinent question that remains unanswered is that to what extent these 'patients' coming to these hospital with 'high hopes' get 'medication'. The degree of their satisfaction would depend on

the kind of 'services' they ultimately receive when they come to the hospital.

The patient coming to this hospital as in the case of any other hospital has certain preconceived notions about the services provided, medical functionaries and of course, about his illness. These ideas colour his expectations in the hospital which however 'fade away' in most cases after the interaction he has during his stay in this complex institution. The patients, however, belonging to different backgrounds, are dealt 'very mechanically' 'without inclination' if the results are not satisfying. The doctor, however is not happy (especially the junior doctors) due to the pressure of the superiors, administrative problems.

The patients, besides their personality vary in economic status, type of disease. age, sex, education, place of residence, caste, religion (now not so peculiar). The situation and the role of the patient also varies in indoor wards, out-patient departments and casualty emergency.

SOCIO - ECONOMIC BACKGROUND OF THE PATIENT POPULATION

The patients coming to Ram Manohar Lohia Hospital mainly hail from the urban and semi-urban areas nearby the capital of

Delhi. The population of the patients coming from the rural peripheral areas is not very significant (relatively) as they come to the hospital in the last stages of the recovery of the patients.

Though the hospital caters to the needs of the population without any discrimination, yet, people from the political sphere are given preference in terms of attention and treatment. This hospital is catering to the needs of all categories of population from rich to the poor, politically-influential to the patients in the general category. The factors influencing the different utilisation of the government hospitals (such as R.M.L.Hospital) specially patients from the rural areas depends on the distance from the house to the hospital, cost per trip to visit the hospital, time taken to visit the hospital and service acceptability. Analysis of the data collected from the hospital, infers, that a vast majority of the population is not satisfied with the present pattern of health delivery. The satisfaction of the patient has been qualitatively found in terms of the behaviour of the health personnel (i.e. doctors, nurses, paramedics) towards the patient, dietary provisions, laboratory facilities, availability of the linen for the indoor patients, mode & degree of communication between the 'deliver' of the health services viz. doctors and the 'receiver' i.e. patient and consequent discharge of the patient after recovery.

A patient coming from remote rural areas to the hospital have to face a lot of difficulties. It is evident from the percentage of such patients actually visiting the hospital. Patient usually go to a nearby private practitioner to get relief from his ailment. It is only when he does not get satisfactory results that he decides to visit the hospital. But coming to the hospital itself is not an easy game for him, it is a lot of economic burden for him. He may have to arrange money from a moneylender or mortgage his other things in order to acquire means to reach the hospital. In some cases people come to the hospital as brought by their concerned relatives living in the same city where the hospital is located. Again they have to arrange for public transport or hire a private vehicle to reach the hospital.

Case No. I Mr. X's daughter had got her leg fractured as she had fallen from the roof of the house in a village near Mehrauli. First she was taken to a nearby general practitioner who advocated to be a specialist in fractures but as the girl couldn't get satisfactory results and kept on crying with pain, the father brought her to the hospital after taking money from a moneylender and arranging for a private transport to reach the hospital. But what was the relief she got after coming to the hospital? The father didn't know where to go? Where the admissions were to be done? Where the X-rays were to be done as it was not during OPD hours. Anyhow, the patient was taken to

the emergency and got the treatment after getting scolding from the doctors for not bringing the patient earlier to the hospital. The socio-economic background of the patient the conditions under which the patient came to the hospital, such factors were not considered by the doctors.

It is not a simple decision to come to the hospital for a poor patient from the rural areas. There are a multiplicity of factors involved in getting treatment finally in the hospital. So the whole process of a patient reaching the hospital and the kind of "service" received ultimately are pertinent issues to be taken into account white carrying out the study of any hospital.

PROCESS OF THE TREATMENT OF THE PATIENT

Usually the patient is received at the enquiry counter and from here he gets the OPD slips made if he comes to the OPD. In other cases, the patient goes to the casualty enquiry and henceforth gets admitted in the casualty department. The process whereby the patient ultimately receives treatment in the hospital is summarized in Chart no. 7. During the stay of the patient in the hospital he forms certain perceptions about the hospital set-up which depends on the behaviour of the health personnel towards him, difficulties (regarding food, linen, drugs) he faced.

In the OPD, he has to wait for long hours for getting his treatment, furthered by the rude behaviour of the nurses, mechanised treatment rather than individualised one, by the doctors and ultimately if he goes for medicines, either the timings are over or drugs are not available.

If the patient happens to be admitted, he has to face another similar set of problems, viz., delay in getting laboratory reports, linen, drugs, quality of diet, behaviour of the nurses which is similar in the cases of casualty though difference lies in the fact that the treatment is a little more efficient.

Ultimately, the perceptions a patient forms in the hospital determines whether he would come back to the hospital for follow up or go to other government hospitals or private practitioners nearby his place of residence.

A few cases to be mentioned here would highlight the kind of problems a patient faces when he is in the hospital

Case II Case of Serious Patient Ultimately Resulting in Death: Patient A in the medical ward II developed serious symptoms at night when there was only one staff nurse on duty, the house surgeon supposed to be present didn't turn up for one hour,

resulting in the patient ultimately dying. The nurse on duty was hence beaten up by the attendants of the patient.

Case III Inadequate Food: A patient in the orthopedic ward who was bed-ridden, couldn't move, had no attendants. The lift had stopped working leading to patients going themselves to the ground floor to get the food. This patient in the absence of anybody to serve him, didn't get food and ultimately when it was known by the fellow-patient's (B) attendant who got the food for him, the quantity of the food was less leaving the patient half-hungry.

Case IV Shortage of Drugs: Patient X was prescribed certain medicines by the doctor at the OPD which were not available at the drugs store, leading to the cost being borne by the patient if he bought from outside. The patient who happened to be a poor one, couldn't afford it, leading to another substitute of the drug being given to the patient which was not - effective, patient henceforth could not get proper treatment.

Case V Rudeness of the Nurses Patient Y had to be given injections by the nurse who was very rude to the patient. Patient informed the consultant when he was on rounds, leading to more aggressive behaviour of the nurse in absence of the doctors towards the patient. The investigator could see the way the

nurse was giving injection to the patient leading to a lot of blood stains and pain on the hand of the patient.

The cases are highlighted to give a lively picture of what is the kind of 'services' the 'patient' receives when he comes to the hospital.

Patient Information System

Patients constitute the nucleus of hospital information system. Information forms the 'Eyes and Ears' of planners, administrators concerned with organisation, coordination, control and monitoring of services. (Dr. Sheela Dutt. 1988)

The system needs to be planned & organised well so that right information can be imparted at the right time to the right patient. Measures to improve patient information system would go a long way in the smooth functioning of a hospital which in turn would facilitate the consumer of its efficient health care delivery.

Ram Manohar Lohia Hospital has tried to develop an organisation of patient information system though it is not adequate. This involves presence of an admission counter, (Reception), display boards enlisting all the services provided by hospital, days and timings. Though assistance is provided by

the social workers yet, negligible, no procedure of information booklets providing details about the services offered, charges etc., audio-visual aids on family planning, immunization though available, are hardly used; suggestion boxes are available and also information on fire alarm and disaster planning is available. Further, need is for provision of information on the discharge of the patient regarding community services and health education material. There is absence of a good public address system though public telephone facilities, intercom is available.

Now the question arises that though the patient information system is available but it is mainly the educated ones who can read these signboards. So facilities, such as, more people from social sciences at the reception to handle the patient and further a group of health guides can be deployed for the help of the patients.

RECORD - KEEPING

The existing health information network fails to provide adequate information about certain important points, on account of lack of uniformity in maintaining the basic data. One of the source of such information are the hospitals and the medical records. These records contain valuable information regarding clinical, legal and administrative interest. Due to lack of systematic set-up of medical records in the hospital (s) in

