

Summer Training at



All India Institute of Medical Sciences, New Delhi

To Study the System of Involvement of the Patient/ Relatives in Decision Making Before Any Surgical Intervention in the CN Center and Main Hospital at AIIMS, Delhi

**By
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**Under the guidance of
Brig. (Dr.) S.K. Puri**

**Post Graduate Diploma in Hospital and Health Management
2011-2013**



**Institute of Health Management Research,
Jaipur
2012**

**TO STUDY THE SYSTEM OF INVOLVEMENT OF THE
PATIENT/RELATIVES IN DECISION MAKING BEFORE ANY SURGICAL
INTERVENTION IN THE CN CENTER AND THE MAIN HOSPITAL AT
AIIMS,DELHI.**



**The project work submitted to the Department of Hospital
Administration,**

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Certificate

This is to certify that Ms. Rekha Bhakuni from Institute of Health Management Research, Jaipur has undergone Summer Training at All India Institute Of Medical Sciences, New Delhi, from 9th April, 2012 to 1st June, 2012.

The candidate herself carried out the project. Her approach to the study has been sincere, scientific and analytical. This summer training is partial fulfillment of the course requirement is recommended for the award of Post Graduate Diploma in Health and Hospital Management.

We wish her success in all her future endeavors.

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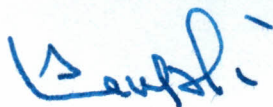
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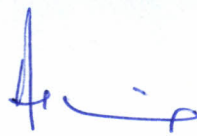
CERTIFICATE

This is to certify that the Project entitled "TO STUDY THE SYSTEM OF INVOLVEMENT OF THE PATIENT/RELATIVES IN DECISION MAKING BEFORE ANY SURGICAL INTERVENTION IN THE CN CENTER AND THE MAIN HOSPITAL AT AIIMS ,DELHI." is the bonafide work of Ms.Rekha Bhakuni and was conducted under our direct supervision and guidance to our satisfaction at the All India Institute of Medical Sciences, New Delhi.

During the training period from 9th April 2012 to the 1st of June 2012, ~~his~~ performance was satisfactory.



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ABOUT SUMMER TRAINING :

The Post Graduate Diploma in Hospital and Health Management PGDHHM of Institute of Health management and Research aims at preparing professionally trained managers of health care organizations and hospitals to meet the increasing need for managerial skills .

It involves a seven week summer placement for the first year students to provide them with a firsthand experience of the hospital system or environment.

As a part of this programme ,I had the privilege to undergo my practical training at AIIMS, New Delhi to get a firsthand knowledge and experience about the functioning of the hospital. I worked all through under the Hospital Administration department from 9th April to 1st July.

Acknowledgement

“The journey is more important than the destination. Excellence is a journey not a destination”

To traverse on the virtuous path of excellence, it required a great passion to pursue the performances of my desire and the path was illuminated by many a person of importance to whom I owe whatever I have been able to accomplish.

I would like to convey my heartfelt gratitude to Dr. S.D. Gupta, Director, IHMR, Jaipur, for their help and guidance all throughout. I would also take this opportunity to pay my tribute to my Mentor and chief advisor Brig Dr. S.K. Puri for his overwhelming and kind support in all the phases of the project development and execution. I would like to convey my sincere thanks to Mr. Hem Bhargava and Mr. Dalbir

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Moreover, I'd like to thank our training coordinator, Dr. Shraddha Sharma, Senior Resident Administrator, who is the person behind all the training schedules and design of the assignments. Further, I'd like to thank all the Senior and Junior Residents of the

Department of Hospital Administration, the Sanitation Officials, and all others who have contributed immensely in my project.

This document could had have been complete without the support of my friends, my mates, my well-wishers and my near and dear ones and hence I convey my deep gratitude towards them.

I would like to bow down my head in front of the Almighty for his invisible hand always behind my destiny.

Finally, I'd like to acknowledge my parents and family, who had been there always for me with all the support I required.

I owe this project to you all.....

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ABBREVIATIONS

AIIMS: All India Institute of Medical Sciences

RAK OPD : Rajkumari Amrit Kaur Out Patient

Department **CN Center:** Cardio Thoracic and Neuro

Sciences Center **PAS:** Patient Assistance Services

PHAMA: Patient Handling and Movement Assessment

AC: Air Conditioner

SPH: Safe Patient Handling

SPHM: Safe Patient Handling and Movement

BMI: Body Mass Index

OSHA: Occupational Safety and Health Administration

QAP: Quality Assurance Project

JCI: Joint Commission International

USAID: Unites States Agency for International Development

BC: British Columbia

JPNATC : Jay Prakash Narayan Apex Trauma Center

RPCOS: Dr. Rajendra Prasad Center for Ophthalmic Sciences

BRAIRCH: Dr. B.R.Ambedkar Institute Rotary Cancer

Hospital

NDDTC: National Drug Dependence Treatment Centre

LIST OF TABLES

Table 1: Description of sample characteristics.

Table 2: The positive responses of the study population.

LIST OF GRAPHS

Graph 1: The age of patient/relatives

Graph 2: The gender of patient/relatives Response

Graph 3: The education status of patient/relatives

Graph 4: The occupation status of patient/relatives

Graph 5: Informed consent taken regarding surgery

Graph 6 : The involvement of surgical decision making of the patient

Graph 7: The written consent of surgical decision making of the patient/relatives

Graph 8: The final decision for surgery

LIST OF ANNEXURES

1. Designed questionnaire used for the conduction of the study.

Section 1

Observation Learning

OBJECTIVES:

1. To have a basic orientation of the hospital set up.
2. To study the functioning of the hospital as a system and its departments as sub systems of the hospital.
3. To observe all the departments in terms of their location, work plan and staffing pattern.
4. To learn about the staffing pattern and job responsibilities of the staff.
5. To do a project work assigned by the Hospital Authority.

INTRODUCTION

N

AIIMS is the premiere institute of the country, that has comprehensive facilities for teaching, research and patient-care.

It serves as a nucleus for nurturing excellence in all aspects of healthcare.

Established in the year 1956, AIIMS has been consistently ranked the top medical college in India to pursue an MBBS degree by *India Today* in annual surveys starting in 1997.

AIIMS has held the top slot for the last six years in a row, and has been ranked first for 11 out of the 12 years that India Today has conducted the survey.

AIIMS' excellence has to do with several factors - small class size, excellent library facilities, liberal clinically oriented teaching, research exposure and the ability to set its own curriculum.

Several surveys by The Week and Outlook magazines have named AIIMS the best hospital in India overall, as well as the best in several individual fields such as Cardiology, Neurology, Gastroenterology, Gynaecology and Ophthalmology, ahead of several specialised institutions.

The hospital has been able to maintain high standards of quality while seeing large



numbers of patients (3.5 million in 2006) at very low cost to patients at 10, many of whom live in extreme poverty.

Twenty-five clinical departments including four super specialty centres manage practically all types of disease conditions with support from pre- and Para-clinical departments. However, burn cases, dog-bite cases and patients suffering from infectious diseases are not entertained in the AIIMS Hospital. AIIMS also manages a 60-bedded hospital in the Comprehensive Rural Health Centre at Ballabgarh, Haryana and provides

health cover to about 2.5 lakhs population through the Centre for Community Medicine.

Data Collection Process

The data collected for the observation learning constituted of both primary and secondary data. Primary data was collected by personal participant and non participant observations during the departmental visits. Further, information was gathered through discussions with key informants of the department including the staff and the heads of various departments on the basis of unstructured interviews.

Secondary data was collected from the past records of the hospital and the hospital management information system and annual reports.

GENERAL OBSERVATIONS

Teaching Departments and Centres	= 50
Faculty members (Sanctioned 629)	= 434
Non-faculty staff (Sanctioned 9198)	= 7832
No. of Undergraduate students	= 673
No. of Postgraduate students	= 1134
Medical graduates	= 2321
Postgraduates	= 7405
Nursing graduates	= 1690

HOSPITAL SERVICES

	OPD	Admission	Surgery	Beds (Gen.)	Beds (Pvt.)
<i>Main Hosp.</i>	1510430	70176	75751	1486	125
<i>Dr. R.P. Centre</i>	229799*	30365	29534	280	21
<i>Dr. BRA,IRCH</i>	74080	26002	6177	167	15
<i>C.T. Centre</i>	148227	11227	3772	166	14
<i>N.S. Centre</i>	106681	4083	2951	166	14
<i>C.C.M.</i>	138894	6436	1712	50	—
<i>JPNAT Centre</i>	44456	5046	4307	203*	—

Average bed occupancy	= 80.7 %
Average period of hospital stay	= 5.5
days Net death rate	= 2.7 %
Infection rate (Crude)	= 8.69
%	

th
(Ref: 54 *AIIMS Annual Report 2009-10*)*Recent
update

DEPARTMENT

S

- Anaesthesiology
- Anatomy
- Biochemistry
- Biomedical Engineering
- Biophysics
- Biostatistics
- Biotechnology
- Centre for Community Medicine
- Dermatology and Venereology
- Endocrinology and Metabolism
- Forensic Medicine
- Gastroenterology and Human Nutrition
- Gastrointestinal Surgery
- Haematology
- Hospital Administration
- Laboratory Medicine
- Medicine
- Microbiology
- Nephrology
- Nuclear Medicine
- Nuclear Magnetic Resonance
- Obstetrics and Gynaecology
- Orthopaedics
- Otorhinolaryngology (ENT)
- Paediatrics
- Paediatric Surgery
- Pathology
- Pharmacology

- Physical medicine and Rehabilitation
- Physiology
- Psychiatry
- Radio-Diagnosis

- Reproductive Biology
- Surgical Disciplines
- Transplant Immunology and Immunogenetics
- Urology

CENTRES

- **Cardiothoracic Sciences Centre**
- **National Drug Dependence Treatment Centre (NDDTC)**
- **Centre for Dental Education and Research**
- **Dr B. R. Ambedkar Institute Rotary Cancer Hospital**
- **Neurosciences Centre**
- **Dr R. P. Centre for Ophthalmic Sciences**
- **Jai Prakash Narayan Apex Trauma Centre**

