CAN WE SATISFY OUR CLIENTS? INTROSPECTION

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ABSTRACT

Criticism of medical professionals is on the rise. The perception of the medical profession and the media, which educates the clientele, is widely different. The likely causes for dissatisfaction of the clientele and some possible solutions are presented.

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Introduction

The medical profession has now been grouped with other paid consumer services, liable to be interpreted and challenged on legal contractual terms. The days of trusted family physician, who enjoyed the implicit faith of his patients, are over. Criticism of medical professionals is on the rise. Armed Forces Medical Service (AFMS) is no exception. Clientele and administrative authorities have commented adversely from time to time. It is time the medical set up does a reappraisal and corrects itself rather than wait for the external forces to force remedial actions.

Perceived Deficiency in Medical Care: The Common Cause

The gap between the "clientele expectation" and its fulfilment is widening rapidly. Today's patient is better informed about advanced medical knowledge and is also more demanding. The health care in service hospital is compared with the elite private hospitals, which cater to the rich. These institutions mainly offer the commercially profitable medical care, while the Armed Forces Medical Services provide a comprehensive medical care. Are these comparable?

The organized health care, made available with tax payer's money, has to be cost effective for the

benefit of maximum possible clients. Health care costs have gone up so much that even the economically advanced countries are finding the cost of organized health care prohibitive [1,2]. The cost reduction on organized health care is their priority area but no easy solution is available. The suggested solutions like rewarding those who save funds, have their own shortcomings and are not acceptable [3]. The cost benefit is calculated statistically by the administrators responsible for providing funds. The clientele however, wants what he perceives as best with an innocent belief that costlier is always better. Under these circumstances can we really provide a "clientele satisfying" health care in an economically poor country like ours?

The patient wants that the doctor should give adequate time in comforting and this definitely helps in healing [4]. The administrator, on the other hand, measures efficiency by the output in quantifiable numbers only. The doctor has to justify his workload accordingly. Will this not lead to dissatisfaction of the client?

The perception of the medical profession and the media, which educates the clientele, is widely different [6]. But the doctor can neither spend time in giving his viewpoint nor has the expertise in countering the media generated misconceptions of

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the patient. Will it surprise any one if this results in loss of faith of the clientele?

On their part, the physicians also want to redefine the Hippocratic oath with changed ethos of the society [5]. Admission to medical profession at entry level does not require any different moral values and is solely on the criteria of "merit"; reservations notwithstanding. The society however, expects a higher moral value from the medical profession. How do we reconcile?

Perceived Deficiency in AFMS: Special Causes

AFMS has some additional disadvantages. The patient does not have a choice of selecting his treating physician and has to use the services of available doctor. The medical set up not only provides the technical expertise but also has to provide for drugs, appliances, diet and transportation. Naturally the demand will always exceed the availability.

The clientele of AFMS is entitled free treatment at the government expense from funds deemed to be placed at the disposal of our corps. The perception of entitled clientele can be summarised as "best possible medical treatment to be provided at all places". They may accept the non-availability of super speciality services at all places but no one likes to accept that all drugs cannot be provided at every place. Many questions are raised on promptness and adequacy of services provided at different places and these have to be answered. Can we even provide all possible drugs at all places at all times?

The medical examination and categorization of medical fitness, which affects promotion and posting, is never welcome. The great benefit of free regular medical examination is totally ignored because it is not voluntary but is forced (obligatory). The medical officer is perceived as a detective trying to find a disability to de-SHAPE the serving soldier. Can the much needed trust be established between the doctor and the patient?

The short comings in our setup

The work load analysis to define the "sufficient work load" for doctors is not available. How many OPD cases can a cardiologist attend to? Can he manage the same number of cases when he is given more and more sophisticated equipment for

investigations?