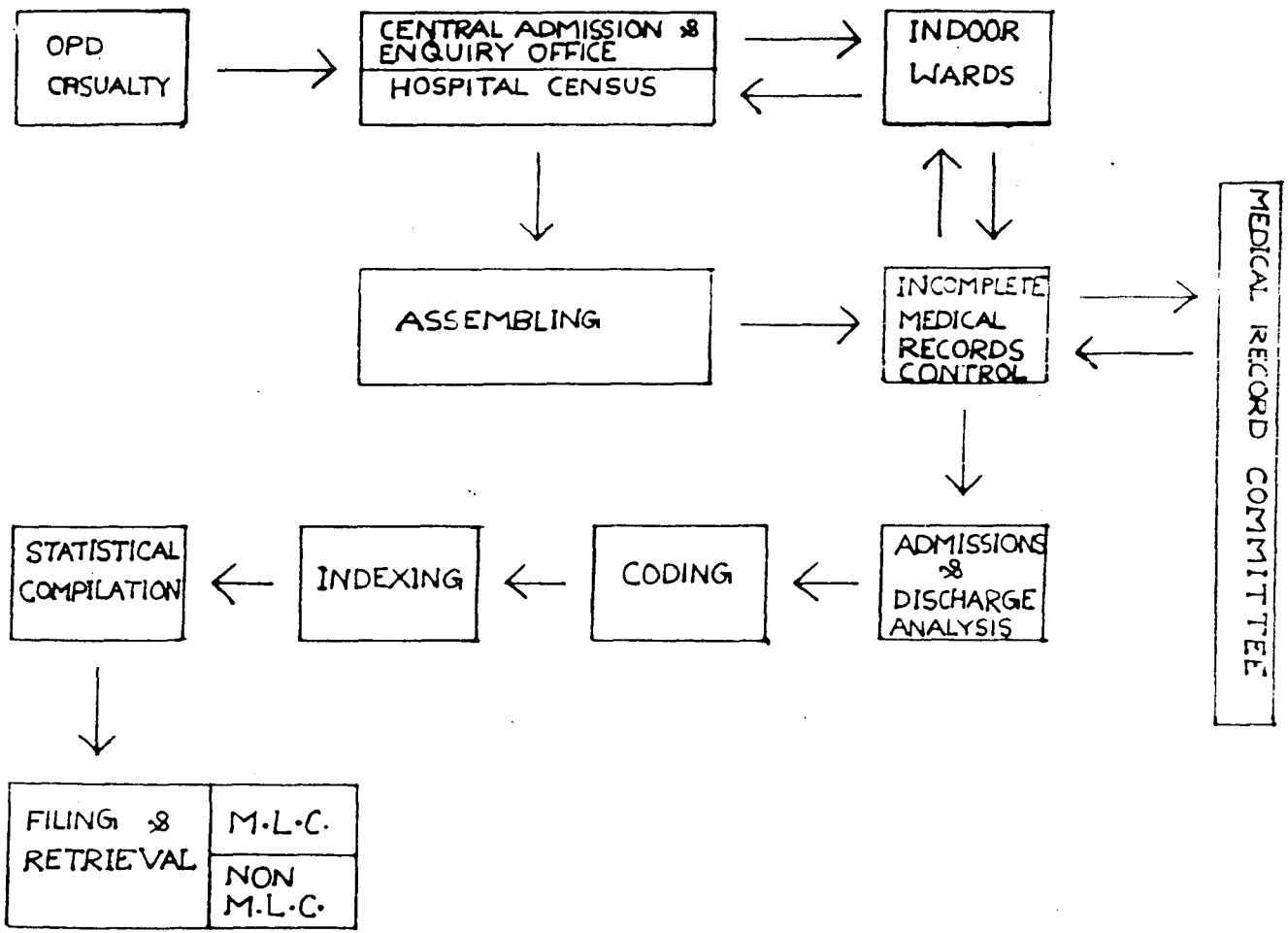
developing countries like India, these information are not analysed and inferred properly. The data remain dead for years together as far as their application in management and research is concerned.

The Existing system of Record System In Ram Manohar Lohia Hospital, the management of the medical records is done by the manual method, similarly, the statistical analysis of information is also done manually. Records containing the case sheets prepared at different intervals (i.e. at the OPD, central admission office, indoor wards, laboratory tests etc) are very inadequately filled and sometimes the most important details are missing from the case sheets, due to the inadequate record filling by the concerned doctor. After completion of the case sheets, the operative procedures & diagnoses are coded according to an internationally accepted system called the I.C.D. Data regarding admissions, discharges etc. are collected by the census clerk from each ward & OPD & brought to the records section of the hospital.

Important clinical and socio-demographic characteristics of the patients like name, age, sex, religion, diagnosis and operation etc are extracted on specially designed cards which are later arranged serially and used as diagnostic index, operation index and alphabetical index etc. The information collected are

CHART - 3

FLOW AND PROCESSING OF IN-PATIENT MEDICAL RECORD



manually compiled for statistical purpose. The data so collected/obtained are insufficient and incapable of exhaustive tabulation and suffer from computation errors. The original records are filed in an ordered manner, according to the central registration number. Further the data so collected are also arranged according to the data of admission and discharge. Some instances have been there when the case sheets could not be located in the absence of central registration number and date of admission of the patients. Records of Only Past Ten Years are Kept in Hospital Records Section. Three types of index are used - diagnostic index, operation index and surgeons index. Dependency on the original records become essential and huge space of filing becomes essential.

Some scholars like Dr. Sridhar and C.M.Pandey(1987) have proposed for record system in the hospitals to be maintained by computers. According to their opinion this would lead to a modest scheme which is simple, economical and practical.

The proposed scheme would be able to maintain the records systematically and would do away with the individual aptitude & ability of the personnel to maintain the quality of the records.

Complaints/Grievances

The hospital maintains a very organised complaints and grievances cell regarding the complaints of the patients towards the hospital. The information regarding these is provided by putting up sign boards regarding where to contact and when to contact & to whom, regarding the complaints at prominent places. Further, suggestion boxes are being provided at various places for the patients.

The hospital organisation is working towards the achievement of some common goals, i.e., health care of the patient, but these goals are perceived differently by different people due to basic differences in personalities, perceptions and motivation leading to conflicts. In cases of conflict, between the various personnel involved in the hospital (doctors, nurses & paramedics), the person can bypass all intermediaries and complain directly to the medical superintendent, who in turn would direct the person to the concerned personnel. Usually the conflict is resolved as soon as as possible.

Reasons for Conflict in the Hospital

Behavioural problems arise because of the increased expectation of the society from the health personnel, whereas,

different categories of health personnel are too busy & many a times not able to look to the psychological values of the patients.

Non-Recognition of individual work - More amongst government hospitals, as the R.M.L. Hospital, as a consequence people try to follow "work to rule" attitudes, thereby creating conflicts in the hospitals.

Diverse power status of personnel - Vast difference in the technical knowledge and socio-economic status of two extreme individuals of particular department of the hospital. Under such circumstances of work situation, inter-personnel or inter-departmental conflicts are more frequent in hospital situation than in any other institution or industry.

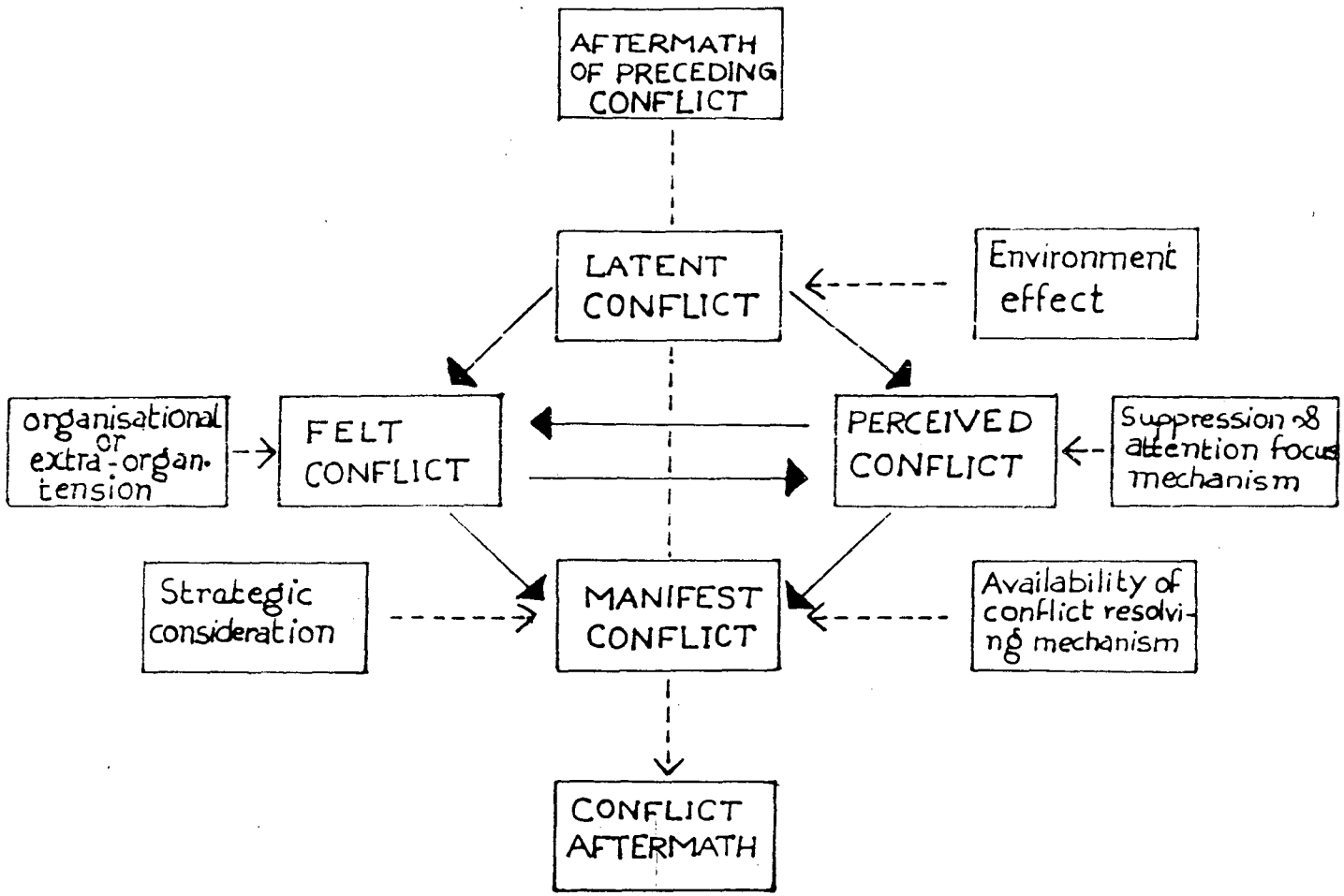
Multiplicity of administration and control - Hospital staff of one trade are administered by their own trade administrators and also by other class simultaneously and when the instructions from different authorities do not coincide, conflict is created.