Significant Departments and Units at Main AIIMS Hospital

- ✓ OPD (Rajkumari Amrit Kaur)
- ✓ EHS OPD
- ✓ Blood Bank
- ✓ CSSD
- ✓ Laundry
- ✓ Mortuary
- ✓ Emergency
 - Medicine ward
 - Surgical ward
- ✓ Dept. of Hospital administration
- ✓ Wards
 - General
 - Orthopaedic
 - Psychiatry
 - Skin & Veneral disease ward

- Maternity
- Gynae & Obs ward
- EHS beds

‘AB’
Win g

- ✓ Ground floor : Orthopaedic ward
- ✓ 1st floor : Orthopaedic ward
- ✓ 2nd floor : Gastro & Liver Unit, Day care & renal lab
- ✓ 3rd floor : Gynae & Obs ward
- ✓ 4th floor : Nephrology & Dialysis
- ✓ 5th floor : Paediatric surgery
- ✓ 6th floor : Endocrinology & EHS Beds
- ✓ 7th floor : Gastrointestinal surgery, KTP & PAR
- ✓ 8th floor : Recovery & ICU

‘C’
Win g

- ✓ Ground floor : MS Office & Hospital administration
- ✓ 1st floor : Psychiatry ward
- ✓ 2nd floor : Medicine & Haematology
- ✓ 3rd floor : Labour room & NICU (Neonatal ICU)
- ✓ 4th floor : Urology ward
- ✓ 5th floor : Paediatric medicine
- ✓ 6th floor : Emergency ward
- ✓ 7th floor : Surgical ward
- ✓ 8th floor : Minor OT (7-12)

‘D’ Wing

Ground floor: Blood bank

1st floor: Skin & Venereal disease

nd
2 floor: medicine ward

3rd floor: Maternity ward

4th floor: ENT ward

5th floor: Paediatric ward

6th floor: Emergency ward

7th floor: Surgical ward

th
8 floor: Main OT (1-6)

MANIFOLD

D

- **Manifold**: A device for connecting one or more gas cylinders to the central piping system for a specific gas
- **Medical gases**: Any gaseous substance meeting medical purity standards and has application in a medical environment
- **AGSS** (Anaesthetic Gas Scavenging System): Excavate the remanant anaesthetic gases

Gases Used

- Liquid Oxygen
- Nitrous Oxide
- Nitrogen
- Compressed Air
- AGSS
- Vacuum

Use of Gases

- ✓ Oxygen – Ventilators and Anaesthesia

- ✓ Nitrous Oxide – Anaesthesia

Cylinders

Oxygen	– Black cylinder with white top
Nitrous Oxide	– Blue cylinder
Carbon Dioxide	–Black cylinder with Grey top
Nitrogen	– Black cylinder with silver top

- Main oxygen supply is through oxygen tank outside the manifold room with capacity of about 12000 litres.
- Liquid oxygen is stored in oxygen tank.
- Oxygen cylinders are now used as a backup or emergency measure
- They are used only to check their functionality.

Nitrous Oxide

- Used as anaesthetic
- Primary supply is through the cylinders

Compressed air

- Mechanism
- A compressor is present that generates continuous pressure.
- Used to clear Field View during surgery
- Alarm systems present

- Emergency release valves present

Medical Vacuum

- Not a medical gas but an essential part of Manifold
- Used in Surgeries, ICU and recovery
- Source – Two Vacuum pumps

<u>Gas</u>	<u>Flow rate</u>	<u>Pressure</u>
Oxygen	40	4
bars Nitrous Oxide	15	4
bars Medical Air	50	4
bars Surgical Air	250	7
bars		
Vacuum		.53 bar

Colour of Pipes

Yellow with white -

Oxygen

Yellow with Blue –

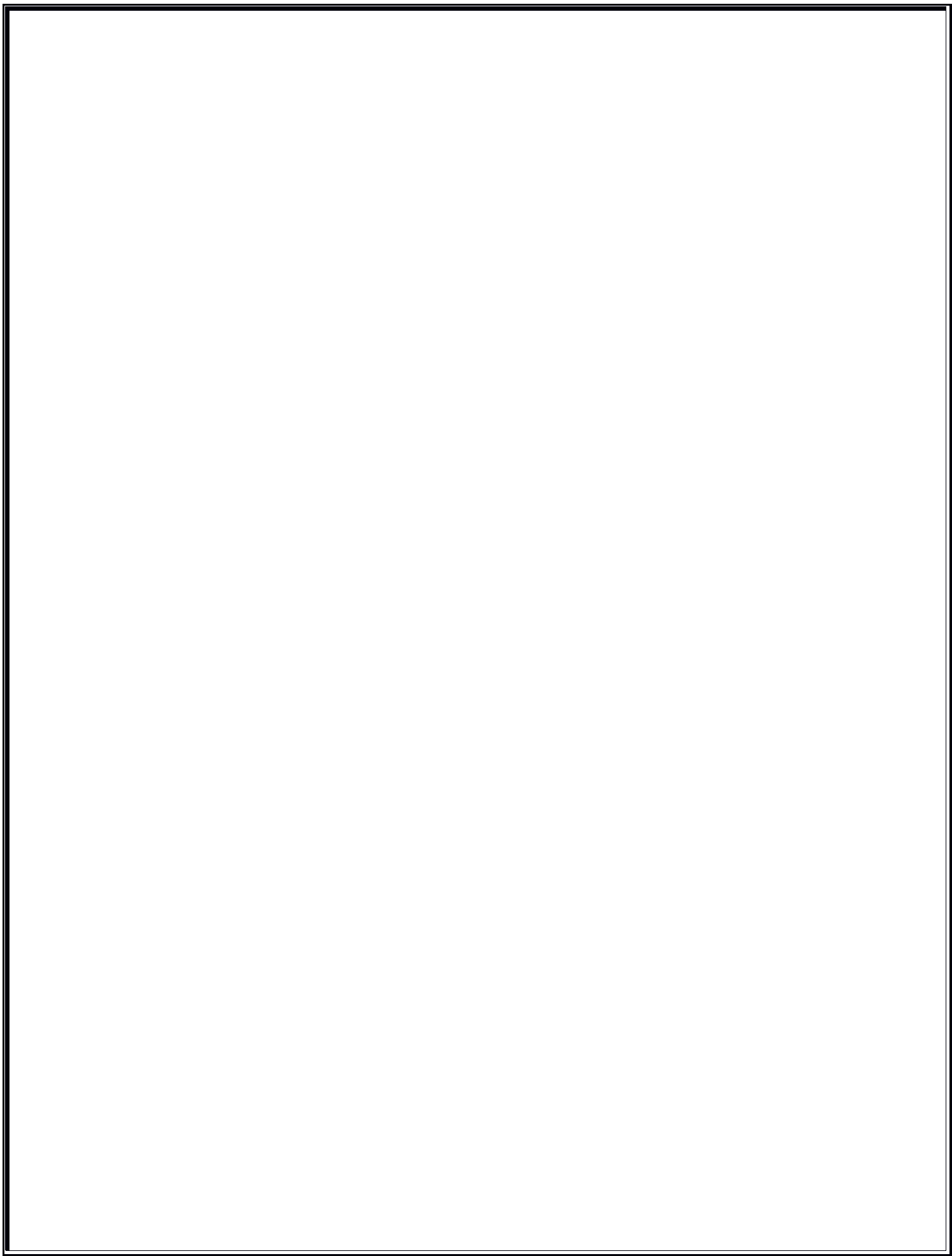
Nitrous

Oxide Sky Blue with White and Black –

Medical Air

Sky Blue and Black -

Vacuum Pipe



LAUNDRY

- Semi outsourced operations.
 - Collection, Sorting, Washing and Hydro Extraction done by the contract workers.
 - Drying, Ironing, Folding and Distribution done by the hospital employees.
 - The equipment and machines belong to the hospital.
 - The annual maintenance of machines is the responsibility of the company that has contract with the hospital for maintenance of the machines.
-
- ✓ 1st entry point 2 vans and a truck are used for supply.
 - ✓ The soiled/ Infected Linen are sorted by a worker (Worker wears necessary rubber gloves, mask and plastic apron).
 - ✓ Sorted linen sent for Sluicing, Washing & Hydro Extraction.
 - ✓ Washing is done on 1st floor of the building in 12 machines of 100 kg and 50 kg capacity.
 - ✓ Steam required for washing done at 70⁰ C for 45 mins.
 - ✓ 1st step rinsing is done around 2 to 3 times with plain water.
 - ✓ 2nd step wash with detergents and drain.
 - ✓ 10% sodium hypochlorite added washing is done.
 - ✓ After washing, linens are checked for stains. If stains are found, then they are washed again.
 - ✓ After washing is done, linen is sent to Hydro extractor to squeeze out water. (Total 9 hydro extractors)
 - ✓ After water is removed, clothes are sent for drying in dryers on 1st floor (Total 6 dryers).
 - ✓ There, the hospital employees take over.
 - ✓ After that the linen moved for press.
 - calendaring machine present which irons the linen.
 - steam presses present.
 - ✓ After ironing, Folding is done.

- ✓ The laundry is then sent to the exit point from where the delivery van takes the linen to the hospital.

One boiler room is present where 2 electrical boilers are used alternatively. Another Diesel Boiler room is under construction.

