Summer Training Report

A systematic review of the literature : Violence against doctors in India

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The purpose of the summer training report is to be familiar to the practical aspects and use of knowledge to clarify the career goals.

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ACRONYMS/ABBREVIATIONS

BBMP = Bruhat Bengaluru Mahanagra Palike

ASHA = Accredited Social Health Activist

OT = Operation Theatre

ICU = Intensive Care Unit

GDP = Gross Domestic Product

MeSH = Medical Subject Headings

PMC = PubMed Central

WPV = Work Place Violence

ED = Emergency Department

WHO = World Health Organization

ILO = International Labour Organization

COVID-19 = CO for corona, VI for virus , D for disease

PART 1

1.INTRODUCTION

According to World Health Organization, about 8–38% healthcare workers suffer physical violence at some point in their careers . Incidences of violence against doctors are increasing in India since the last few years. Violence against doctors can occur in different forms such as physical, verbal abuse and threats, cyber bullying, mob lynching and blackmailing. The violence faced by the medical profession is one of the highest among different professions in the country. In a country like India where doctors are given divine status such rising cases of violence are the matter of concern. "The Indian Medical Association has reported that 75% of doctors face verbal or physical abuse in hospital premises and fear of violence was the most common cause for stress for 43% doctors." The reasons for increase in violence includes – limited investment of healthcare in India, large share of private healthcare in India, low level of health education, violation of the image of doctors by media and many more (Nagpal N) . Such incidences have resulted in stress, anxiety, frustration, and fear among the doctors.

The recent incidents happened across the country gathered the attention of the government and the citizens of the nations where doctors are attacked across many parts of the nation. The doctors who went to help patient suffering from Corona virus were attacked and chased after in various parts of the country . The first incident of attack on doctors helping COVID-19 patients occurred at Indore . The doctors were attacked with stones and bricks in the area. (Choukse,2020). In Bareilly , a team of cops and doctors were attacked with pelting stones when they went to take away the brother of a deceased corona patient into the quarantine facility. The doctors suffered various injurious as the result of attack by the angry mob. A similar case occurred in Bengaluru, The BBMP team of doctors and ASHA workers had gone to Padara to take contacts of the corona patients to a public quarantine facility. (TNN, 2020)

Under the wake of such incidents the government recently cleared an ordinance which comes as a sigh of relief for the whole medical fraternity. The ordinance brings stricter punishments against the violent against doctors. The amendment in the Epidemic Diseases Act, 1987 through an ordinance to ensure the safety of doctors at a time in the case of attacks on them. It stated stringer fines up to 5 lakhs and imprisonment of 6 months up to 7 years. (Azad, 2020) The offense will be non bailable and requires fast track judgement. The offender will also be liable to pay compensation to the victim and twice the fair market value for damage of property.

The fact that the problem is of grave nature cannot be neglected. Proper measures on the part of the government, the society , and doctors as a huge can only help curb this issue.

DEFINITIONS

Violence : (definition by ILO) "The intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community, which either results in or has a high likelihood of resulting in injury, death, community, which either results in or has a high likelihood of resulting in injury, death, physiological harm, maldevelopment, or deprivation."

The health sector workplace is defined as: "Any health care facility, whatever the size, location (urban or rural) and the types of service(s) provided, including major referral hospitals of large cities, regional and district hospitals, health care centres, clinics, community health posts, rehabilitation centres, long-term care facilities, general practitioners' offices, other independent health care professionals. In the case of services provided outside the health care facility, such as ambulance services or home care, any place where such services are performed will be considered a workplace."

Framework Guidelines for addressing Workplace violence in the health sector published by the ILO and WHO: "Workplace violence covers a spectrum of unacceptable behaviours. It includes incidents where staff are abused, threatened, discriminated against or assaulted in circumstances related to their work, including commuting to and from work, and which represent a threat to their safety, health, and well- being."

Boyle and Wallis proposed the following six definitions, (2:4)

Bullying - "Bullying is a person's perception of repeated negative acts such as harassment, intimidation, exclusion, isolation, hostility, character assignation and constant criticism."

Verbal abuse - "Verbal abuse is a person's perception of being professional and personally attacked devalued or humiliated via the spoken word."

Threat - "Threat is a person's perception of an intention to inflict personal pain, harm, damage, disadvantage, or psychological harm."

Physical Abuse - “Physical abuse is a person’s perception of an unwelcome or uninvited action that involves physical contact with a person with the intent of causing physiological, emotional and bodily harm.”

Sexual harassment -“Sexual harassment is a person’s perception of a sexual prepositioning or unwelcome sexual attention. This can include behaviours such as humiliating, offensive jokes, stories, remarks or voyeurism with sexual overtones, suggestive looks or physical gestures, exposed genitalia, gifts of a sexual connotation or requests for inappropriate physical examinations, pressure for dates.”

Sexual Abuse -“Sexual abuse is a person’s perception of an unwelcome or uninvited action that involves physical contact of a sexual nature.”