Consequential of such conflicts, working of the hospital is affected at different levels, i.e.,

(a) At the personal level (tension, stress dissatisfaction, various illnesses, spoiled relation with others)

CHART-4

DYNAMICS OF THE CONFLICTS IN THE - HOSPITAL



SOURCE : Hospital Administration , Vol. XXIV , no. 3 & 4 , Sept. 1987

(b) At the inter-group level (intensified loyalties and contributes to the formation of inaccurate stereotypes)

(c) Organisational level leading to strikes & lockouts.

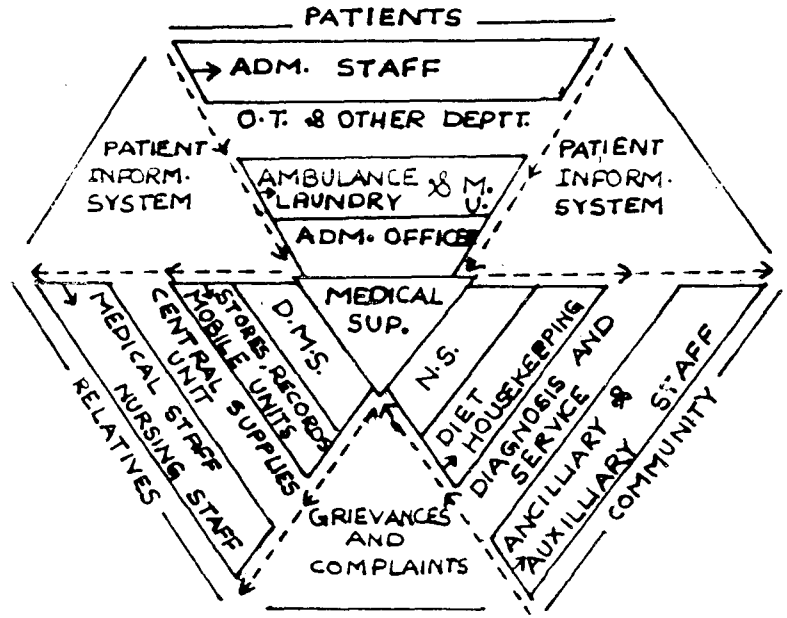
The modalities involved in resolving the conflict constitute of the role of the advisory boards, high interaction & communication and some kind of accommodation to be arrived at between the conflicting parties.

Referral System in R.M.L.Hospital

Though a chain of patient-information system exists in the hospital wherein, the information is percolated down to the patients, yet there is absence of good referral system. The patients coming from other dispensaries, primary health centre or for that matter, from the local private practioners are not given due consideration. They are also queued up in the OPD for long hours to get their treatment and no attention is given to the referral. Even within the hospital also, there is lack of coordination which creates problems for the patients. Any patient referred from the emergency to the concerned OPD is not given any proper attention. Lack of inter and intra-departmental coordination and hence referral system leads to inadequate functioning of the hospital as a whole and finally the patients at large feel

CHART - V

DESIRABLE CHANNELS OF COMMUNICATION IN HOSPITALS



SOURCE : Master plan R.M.L. Hospital (1978 - 2003)

that this hospital is rich-class oriented because a much more systematic attention is usually available in private ward and nursing home. This very situation creates a difficult organizational culture which leads to conflict and unsatisfaction among the functionaries and patients.

Because of the different class background of this patients, doctors, nurses, and paramedics, they also bring along with their own culture, social norms, values and customs which interacts here and develops a different social situation with full of conflicting expectation and value.

Hospital as a Fragmented System

It has been observed several times that whenever a VIP is admitted to the R.M.L.Hospital, i.e., in the nursing home which is part of the overall set-up of the hospital, the services of all the units gets tilted towards him. The hospital which should have been an integrated whole of various segments, inter-related and interdependent, tends to be a fragmented whole, wherein, the needs of the VIP are given the utmost importance. Various services such as that of the laboratory, doctors, (specialists), nurses all try to give attention towards the nursing home. Though the hospital may be running short of the strength of the doctors & nurses but the nursing home is always over-staffed.

The maximum importance is given to the nursing home, as a result of which the other wards occupied by the general patients are neglected and ignored.

Since the inception of the hospital in 1935 the seeds of special attention has been laid down for the nursing home. As the society is stratified and class oriented rather than being a integrated whole, the hospital also tends to be a fragmented, class-oriented and not an integrated one because of the presence of the nursing home. Very less co-ordination exists between the various departments within the hospital set-up. Due to lack of co-ordination, the general patients at large are neglected and feel alienated, from the proper medication.

CHART - VI

ORGANISATIONAL SET-UP (R.M.L. HOSPITAL)