Staffing

1 Laundry
Manager

4 Laundry
Supervisors

Laundry Attendants (Around 90 hospital employees + 30 Contract Worker)

Blood Banking Services

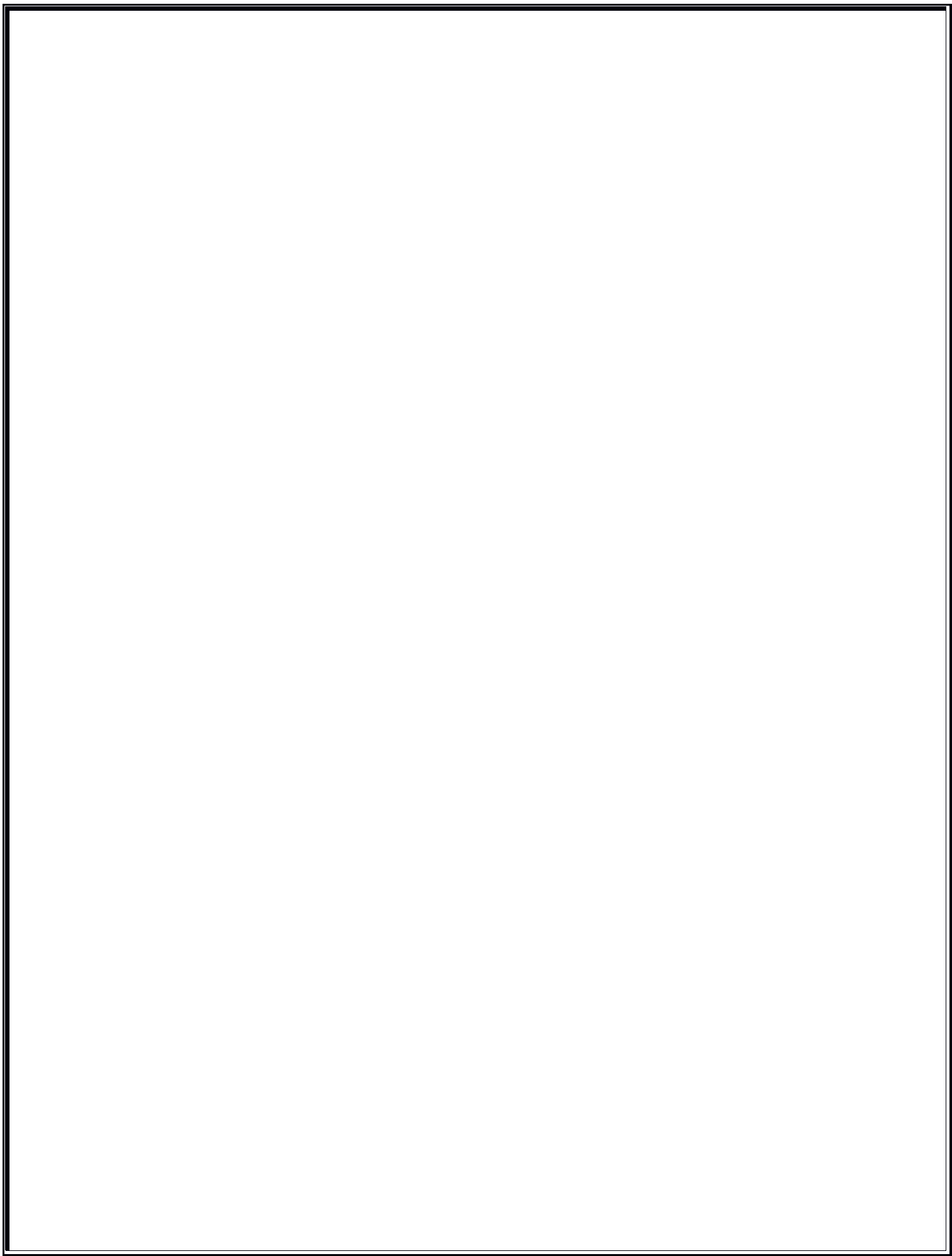
It is the dept. that deals with the collection, testing, processing (including component separation), storage, prescription & issue of blood & its products for safe transfusion to the patients as requisitioned by the physicians.

Blood bank should be located at the ground floor near the emergency & OT and the area should have good hygiene & sanitation to have an infection – free environment.

In AIIMS, the Blood bank is located at the Ground floor of the D – Wing.

Entrance is guarded by a security personnel who also gives the form for blood donation. Average donors daily = 150 donors

Donors are of 2 types – Voluntary & Relatives.



Work Flow of Blood
Bank

Dono
rs

Reception room Screening

by a Medical officer

Bleeding room

Lab for grouping & Bag-marking
refreshments

Resting room for

Exit

Component preparation

Sample sent for screening
stored

Unscreened blood

i

n refrigerator

Components storage

Reports of screened samples

Issue of components +ve of infection

-ve of infection

Blood discarded

Cold room

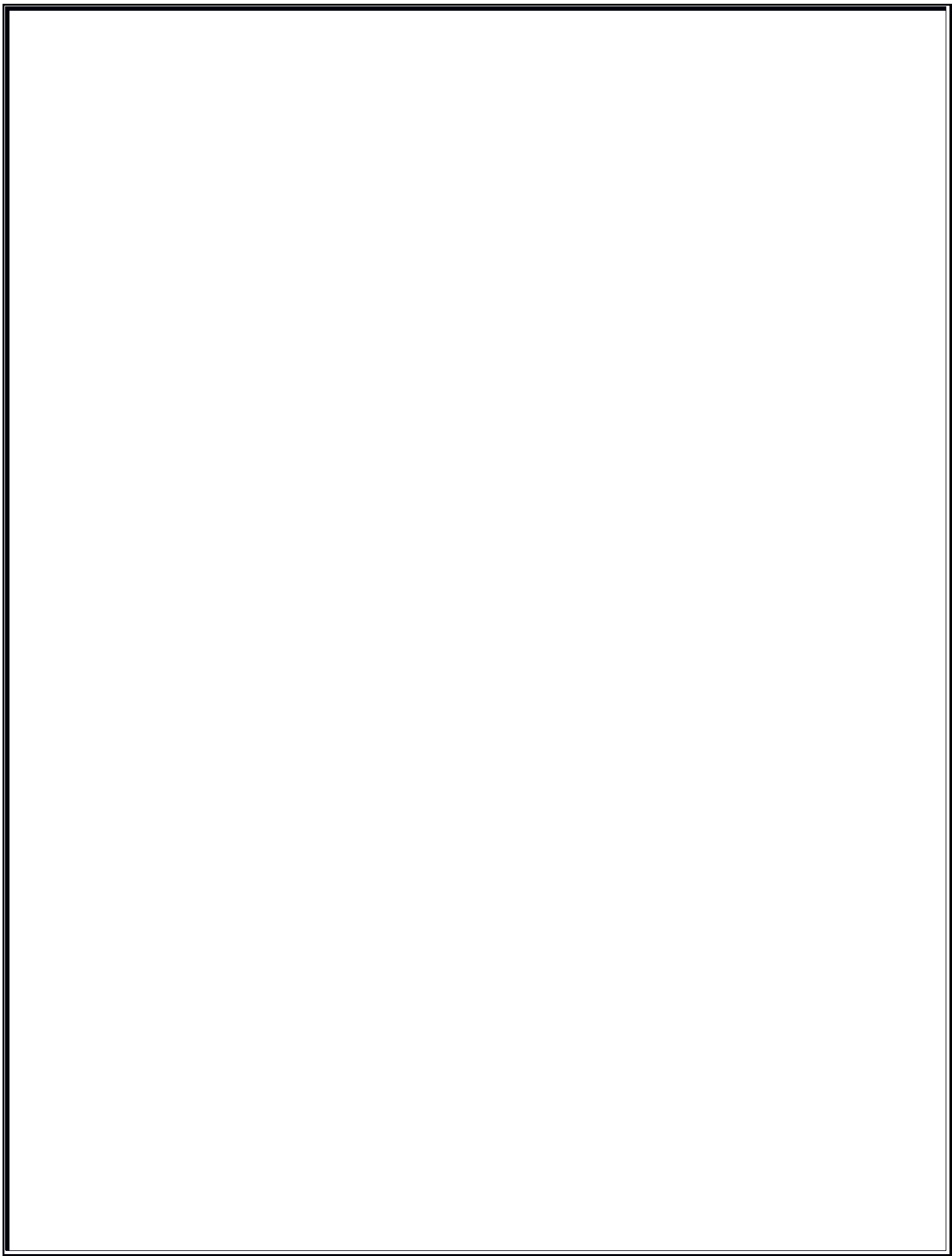
Registration room

Waiting area – 1 Doctor + 1
Attendant

Doctor conducts physical examination for anaemia, jaundice or any infectious disease. CuSo₄ (of 12.5 gravity) Test for Hb is done.

Then the eligible donor is registered on computer system. After clearance the donor proceeds

to the bleeding room.



In bleeding room, there are 8 couches for donors where blood is procured in 350 (for females) & 450 ml (for males) bags & samples are sent to screening room for testing of blood.

There 3 samples are taken

1. Grouping
2. ELISA (HIV test)
3. NAT lab

The *Debanchi quarto machine* (ELISA machine) is capable to test 88 samples at a time & takes around three & a half hrs to complete the test. From here the samples are sent to Nucleic Acid Test (NAT) lab to confirm the test –ve samples.

Then the blood is sent to the Component room for processing and division into various components such as FPP (Frozen Plasma Precipitate), Cryoprecipitate, Platelet rich Plasma / Platelets, Packed RBCs.

Component room is that area of blood bank where some blood components are kept at optimum temperatures and suitable environment for future use.

Processes in component room:-

Blood bag comes from the bleeding room. This blood is put in bucket & is weighed. Then the blood is centrifuged to separate the components in the bag.

There are 2 types of movements in centrifuge – Hard spin & Light spin.

From the whole blood, plasma is separated 1st, then the platelets, and later the RBCs.

Storage criteria

- ✓ Platelet storage is of 2 types –
 - 1st five days stored at 20⁰ – 24⁰ C for instant use.
 - Fresh frozen plasma (FFP) is & stored at -20⁰ C for a year.
- ✓ 4-Cryoprecipitate is kept for 1 yr at -20⁰ C.
- ✓ The RBC life span is 42 days and is kept at 2⁰ – 8⁰ C.

RBC is stored in a bag that includes 80 ml SAGM -2 solution for the preservation of RBCs collected from human blood. Each 100 ml SAGM-2 solution contains:-

NaCl IP	– 0.877
gm Adenine IP	- 0.030
gm Dextrose Anhydrous	- 0.90 gm
<i>(equivalent to Dextrose monohydrate IP)</i>	
Mannitol IP	-0.52gm
Water (for injection) IP	– 100 ml

Colour coding for different blood

groups:- A = Yellow

B = Red

O = Blue

AB = White

“Apheresis room”

There are 3 couches. It is meant for Single donor platelet (SDP) donor. 5-10 donors donate every day. One procedure takes 35 – 40 mins. Time schedule = 9:30 am – 5:00 pm (Sunday closed).

Storage room

Here the blood is stored that is collected both from the blood bank as well as the camps. 100-125 blood bags are collected in a day by the camps.

The blood collected from camps comes to the storage room directly & not to the component room. Here it is tested for different blood groups and cross matching is also done.

Just adjacent to the storage room is the Blood Dispensing Unit from where the blood is issued.