Physical violence - “Physical violence is defined as any physical force against another person or group that results in physical, sexual or psychological harm. This includes beating, kicking, slapping, stabbing, shooting, pushing, biting and pinching.”

Definitions given by Jessica L Taylor and Lynn Rew

“‘Physical abuse’ refers to physical assault, beatings, punching, kicking, biting, spitting, or any form of physical aggression.

‘Verbal abuse’ refers to threats of violence without actual

physical contact, threatening or harassing behaviours, emotional abuse and emotional aggression.”

2.RATIONALE

Based on the evidence of violence and its consequences on doctors due to Recent incidents of violence against the doctors during the Corona pandemic where the doctors were attacked by mob with stones ,bricks and suffered various injuries gathered attention of the whole nation towards the seriousness of the issue. The study is trying to identify the causes of the incidences of violence on doctors, the various types of the workplace violence in hospitals and the impact of such incidents on the doctors.

After the rise of such incidents throughout the country . The government approved of the Epidemic disease (amendment) ordinance, 2020. The amendment states that any commission or abetment to acts of violence shall be punished with imprisonment of three months to five years and a fine of ₹50,000 to ₹2 lakh

3.RESEARCH QUESTION

Research question 1 – What are the level of incidence of violence on doctors at workplace in India ?

Research question 2 – What is the impact of violence on the doctors ?

OBJECTIVES

Objective 1 – Assess the level of incidence of violence on doctors at workplace.

Objective 2 – Assess the impact of violence on the doctors.

DESIGN –

Systematic literature review.

4.METHODS

The search strategy was to get literature review from online search databases – Pubmed, MeSH databases, PMC articles and ePub. the keywords used are violence, doctors, India, abuse and bullying.

The search was designed and conducted with the search strategies from the last five year that between 2015 to 2020 and used the combinations of key words. A range of different keywords were used to diversify the search results. Additionally, Google search engine was used using the search words. The language used for the search results is English and google scholar articles were reviewed.

Exclusion/inclusion criteria

The language for the inclusion of articles is English. All the articles that are not written in English were excluded. All articles that are included were original research conducted with different research designs and methods in India Between the year 2015 and 2020 .

For the research to be included in the review, the primary aim and objectives of the study should be focused on WPV, the effects of the WPV and the prevention of the WPV.

In the case of numerous publications from the same study were

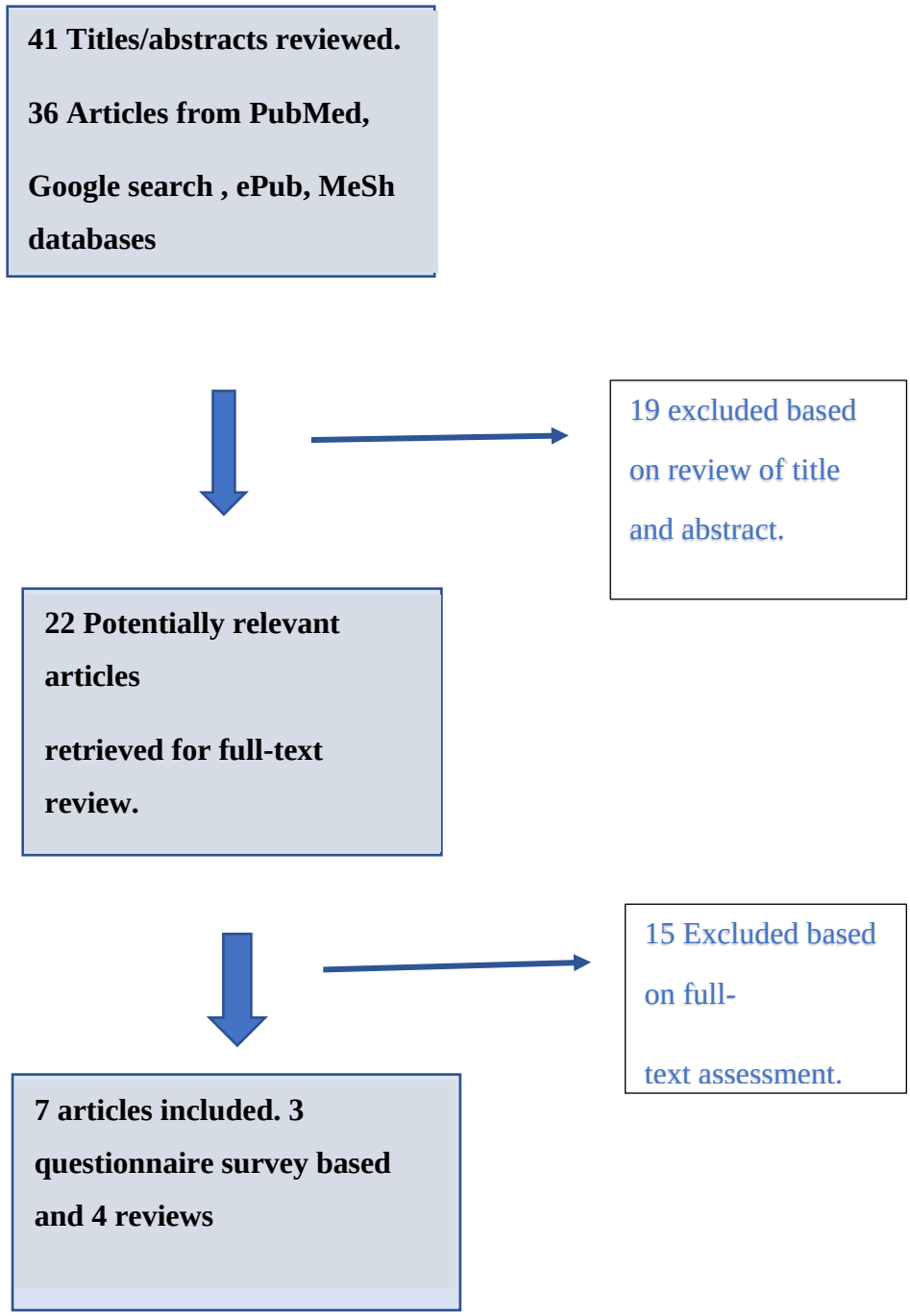
found, the one with the most amount of significance and adherence to the issues were included.