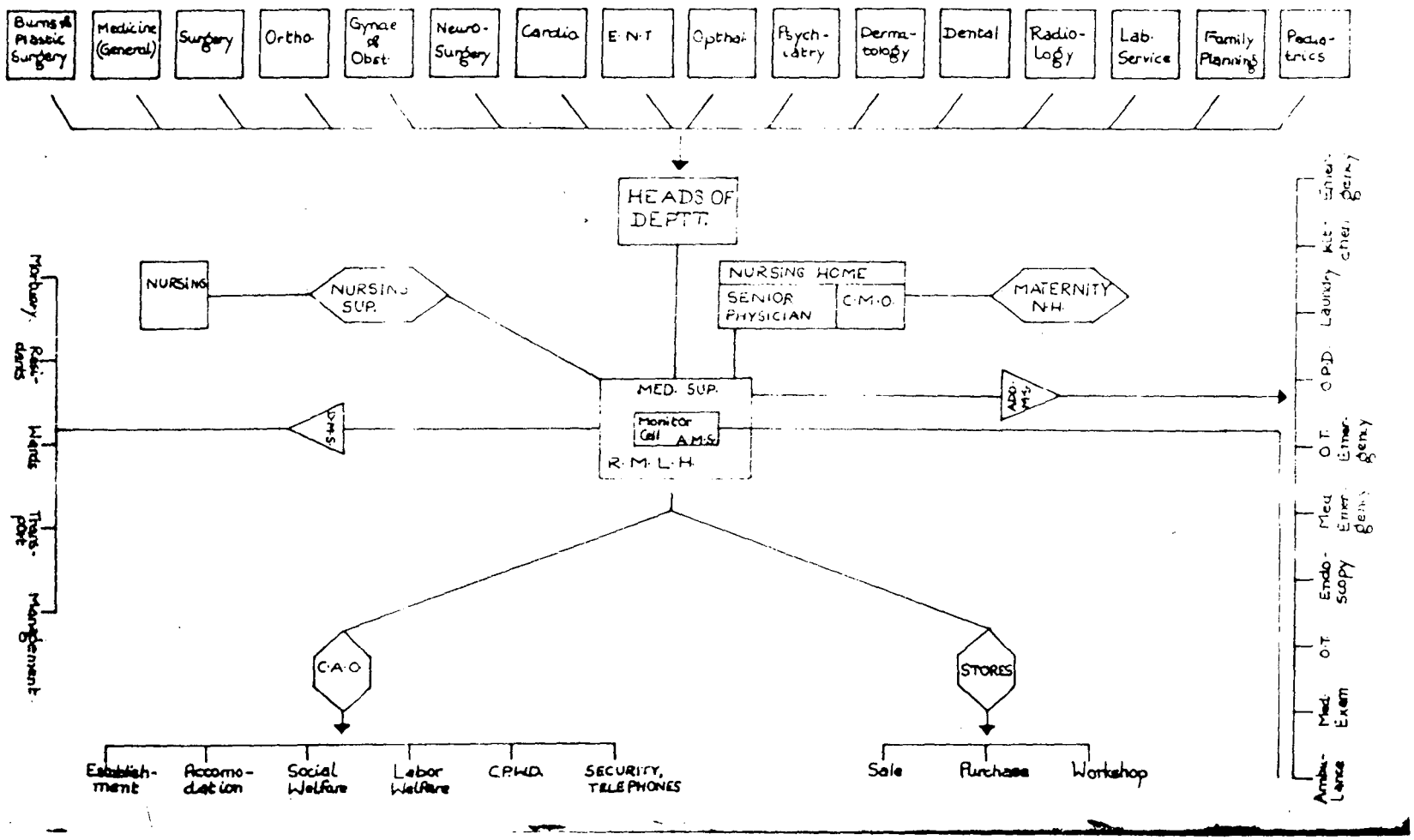


TABLE - 5

DR. RAM MANOHAR LOHIA HOSPITAL : NEW DELHI

Coverage Data for the (Year 1985-89) for Five Years

	1985	1986	1987	1988	1989
1. Bed Strength	800	800	800	800	800
(a) Sanctioned Beds	800	800	800	800	800
(b) Actual Beds (including mini beds)	917	904	904	904	929
(c) Average length of Stay	6.2	5.4	5.7	5.9	5.7
(d) Bed turn over rate	5.0	5.5	4.8	43	3.0
2. Bed Occupancy %	115.1	113.0	102.8	102.7	95.8
(a) Medicine and its specialities	113.3	112.4	102.3	103.4	95.6
b) Surgery and its Specialities	113.4	112.7	103.1	102.1	94.9
(c) Pediatrics and its Specialities	116.9	115.1	103.7	103.1	96.2

TABLE 5 (CONTD..2)

	1985	1986	1987	1988	1989
(d) Obst & Gynae and its Specialities	116.9	111.9	102.1	102.2	96.5
3. Admissions:	44033	49136	44747	42663	36738
(a) General Wards	10434	11777	10252	9834	9704
(b) Emergency	30549	34568	31734	29957	23795
(c) Nursing Home	1295	1149	1133	1232	1308
(d) Maternity Nursing Home	1177	1110	978	1014	1239
(e) Nursery in Unit (Paed)	578	552	650	626	692
4. Total Discharges	40503	44416	38231	34721	32989

TABLE 5 (CONTD..3)

	1985	1986	1987	1988	1989
5. Total delivery	578	532	650	-	-
6. Total Deaths	3392	3294	3691	3571	3043
7. Total Hospital Attendance	1067267	1007219	1038651	1072240	988976
(a) General OPD attendance	854343	797560	834886	870531	789630
(b) Special Clinic	64192	62979	70223	64224	76560
(c) Emergency attendance	148732	146680	133542	137485	122786
8. X-ray Cases	131845	135833	-	168910	161750
(a) Main Building	83999	72004	73221	79877	68174
(b) Emergency	51899	55044	53341	58721	55720
(c) Ortho OPD	15947	8785	9898	11793	22060
(d) Cat Scan	-	-	2560	2036	1881
(e) N. Home	-	-	2740	6655	6043
(f) Ultra Sound	-	-	-	9828	7872

TABLE 5 (CONTD..4)

	1985	1986	1987	1988	1989
9. Operations					
(a) Major	6122	5802	5567	5052	4737
(b) Minor	53426	46559	58277	54035	42032
(c) Plaster Room	37340	25516	31481	32358	34381
10) Neurosurgery Department					
(a) New Cases	3872	4429	4670	5278	5494
(b) Old Cases	3330	2980	3340	3588	3325
(c) Total Cases	7202	7409	8010	8867	8819
11) Laboratories Tests					
(a) Pathology	1868277	591436	682311	666308	533695
(b) Histo Pathology	118973	121439	326717	142875	141257
c) Cytology	32239	17840	10840	10304	9201
(d) Bacteriology	635874	624490	210920	570570	446158
(e) Bio chemistry	197013	218833	211055	225119	298902
(f) Blood Bank	52193	69394	65712	83500	74560
(g) Total	2404569	1643432	1296635	1698676	1503863

TABLE 5 (CONTD..5)

	1985	1986	1987	1988	1989
12) Deaths					
(a) Within 48 hours	1901	1611	1760	1691*	1566*
(b) Within 72 hours	284	247	327*	351	257
(c) After 3 days	1207	1436	1604	1529	1220
(d) Total	3392	3294	3691	3571	3043
@ Within 24 hours					
* Within 42 hours					
13) Medical legal Cases	8312	8638	8973	6902	6263
14) Details O.P.D.Attendance Speciality-wise					
1. Medical	120072	105835	123869		99517
2. Medical CGHS	30369	34842	34003	131305	43573
3. Medical Nursing Home	8766	5123	3397	41127	6182
4. Surgical	84423	83550	79425	5126	72019
5. Surgical CGHS	10910	13248	14713	84054	10747

TABLE 5 (CONTD..6)

	1985	1986	1987	1988	1989
10. Dental	55558	57618	60470	75529	59133
11. Skin	74269	76373	86550	69489	68970
12. Pediatric	48183	47208	43285	79453	42272
13. Orthopedic	84697	67306	88245	46600	92332
14. Post Operative Clinic	3949	2834	2740	88286	1152
15. Neuro Clinic(Paed)	5151	4334	4389	5052	6027
16. Nephrology(Paed.)	467	490	252	308	176
17. Well Baby Clinic (Paed.)	8555	5621	5086	3970	3567
18. Cardiac Clinic (Paed.)	278	292	206	273	134
19. Neuropsychiatry Clinic	638	868	364	-	-
20 Neurosurgery Clinic	2818	2849	3739	4131	3924
21. Head Injury clinic	2699	2744	2976	3425	3475
22. Post traumatic Epilepsy clinic	1047	948	931	1311	-
23. Diabetic Clinic	2885	2304	2726	2668	2403
24. Cardiology clinic	8732	7003	6972	8500	8474

TABLE 5 (CONTD..7)

	1985	1986	1987	1988	1989
25. Neurology clinic	1333	1043	1288	1665	1285
26. Leprosy Clinic	3038	3371	3758	5181	4409
27. Antirabic Clinic	22602	2827	29707	15601	30510
28. Family Welfare	36643	28931	21323	25731	23792
29. Injection Room	43328	30366	26185	23780	18457
30. Physiotherapy cases	37899	42348	47832	40307	41146
31. Medical Examination cases	8366	4807	6457	4069	6441
32. Medical Board cases	2043	1783	1492	1535	1556
33. Total	913535	860539	905109	934755	866190

Average OPD attendance per day = 2936

Family Welfare Department (1989)

1)	Total Attendance	23792
2)	M.T.P. Cases	1206
3)	Operations male	103
4)	- do - Female	403
5)	IUCD	1125

CHAPTER V

DISCUSSION

A hospital is an organised and a highly complex system. A hospital is a component of a medical care system, which in turn, is a part of the health service system. The health service system, again can be considered as a component of a still bigger socio-economic system. As a hospital itself is a highly complex system, it is possible to draw various kinds of boundaries to visualise it as a closely interacting network of a number of sub-systems - e.g. the outpatient department, the various wards, the operation theatre, the casualty department, laundry and linen services, other supportive departments, the personnel working in the hospital and so on.

General system theory as applied on the hospital as a social-system can be seen analogous to tossing a stone into the pool of water and noting the shock waves moving outward in ever larger circles, the hospital being at the impact point. When a patient enters a hospital, a great many groups are involved with admissions---doctors, nurses, dietitics, the business office and housekeeping, to name only a few, of the numerous internal relationships. Externally, a patient is involved with relatives, friends and is influenced by the government regulations,

accreditation and the community, to name a few (Schulz & Johnson 87)[1]

The present study visualized the hospital as a social system wherein the institution of hospital being a sub-system of the society, is influenced by it and in turn influences the entire society. In other words, hospital being a sub-system of the social system on the one hand is influenced by it, and on the other, influences it. Recruited personnel and patients and other visitors carry with them the cultural and social values of the larger system and affect the culture and functioning of the organisation. In this relation, Banerji,[2] identifies four categories of components in most of the sub-systems of a hospital viz., different communities & the individuals constituting these communities; epidemiological considerations concerning the different health problems dealt with by the hospital; the package of technologies to deal with the health problems; and the wider issues of organization and management for providing services to the community served by the hospital.

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1. Schulz,R. & Johnson,A.C. (1987)," Management of Hospitals", California, University of California.

2. D. Banerji(1983), Social Science Issues in Hospital Administration, Indian Journal of Social Work, vol. XIV, no. 1, pp. 7-12.

Studies on hospital as a social system describe hospital as an elaborately structured, rigidly stratified, tightly disciplined bureaucratic organization which have repercussions on the patients : the patient become habituated to a predictable amount of daily activities and a closely delineated set of duties, rights & privileges that any alteration in them causes tension.