Staffing pattern

Medical Superintendent

(HOD) Faculty-in-charge

Blood Transfusion
Officer

Assistant Blood Transfusion Officer

Senior Transfusion Officer

Transfusion Officer

Nurses Transfusion

Assistant Hospital

Attendant (Orderly)

Dr. B.R. Ambedkar Institute Rotary Cancer Hospital

(Dr. BRAIRCH)

- One of the Speciality centres of AIIMS primarily concentrating on cancer patients.
- It started functioning in 1983-84 with 35 beds & infrastructure of 2 floors & was converted into a 182 bedded, 7 floor building on 5th Oct, 2003.
- Current bed capacity = 182 (167 Gen. + 15 Pvt.)
- Location = Within AIIMS campus, adjacent to CN centre & near Hostel #7.
- General Beds:-
 - Day care unit beds = 22
 - Intensive care unit beds = 6
 - Palliative care unit beds = 6
 - Rest are in Medical Radiation and Surgical Oncology
 - Minor OT
- Specialities include :-
 - Surgical oncology
 - Medical oncology
 - Radiation oncology
 - Lab oncology (tumor pathology)
 - Medical Physics
 - Radiodiagnosis

- Anesthesiology
- Preventive and community oncology
- Total OPD attendance =74,080
 - New cases = 8,893
 - Old cases =65,587
- Total Admissions =26,002
 - Regular =5222
 - Day care =20780
- Surgeries = 6177
 - Major =632
 - Minor =5545
- Bed occupancy rate 80.7 %
- Average length of stay = 5.5 days
- Net death rate =2.7 %
- Crude infection rate =8.69 %

Hospital Layout and Facilities

- Basement
floor
 - Medical record section – Records of last 20 yrs kept
 - Stores

- Medical
 - Surgical
 - General
- Cell Irradiation Room
- Ground floor
 - Day care room
 - Bolus Chemotherapy
 - Wheel chair & trolley bay
 - Board room for multidisciplinary clinics
 - May I Help You / Enquiry counter at the reception
 - OPD registration - Old cases & new cases counters & Delhi Cancer Registry
 - Main waiting area – adjacent to registration
 - Treatment room

Layout of Ground floor

- Consultation rooms –
 - Sub-waiting consultation room
 - Dressing room
 - Sample collection
- PCU (Day care admissions + overnight)
- Ultrasonography room

- Digital X-ray
- MSSO Office
- Radiotherapy
- Server room
- Admin office
- Accounts
- Delhi Cancer registry
- Sanitation office
- Driver room
- Manifold room

Multidisciplinary Organ based clinics

Morning OPDs

New cases = 8:30 am – 11:00 am

Old cases = 8:30 am – 11:30 am

Afternoon OPDs

New cases 1:00 pm – 3:00 pm

Old cases 1:00 pm– 3:30 pm

Radiotherapy **Unit**

Layout of Radiotherapy department has the following components:

- Radiotherapy department
- X-ray simulator
- CT /CT simulator with console
- Radio therapist room
- Medical physicist
- Conference room
- Treatment planning room
- Co teletherapy – 1
- HDR Radiotherapy – 1
- Linear accelerator – 2

RT at 1st floor

Selectron OT – 1

- LDR
RT
- PDR
RT

Selectron OT : Insertion of applicators for brachytherapy

Mould preparations / shielding block / immobilization devices preparation room /
compensator.

st
1
floor

- ✓ Radiotherapy Ward
- ✓ Haematology lab
- ✓ Oncology lab
- ✓ Minor OT
- ✓ Aphaeresis: SDP, Stem cell harvest
- ✓ Surgical Oncology – 20 beds
 - 1-12 =Beds for use
 - 13-18 =Cubicle given to Physiotherapy dept.
 - 19-20 =Not utilised

nd
2
floor

- ✓ Day care (chemotherapy)
- ✓ Medical Radiation Oncology ward
 - Radiation Oncology = 6 beds
 - Medical Oncology = 20 beds
- ✓ Faculty offices

rd
3
floor

- ✓ Private wards
 - 15 rooms – (5 beds each for Medical, Radiation & Surgical Oncology)
- ✓ 2 Deluxe rooms
- ✓ Aiiims staff cafe

th
4
floor

- ✓ Medical Oncology
 - Lab ○ Flow
 - Cytometry ○
 - PCR

- Stem cell research (*Cryopreservation of stem cells*)

_____ ○ Routine Cytogenetics

- Tissue culture lab - research
- Molecular oncology
- RT-PCR (polymerase chain reaction)
- ELISA Test for Fungal Infections
- CD 34

5th
floor

✓ Surgical Oncology Ward

✓ Fully equipped ICU

- 6 bedded 4+ 2
(septic)

6th
floor

✓ 3 OT suites

7th
floor

✓ BMT ward

- 9 beds :- Single room with attached WC
- Autologous & Allogenic BMT (*Bone Marrow Transplant*)

✓ Medical Oncology
Ward

- 18 beds
- Treatment room
- Stores
- Pantry

Key Findings

- No Casualty – Cases are referred from AIIMS main hospital.
- MSSO – Kidscan, Cancer sahyog, Cancer foundation & Indian Ostomy Assn.
- In Medical Record Department every entry was computerized.
- All the discharge records are kept for 10 years in the basement.

- Medico Legal Cases are kept with MRD officer.
- There was a Chemotherapy room in Room no. 15 only for the OPD cases which are referred by the doctor. After this the patient is sent to the daycare unit.
- In private wards admission were in two categories: A and B
- Payments General 200 Rs at time of admission
- B class payment 1100 Rs per day.
- A class payment 1700 Rs per day.
- Dietary Charge
 - 100 Rs per day Advance payment at the time of admission.
 - Billing cycle on weekly basis.

Hospital Personnel

- Faculty
- Technical staff
- Nursing staff
- Residents
- Ministerial staff
- Store staff
- Group A,B
- Group D
- Outsourced data entry operator

- Outsourced sanitation staff

Dr. Rajendra Prasad Center for Ophthalmic Sciences, AIIMS

- ❖ Established in 1967, as a National Centre for ophthalmic sciences.
- ❖ There are 14 clinical sub-specialities of ophthalmology complementing by depts. of Community ophthalmology, Ocular pathology, Ocular Biochemistry, Ocular pharmacology and Ocular microbiology.
- ❖ In a day, 1400 patients are handled & 70 surgeries are done on average.
- ❖ Total 7 seven floors
- ❖ 302 beds
- ❖ 36 beds in each ward
- ❖ 1,2,3,4 wards
 - In each ward there is 1 ANS, 2 Nurses in-charge & 8 staff nurses.
- ❖ EHS community – 28 beds
- ❖ 2, 3- private wards – 11 beds
- ❖ OPD time :- 9:00 am – 1:00 pm (after 2:00 pm, specialty clinics commence)

- ❖ Round the clock Ocular Emergency Service (15 beds for casualty cases + attached O T)
 - 1 JR (junior resident)
 - 1 SR (senior resident)
 - 1 Consultant

Ground floor

- OPD (10 Registration Counters)
 - New cases
 - Old cases
 - EHS patients
 - Physically challenged patients
 - Reimbursement forms & Medical

- Anterior segment room

- Orthoptic section
- Consultants' rooms
- MSSO
- MRD (Medical Records Dept.)
- Casualty

- Minor OT
- Radiology
 - X-ray (Pre – anaesthetic Check-up)
 - CT Scan

st
1
floor

- Research lab

- MS (Medical Superintendent) Office

- Investigations Department
 - Oculoplasty lab
 - Retinoblastoma clinic
 - Ultrasonography lab
 - Neuro-ophthalmology lab

- Retina Clinic

- Cornea Clinic

- Laser room

- FFA
- IOCL
- NDI
- Contact lens
- Ultra-sonography
- Wards
 - 1A -Squint + Glaucoma + Cataract
 - 1B -Oculoplasty & Retinoblastic

nd
2
floor

- Wards
 - 2A & 2B – Corneal Ulcer + Cataract + Keretoplastic Glaucoma

rd
3
floor

- Wards
 - 3A & 3B – Retina + Cataract + Vetero-retinal surgery ward

th
4
floor

- Wards
 - 4A - Misc + Casualty ward
 - 4B - Community + EHS (28 beds) + Private ward 2 & 3 (11 beds)

5th floor

- Day care
- Operation Theatre

6th floor

- Pharmacology Research Lab
- Biochemistry Research Lab
- Glaucoma Research Lab

7th Floor

- Pathology Lab
- Micro Biology Lab

Other points:-

Elevators

- Total elevators = 4 with lift operators
- 1 lift for Faculty & staff only
- All are stretcher accessible elevators

Sanitation

Outsourced to *BVG*

Total 30 employees including sanitation in-charge

Security

Contracted to *Good Year*

A guard is always present on every floor (7 floors)

Cardio Thoracic & Neurosciences Centre, AIIMS

Provide *state-of-the-art* cardiac & neurological care to patients from all over the country at affordable cost.

- ✓ Ground floor
 - Registration counters, OPD and lab services, blood bank, CT scan
 - Enquiry –manned by a receptionist functioning round the clock
- ✓ Floors 1 to 6 : Each ward has 34 beds
- ✓ NS3 & NS6 are under renovation
- ✓ CT2 has CCU(16 adult + 16 paediatric beds)
- ✓ First floor - Operating rooms & ICUs
- ✓ CTVS OTs, NS ICUs A B C & CTVS ICUs A B on 1st floor
- ✓ Basement : Medical records, Establishment & Engineering services section

Cardio Thoracic Centre **(CTC)**

The Centre has 180 beds exclusively for cardiology and Cardiovascular Surgery with all the ancillary facilities required for comprehensive care for all cardiovascular disorders.

In 1986 the Centre became fully independent and functional from the new 7 floor building. The department has 102 beds exclusively for cardiovascular Surgery.

There are seven operating rooms fully equipped for any cardiovascular surgical procedure. The office of the faculty is on the 7th floor.