The other publications of findings from the same research study contributed significant new information and/or findings specifically about WPV in the ED, they were included in the review and treated as separate studies.

There were also several reasons for the exclusion of articles. The articles which are not contributing directly to the study were excluded.

The articles which were not accessible were also excluded from the review.

An exception is made with the study published in 2009 which is a systemic review of literature: workplace violence in the emergency department by Jessica L Taylor and Lynn Rew. This study is included because of the lack of systemic reviews on the topic .



Flowchart based on the study selection process

5.RESULTS

Seven articles are included in this literature review. The majority of the studies are qualitative, and others are descriptive in nature. The methods used in the descriptive studies are the self-questionnaire surveys.
The qualitative literature focused on analysing the main reasons for the violent incidents, the prevention measures for the same.

The questionnaire is used in the hospitals to investigate the number of violence incidents in the hospitals, the perceived threat to the doctors and the impact of the incident on the well-being of the doctor. One of the studies that used the questionnaire based surveys is conducted by Anand, T., Grover, S., Kumar, R., Kumar, M., & Ingle, G. K in a tertiary care hospital in Delhi

And the second is done by the Kumar NS, Munta K, Kumar JR, Rao S , Dnyaneshwar M, Harde Ywho conducted a Survey on Workplace Violence Experienced by Critical Care Physicians.

A multi centric cross sectional study is done by Singh G, Singh A, Chaturvedi S, Khan S (2019) in government medical colleges of Uttar Pradesh from November 2017 to January 2018**.**
Four of the studies are focused on the causes of violence. The main causes of violence are found as Poor image of doctors and the role of the media, Meagre health budget and poor quality healthcare, Vulnerability of small and medium healthcare establishments ,Lack of faith in the judicial process ,Mob mentality, Low health literacy , Cost of healthcare ,Poor communication and the Lack of security. The main causes of violence are identified as the image of doctors the role of media medical Institution

three of the studies focused on prevention of violence. The main measures to prevent the violence are the steps by the government by doctors such as documentation, consent, not overreach , alertness and communication. The role of the media, the government, the Institution and all of the doctors are identified as the means to prevent the violence against doctors in most of the studies.

Two studies discussed about the impact of the violence on the doctors and their mental health and well being .

One study provides the definition of the workplace violence

In most of the studies the lack of communication is identified the important cause of violence

The studies revealed that there are various impacts of violence in the wellbeing and mental state of the health of the doctors such as stress, insomnia, job dissatisfaction, lack of confidence. The doctors are recognized as the profession working in the one of most stressful work conditions

One of the research papers identified that the highest number of violence incident close to 50% occurs in ICU and 70% by the relatives and attendants.

The study by Siddharth P Kar states that each state has a right to connect with its own laws regarding the doctors' safety. 2015 survey of IMA suggest that 70% have face some form of violence at work

MAJOR FINDINGS

The studies included in this literature review focus on providing an important understanding into the violent incidents against doctors , the main reasons behind the criminal acts as well as the methods of prevention **. Ambesh (2016)** , stated that the problem is multifactorial in origin. "With the rise of corporate hospitals, the mentality of physicians has changed from a charitable to a lucrative one. Trust in the doctor–patient relationship has taken a beating over the last few decades." Government hospitals in India follow the welfare model, as majority of people are poor and lacking health insurance. **Most violent incidents (approximately 50%) are found to occur in ICU and almost 70% by relatives of patients**. Miscommunication by physicians, lack of adequate security personnel, no laws for the protection and safety of the medical community add to the cause of the problem.