The hospital is an institution which shares the maximum slice of the health out-lay and is full of skilled and non-skilled workers inclusive of doctors, nurses and paramedics. But the studies conducted by the social scientists in this field are very inadequate in their understanding of the hospital as a social institution. Majority of the studies have been conducted in relation to doctor-patient interaction, doctor-nurse interaction and nurses in society or medical students and socialization of the personnel or the hospital administration and management. These studies are 'no doubt' important and help in understanding, but, they highlight only one of the aspects of the hospital and can be fruitful only when seen in relation to each other. Majority of the studies have been done on the same concept of Parsons and Weber. The Indian scholars by and large have picked up the thread from these earlier studies and so the results of the studies do not portray the reality of the

situation in India due to the very built-in fault of the concepts and ideologies.

Further, other studies have focused on management issues too much, not paying attention to the patient population. The necessity is to know the 'felt need' and 'demand' and then a purposive intervention to help maintain the dynamic equilibrium of health. The studies carried out by the governmental organisation also tackled the institutional health care in short-cut manner by giving statistical data for much human problems. The solutions of any dilemma has been given in such a general and straight-jacket manner that the very feasibility of the solutions is highly questionable. The study by Timmappaya[3] on patient satisfaction and ward social system though helped in further understanding of the hospital, yet it remained more of survey than on academic exercise. The sample size was not adequate to generalise. Further these studies were not cross-checked in order to cross-check the authenticity of the data collected.

To sum up, the studies in relation to the hospital have focussed more on the functionaries of the hospital having a peripheral account given to the patients, the patient around whom the whole system of the health care delivery revolves.

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3. Timmappaya A. (1973), Patient Satisfaction and Word Social System, New Delhi, NIHAE.

The present study conducted in Dr. Ram Manohar Lohia Hospital, New Delhi has tried to focus upon all possible sub-systems of the hospital. The organization of the hospital from the M.S. to the the D.M.S and A.M.S along with N.S and A.N.S., other supportive staff, the percolation of the authority structure from top to bottom have been seen on one hand, while equal attention has been granted to the patient population as closely interacting with the medical functionaries comprising of the doctors, nurses and other ancillary staff, on the other. A representative sample of the medical functionaries on one hand and patient population on the other were selected and were administered with check-lists of questions to quantify the extensive qualitative data collected with the help of observations, interviews and case studies.

TABLE - VI

OPINION OF THE HOSPITAL FUNCTIONARIES AND PATIENTS REGARDING FUNCTIONING OF THE HOSPITAL

S.No	Opinion	Doctors	Nurses	Paramedics	Patients
1.	Good	31.4%	8.5%	14.2%	20%
2.	Fair	45.7%	54.2%	62.8%	39%
3.	Bad	22.8%	37.14%	22.8%	41%

The study revealed that majority of the doctors rate the functioning of the hospital as it exists to be either good or fair while in contrast, in the case of the nurses and paramedics, it tends to drift from fair to bad or improper functioning of the hospital. This shows that the level of satisfaction of these two are comparatively less than the doctors. If compared with the opinion of the patients, majority of them rate the services provided by the hospital to be unsatisfactory i.e.,41% followed by 39% in the category of 'fair'.

Further, opinion regarding the ultimate beneficiary of the hospital services, the category of patients receiving attention, revealed that majority of the patients were treated equally, as opined by the functionaries. While the patients maintained that they were treated equally, yet a substantial number of them revealed that more attention was provided to the persons known to the functionaries of the hospital.

TABLE - VII(A)

ULTIMATE BENEFICIARY - WHO?

S.No	Category of Patients	Doctor's	Nurses	Paramedics
1.	Referral Cases	-	-	-
2.	All are treated equally	51.4%	40%	42.8%
3.	Seriously ill	17.1%	22.8%	28.5%
4.	Known to the functionaries of the hospital	2.8%	5.7%	8.5%
5.	V.I.Ps & higher CGHS employees	28.5%	31.4%	22.8%

As opined by the lot of doctors, nurses and paramedics, the V.I.Ps & higher CGHS employees receive more attention than patients in the general category.

TABLE - 7(B)

ULTIMATE BENEFICIARY - WHO?

S.No	Category of patients	%(Patient's opinion)
1.	All treated equally	40%
2.	Known to functionaries	30%
3.	Serious ones	20%
4.	Economically better off	10%

In most instances, the patients hesitated to reveal the truth as it may bring problems for their treatment in the hospital, yet 30% maintained that more attention was provided by patients known to the functionaries of the hospital.

The data regarding the presence of cooperation among the work-team revealed that majority of the doctors feel there is perfect coordination & cooperation, while patients seem to be very unhappy with the lack of coordination & cooperation by the doctors and paramedics.

TABLE - 8

CO-OPERATION AMONG THE WORK TEAM

S.No	Opinion	Doctor's	Nurses	Paramedics
1.	Perfect coordination and cooperation	60%	37.1%	57.1%
2.	Either of them not cooperative	37.1%	57.1%	31.4%
3.	Depends from person to person	2.8%	5.7%	11.4%

Further, questions were asked pertaining to the probabilities of a serious patient to get hospitalized from the hospital functionaries, which highlighted that in most cases the patient was admitted after preliminary examinations and procedures - doctors (57.1), nurses (42.8%) and paramedics 42.8%).

TABLE - 9

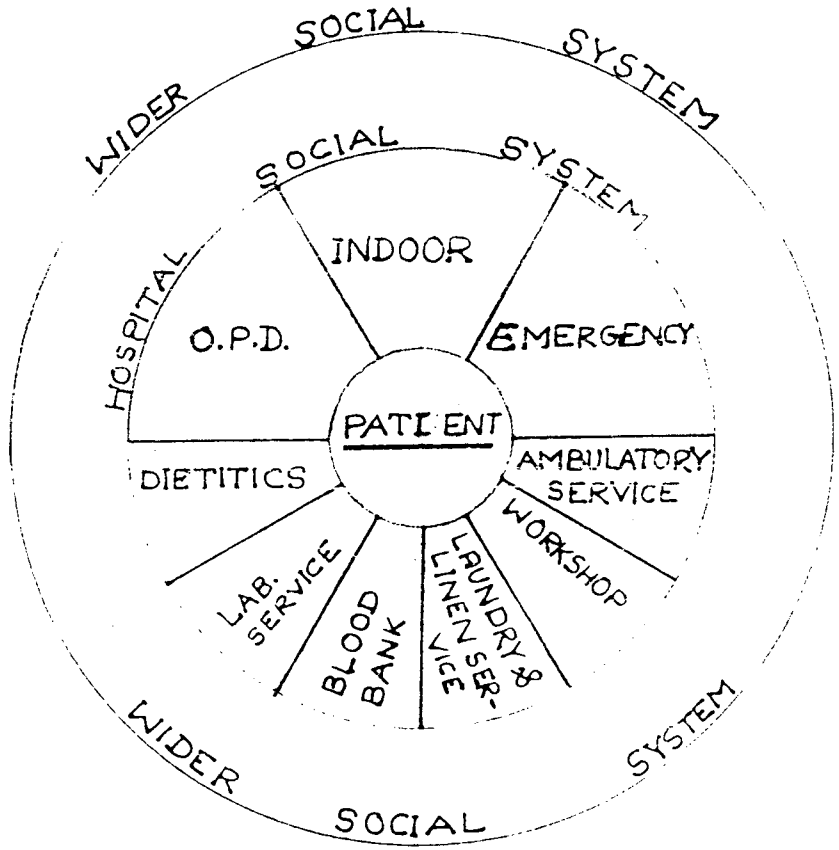
PROBABILITIES OF A SERIOUS PATIENT TO GET HOSPITALIZED

S.No	Opinion Held	Doctor's	Nurses	Paramedics
1.	Admitted instantly	20%	28.5%	22.8%
2.	After preliminary examination	57.1%	42.8%	42.8%
3.	Depending on availability of beds/sometimes not admitted	14.2%	14.2%	14.2%
4.	Alternative arrangements made (two patients on one bed)	8.5%	14.2%	20%

The hospital social system as taken into account by the study focussed on all the sub-systems of the hospital as a complex organisation apart from the authority structure, the pattern of interaction of the functionaries amongst themselves and with the patients as a category. The hospital is visualized as a sub-system of the wider social system comprising of sub-sub-systems.

CHART - VII

HOSPITAL AS A SOCIAL SYSTEM



The present study has given major impetus to the patient population as 'the patient is the pivot around which the whole hospital revolves'. The studies which have been reported till now, majority of them have either not considered the patient as a category or have given it very less importance. The studies have collected data regarding the patients'age, sex, income, religion, place of residence, education, total number of family members, eating behaviour while admitted, and so on. But unfortunately, these studies remained so individualistic and uni-dimensional that each of the studies dealt with only one parameter and inadequately generalized to get an overall picture of the institutional health care practices. And moreover the remained confined to such an extent that no epidemiological or holistic studies were given any thought in the institutional health care. Some scholars, have mainly studied the staff of the hospital besides training of medical students of different years (Madan, Oommen, Venkataratnam). These studies dealt with different staff but no patients were considered seriously to get a true picture of the hospital care system. Moreover, these studies remain incomplete and unidimensional simply because, while studying the complex system they ignore an important sub-system, i.e., patients.

