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The 'Customer' as a 'Case'? - Patient Dignity and Service Quality in a Tertiary Hospital

*This caselet was written by **Manjul Menon,** with the guidance of **Ramalingam Meenakshisundaram,** IBS Center for Management Research. It was compiled from generalized experience, and is intended to be used as a basis for class discussion rather than to illustrate either effective or ineffective handling of a management situation.*

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It was the fifth successful year of operations for CareServ Hospitals, India's leading chain of corporate hospitals. Its flagship hospital in New Delhi had, by then, established itself as the premier provider of choice for tertiary care. Internal analysis of patients' data showed that just over half of them came to the hospital based on the positive experiences of and word-of-mouth from other patients. The remaining came through the hub-and-spoke model of reference by independent practitioners and other hospitals. There were seven other hospitals in this chain, but the one at New Delhi was the first among equals.

Dr. Mohan Srivastava (Dr. Srivastava), the Medical Director of the New Delhi hospital, shoved his glasses off the bridge of his nose and onto his still black hair. It was 11:00 AM and his day had started with a mini-crisis. Pushing his chair back, he thought wryly that he should not have disputed his brother-in-law's wager that he would be significantly grey in another year. Maybe he should be thankful that baldness was not a family trait!

Dr. Srivastava had earlier served as Deputy Medical Director in the same hospital for two years, assisting Dr. Lalitha Murthy (Dr. Murthy). He had been promoted as Medical Director a year ago. After two months of jointly managing the show with Dr. Murthy, he had been holding independent charge for the past ten months. While playing second fiddle to Dr. Murthy, stress had not seemed the bugbear it was now; her calm, decisive manner had made the job appear simple.

Dr. Srivastava had just finished a meeting with an angry customer who had not minced her words. She had been loud and articulate, and had threatened to use her position in the city's social scene to 'punish' the hospital. Her issue was that of 'intrusive, disrespectful behaviour' toward her mother, a cancer patient at the hospital. The patient had been diagnosed five days ago with advanced malignancy of the breast. The consultant oncologist had termed it 'an unusual presentation' and there was growing interest in the case among medical staff in related medical specialties and among the nursing staff. The oncologist had requested the patient's permission to take a close-up photograph for his records, but the patient had expressed her discomfort in complying with such a request, though she clearly understood its academic nature. The consultant had been graceful about the refusal and had perforce decided to prepare detailed notes for reference and teaching purposes, though he had ruefully thought about the adage that a picture was worth a thousand words. Word of the patient's refusal had spread, generating an intense if quiet competition among the nurses to view this interesting case by assisting the duty doctor during the daily process of wound management.

This competitiveness had resulted in two nurses being present in the Dressing Room this morning to attend on the patient. The patient, perceiving the unusual interest and lack of a caring spirit, had become uncomfortable and requested any one of the nurses to leave. But her request had been ignored: the duty doctor had said nothing to the nurses and neither nurse had volunteered to leave. Afterward, the patient had broken down and confided sobbingly to her daughter that she felt like a 'thing', 'was humiliated' and 'wanted to die'.

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The customer had threatened to file a case under the Consumer Protection Act; she had also strongly hinted that she might report the incident to the press and raise fundamental questions about the values and beliefs of CareServ Hospitals. The Medical Director had to act fast and in a way that would not just prevent such undesirable events in the future, but also send a powerful message to both employees and customers. He marshalled his thoughts as he looked across at the Nursing Superintendent who had also been in that meeting with the customer. She met Dr. Srivastava's eye and said weakly, "They were curious and wanted to see a case that is unusual."

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The Medical Director nodded grimly. The lodestar for the decision he would make would be the words that Dr. Murthy had set in cement – literally: "The customer is always right." The proviso was that most medical decisions would be the preserve of the concerned medical specialists, unless the patient refused their advice in writing.

He thought of all the planning and effort that had gone toward ensuring the hospital's pre-eminent position, and the relentless energy and vision of Dr. Murthy in institutionalizing a humane approach in all interactions of hospital personnel with patients.

Dr. Srivastava mentally reviewed the effectiveness of the five-day orientation program that all new hires were put through. The administrative staff seemed to be better able to put the service training into action. Consultants seemed to practice it already. But medical and paramedical personnel at most levels seemed to acquire, at best, a mere patina of customer service skills. By and large, their view seemed to be that if this was the price they needed to pay to work with CareServ Hospitals, then it was behavior they would slip on and off like they did their uniforms. There were apparently many reasons for this attitude, and Dr. Murthy had understood this. One was that the entire process of medical education, or what the research journals called *the medical socialization process*, seemed to dehumanize the practice of medicine. Doctors necessarily needed to develop emotional detachment from the daily suffering they witnessed, if they were to function rationally and maintain their own emotional integrity. Few were able to maintain emotional distance and simultaneously behave in a compassionate manner. This was perhaps compounded by the culture of deification of doctors that most patients seemed to practice consciously or unconsciously, and the culture of appeasement that they practiced with nurses. Added to these factors was the genuine desire of most medical and paramedical personnel to see and learn from as many new cases as opportunity and timing permitted in such a tertiary hospital; in that process, they sometimes forgot the 'person' behind the 'case'.