The literature review consists the descriptive studies conducted in hospitals in various departments using surveys. **Anand T, Grover S, Kumar R, Kumar M, Ingle GK (2016)** , conducted a study among doctors working in a **tertiary care hospital in Delhi** by using a self-administered questionnaire containing items for assessment of workplace violence against doctors, its consequences among those who were assaulted, reporting mechanisms and perceived risk factors. Total 169 respondents were included in which 104 (61.4%) were men. "**Sixty-nine doctors (40.8%)** reported being exposed to violence at their workplace in the past 12 months. However, there was no gender-wise difference in the exposure to violence (p=0.86). The point of delivery of emergency services was reported as the most common place for experiencing violence. **Verbal abuse was the most common form of violence reported** (n=52; 75.4%). **Anger, frustration and irritability were the most common symptoms**

experienced by the doctors who were subjected to violence at the workplace. **Only 44.2%** of doctors reported the event to the authorities. **'Poor communication skills'** was the most common physician factor responsible for workplace violence against doctors."

The grave problem is identified not a national issue but as a global pandemic . There are incidents reported in various parts of the world including US, China, Nepal, and Bangladesh.

The definition of workplace violence is identified in the review. Kumar NS, Munta K, Kumar JR, Rao SM, Dnyaneshwar M, Harde Y (2019) defined workplace violence as "violent acts including physical assault and threats of assault directed towards personnel at work or on duty".

They conducted a questionnaire-based survey on 160 delegates and Maximum responses (84%) received were of age group 20–40 years. The results were : **Seventy-two percent respondents experienced WPV** during their work hours. Most common type of violence reported was **verbal violence (67%). Sixty-five percent respondents reported that poor communication was the leading cause of WPV. Due to WPV, most of the respondents (60%) had to change their place and pattern of work. Proper communication (76%) was the most common measure** among multiple measures suggested by respondents for avoiding WPV. **Eighty-three (98%) respondents opined that conflict management should be part of regular curriculum in medical education**

Singh G, Singh A, Chaturvedi S, Khan S (2019) conducted a multicentric **cross-sectional study in government medical colleges of Uttar Pradesh from November 2017 to January 2018**. Eligibility for the study was All resident doctors working for at least 1 year in the hospital from all clinical departments .305 doctors participated in the study. A self-administered questionnaire is used.

Out of total 305 resident doctors participated in the study, 98 (32.1%) were female and 207 (67.9%) were male. Nearly 87% have witnessed WPV in the past 12 months. Thirty percent said that they have witnessed violence several times in a month. 69.5% of resident doctors reported to have experienced violence in one or other form. It was observed that out of 212 participants who were victims of violence, 70% were exposed to verbal abuse, followed by physical (47.2%) and threat (20%). The most common place of violence was emergency department (ED) (68.4%) and wards (30.1%). On further analysis, no department-wise difference was found. Incidents occurred during day (43.4%), evening (42.3%), or night

(48.1%). In most incidents, relatives and attendants (69.3%) were involved in violence. **The participants stated that in most instances (35.3%), no action was taken immediately about violence**. Some of immediate actions were **verbal warning issued to perpetrators, incident reported to police, and care given to patients** discontinued. In none of the cases, an aggressor was prosecuted. Sixty-five percent of doctors said that the incident could be prevented and 85% felt that dissatisfied the way incident was handled. **Half of the respondents stated that it was useless to report the matter**. **60.3% of study participants reported that they had repeated disturbing memories, thoughts, or images of the attack.**

Neeraj Nagpal (2017) is an excellent exemplar who conducted a research and found that Violence against doctors in India comprises of intimidation, verbal abuse, physical but non injurious assault ,physical assault causing injury: simple and grievous, murder, vandalism and arson Doctors facing violence have been known to go into **depression, develop insomnia, post-traumatic stress and even fear and anxiety causing absenteeism** in the UK; a similar situation likely prevails in India.

According to Kar S P, 2017, each state of India has the right to enact its own laws of healthcare which means that each state has the rights to modify the laws according to the situation. An incidence which took place in 2017 in Kolkata vandalizing the property of a Private hospital leads to the enactment of a new law in the state. Thus if requirement arises , the changes in the laws can be made accordingly. He also focused on the medical education of the country, the need for specialization and its consequences.

A synthesis of included studies

Reference	Date	Design	Aim of the review	Main conclusion stated by the authors
Anand T,Grover S, Kumar R, Kumar M, Ingle GK	2016	Self administered questionnaire	To assess the exposure of WPV among doctors, the consequences and the risk factors	There is under-reporting of the violence by the doctors, only 44.2% incidences are reported. Miscommunication was the major cause of violence
Singh G, Singh A, Chaturvedi s, Khan S.	2019	Multicentric cross-sectional study	To measure prevalence, risk factors, ways to prevent WPV	In 69.3% of the cases the patients' relatives and attendants are involved in violence. Lack of drugs, and less staff were found as the main reasons of violence.
Kumar NS, Munta K, Kumar JR. Rao SM, Dhyaneshwar M, Harde Y	2019	Pretested questionnaire	To identify the incidence of WPV amongst critical care physicians.	Verbal violence was the most common violence reported. 72% doctors faced WPV. Conflict management as a part of curriculum was suggested
Ambesh P	2016	Journal article	To identify and discuss the causative factors and find the solutions	The requirement of legal provisions for the safety of doctors.