The present study has tried to focus on the patient as most important element of the health care delivery system of the country.

THE PATIENTS

Randomly selected patients from different units and wards of this hospital were posed with a set of questions to cross-check and the information was collected through direct observation as well. About 66% belonged to the rural and semi-urban areas, while 34% belonged to the urban areas. Data collected regarding the occupational background of the patients coming to hospital comprised mainly of government servants, followed by cultivators, daily wage labourers, private-sector employees and business men. The percentages being 30%, 20%, 18%, 16%, and 16% respectively. Most of patients belonged to the lower and lower middle class in case of the general wards while in the maternity-home people were from the so called 'affluent' class. This leads us to the very question, whether the amount of funds allocated to the building of such hospitals is based on the epidemiological considerations and if so, is it really catering to the needs of population whom it should serve?

Patients were taken from all the departments of the hospital, i.e., OPD, indoor, emergency as well as a few from the

nursing home. People with varying degree of hospitalization(i.e. period) were posed with a set of questions, viz. a week (44%), a fortnight (24%), a month (8%) more than a year (4%) and with no hospitalization,i.e.,OPD(20%). Of the total patients interviewed, selected on a random basis, about 32% were referral cases from private practitioners, 36% by a government hospital/dispensary, while about 32% came directly to the hospital. But in majority of the cases, no importance was given to any referrals as reported by the doctors, nurses and paramedics (table 2 (A)).

TABLE - 10 (A)

DIFFICULTIES FACED AT OPD/INDOOR (ADMISSIONS)

S.No	Opinion Held	Response %
1.	Difficulty to get the slips made	16%
2.	Rude behaviour of the functionaries	38%
3.	Arrival at odd hours - no treatment henceforth	16%
4.	No problems faced	30%

In majority of the cases, the patients were faced with the rude behaviour of the functionaries of the hospital, particularly the nurses. About 38% reported of the rude behaviour of the hospital employees, while others due to various reasons could not tell the true thing; due to which, about 30% reported no problems at all; 16% had difficulties to get the slips made and similar were denied any treatment as they came during odd hours, i.e., after the OPD hours.

The similar questions when posed to the functionaries of the hospital, it revealed various problems being faced by the patients - no orientation to the hospital set-up, time consuming, communication gap between the doctors & patient, shortage of drugs, linen & so on.

TABLE - 10 (B)

DIFFICULTIES FACED BY THE PATIENTS WHILE ADMITTED

S.No	Problems Faced	Doctor's	Nurses	Paramedics
1.	No orientation to hospital set-up	14.2%	22.8%	14.2%
2.	Time consuming/delay	8.5%	8.5%	14.2%
3.	Communication gap between doctors and patients	5.7%	11.4%	14.2%
4.	Shortage of drugs	34.2%	37.14%	22.8%
5.	Problem of attendant to stay	8.5%	8.5%	14.2%
6.	Shortage of linen	11.4%	8.5%	14.2%
7.	Rude behaviour of functionaries	-	2.8%	5.7%
8.	No difficulty	14.2%	-	-

As the table indicates, most of the functionaries report of the shortage of drugs which are not available for the patient. The patient, henceforth, has to buy drugs. Hardly any local purchase is made. About 34.2% doctors reported of shortage of

drugs while nurses (37.1%) and paramedics (22.8%) supported the argument.

TABLE - 11

OPINION ABOUT DIET PROVIDED - PATIENTS' VIEW

S.No	Opinion Held	%
1.	Good/properly cooked/ adequate quantity	40%
2.	Not properly cooked	26%
3.	Bring from home	14%
4.	No response	20%

About 40% of the patients held the view that the food provided was good, properly cooked, and was served in adequate quantity, while about 26% held that food was not properly cooked; 14% brought from home as they didn't like the hospital food (Case II). Sometimes food is not supplied in adequate quantity as reported earlier in particular case.

TABLE - 12

OPINION ABOUT DRUGS SUPPLY - PATIENTS' VIEW

S.No	Opinion Held	%
1.	All medicines available	30%
2.	Purchase sometimes	44%
3.	Purchase always	26%

Most of the patients reported that the medicine have to be purchased sometimes, when not available in the drugs store (44%) while others maintained that drugs have to be purchased always, by them (26%). About 30% of the patients held the view that all the medicines are available in the hospital, while in some cases, acute shortage of drugs have been reported, leading to detrimental effects on the health of the poor patient who is unable to buy the drugs (Case III).

TABLE -13

LABORATORY SERVICES - PATIENTS' VIEW

S.No	Opinion Held	%
1.	Quite efficient	60%
2.	Reports get misplaced	40%

About 60% of the cases reported of quite efficient laboratory services while 40% reported of non-efficient services, leading to the reports getting misplaced. It would be essential to highlight a case to show the state of services of laboratories in the hospital.

Case V _ Mr. A, from very poor family coming from a village in the outskirts of the capital of Delhi, found his reports to be missing on the OPD day. When he asked from the sister incharge, she sent him to the concerned laboratory (bio-chemistry) where he was directed again back to the OPD. The whole morning he kept wandering in the hospital, by the time, OPD hours were over. The investigator met the person and directed him to the incharge of laboratories room from where he could get a duplicate report made.

TABLE - 14

SUPPLY OF LINEN - PATIENTS' VIEW

S.No	Opinion Held	%
1.	Adequate/charged frequently	30%
2.	Less supply/charged after a week or so	50%
3.	No response	20%

Of the patients interviewed, about 50% reported of less supply and hence the linen was not changed frequently in most of the cases. Though the functionaries reported of adequate supply, yet the patients faced problems regarding supply of linen. Only 30% revealed that the linen was changed quite frequently. The state of affairs in relation to the linen supply was evidenced by the fact that in majority of the cases, the patient used his own bed sheets brought from home.

Ambulatory services are one of the main prerequisites for an efficient working casualty as well as for the rest of the hospital functioning. Yet, in this hospital (R.M.L) out of the thirty ambulances available only three were in the working order. Only 10% of the patients were aware about this facility and

thought it to be efficient. About 44% of the cases did not use the services. While 20% were ignorant about its existence. 26% of the patients reported that ambulatory services were available with a lot of difficulties and sometime it is also non-available.

TABLE -15

AMBULATORY SERVICES - PATIENTS' ATTITUDE

S.No	Opinion of Patients	%
1.	Used/quite efficient	10
2.	Not used	44
3.	Ignorant about the facility	20
4.	Availability with difficulty/not available sometimes	26

Though, general sanitation in most of the wards of the hospital seemed quite all right during the morning rounds of the consultants, yet, throughout the day, cleanliness was not maintained in some wards especially the surgical and neuro-surgical wards.

TABLE - 16

SANITATION OF THE WARD - PATIENTS' OPINION

S.No	Opinion of Patients	%
1.	Quite neat and clean always	30
2.	Cleaned during morning rounds	40
3.	Dirty mostly	30

(40%) Majority of the patients maintained that wards were cleaned thoroughly before the rounds of the consultants, senior doctors and following that, not much attention is been put regarding cleanliness of the ward. About 30% maintained that the wards remain neat and clean and the similar percentage reported it otherwise.

When counter checked by the hospital functionaries (including doctors, nurses and paramedics) regarding the difficulties they face while treating or managing a patient, majority of the doctors maintained that the patients were quite cooperative (71.4%) while in the case of nurses, they tend to be partially cooperative (48.5%). majority of the paramedics (65.7%) also had a positive response regarding the cooperativeness of the patient in the treatment process.

TABLE - 17

DIFFICULTIES IN TREATMENT - WHETHER PATIENTS ARE COOPERATIVE

S.No	Opinion	Doctors	Nurses	Paramedics
1.	Cooperative patient	71.4%	37.1%	65.7%
2.	Partially cooperative	22.8%	48.5%	17.1%
3.	Sometimes non-cooperative	5.7%	14.2%	17.1%

Further opinion of the functionaries regarding the treatment of the poor patients eventually revealed that a majority of them maintained that no discrimination was made regarding routine OPD cases as well as the serious ones - doctors (85%), nurses (57.1%), paramedics (65.7%). Though it was seen quite frequently that the VIP cases were allowed to ignore the queue system and go straight away to the concerned doctor without any waiting time.

TABLE - 18

POOR PATIENTS - THEIR TREATMENT

S.No	Opinion	Doctors	Nurses	Paramedics
1.	No discrimination in routine OPD cases and in serious ones	85.7%	57.1%	65.7%
2.	Economic & political influence matters	14.2%	42.8%	34.2%

When enquired as to whether, knowing a functionary of the hospital helps in getting treatment in the hospital, majority of the functionaries maintained that it helps though in contrast, earlier they held that no discrimination was made regarding patients.