OPD attendance: > 1.1 lakhs
annually Indoor admissions: >10,000 patients annually
Surgical procedures: >7000 annually
Cardiac diagnostic procedures: > 20,000 annually

Departments in CTC:

- Cardiology
- Cardiac Anesthesiology
- Cardiac Pathology
- Cardiac Radiology
- Cardio Thoracic & Vascular Surgery
- Cardiac Biochemistry

✓ **Specialty clinics**

- Arrhythmia/pacemaker clinic-Wednesday morning
- Hypertension clinic- Thursday morning
- Coronary/prosthetic valve clinic-Thursday afternoon
- Heart transplant/Heart Muscle-Thursday afternoon

Package *charges* for cardiac surgeries:

<u>Procedures</u>	<u>Rate (in</u>
	<u>Rs.)</u>
○ Conduit repair/ Rev. repair	65,000 - 82,000
○ CABG	60,000 - 80,000
○ CABG+1 ABP	85,000 - 1,05,000
○ Heart Transplant	1,00,000

The Neurosciences
Center

- Departments
 - Neurology
 - Neurosurgery
 - Neuro Anaesthesiology
 - Neuro Pathology
 - Neuro Biochemistry
 - Neuro Radiology
- Department has Laser, Ultrasound, Intra-operative MRI, *Gamma Knife* and Image Guidance System facilities
- Over 850 patients have been treated with Gamma Knife Radiosurgery , which started functioning in 1997
- Clinico-pathological research on head injury, neuro-tuberculosis, glioma, pituitary tumors, peripheral nerve and brachial plexus injury & intracranial aneurysms are being pursued.
- Neurosurgical operations:
- Neurology
 - There are 75 beds including neurointensive care.
 - Clinical care and research activities in the sub-specialities of Movement Disorders, Neuroinfections and immunology, Stroke, Intractable epilepsy, Neuro-muscular Disorders, Sleep, Headache, Dementia.

- **Special clinics**

- Pain clinic
- Movement Disorder Clinic
- Headache clinic
- Dementia clinic
- Stroke clinic
- Sleep disorders clinic
- Neuromuscular clinic
- Neuropsychiatry clinic
- Ataxia clinic

- **CN Tower**

- Private rooms : 63 total
- Seven floors new building , connected to CNC at 1st floor & 3rd floor
- 1st to 6th floor—private wards (each floor has 11 rooms)
 - 2nd & 4th floor for cardiac patients only
 - 5th & 6th floor for Neuro patients only
- 7th floor houses four Neurology OTs

- **Nursing Personnel**

- CT center

- 377 (sanctioned 419) includes staff strength of CN tower

- Bed strength =180

- NS
center

- 311 (sanctioned 405)
- Bed strength =180

Medical records are stored in the basement of CNC.

ORBO (Organ Retrieval Banking Organization)

- ✓ National Facility & Nodal Centre
- ✓ Objectives
 - Encouragement of organ donation
 - Fair and equitable distribution of human organs
 - Optimum utilization of human organs
- ✓ Functions
 - Donor registration
 - Co-ordination from Procurement of Organs to transplantation.
 - Networking with other hospitals.
 - Delhi, Other metropolitan cities and later internationally.
 - Dissemination of information to all hospitals, organizations and individuals.
 - Public education and awareness regarding organ donation.
 - Promotion of organ donation and transplantation.
 - Research & other related functions.

Dr. Jai Prakash Narayan Apex Trauma Centre, AIIMS

- No. of beds 302
- No. of Floors 7

Floors layout:

Basement

- Hospital maintenance
- CSSD (Central Sterile Service Department)
- Laundry
- Dietary services (outsourced)
- Security
- Mortuary
- Forensic medicine.
- Medical Record Office
- Training section for ‘Advanced Techniques related to Trauma Management’

Ground Floor

- Duty Officer Room (behind the reception)
- Casualty Ward
- The patients are allotted beds on the basis of Severity

- Radio diagnosis lab (near the Casualty Ward)
- Zoning (acc to severity)
 - Green Zone – Not Severe
 - Yellow Zone – Moderately Severity
 - Red zone - High severity

First Floor

- Disaster Ward (20 Gen + 6 ICU beds)

3rd – 7th floor

- Surgery Wards With capacity of 30 beds each.

Key Features

- All the wards on all the floor have access to main OT through a ‘Stretcher Assessable Elevator’.
- Ramp Access on all the Floors (aids in mobility & fire exit).
- Separate door for ambulance.
- Provision of life support services
- Disaster ward has automatic door opening system

TITLE:

A study of the system of involvement of the patient/relatives in decision making before any surgical intervention.

INTRODUCTION:

BACKGROUND OF THE STUDY

The Doctor–patient relationship has changed in recent years. Now the ideal is a partnership between patient and physician, where the available information is shared and decisions based on the patients' preferences, with members of the health-care team acting as advisors and interpreters¹. Patients' participation in surgical decision-making is believed to have several potential benefits: decreased anxiety and depression, increased feelings of control over illness, enhanced sense of hope, increased self-efficacy, a better understanding of and commitment to their treatment, better compliance, and increased patient satisfaction with physicians².

Patient involvement in decision-making is now widely regarded as a feature of good quality health care and many professional and consumer organizations and government agencies now advocate that patients should be involved in some way in decisions about their health care. **For example**, the General Medical Council of the UK requires doctors to “**respect the right of patients to be fully involved in decisions about their care**”

Despite broad support for the general notion of patient involvement in decision-making, however, there is no clear consensus about what it means for patients to be ‘involved’ in surgical decisions, about what constitutes ‘full’ (or ‘good’ or even ‘adequate’) patient involvement in decision-making, or about how the appropriateness of different possible forms of patient involvement might vary across diverse health care situations.

Some Doctors argue that “**patients would not be able to understand the finer complexities of illness conditions and treatment actions, and therefore do not attempt to explain them. They may also claim that because some of their patients do not ask questions, they do not wish for explanation** (1975)”⁵

NEED FOR STUDY

The legal and ethical aspects are gaining much importance nowadays. Now there is a mutual participation, in patient care in which patient education and patient involvement is given more importance.

A study was conducted by the rock view general hospital on patient participation on decision making, they found that 71% of physician were prepared to discuss therapy with patient as much or more than the patients wished(although deber focuses on the 29%of physician who underestimated their patients; desire for discussion and the11%who overestimated this)⁵.

A study was conducted by Larsson and collaborators showed less patient interest in participation⁵ surveyed 666 patients on a surgical waiting list 1 week before their operations about their involvement in the decision to operate. Only8% of the patients saw the decision as their own, 41saw it as a joint physician-patient decision, and 29%said it was the physician's idea. Although 73% of the patients responded that they had been involved in the decision making " In the whole, these study results lead to the conclusion that, although almost all patients want information, not all want to participate in decision making. However, this judgment may be premature.⁵

Thus the investigators felt that there is a need of study the system of involvement in the decision making of the patient/relatives before doing any surgical intervention so that necessary intervention can be implemented in the future& thus types of study not done earlier at the AIIMS, DELHI.

REVIEW OF LITERATURE

The literature review for this study was undertaken on following aspects:

- Review of literature related to knowledge and patients preferences
- Review of literature related to patient involvement in the decision making

HISTORY:

The concept of ‘informed consent’ has its origins in ethics, in law, and in contemporary medicine’s own understanding about the nature of the doctor–patient relationship and the advantages that accrue when patients are knowledgeable about their treatment. (Berg et al. 2001). The ‘informed consent’ procedure aspires to protect the right of an individual as a rational being to make autonomous decisions on matters concerning his/her own health and body (Steinberg 1988). Ideally, this required practice institutes a fully rational and comprehensive process of decision-making, one the potential subjects complete before electing to sign the ‘informed consent’ form and joining the trial or, alternatively, refusing to participate (Marta 1998, Berg et al. 2001).⁶

KNOWLEDGE AND PATIENTS PREFERENCES

A study was conducted on Informed consent in elective surgical procedures: “What do the patients think?” By Mohammed Amir, Mohammad Zafar Rabbani in 2009. A total of 98% of patients admitted that informed consent was taken, however, only 81 (40.5%) patients understood the information provided. Patients reporting that their decision to proceed with surgery was actually influenced by other people including the treating doctor numbered 112 (56%). Only 58 (29%) signed their own consent form, the rest of them were signed by relatives. Only 96 (48%) patients admitted having been informed about possible complications of surgery as against 156 (78%) who were informed of sequelae of not having the surgery done. Signatures taken by the paramedics were 138 (69%).⁷

A study was conducted on a patients preferences for involvement in the treatment decision making in japan by miho sekimoto in 2004. The majority of the respondents for each vignette (68% to 75%) expressed a preference for making treatment decisions in collaboration with a physician. Only 16% (22 of 133 respondents) expressed a preference for delegating decision-making to their families or to the physician alone always given, independent of the importance patients attached to this aspect. However, More than half of the patients (60%) were not involved in the decision about a treatment, at least in their own view; most of them had a preference to be involved, but not all of them. ⁸

2 .THE PATIENT INVOLVEMENT IN THE DECISION MAKING

According to Sainio et al (2001), patient participation is a highly complex issue with varying layers of decision-making embedded in it. These authors report that patients differ in the way and extent to which they want to participate in their health care. For example, some patients may make a conscious decision to take a passive role in decision making while others may want to be treated as partners in care (Chewing and Sleath, 1996).⁹

A study was done on the Patient involvement treatment decision making among women with breast cancer: Creating person-centred and equitable health service system in Uganda by Anthony Bette and Professor Richard Odoi- Adome Kampala in may2006. Most patients in this study felt that they were not given a chance to participate in treatment decision-making. They took up a specific intervention because the doctors had chosen the interventions for them. Many patients think they do not have a right to participate in the treatment decision making process¹³.

A study was conducted on has patients' involvement in the decision-making process changed over time? In The Netherlands by Atie van den Brink in march 2006 .The results of this study indicate that most patients consider it important to be informed by GPs with respect to the main issues related to the medical treatment act(MTA) of 1995. They want information about the treatment, possible other available treatments and side-effects and risks of treatments¹⁴.

A study was done by Patient involvement in treatment decision-making: The case for a broader conceptual framework by Vikki A. in 2006 . It encourages attention not just to the kind of involvement that can be achieved 'directly' in discussion with patients about health care options, but also to the ways in which clinicians might enable patients to engage in the full range of decision-making activities within and outside of consultations and to develop a positive sense of involvement in these activities and with their health care providers.¹

A study was done on patient involvement in decision –making in surgical and orthopedic practice: the project peri-operative risk in Sweden by Larsson Us, Savardsudd k in 1992. The results show that 41% regarded the decision to have an operation as a joint patient-doctor decision, in 29% of the cases the doctor advocated an operation and in 8% the patient asked to be operated. A clear majority, 73% felt involved in the decision-making as much as they wished .Two groups--women and immigrants from non-European countries--were least satisfied with their involvement and they also found the decision more difficult to make.¹⁵

OPERATIONAL DEFINITION:

PATIENT: It refers to client receiving or registered to receive medical treatment. In this study it refers to patients undergoing any surgical intervention for the first time.