Nagpal N	2017	Journal article	To identify the causes, types of violence and methods of prevention of violence	The expenditure on healthcare should be increased by government and stricter penalties imposed by the government
Taylor JL, Lynn R	2009	Systematic Review	Literature review of WPV in ED and identification of the characteristics of the studies for evidence based practice	Lack of interventions to guide evidence based studies, under-reporting of events, incidences reported in most of the studies and they are more prominent in ED.
Kar SP	2017	Journal article	Identify the causes of the violence	Patient dissatisfaction is the prominent cause .

6.DISCUSSION

The aim of the study is to provide a review based on the issue of violence against the doctors in India , its incidence ,reasons , effects, and results.

Study by Neeraj Nagpal focused on finding the major reasons, and the preventive measures for the violence against doctors. The causes for the increase in violence against medical personnel are immense .The most common ones are stated the image of the doctors is deteriorating , even though traditionally the doctors are regarded highly in the country and the profession is the one with upmost respect. The recent impact of the private hospitals has led the impression that the hospitals have become business minded . The news reporters often display the doctors as culprit and present the news as a sensation , ignoring the details and the conditions at which the doctors have no control whatsoever.

India is among the countries with the lowest investment of the GDP in the healthcare sector that is less than 2%. The conditions of patients being treated in the government hospitals are pitiable . The patients go through long duration of waiting in overcrowded hospitals , unhygienic environment , long queues at pharmacy , multiple visits for laboratory and radiological investigations, and even sharing the bed with other patients in some cases. The medical equipments are sometimes out of maintenance pertaining to the low budget of the hospital . Such conditions sometimes also health to hospital acquired infections which results in more serious outcomes for the patients and their dissatisfaction.

The lack of insurance policies in the countries lead to the problem of the out of pocket expenditure of the patients. The expenditures push people on the verge of poverty and even below the poverty line. The catastrophic expenditures and switch to the private hospitals for quality care services further pushes the patient's family in debt. Most of the conflicts in the hospitals occur at the time of billing and the patient perceive it as wrongly charged . this leads to many incidences of violence with the billing, management, and the hospital staff.

In India where each year an estimated 60 million patients are forced to pay out of their own pocket for drugs and surgical procedures that they are in no position to afford. (A, 2012)

The cost of healthcare is high with bulk of patients visiting the private hospitals in the country. The high healthcare cost in the country with a low per capita income poses a problem. With new medical technologies and investigations required for the treatment , the cost of treatment further adds up. Dissatisfied patients dealing with the expenditure tend to get violent when the

outcomes are not favourable. This happens particularly in the emergency and surgery departments where the chances of the survival are less combined with high costs of treatment . The incidences of the violence are higher in the department of surgery as compared to other departments.(Anand T, Grover S, Kumar R, Kumar M, Ingle GK)

Many incidences of mob mentality have occurred in the country and the recent time as well.

These accidents gathered attention from all over the country regarding the safety of the doctors in the country and led to the passing of strict laws for doctor's safety.

Miscommunication and ineffective communication can act as trigger for the violence between doctors and attendants. Lack of trust between the doctor- patient relations because of inability to communicate in a friendly manner, use of jargons, non-empathetic behaviour, and not treating the patients as partners in the caregiving process often leads to the aggravation of conflicts. The role of proper communication as a measure to prevent violence is depicted in the study of Kumar et al.

This can also give rise to the patient dissatisfaction as he/she is not able to comprehend the signs and symptoms of the disease and the recovery process.

There is no curriculum in the medical education for the communication skills required by a resident while dealing with patients' relatives and how to give them the news about the patient's conditions. They rely on the experience which in lacking in the new residents or PG doctors. As depicted by the studies of Kumar et al and Kar SP , the curriculum should include these skills also.

The lack of faith in the judiciary system and the grievance redressal mechanism also leads to the violence incidents. The mentality of taking the law in one's hands if unsatisfied leads to grave incidents. Many times, the patients' attendants go unpunished because of the lack of proper laws until recently . Lack of trust in the system is a serious issue which should be addressed.

The reason for the death is considered to be the sole responsibility of the doctor , resulting from failure of doctor, referral mechanism, etc

Presence of health beliefs and myths among the society and low health literacy leads to such incidents.

Political agenda and interference by the political parties cannot be overlooked as many times the violence emerges from such parties,

The literature review suggested that the violent incidents can be prevented by Steps taken by the doctor, the organization, the society, and the government.

A proper documentation is important in the case of violence and police cases. The doctor will find it easier to protect himself/herself if the documents are properly maintained throughout the course of the treatment. The habit of keeping the records maintained should be inculcated in the healthcare personnel.

The valid and informed consent is an important step in preventing violence. Detailed consent in the patients' own dialect and language with witnesses (preferable) is mandatory before any invasive procedure with the explanation of the purpose of treatment/surgery/procedure. Its prognosis ,life-threatening and non-life-threatening complications ,available alternatives, advantages/ disadvantages, and the consequences of refusal by the patient of treatment should be explained and mentioned in the consent form.