TABLE - 19

DEGREE TO WHICH KNOWING A FUNCTIONARY HELPS

S.No	Opinion	Doctors	Nurses	Paramedics
1.	Always helps	48.5%	42.8%	28.5%
2.	Sometimes	25.7%	34.2%	42.8%
3.	Not necessarily	25.7%	22.8%	28.5%

From the time a patient entered this hospital and got treatment, the impression he got, attitudes he developed regarding the hospital personnel and treatment would determine whether the patient would come for follow-up or not. In majority of the cases, the patients opined that they would come back to the hospital for follow-up (62%). While 22% revealed that they would go back to a private practitioners nearby their place of residence, about 16% gave no response. (refer table 20)

TABLE - 20

REHABILITATION AND FOLLOW - UP - PATIENTS' VIEW

S.No	Opinion	%
1.	In case of any problem, come back for follow-up	62
2.	See some private practioner	22
3.	No response	16

Another study[4] conducted in the same hospital in 1974 revealed that in the emergency services provided by the hospital, there is absence of policies and procedures, poor system of recording, absence of social services and added to it poor referral system. Though, major facts remain even till today yet now social service department has come into being though there is hardly any coordination amongst the social workers present.

Further, another study conducted by NIHAE[5] regarding the laboratory services provided by R.M.L.Hospital revealed that

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4. Anand, R.C. (1974), Comparative Study of Emergency Services in Three Large Delhi Hospitals. (M.D.Thesis), New Delhi, NIHAE.

5. NIHAE (1975), A Study of Laboratories of Willingdon Hospital Research Repor Series, No 26, New Delhi, NIHAE.

there was increase in quantum of work with more work load per head though seasonal & day to day fluctuations in work load remained leading to about 83 tests/100 patients in the OPD to about 63/100 patients in the indoor cases. Further about 27% (also present study table 13) cases were refused after the scheduled time. Further a long waiting time for the patient and the issue of duplicate records was highlighted.

The findings of the present study can be summarized as follows : -

Problems of the Patients regarding Laboratory Services - It was seen in most of the cases that it was difficult to locate the registration desk and laboratory for the patient. When the cases are refused back, it is difficult for the patient to come again the following day, specially the long distance cases. Sometimes the reports are not available and it becomes quite difficult to locate them. Time for the collection of the specimen is very limited, furthered by absence of adequate number of collection counters.

Personnel - A lot of latent conflict is present amongst the junior residents and the senior consultants as they are not given importance in the treatment plan by the seniors. Further the number of ancillary workers like sweepers, nursing orderlies & stretcher-bearers, allocated to the casualty specially are

inadequate and it is further reduced by using them for calling specialists etc. The staffing pattern, staffing strength of the nurses is very inadequate as pointed out earlier in the case study of the hospital, leading to too much work-load and rude behaviour towards the patients at large.

Drugs - Drugs are always in shortage, most drugs have to be purchased. Hardly there are instances where local purchase was made except in the case of life saving drugs. In the case of poor people who can't buy medicines, some substitute available in the hospital is provided which sometimes is not so effective. (Table 12) In emergency, systematic emergency tray system does not exist.

Linen - Linen supply is in-adequate with the result, the bed sheets and other linen appears to be dirty. In actual no reserves of linen supply are maintained by the sisters. (Table 14) sometimes the soiled sheets are found lying in the ward abandoned, yet, the sister doesn't send it for washing frequently.

Ambulance - Most of the times, it is not available as very less are in working condition and two are used for school of nursing. It is used for official purposes sometimes. The ambulance is used by staff members to get doctors on call duty or leave staff

at his residence. As a result the ambulance service not readily available for needy patients. There is no internal communication system between the CMO and ambulance driver, with the result a messenger has to be sent every time for the driver.

Policies and Standing Orders - Policies not progressive in nature. They are unwritten & exist as conventions. Staff including doctors and nurses are normally not aware of procedures and regulations governing them. Written department procedures and standing orders need to be supplied to each officer. There does not exist, a planned system of orientation programme of in-service training of any category of the staff.

Records - Records not maintained satisfactorily except for medico legal cases. There does not exist a system of preparing statistical report separately in casualty department. (also refer to ch. 4)

Inter - Departmental Relationships - It appears to be strictly a routine. No efforts are made to develop coordinated working relations between the clinical, diagnostic and emergency services. Hardly any discussions are held to sort out mutual problems.

Casualty Services - In the present state of great pressure on hospital beds, patients who in ordinary circumstances would have to wait for long time for admission through normal channels of OPD, get admitted masquerading as emergency. Moreover patients and their relatives sometimes exaggerate their condition to get admission as a result, thereof, a genuinely critical patient is many a times, deprived of getting prompt and quick attention.

Further, when the patient comes to emergency, no stretcher is available, delay in seeking doctor's attention, furthered by drugs not available. The doctor would look around for a nursing orderly to fetch medicines. But he is not available, when most needed.

Interaction Pattern - As highlighted earlier, the pattern of interaction between the patients and the hospital functionaries tend to be quite stringent as the functionaries, especially, behave very rudely with the patient. The patient is not able to communicate all his complaints to the doctor as there exists a communication gap.

Nurses tend to be very rude with the patients (Case V ch.4). Sometimes the patients wants to know about the treatment given to him but is discouraged by the doctors as well as the nurses. The doctors speak in English usually which sometimes put the patient

into a lot a queries which remain unanswered. Sometimes, non-availability of the doctor, also, leads to a lot of problems. (Case II, ch.4) Further, the interaction sequence can be evidenced when we have a look on the tables 10(A) and 10(B).

Further, the paramedic staff is not cooperative with the patient, specially in the laboratories, wherein the patients is made to run from OPD to the laboratory and vice versa, if the reports get misplaced.

Case VII - Mrs X was shunted who with her two children waited in the queue for long time to get her slip at the OPD, by the registration clerk, stating that she is exaggerating his illness and does not need any medication.

Case VIII - Mrs. Y was treated very badly by the nurse incharge in the Gynae ward as it was her fourth pregnancy. The nurse literally abused her for having a fourth kid. Poor lady didn't know what to say as her's was a case where the husband was a drunkard & literally beat his wife everyday.

Both these cases show the misbehaviour of the staff towards the patient. Further in case of physiotherapy, a lot of time was spent just waiting for the turn to come.

Class IX - Mr. A had to come for physiotherapy everyday at 11 a.m. for which he had to start from his village early in the morning as there was no other bus later. He had to sit idle till 11 a.m. from 8 a.m. as the clerk & the sister in-charge refused to change his timings to 9 a.m. in the morning.

Patient thus is eventually faced with this unkind behaviour by the hospital staff, though exceptions exists, wherein mainly some doctors nurses and paramedics turn out to be really kind to patients, specially, who are old, poor and usually come from far-flung areas.

Not only there is communication gap between the hospital functionaries as a category and patients but also amongst them (i.e., among the doctors in various departments, nurses and the paramedics). A person in one department doesn't really know, what is happening in the other parts of the hospital. Hardly any direct communication is maintained. Further, amongst the doctors too hardly any seminars, discussions are held to share their findings about the functioning of the units/wards or hospital at large. Lack of coordination and cooperation amongst the hospital staff and amongst the various units affects the functioning of the hospital as a complex system. (refer to ch.4.)

OTHER LOGISTICS INVOLVED

As seen in other studies conducted (ch.3) on the institution of hospital, not much attention has been focused on the patient. Though in some studies peripheral attention has been provided to the patients, yet, not much reference is made to that fact that what is the kind of treatment a patient receives in the hospital? What it really means for the patient to be in hospital? Does he feel that he is alien to the culture of the hospital? What is the kind of treatment he eventually gets when he comes to the hospital?

The communication gap between the providers of health care and receivers of health care should be filled up. The doctors should be aware about the health culture of the patient to provide more meaningful health services to him. Though connoted as a social institution, the hospital tends to be - not a social institution, as it is not up to the needs of the people at large. The hospital should be a community institution serving the community at large not confined to a limited strata of the population.

The health needs of the people are related to the community social structure and would change according to changes observed in it. The health behaviour of an individual to a large extent

will be determined by the attitude, motive and normative pattern often influenced by the social, psychological, cultural and economic factors operating within the social structure of the community or society. The notion of health, as perceived by the people, will affect the motivational aspects related to health care. The delivery of health care system has to be determined by the health expectations of the people and these are also influenced mostly by the social, cultural, economic and situational factors within the community.

The issue henceforth is to see whether hospital is a community institution, i.e., how does the hospital came into being within a community? How does community considerations come in hospital planning? What is the process of development of linkages between the hospital and the community and what is the role of the hospital to development of new linkages?