DECISION MAKING

Decision making is the study of identifying and choosing alternatives based on the values and preferences of the decision maker.

SHARED DECISION MAKING: Shared decision-making is “a process in which patients are involved as active partners with the clinician in clarifying acceptable medical options and in choosing a preferred course of clinical care”

CONSENT: Consent means an agreement, compliance or permission given voluntarily without any compulsion.²⁴

Section 13 of *The Indian Contract Act* states that 'two or more persons are said to consent when they agree upon the same thing in the same sense'. Common meaning of consent is permission whereas the law perceives it as a contract i.e. an agreement enforceable by law.

TYPES OF CONSENT:

- Implied
- Express
 1. – Oral
 2. – Written

IMPLIED CONSENT: Usually the way a patient present himself for treatment imply consent. So it is basically the conduct of the patient when he comes to the doctor for examination / treatment.

EXPRESS CONSENT: This may be written or verbal and should be taken for all procedures beyond routine examination.

INFORMED CONSENT. A legal concept predicated on the duty of the practitioner to disclose to the patient information necessary to enable the patient to evaluate a proposed medical or surgical procedure before submitting to it (Pozgar & Pozgar, 1996).

ETHICAL AND LEGAL ISSUES INVOLVED

1. First and foremost is the age at which valid consent can be given in India.

2. Relative importance of written and verbal consent.
3. When and how the consent should be taken. Who should sign the forms?
4. Circumstances in which full disclosure of medical facts can be dispensed with.
5. Role of proxy consent.
6. Consent in Medical Emergencies

ETHICAL, LEGAL AND CLINICAL PRINCIPLES OF INFORMED CONSENT

1. Consent is said to be free when it is not caused by coercion, undue influence, fraud, misinterpretation or mistake. The consent must be to do a lawful act and it must not disobey any provision of the law.

Consent by intoxicated person, person of unsound mind or a person below twelve years of age is invalid {**Section 90 IPC(Indian Penal Code)**}.

2. Many countries have legislated age for giving valid consent for medical examination and procedures. In England sixteen years is the age for giving valid consent for medical examination and procedures. But unfortunately the **Indian Statue Book** does not contain separate legislation regarding consent to medical treatment nor do the various acts relating to majority, minority and guardianship throw any light on the subject. As a result, the laws for consent in general are also being applied to the medical profession.

According to **Section 90 IPC** a child less than twelve years of age or insane person cannot give valid consent.

By implication from **Section 90 IPC**, One can say that in general a boy or girl can consent to medical or surgical treatment if he or she is above twelve years of age provided the treatment is intended for his or her benefit and is undertaken in good faith.

Section 88 and Section 90 of the IPC Suggest that the age for giving valid consent for any medical procedure is twelve years. Hence a doctor taking consent for medical or surgical treatment from a person aged twelve years or more can be legally said to have taken a valid cons

Further, even though consent is said to be a contract (**under Indian Contract Act**), various Acts do not override **the Indian Penal Code**. .

Oral consent is legally valid when taken for some specific procedures like injecting medication, drawing blood for pathological examination, gynecological examinations etc. Oral consent can be proved in court if it was taken in the presence of witnesses or if the doctor records in the case record of the patient that oral consent was taken. For major procedures and surgery, written consent should be taken but if for some reason only oral consent is possible then the doctor should enter it into the case record of the patient

The value of signed written consent is important for those cases that go to court as a written consent will be of great value for the doctor when he defends himself. **According to the Indian Medical Council** (Professional Conduct and Ethics) Regulations 2002, before performing an operation written consent should be obtained. Those doctors who take consent to be legal contracts between two parties feel that both the doctor and patient should sign the consent form as this is the basic requirement of a contract, otherwise it becomes null and void. Two witnesses who are uninterested third parties should preferably also sign it.²⁵

The Consent form used in **All India Institute of Medical Sciences, New Delhi** (our country's premier medical institute) also requires the form to be countersigned by the treating doctor who certifies that informed consent has been taken.²⁶

Consent should be individual and procedure specific. It should be taken before the procedure as blanket consents are not acceptable.

3. Full disclosure must be there for consent to be legally valid. There should not be any suppression of facts. All relevant information of the disease and treatment, material risks involved, other alternative treatment, must be given by the doctor himself to the patient as it is a contract between the patient and the doctor. .
4. Proxy consent or Surrogate decision maker. When a person is incapable of giving expressed consent a substituted consent can be taken from the next of kin. Generally accepted order is spouse, adult child, parents, siblings, and lawful guardian.
5. In medical emergencies consent need not be obtained if circumstances are such that it is impossible for that person to give consent (Section 92 IPC). Locoparentis: In an emergency

involving children when their parents or guardians are not available, consent is taken from the person in charge of the child e.g. school teacher.

6. With regard to any person charged with criminal acts who has not been arrested, ethical considerations preclude forensic evaluation prior to access to, or availability of legal counsel. The only exception is an examination for the purpose of rendering emergency medical care and treatment.

7. It is important to appreciate that in a particular situation such as court ordered evaluations for competency to stand trial, consent is not required. In such a case a psychiatrist should inform the subject and explain that the evaluation is legally required and if the subject refuses to participate in the evaluation this fact will be included in any report or testimony.

8. Consent of an intoxicated person is invalid (Section 90 IPC).

9. An arrested person can be examined without consent if requested to do so by a police officer not below the rank of a Sub-Inspector (Section 53 IPC).

10. A prisoner can be treated without consent in the interest of society.

11. Consent of one spouse is not necessary for an operation (including MTP) or treatment of another. For contraceptive sterilization consent of both husband and wife should be taken.

AIM:

To study the involvement of the patient/relatives in decision making before any surgical intervention.

OBJECTIVE:

1. To study the standard guidelines for involvement of the patient /relatives in the decision making.
2. To study the various steps involved in the decision making of the patient /relatives before any surgical intervention.
3. To do the gap analysis.
4. To give recommendation for further improvement.

—

CONCEPTUAL FRAMEWORK:

The conceptual framework of the present study is based on the model of shared decision-making put forward by Charles et al the model focuses primarily on the micro-social aspects of clinician–patient interaction and the other more on the psychological aspects of decision-making.

Shared decision –making and other models of clinician-patient/relative communication:

The first main approach to considering patient involvement in decision-making, which focuses on micro-social issues, this model has been particularly influential in recent years. Like the ‘paternalistic’ and ‘informed’ models from which it is differentiated, it focuses on doctor–patient/relatives communication and the selection of one course of action from a menu of surgical intervention options relevant to the patient's diagnosis. They consider three main activities: information transfer, deliberation and a decision about implementing treatment. Their key features are summarized in the box. (1)

The second main approach to thinking about patient involvement in decision-making draws more heavily on psychology. This approach emphasizes the cognitive and emotional information processing work that patients undertake in relation to decision-making.

Models of treatment decision making as outlined by Charles et al.

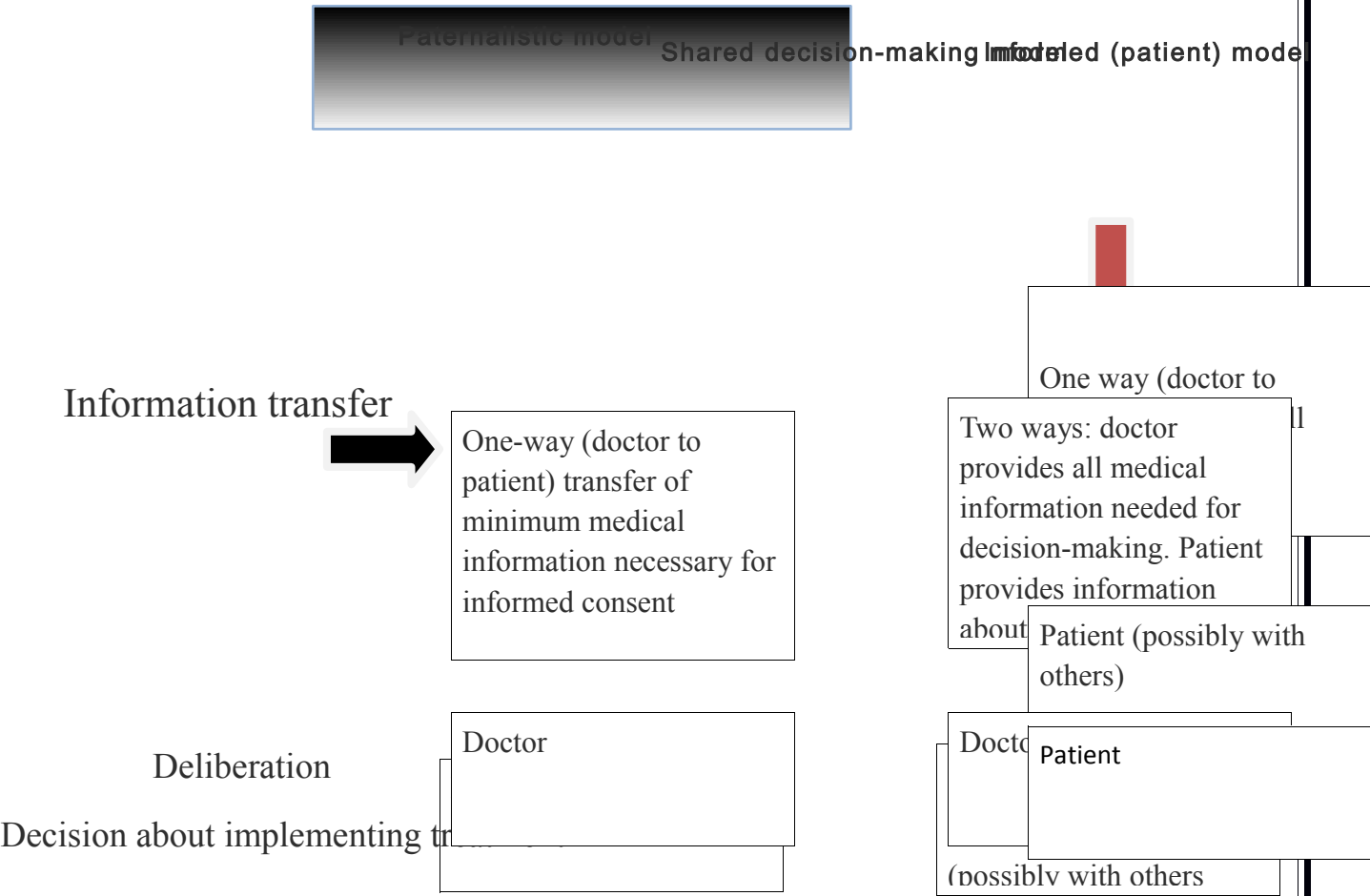


Fig1: model of treatment decision making as outlined by Charles et al.