Staying within once experience and capabilities according to the training and facilities is essential in the modern medicine scenario.

Singh et al stated that miscommunication (20.9%) and ineffective communication (14.7%) between attendants and doctors can trigger the violence. The doctors should focus on improving the communication skills which will help them in the long run.

Use of technology to limit the waiting duration of the patient. Latest technology can be used to limit the long hours that the patients spend waiting in long queues leading to frustration and violent incidences.

The doctor should keep in mind the patient related characteristics that lead to the violence. Nagpal explains the STAMP technique, which is also mentioned in other studies.

"S = Staring or eye contact,

T = Tone of voice,

A = Anxiety,

M = Mumbling,

P = Pacing”

Steps taken by the hospitals in the form of Insurance**,** Security measures in the form of

Limit the entry inside the hospital and the security personnel outside the sensitive areas.

Increase the security by placing the security guards outside the hospital as well as sensitive areas such as OT, ICU .

Recruitment of appropriate human resources by Employing doctors in adequate numbers to prevent the shortage of staff

use of technology

The formulation of proper grievance and complaint redressal system in the hospital

And Transparency of hospital charging rates to avoid disputes at the time of billing.

The steps should be taken by society and government -The violence against doctors should be treated as a criminal offence and community fines should be filed against it.

Also, this should be treated as a heinous act.

The change in the present condition cannot be brought without the role of government

The government should take appropriate actions against such acts and strict the laws and regulations.

The health budget which is meagre and less than 2 percent should be increased.

Steps taken by Media –

Media should stop sensationalizing the news items and portrayal of negative image of the doctors.

Kar SP brings to notice the medical education of the India which focuses on the super specialization and the drift of the patients to the tertiary hospitals. This leads to the overburden on the tertiary hospitals, resulting in less duration of doctor patient encounter and deteriorating of the relations between the doctor and the patient. Such relations lead to violence incidents with the financial implication of the care.

The major effects of violence on the doctors is identified in the studies conducted by Nagpal N and Anand T et al. these are:

The effects ranges from behavioural to psychological conditions

1) Burnout
2) Depression,
3) Insomnia,
4) Post-traumatic stress
5) Even fear and anxiety causing absenteeism
6) Lack of job satisfaction
7) Decreased work output
8) Insecurity
9) Anger
10) Irritability
11) Frustration
12) Increase in Absenteeism

7.CONCLUSION

This review of the literature provides the comprehensive overview on the reasons behind the violent incidents on doctors throughout the country, the effects of such effects on the mindset and well-being of doctors, and types of violence.

Most of the studies depicted incidences of violence. The incidence of the violence is on the rise throughout the country which differs in various forms and varies according to the different departments of the hospitals with more prominence in ED and ICU .

The study also emphasises on the role of government in making stricter laws for the safety and protection of the doctors and the role of society to treat such acts as heinous crimes and come forward in the support of doctors. The hospitals can also help in ensuring the safety of the doctors by adopting appropriate security measures inside and outside the hospital. Insurance and use of technology can go a long way on the part of organizations.

The various forms of violence are covered in the review which include intimidation, verbal abuse, physical but non injurious assault ,physical assault causing injury: simple and grievous, murder, vandalism and arson. The definitions of the forms of violence are included in the review.

On the part of doctors , proper training in dealing with such incidents and communication skills need to be introduced. The medical curriculum which is lacking in such aspects should be updated so that the young residents can be protected and trained in the better way. The STAMP technique should be taught and practiced.

The reform is only possible by the change in the mindset of people. The society and government should make this an agenda that under no condition should the doctors be treated by violence. Doctors in India need to be provided a safe workplace environment for performing their duties.

Further , new studies while keeping in mind the nature of the acts should be conducted beyond the descriptive studies which will find the missing links in the literature.

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PART 2

ONLINE COURSE

IMPROVING GLOBAL HEALTH : FOCUSING ON QUALITY AND SAFETY

FACULTY LEAD : Ashish Jha , Harvard T.H C CHAN School of Public Health

COURSE DESCRIPTION

The course offers an introduction to the emerging field of global healthcare quality. The past 20 years has seen an increasing realization that for healthcare to improve population health , it is required to be safe , effective , and reliably delivered. Regardless of the realization, the quality of care received by the world's citizens is not as good as it could be. This takes a substantial toll on the general population as poor healthcare. It is suggested by the most recent data that poor healthcare is likely to be one of the top causes of morbidity and mortality in the world. Several initiatives are there to improve health care quality in the United States with broad evidence from other high income countries and new evidences appearing from low and middle income countries suggesting global focus as a need.