The approach of primary health care envisages that a hospital becomes responsive to the community within which it is located. A hospital henceforth, is required to become a community institution, i.e., change in the relationship of technology, and a community, to respond to the needs of the community.

The case of R.M.L.Hospital ceases to be a community institution in proper sense - too much of bureaucratization and overmedicalisation as reported in the studies, prevails to some extent here also. Though importance should be given, to peripheral cases yet no attention is provided, to maintain linkages with the community at large.

RAM MANOHAR LOHIA HOSPITAL : A SOCIAL INSTITUTION

Questions were raised in this study whether R.M.L.Hospital being a government - run hospital is functioning in a integrated manner or a fragmented institution catering medical care to the patients. In a hospital all the functions revolves around the 'patients' but here the patients coming to this hospital are found to be from various socio-economic background and from different walks of life. Because of their different social background they possess different values, social norms, ideologies, beliefs, customs and their overall way of life, i.e., their culture also differs. These variations of culture, their health problems are found to be different and they seek health care getting hospitalized in this hospital. Being a patient, suffering from different ailments they are no longer the 'normal person' but having pains, anxieties to get relief from the sufferings. The fellow relatives accompanying the patients to the hospital as attendants carry their cultural life process

to the hospital and interact with the doctors, nurses and para-medical staff for the treatment of their patients.

The personnel of R.M.L.Hospital like the specialists, general doctors, nurses, paramedics and class - IV employees also are from different socio-economic background and like patients, they also possess their own cultural values, social norms, beliefs and ideas. These varieties of cultural groupings come together and interact in the hospital which has also of its own organisational culture. Because of the diversified cultural groupings, the organisational culture of the hospital doesn't become an integrated whole rather a variety of conflicting situations have been observed between doctor and patients, class IV employees and patients as well as doctors and nurses, nurses and paramedics, doctors and paramedics, doctors, nurses, and the class IV employees. It has also been observed in R.M.L.Hospital that these conflicts and differences get aggravated with the help of different associations (doctors association, nurses associations, paramedics association and karamchari association). No doubt the grievance - redressal procedure of the hospital and the role of management frequently takes care of these conflicts but, by and large, the root cause of these conflicts remain at the various cultural level. This requires to be understood by the social scientists who can study this into greater details and identify these conflicting forces operating in this hospital in

order to fragmentize the integrated process of functioning of this hospital. No doubt R.M.L.Hospital has different complex sub-system but as a social institution having all characteristics of a stratified society, it can function as an integrated community hospital by plucking this conflicting cleavages.

CHAPTER VI

ISSUES AND PERSPECTIVES

In the process of evolution of modern health services hospitals have by far the most status, prestige and political clout in the health field. Too much time - and money - is wasted in hospitals at present on patients who could quite adequately be cared for outside the hospital - at home or at neighbourhood health centres. This clout supports the Alma Ata Conference which has put into motion national and international efforts to formulate strategies for achieving health for all by the year 2000 A.D through primary health care. By defining primary health care and by characterising the kind of health system needed to make primary health care its central function and main focus, Alma Ata has shown the way to converting the dream of health as a basic right of all to a reality. The primary care movements will only succeed if it can enlist the support of the hospitals. Alma Ata called on hospitals to review their methods, techniques, equipment and drugs.

All hospitals form an integral component of the health service system, decisions concerning hospitals get linked with the wider decisions concerning health service development. Moreover, the philosophy of primary health care introduces some additional dimensions to this approach. The primary health care

approach envisages that a hospital becomes responsive to the community within which it is located. It is required to become a community institution. This calls for a basic change in its traditional "culture". This does not imply that it will cease to offer high technology services and that there would be a decline in the status of those who provide high technology services. A basic change in the culture of a hospital implies essentially a change in the relationship between technology and community.

The members of a community perceive a hospital in two different ways : (a) as a source of liberation from suffering caused by ailments of various kinds; (b) as an awe-inspiring, forbidding, mystifying and culturally alien institution.

In this relationship between a hospital and the community it serves to form the most dominant feature of the changing role of hospitals in the context of primary health care. These changes call for many changes in the internal functioning of a hospital. Starting as an inward looking, market dominated, technology - oriented institution, a hospital opens itself to the community to respond to its requirements bringing about the necessary reorientation in its technology and in its organization and management.

Historically, it has been found that hospitals built on the western model brought little or no benefit to the large mass of the Indian people, especially the rural masses. Indeed, by diverting the scarce resources to building and maintaining sophisticated hospitals, principally meant for the privileged, they did positive harm by leaving nothing for development of community medical care.

Considered as a whole, the entire complex of patients and hospital form a social system within a hospital system. Social sciences competence is needed to understand boundaries, content, function and dynamics of change within the system and to determine the strategy for intervening in this system to change it in a desired direction.

Apart from the above considerations, studies of organizational behaviour and human relations have given limited inputs for improving the management of different hospitals. Study of the process of socialization and training of personnel in the "culture" of a hospital is yet another important field. But socialization studies have also not contributed holistically in order to build up the education and training of health workers in the desired way.

Teaching hospitals also provide the very wide field of social science studies concerning education and training of health personnel. So far the studies carried out earlier on other hospitals which have other major programmes of medical care had suffered from inadequate findings on the health behaviour of different patient communities in the context of their cultural perceptions and cultural meanings of health problems and the degree of access to the services provided by the hospital.

The present study on R.M.L.Hospital in Delhi is a departure from the earlier one because it has raised a few basic questions: How does a hospital come into being within a community? What are its linkages with different segments of a community? How does community considerations come in hospital planning? What is the process of development of linkages between the hospital and the community and what is the response of the hospital to development of new linkages? In this study an attempt has been made to answer to such questions and to find out how much R.M.L.Hospital had given importance to the community feltneeds as a social institution.

R.M.L.Hospital being a large govt hospital in Delhi is found to be an institution which provides a long range of technological services having its own norms and procedures (such as OPD, diagnostic procedure, surgical operation and other treatment

regimens). It has also been seen a very frequent tendency to add an overcoating of mystification to these services just to impress the patients and the general public. Because of this, patients are found to put up with certain additional inconvenience, during the stay in hospitals. Apart from the element of mystification, alien norms and procedures that are required for providing technological services, R.M.L.Hospital was found to be no-way different from western - industrial - medical culture.

The patients in R.M.L.Hospital coming from different cultural context find this hospital to be an institution which has a culture giving primacy to the upper sections of the society who come as a "V.I.P. patient", to this hospital. For the cause of primary health care the entire R.M.L.Hospital system, physician, nurses, administrative and other staff will have to face the formidable cultural challenge to make this hospital a meaningful social institution which will provide more deprived sections of the community, a desired community health service.

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CHECK LIST - I

(For Hospital Functionaries)

Appendix - I

1. Name of Specialist/Physician/Nurse Unit/Ward.

2. Since when you have joined

3. What is opinion about the functioning of the branch

4. How is your branch/unit/ward placed in the hospital

5. What is your opinion/experience about the overall functioning of this hospital - OPD/any ward/emergency

6. Who are the patient get maximum attention in this hospitals

7. Do you think it is difficult to get hospitalized for any patient with serious ailments.

8. Do you get co-operation in your workplace from your Seniors/Subordinates (Nurse, Paramedics, Junior doctors)

9. Do you face any difficulty in treating the patients and do they follow your instruction and suggestion ?

10. What is your opinion about the poor patients and their treatment ?

11. What kind of difficulties these patients encounter while admitted to this hospital ?

12. What do you suggest to solve these problems ?

13. Do you feel that the patients should gave known some functioning here to get better treatment ?

14. What do you suggest to improve/streamlining the functioning of this complex hospital/unit ?

15. Any special instance/experience ?

CHECK LIST - II

(For the Patients Only)

Appendix - II

1. Name of the Patient

2. Unit where he was placed. OPD/ward/emergency/Nursing Home/Private Ward.

3. Address - Rural/Urban:

4. Occupation:

5. Since where he has been hospitalized:

   i) What is the ailment ?

6. Who has asked him/her to come to this hospital ?

7. Was he/she a referral case ? If so from where ?

8. Any difficulty faced at OPD ? If so what kind ?

9. Any difficulty faced at the time of admission, what kind

10. Any difficulty faced while on the bed -

11. What do you think about the functioning of : -

i) Doctors

ii) Nurses

iii) Paramedics

iv) Diet

v) Medicine

vi) Laboratory services

vii) Linen

viii) Ambulatory Service

ix) Sanitation of the Ward

12. What do you suggest in solving these problems ?

13. What is your opinion about the post-operative care ?

14. What do you think about your rehabilitation and follow up of treatment outside the hospitals ?

15. Did you purchase medicine while admitted in the hospital. Why?

16. Who gets maximum attention as a patient in the ward ?

17. Any case/experience in detail through which you like to demonstrate the malfunction of this hospital.

18. What suggestion do you like to offer to improve the service conditions of the hospital ?