METHODOLOGY

The present study is carried out on the basis of NABH standard guidelines to assess the system involvement of the parent/relatives in the decision making process before any surgical intervention in the CN Center & main hospital at AIIMS, Delhi.

STUDY DESIGN:

For the present study descriptive, cross-sectional, Prospective design is adopted, with a standardized structured questionnaire.

VARIABLES OF THE STUDY:

In this study two types of variables are used, these are:

Key Variable: patient involvement, patient participation, decision-making process, surgery, patient satisfaction, patient-doctor communication.

Demographic Variables: These are age, sex, education status, occupation, income.

Settings

The study was conducted on patients undergoing some kind of surgical intervention in the CTVS & main hospital in the AIIMS

The reasons for selecting this setting are

1. Availability of samples in large number.
2. Expected cooperation from the patient/relatives.
3. Convenience for the researchers to travel

STUDY POPULATION:

All surgical Patients undergoing any surgical intervention.

STUDY PERIOD: the study was carried out from 26 April to 27 May (2012).

SAMPLE AND SAMPLE SIZE:

130 patients using informed consent going under any surgical intervention. Who fulfills the inclusion criteria for the study?

SAMPLING TECHNIQUE:

In this present study, purposive random sampling technique was adopted. It is a kind of non-probability sampling.

CRITERIA FOR SAMPLING SELECTION:

Inclusion Criteria For Sampling

1. The patient/relatives who are willing to participate in the study.
2. Patient/relatives who are conscious and oriented.
3. Patients undergoing any surgical intervention.

Exclusion Criteria for Sampling

1. Patients who have mental impairment.
2. Patients having emergency surgical procedures, minors (consent not valid),
3. Patients belonging to a medical profession and
4. Patients who refused to participate in the study were not included

—

DATA COLLECTION TOOLS AND TECHNIQUES:

ACCORDING TO NABH STANDARD GUIDELINES:

PRE.3: A documented procedure for obtaining patient and / or family's consent exists for informed decision making about their care.

1. General consent for treatment is obtained when the patient enters the organization.
2. Patient and/or his family members are informed of the scope of such general consent.
3. Informed consent includes information regarding the procedure, risks, benefits, alternatives and as to who will perform the requisite procedure in a language that they can understand.
4. The procedure describes who can give consent when patient is incapable of independent decision making.
5. Informed consent is taken by the person performing the procedure

In this Present study Standardized Structured Questionnaire was used to gather information regarding the system of involvement of patient/relatives in the decision making. Patients were randomly selected from the wards at main hospital AIIMS , Delhi, data collected from 130 patients(20GI.surgery,20 orthopedic,20pedia-surgery,20gyne,20ENT surgery,30CN Center)who had undergone surgical procedures. The data collected from the patients in Hindi (National language) ,English and other local languages, if needed, in order to fill out the questionnaire.

Wherever required, patients were asked further explanatory and supplemental questions to get a better in-sight into their thought processes. Similar technique was used when the patients were asked if they understood the informed consent process and its information. Any patient who claimed to have understood the information was asked the relevant questions such as if he/she could describe the nature of his/her illness, the type of treatment he/she was offered and if he could name alternative options of treatment.

DESCRIPTION OF THE TOOL

The tool used for the study was prepared in two sections.

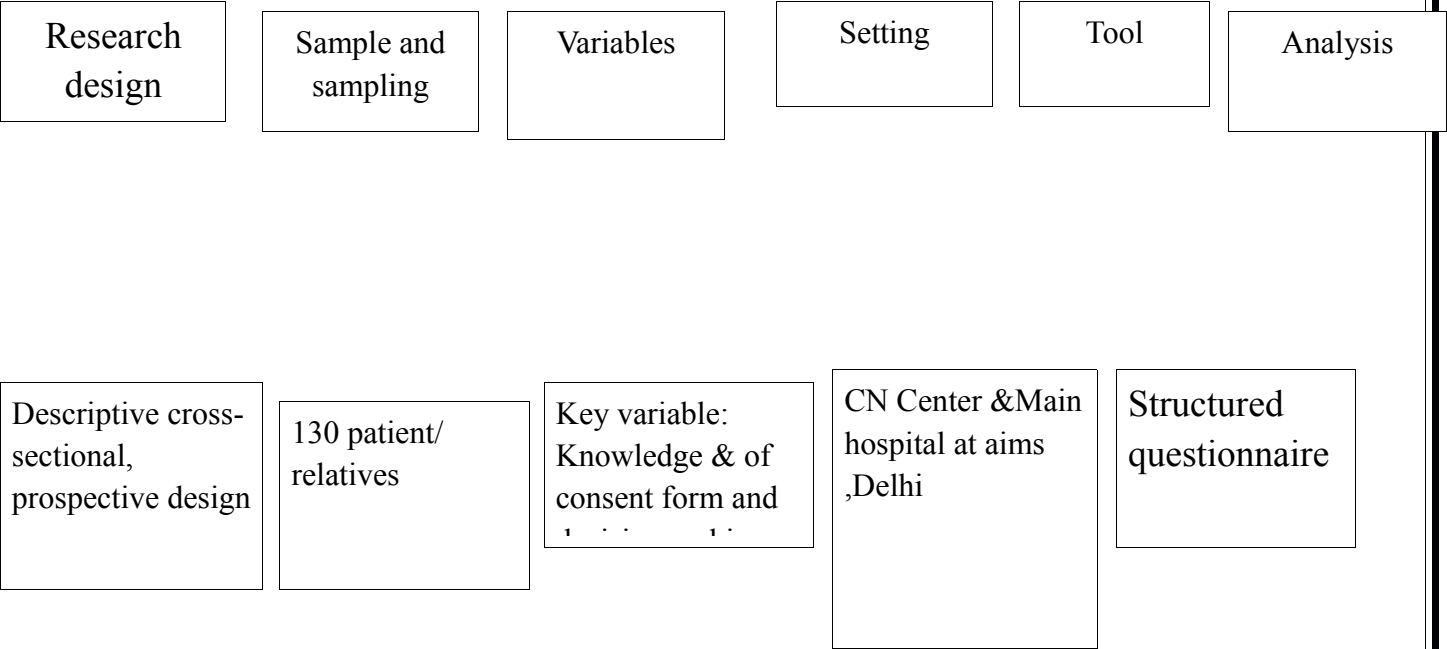
Section 1: Demographic data

This section attempts to seek information on base line information of the patient/relatives. It consists of five items which include age, sex, educational status, occupation, family income,

Section 2:

This section attempts to seek information of the knowledge regarding informed consent form, its alternative, benefits, complication and final decision making. It consists of 24 items

FIG 2: STUDY DESIGN



Non probability
sampling

Demographic
variables

Using SPSS



Finding

and interpretation

ANALYSIS AND INTERPRETATION

The analysis and interpretation of data collected from 130 patient/relatives regarding involvement in the decision making at AIIMS, DELHI. The present study is aimed to assess the involvement of the patient/relatives in decision making before any surgical intervention. The purpose of analysis is to reduce the data in an interpretable form, so that research problem can be studied.

SPSS, a statistical computer software program, was used for a descriptive analysis that consisted of frequencies and percentages for each variable that elicited nominal data.

ORGANIZATION AND INTERPRETATION OF DATA

The data have organized under following sections

Section1: Description of sample characteristics.

Section2: Findings related to knowledge/ involvement of the patient/relatives regarding decision making.

SECTION-1

This section describes the data on demographic variables of the patient/relatives like age, gender, occupation of the patient/relatives, educational status, family income per annum. These are represented in the table 1, respectively.

TABLE: 1

FREQUENCY AND PERCENTAGE DISTRIBUTION OF PATIENT/RELATIVES ACCORDING TO BACKGROUND INFORMATION

N= 100

Sl No	Background information	No. of subjects	Percentage(%)
1	Age		
1.1	12-25yrs	39	30
1.2	26-40yrs	56	43%

1.3	41-50yrs	27	20.8
1.4	51-60yrs	7	5.4
1.5	Above60	1	.8
2	Gender		
2.1	Male	74	56.9
2.2	Female	56	43.1
3	Educational status		
3.1	Illiterate	10	7.7
3.2	Primary	14	10.8
3.3	Secondary	41	31.5
3.4	Higher secondary	43	33.1
3.5	Graduate and above	21	16.2
4	Occupation		
4.1	Govt –employed	11	8.5
4.2	Self-employed	96	73.8
4.3	Unemployed	14	10.8
4.4	Student	9	6.9
5	Family income per annum		
5.1	Below rs 100000	53	40.8
5.2	Rs100000-200000	33	25.4
5.3	Rs200000-500000	34	26.2
5.4	Above Rs 500000	10	7.7

Data presented in table 1 shows that majority of patient/relatives (43%) were in the age group of 26-40yrs. 30% of patient/relatives were in the age group of 12-25 yrs, 20.8% were in the age group of 41-50yrs whereas, only .8% Patient/relatives were in the age group more than 60yrs.

In relation to the occupation data revealed that 73% of the patient/relatives were self-employed, 10.8 % were un-employed, and only 8.5% were in govt-service.

In regards to educational status data showed that 33.5% of the patient/relatives studied upto primary school, higher secondary, 16% of patient/relatives studied upto graduation, 10.7% studied till secondary level and only 7.7% patient/relatives were illiterate.

In relation to family income per annum data showed that majority of the patient/relatives (40.8%) fall under the family income group of less than Rs 100000 whereas 25.4%, 26.4% were from the income group of ,100000-200000, 200000 – 500000 and respectively. Only 7.7% patient/relatives family income was more than 500000 per month.