Within how much time a call duty specialist must be available? How to decide whether he has attended to the patient promptly or not? What type of equipment must be available at different places in the hospital? What facilities must be available in different types of hospitals classified as Command, or Zonal hospitals? Is it a case of deficiency in service if CATscan is not available in a peripheral hospital for use in a case of head injury occurring occasionally? All the above are examples on which the norms have not been laid but are required to be laid.

There is a feeling that the services provided by hospitals are not being audited or evaluated adequately. This adds to the mistrust. We all know that this is not correct and senior administrative professionals are monitoring all the work. This information is however, not disseminated to the clients properly.

AFMS is considered to be conservative. We do not change as quickly as private practitioners treating the rich patient. While a very quick change is not possible in organized service, it is also not always correct. Changing an established mode of treatment on media hyped breakthrough before the modality gets established may be detrimental. The well-known example, when shifting all well controlled cases of epilepsy from phenobarbitone to carbamazepine had resulted in some cases having breakthrough fits, needs to be remembered. We are more scientific as we introduce a new technology after it gets established. We however, lack in educating our clientele on this aspect.

Action suggested

This brings us to the question of what do we need to do? Firstly, of course we need to lay down the norms and decide on quantum of possible workload for medical professionals of different category. A self-audit (medical audit) should be done very carefully. Medical audit is a systematic approach to peer review of medical cases [7] as per defined guidelines [8]. The health authorities and medical staff should explicitly define their respective responsibilities and expected standards for the quality of patient care. This has been started and should be given due importance. The clients must know that medical audit will weed out

the incompetence.

The differences, inherent in the perception of medical professionals, media and clientele, are known and justifiable. The differences in perception of different medical professionals however, are beyond the conception of clientele and media. There can be no doubt that there are justifiable differences in perception of specialists and family physicians, specialist and super specialists or specialists of different disciplines [9]. However, these can not be understood by the patient and hence should never be communicated to him. There can be no greater damage to the credibility of treating doctor than the expression of differing opinion by another doctor. This must be avoided very scrupulously. Wrong treatment of course, is not to be shielded and deserved to be penalised.

Active participation by the physicians in propagating their ideas and work goes a long way in establishing their credibility in the present social ethos. The difficulties in working created by situations beyond their control must be brought to knowledge of the clientele; not in the form of complaint but as a piece of information. This should be a part of health education to inform the client on what to expect in the present set up. A constant dialogue is very necessary.

The AFMS cannot ignore cost consciousness because we spend taxpayer's money. We have to justify our budgetary demands. We are not fund providers. We have to plead on behalf of our patients to the fund controllers. What is the solution to the fund controllers saying that funds will be provided if justified and patient demanding that all that is perceived to be best (read costliest) must be made available? We have to strike the balance by first being conscious ourselves that all that is sophisticated or expensive is not always the best. We can then educate the patient and reduce his demands for CATscan or thallium studies to improve the satisfaction level. We are required to improve the satisfaction level because this affects our image and respect in society.

The availability of drugs and equipment is also a point in consideration. The inadequacy has to be

decided in the background of limited fund availability, inadequate powers at all levels and time consuming procedures. Since we are considered to be responsible for provisioning, we are also blamed for inadequacy. Do we admit that we are incapable of proper management or is it due to a variety of factors beyond our control? Are we worse off than any other comparable organization like ESIS or CGHS? If not, then why can we not convince our patients that they are getting much better service than any other comparable service. Let us do some studies and see where we stand. The periodic meetings of medical administrators and peer leaders amongst the clientele have been advocated. This is an absolute necessity in order to understand the viewpoints of the clientele and make them aware of our views.

It is time that we develop cost consciousness, improve communication skills and build better public relations so that adverse judgements are not passed on our corps inspite of our efforts. The patient is the *"raison d'etre"* of our existence. We have to try to live upto his expectation and also try to convince him of the sincerity of purpose. We have voluntarily chosen the profession dealing essentially with the suffering humans. We must try to relieve suffering and surely not add to it.

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