The hospital chain's human resource management policies recognized all these perspectives and sought to encourage desired behaviours through systems of rewards and negative consequences that were almost simplistic in their artful design. For instance, doctors were appraised, among other things, on their 'bedside manner'. To ensure that this section of the appraisal had teeth, it was given equal importance as the appraisal of clinical knowledge and skills. Consistently good scores on both sections was an eligibility criterion for promotion. Other rewards included a graded program of participation in Continuing Medical Education (CME) programs, initially within the country and then abroad; sponsorship for obtaining higher qualifications; residency and internship programs in world-renowned hospitals; recognition in the *Stars and Stripes* monthly newsletter for employees; paid holidays for the employee, spouse, and children; and gifts of consumer durables. Similar reward systems existed for nurses as well.

Programs based on consequences were graded as well: an initial verbal admonition, a written warning for repeat offences, a hefty fine, and in extreme cases, the person was requested to tender his/her resignation and no references were provided to future employers.

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Undoubtedly, in this case, the patient's dignity appeared to have been violated. The patient had a right to be treated humanely, and not to be reduced to be being a 'case'. This was not a teaching hospital where a patient might have expected to be surrounded by medical and paramedical staff following a specialist around, perhaps even inured to it. Rather, this was a hospital that had successfully pioneered the concept of 'a hospital that belonged in the hospitality sector'.

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Dr. Srivastava acknowledged the Nursing Superintendent's remark with a wry smile. He also sensed her unspoken concern – high turnover of nurses who used the hospital as a training ground and then left for jobs abroad. Recent HR initiatives had slowed down the rate of attrition. Would disciplinary action on even one nurse be the equivalent of taking two steps backward? Then he straightened in his chair and said, "I will call a meeting at 2 o'clock this afternoon. You should also be there. I will ask the Director, Personnel, to join us, as well as the Head of Outpatient Services. We need to make a decision as quickly and fairly as we can. I believe the lady is seriously angry and we need to do damage control. I will call her and tell her we are on the job, so that she doesn't do something rash like contacting the press." He smiled at the NS and reached for the phone.

The Medical Director was at his charming best as he spoke to the customer. He reiterated what he had said to her in the meeting in his office, that the medical personnel concerned had been thoughtless and insensitive. He asked permission to personally apologize on behalf of the hospital to the patient in her daughter's presence. He also updated her about convening the afternoon meeting to decide on disciplinary action.

"An iron fist in a velvet glove – that is the need of the hour," thought Dr. Srivastava. He intended to propose the following course of action in the 2:00 PM meeting. The duty doctor who had not taken the patient's request seriously would have to be censured with a verbal warning. Both nurses involved in the incident would also be warned, and the one who was not supposed to be in the room would perhaps be transferred. All three would also have to apologize in person to the offended patient and her daughter, and be warned to expect some harsh words. He would have to explain, both at the meeting and to the three people involved in the incident, what the legal and financial implications were if a complaint was lodged under the Consumer Protection Act. Finally, the background and the disciplinary action it necessitated had to be communicated to the employees. This was in line with the corporate culture of transparency and open communication at CareServ Hospitals.

He wondered how convinced the NS was about what she would be required to do. He suspected that her heart would not be in it because she shared the medical profession's general perception that patients valued their professional skills, not their social skills. However, she was a compassionate person by nature. Her role and the associated compensation package at the hospital rewarded her for ensuring that her staff too demonstrated compassion in their dealings with patients. She would toe the organizational line as would the Director, Personnel, who had come from the hospitality industry.

He would also call Dr. Murthy, who had moved up to the Corporate Headquarters to oversee the expansion of CareServ Hospitals to Tier II cities, and keep her informed. She might have a few other options he could try. And keeping her in the loop would be beneficial, even if the issue did not get escalated by the customer to the Corporate Headquarters or any third party.

Questions for Discussion:

1. The 'incident' involving the 'violation of a customer's dignity' can be viewed as a failure to maintain the high levels of service quality that CareServ Hospitals was known for. Do you agree with Dr. Srivastava's proposed course of disciplinary action? If yes, why? If not, suggest a suitable alternative and provide the rationale for your decision.
2. How can CareServ Hospitals prevent such incidents in the future, either in the same location or in other locations?
3. In the context of a chain of corporate hospitals, discuss the role of corporate communications (both internal and external) for crisis prevention as well as for crisis management.