LEARNING OBJECTIVES

It is understood that quality is important but what is the definition of quality, ways to measure it, and most importantly what can be done for the betterment of it. The course will help to learn :

1. The importance of focusing on quality on quality for improving population health
2. A framework for understanding healthcare quality
3. Approaches to measure quality
4. The role of information and communication technology in quality improvement
5. Tools and contextual knowledge for quality improvement

COURSE OUTLINE

Lesson 1 : Burden

Lesson 2 : Measurement

Lesson 3 : Standards

Lesson 4 : Improvement

Lesson 5 : IT and data

Lesson 6 : Management

Lesson 7 : Patients

Lesson 8 : Public systems

LEARNING METHODOLOGY – Video lectures

ABBREVIATIONS :

ICT = Information and Communication Technology

TB = Tuberculosis

EPPI = Evidence for Policy and Practice Information and Co-ordinating Centre

OECD = Organization for Economic Co-operation and Development

HCHAPS = Hospital Consumer Assessment of Healthcare Providers and Systems

WHO = World Health Organization

PDSA = Plan Do Study Act

IT = Information Technology

HCQI = Health Care Quality Indicator

HER = Electronic Health Record

HIE = Electronic Health Information Exchange

DOTS = Directly Observed Treatment. Short course

KEY LEARNINGS

LESSON 1 :BURDEN –

An adverse drug event is any injury that is caused by a medication which is caused in 15 per 100 admissions. Infections comprises about 3 per 100 admissions, falls – 1%, pressure ulcers about 3% surgical complications about 3%, and deep vein thrombosis about 1%. Adding up, it turns out between 10 to 25% of patients visiting hospital with something bad happening to them a as result of hospitalization. Most of the international studies from the developed countries , the rate is about 10 in 100 admissions

Preventability –

Roughly 70% of adverse drug events and 80% infections are preventable. The catheter related bloodstream is an important adverse drug event. Ventilator associated pneumonia is the biggest category of infections. An essential approach to prevent infections is the practice of hand washing.

High and low income countries –

The risk of having an infection in a hospital is probably no different in a lower middle country than a high income country but differ in the way that it is less likely to have a medication problem, adverse drug event ,and infection.

In the developing countries , both the infant and maternal mortality rates are higher. It is probably the third leading cause of death after cardiac diseases and cancer. Research done with WHO found that about 23 million disability adjusted life years are lost around the globe by such events

Tuberculosis background and burden

The health ministry of India has developed a fabulous national strategic plan with all the necessary interventions, better diagnostics, better tools, ICT , private sector interventions, and active case finding. If they are planning to eliminate TB by 2025 , the overall health expenditure needs to be increases from 1.4 to 2.5 %

Public sector and private sector care for Tuberculosis in India –

The public sector on paper is 100% DOTS coverage. Anyone in India can walk into the public facility with signs and symptoms of TB . The public sector doctors are knowledgeable than the private sector.

The chances to complete the DOTS treatment in India is 85%. Once the diagnosis is made the public sector does a reasonable job at executing whereas the private sector does a much worse job.

Measuring quality globally-

India is about to do its first ever national prevalence survey. TB research consortium is launched at a national level and Indian council of medical research has shown great leadership. EPPI, routine data mentoring, special surveys on quality might help in eliminating TB .

LESSON 2 : MEASUREMENT

Public private variation

The country's bifurcated into two : a better performing south and a worse performing north. The first failure will be that the doctor is not trained or does not have medical the knowledge, and the literature suggesting a massive shortage of the health care workers the second failure is of the patient's perception that the doctor is not putting sufficient effort and the third is that the doctor is getting paid to do something which is not right e.g. to get a bunch of tests done.

Resource allocation -

More resources in the system would be great but there is also a requirement of the ways that make sure that the doctors and the healthcare system works in the way which is beneficial to the patients.

The right way to do so will be resources with accountability

Accountability coming from the patient, peers, administration, and the doctors.

Surveillance –

A surveillance system where you send the standardized patients on a regular basis mimicking different stages of the TB process. Simple metrics like the duration of interaction , number of questions , number of physical examinations done are very good predictors

Global metrics – introduction and background

OECD stands for the Organization for Economic Co-operation and Development , which is a group of industrialized countries trying to exchange information about economy and economics. They gather the information on spending, on patient outcomes and public health , in between about what role the health system is playing and its performance.

HCQI – Indicators of focus

We now have the method of collecting the data , adjusting for the level of details of database .

ICTS

It is possible to measure it if the right data systems are present. The job in the HCQI work is to think about measures that are comparable around 30-40 counties.

LESSON 3 : STANDARDS

Legal system and regulation

There are three ways that the law helps assure that we have high quality or self-care in this country. The first is regulation, state or the federal government sets minimum standards which a practitioner or a hospital must meet if it wants to operate.

The second is the liability system malpractice that is a system of accountability .

The third is when it creates financial incentives , or penalties, for hospitals and physicians and other providers . in this way if something goes wrong the doctor has the proof that everything was done the way it should be done. Defensive medicine accounts for about $45 billion of costs across US , under about 2% of health care expenditures.

Lesson 4: IMPROVEMENT

Compensation , deterrence, and negligence

One of the roles of malpractice system is to compensate patients for injuries. The second role is that if the physician knows that he will be held accountable for the mistakes made and

made to pay for them , he/she will be more careful with the care he delivers. This is called the deterrence effect in negligence. A more recent study done looked at the claims and found that the physician reviewer thought that there was error in claims in 60% of the cases.