The sample characteristics

Fig 1: Graph showing the age of patient/relatives

Fig 2: Graph showing the gender of patient/relatives

Fig 3: Graph showing the education status of patient/relatives

Fig 4: Graph showing the occupation status of patient/relatives

SECTION 2: The patients/relatives' perspectives on involvement in the decision making
& consent form:

Fig 5: Graph showing an informed consent taken regarding surgery

Another finding was of the involvement of friends and relatives of the patient in the decision making process. (44.6%) patients reported that their decision to proceed with surgery was actually influenced by other people including the treating doctor, while 50.7% decision taken with the co-ordination of relative& doctors

Fig 6: Graph showing the involvement of surgical decision making of the patient

In all 103 (93%) patients signed their own forms while the rest of the forms were signed by husbands (N=38, 29.5%), parents (N=55, 42.3%), children (N=28, 21%) friends (n=5, 3.8%) and other relatives (N= 4, 3.1%).

Only 62 patients (47%) admitted having been informed about possible complications of surgery as against 108 (83.7%) who were informed of complications of not having the surgery done.

Fig 7: Graph showing the written consent of surgical decision making of the patient/relatives.

Although 127(97.6%) patients were verbally informed by the treating surgeon or his assistant about the nature and indications for surgery, however, written consent was taken by doctor 71(54.5%), paramedical (nurses/brother) staff (N=53, 41.8%). Five (3.8%) Patients could not recall who took the consent from them.

Most of the patients (N=108, 83.1%) felt satisfied with the process of informed. The positive responses of the study population to most of the questions are given in Table-2.

In all 58(44.6%) patients final decision taken by Doctor only&66(50%) with the co-ordination of Doctor & parents.

s

Fig: 8 Graph showing the final decision for surgery

Table: 2

The positive response of the patient/relative to the question used in the standardize questionnaires

QUESTIONS	Patient/relative's response=130(%)
1. Was an informed consent taken regarding surgery?	118(91%)
5. Were you in a condition to give consent for surgery?	102(78%)
6. Have you/ relatives read the consent form before signature?	41(31.5%)
7. Were you/your relatives informed about the scope of taking consent?	48(36.9%)
8. Was the information explained in a language which you/ your relative can understand?	105(61%)
10. Were you/ your relatives informed of the nature of surgery?	127(97.7%)
11. Were you/your relatives informed of the indication for surgery?	124(95.4%)
12. Were you/your relatives informed of the possible complication of surgery?	62(47.7%)
13. Were you/your relatives informed of the alternative surgery?	106(81.5%)
14. Were you/your relatives informed the possible complication if surgery is not done?	108(83.1%)
15. Were you informed of expected benefits of surgery?	118(90.8)
16. Were you informed of the type of anesthesia	74(56%)
17. Were you given an opportunity to have your questions answered?	120(92.3%)
18. Have you/your relative been given adequate time to take decision for the surgery?	58(44.6%)
21. Did the informed consent influence your decision to go for surgery?	106(81.5%)
22. Are you in favor of the process of informed consent?	111(85.4%)
23. Is there any medico-legal significance of informed consent?	106(81.5%)
24. Were you/your relatives satisfied with the info provided?	108(81.5%)

DISCUSSION & CONCLUSION:

The present study has shown some interesting trends in the patients/Relatives' perceptions and values about decision making before any surgical intervention being taken at AIIMS, DELHI. Majority of the patients (N=110, 84.6%) acknowledged that informed consent was taken from them before going for surgery. However, there is extensive involvement of family members (especially in case of females) and friends in the decision making process (N=63, 34.8%)

The review of international literature highlights the importance of informed consent and the need for more specific information related to the surgery and its complications. Patients feel more confident and satisfied if the treating surgeon prior to surgery shares important and relevant information with them.^{17,18} The poor understanding of the process exists despite the patients being given opportunity to have their questions answered (N=120, 92.3%).

Other than low literacy rates, a review article²² identified factors in the poor understanding and the delivery of the process of informed consent such as inefficient decision making process, unwillingness to hear bad news.

The present study also highlighted lack of awareness amongst the population for their individual rights e.g. almost half of the patients did not know that the informed consent process had a medico legal significance.

88 (67.7%) patients did not read the consent form, 83.1% (N=108) More patients were informed of the possible complications if surgery was not done as opposed to complications of the surgery itself. The patients, too, felt discouraged on mentioning of possible risks of the procedure.

At the end of complete discussion, they had a feeling of being involved in their treatment and more confidence to go for surgery. Despite poor understanding of the information and other inadequacies, majority of the patients (N= 108, 83.5%) still felt satisfied with the process of informed consent.

The patients' perception of satisfaction appears to be dependent upon engagement in the discussion and decision-making rather than complete understanding of the information being provided.

The present study appears limited in respect of a quantitative rather than qualitative analysis of the perceptions of the patients which are affected by, and dependent upon, multiple personal,

family and social setup-related factors. So at the end it concluded that, the patients prefer that decisions be made principally by their physicians, not themselves, although they very much want to be informed" could have a similar explanation.

RECOMMENDATION:

1. Patient/relatives should be given sufficient time to take decision for surgery.
2. To achieve this type of involvement in the decision making, patient/relatives will require sufficient information to make full and informed choices. At the least, they will need clarification of the following:
 - * The available alternatives.
 - * The potential outcomes of each alternative.
 - * The costs, risks and benefits of each alternative.
 - * The values of each potential outcome
3. There should be one display board in the every surgical ward that should include patient/relatives right to information.
4. Proper communication between the patient/relatives should be done.
5. Patient/relatives should be informed the scope of taking consent.

SUMMARY

The aim of the study was to study the system involvement of the patient/relatives in the decision making process before any surgical intervention in the two centers of AIIMS- Main Hospital and CN Center. The prime objectives were to study the standard guidelines for involvement of the patient /relatives in the decision making,, to study the various steps involved in the decision making of the patient /relatives before any surgical intervention, to do the gap analysis, to give recommendation for further improvement in all the centers of AIIMS.

The study had been conducted over a period of one month, the study population being all the Patient/relatives those are undergoing any surgical intervention in the two centers as mentioned. A sample of one hundred and thirty subjects were selected on a rational basis for conducting the study. The methods adopted were standardized structured questionnaire based on NABH guidelines.

.The analysis of the various variables done on SPSS. Finally, a number of recommendations ranging from providing sufficient time to take decision for surgery, at least, they will need to clarification of following The available alternatives, The potential outcomes of each alternative, The costs, risks and benefits of each alternative, Proper communication between the patient/relatives, informed the scope of taking consent.

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ANNEXURES

APPENDIX A

A study of the system of involvement of the patient/relatives in decision making before any surgical intervention.

INFORMED CONSENT

This is a project to know about your involvement in the decision making. This questionnaire is strictly for academic purposes. It would not take more than 10 minutes of your time. You are requested to kindly cooperate and give the necessary information. You can quit at anytime during the process if you feel like.

Respondent's Signature

Questionnaire

INSTRUCTION: You are requested to answer the questions related to the personal information.

Sample No.

SECTION-A DEMOGRAPHIC DATA

1) Age of patient/relative in years

a) 12-25

☐

b) 26-40

☐

c) 41-50

☐

d) 51-60

☐

e) Above 60

☐

2) Sex of the patient/relative

a. Male

☐

b. female

3) Educational status

☐☐

a) Illiterate

b) Primary

☐☐

c) Secondary

d) Higher secondary

e) Graduate and above

4) Occupation of patient/relative

☐☐

a) Govt-employed

b) self-employed

☐

c) unemployed

☐

d) student

5) Family income per/Annam

☐

a) Below Rs 100000/-

☐

b) Rs 100000 -200000/-

☐

c) Rs 200000 – 500000/-

☐

d) Above Rs 500000/-

Thank you for your time and cooperation!!!!!!

SECTION –B

QUESTIONS TO EVALUATE THE KNOWLEDGE OF TREATMENT OPTIONS AND DESIRE FOR INFORMATION

1. Was an informed consent taken regarding surgery?
 - a. Yes
 - b. No

2. Who has taken ?
 - a. Doctor
 - b. Paramedical (nurses& brother)staff
 - c.. Don't know

3. When did He/She take the consent?
 - a. Before surgery
 - b. After surgery
 - c .Some other time
 - d. Don't know

4. Were you in a condition to gave consent for surgery
 - a. Yes
 - b. No

5. Who others gave the consent?
 - a. Husband/wife
 - b. Parents
 - c. Friends
 - d. Other relatives

6. Have you/ your relative read the consent form before signature?

- a. Yes
- b. No
- c. Don't know

7. Were you/ your relative informed about the scope of taking consent?

- a. Yes
- b. No

8. Was the consent form explained in a language which you/ your relative can understand?

- a. Yes
- b. No

9. What was the language used in consent form?

- a. Hindi
- b. English
- c. Regional language
- d. Others

10. Were you/ your relatives informed of the nature of surgery?

- a. Yes
- b. No

11. Were you/your relatives informed of the indication for surgery?

- a. Yes
- b. No

12. Were you/your relatives informed of the possible complication of surgery?

- a. Yes
- b. No

13. Were you/your relatives informed of the alternative surgery?

- a. Yes

b.No

14.Were you/your relatives informed the possible complication if surgery is not done?

a.Yes

b.No

c.Not asked

15.Were you informed of expected benefits of surgery?

a. Yes

b. No

16.Were you informed of the type of anesthesia

a.Yes

b.No

17.Were you given an opportunity to have your questions answered?

a.Yes

b.No

18.Have you/your relative been given adequate time to take decision for the surgery?

a. Yes

b. No

19.Who took the final decision for the surgery?

a. Only myself

b. Only doctor

c. Parents/relatives

d. Co-ordination with parents& doctor

e. Other

20.Was the decision taken independently?(if a option is there)

a. Yes

b. No

c. Can't say

21. Did the informed consent influence your decision to go for surgery?

a. Yes

b. No

22. Are you in favor of the process of informed consent?

a. Yes

b. No

c. Can't say

23. Is there any medico-legal significance of informed consent?

a. Yes

b. No

c. don't know

24. Were you/your relatives satisfied with the info provided?

a. Yes

b. No

Thank you for your time and cooperation!!!!!!