Defensive medicine-

People talk about the fact that physicians simply to avoid liability will order extra tests

PDSA

It is called the model for improvement and it has got three questions and then Plan – Do - Study-Act cycles. First is how to apply the PDSA cycle and approach to a situation like that ? the second question is how will you know that this change is an improvement ? That is the measurement system. The third is what changes you can try ?

Lesson 5 : IT & DATA

HIE promise of Health IT

It will help us understand how to improve our health care delivery system.

We will be able to use this data to understand sort of populations of people , what kinds of treatments are most effective for them. More data on genomics can be captures.

It holds the potential for innovation in all sorts of dimensions

HIE /EHR

There has been a set of policies that have been put in place in place to promote electronic health record adoption in both the hospital and physician office settings. There has been growth in orders of magnitude from less than 10% on 2008 to about 17 % of physicians and about 9% of hospitals. the heart of it is financial incentives.

There is a recognition that many countries are working on adopting and getting to effective use of health IT that there is a huge opportunity for cross country learning.

Lesson 6 : MANAGEMENT

Management in healthcare

2000 hospitals were interviewed , acute care hospitals in Europe, the US , Canada and developing countries that is India and Brazil. Within the country there are hospitals that are

well advanced. They measure everything , very good at motivating and rewarding employees , identify targets and, communicate effectively. These are exceptional organizations co existing side by side with organizations that are very informal with little standardization work and adoption of basic managerial practices.

Measuring quality of management

The starting point here is the diagnostic tool. This survey tool is essentially a set of questions. Everything is based on an open conversation with middle managers.

This conversation lasts for about an hour and we introduce the conversation as a research project and do not tell in advance.

7. MEASURING EXPERIENCE

Patients satisfaction is giving a rating by the patient about the hospitalization or any other care setting, but it does not enable us to improve patient experience based on this rating.

Since March 2008 , majority of the hospitals in the unites states need to use this valid tool , HCAHPS containing 32 questions which have domains about nurses, physicians, and other material important to the patient while he is in the hospital. All the hospitals have the same questionnaire with very strict guidelines about how to use it. It is creating a benchmark between all the hospitals which enables the patients and their families.

Quality in Maternal and Newborn Care

The lessons learned from the wealthy countries is that we need obstetricians for backup and within reach to be able to look after the complications that arise suddenly which is usually within half hour. The hospitals should be able to provide a woman who develops a complication and in the need of caesarean section or other emergency procedures within half an hour or a baby to a neonatal intensive care unit.

Women’s delivery preferences and understanding access

The reasons for women not preferring some facilities could be understaffing of the facilities, absence of the staff overnight and it is not necessary that the facilities will be within half an hour walk of every woman everywhere .

There is a need to look at other sectors to work with such as the private transport sector for taxis and vouchers.

Rating hospitals

It increases transparency. Gives users a voice in the system, breaks down some of the traditional professional and hierarchical boundaries that existed between the patients and doctors and the clinicians serving them.

Rating doctors

People perhaps are more interested in rating the doctors than the hospitals and the system they are treated in . there is more risk on this approach with a risk of defamation, people being rude the doctor whether they deserve it or not, fear of vulnerability. In England it is found that about 75% of reviews are positive which is like the patient survey.

If doctors get feedback and it is given to them in the right way , it can improve their experience.

Social Media

In high income countries , about 60% of the country is online using a social network regularly. About 2 lakhs messages sent to English hospitals every year that is four to five per hospital per day. People talk about the quality of care ,their friend who is in the hospital, describing waiting at a clinic and at the same time describing about the wonderful care received at the hospital. Most of the comments at the social media are positive.

Lesson 8 : PUBLIC SYSTEMS

The quality movement in healthcare

Era 3 in Healthcare

1) release of the assumptions of Era 1 and 2

2) stop excessive movement

3) reduce incentive complexity

4) focus on improvement sciences

5) stringer voices for patients and families

The triple aim of healthcare

1) Better care

2) Better population health

3) Lower costs

The Institute of Medicine has six aims for improvement

Safety, effectiveness, patient – centredness, timeliness, efficiency, equity

Healthcare and public health

How you manage one has huge effects on the other hand in a bidirectional way. For example – if breast cancer is detected in early stages survival is higher with better outcomes and the treatment is less expensive. If the patient waits , she is faced with much higher costs and worse outcomes. So, it is an investment.

Accreditation

Accreditation is a way of bringing transparency and building confidence in the system because it corrects the information asymmetry. It is the means for telling the client that this facility has necessary conditions to provide high quality health care.

WHO – World Alliance for Patient Safety

Started with a focus on three areas

One, on the research aspect , putting numbers to the problem and not just the countries that could pay for it

Second a program that help address some of the problems

Third , patient engagement program which Patients for Patient safety Program.

The idea of building more facilities for better access but if we do not have more people coming to them than the previous health care facilities , then in this cost recovery environment we will be out of money soon. So ,the two needs to go hand in hand. And assessing the patient experience and how effectively the care is delivered must go hand in hand to have the basic tools to actually deliver the care.