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Clipboard

A Quarterly Update on Management Issues from the Administrators Section of the Christian Medical Association of India

Dear Members,

Greetings!

I am very happy to be in touch with you through my first editorial as Secretary of the Administrator's Section.

My association with CMAI started over 7 years ago. This was after I had joined Christian Medical College & Hospital, Ludhiana, Punjab as Chief Maintenance Officer. Later I served as North West Regional Secretary for the Administrators Section. After a long and close association with CMAI, it is exciting to be part of the CMAI family and be even closer to it.

Hospital Engineering has been my USP. During my tenure in CMC, Ludhiana, I was involved in several engineering areas like building/ renovating operating theatres, design and implementation of air conditioning systems and upgradation of medical gas systems (compressed air, oxygen, suction, nitrous oxide, steam). A few years back, I helped coordinate and organise a CMAI workshop called "Medical Equipment Maintenance" in CMC, Vellore. Another such workshop is being planned in North India. Apart from this, several need-based workshops on topics like Laws on Hospital Administration, Inventory Management, Financial Management etc can be arranged. Please do send in your ideas and suggestions.

From this issue I would like to reintroduce the column LEGAL WATCH. Kindly send in your articles if you come across issues of common interest.

Your contribution is important to ensure sustained effectiveness and growth of this section. Please pray that God may use me to strengthen the activities of this section and bless CMAI at large. Do write to me at stephen.victor@cmai.org

Stephen Victor
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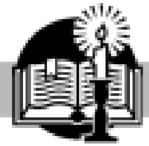
Biblespeak



Isa 30:15

"In quietness and hope shall be your strength."

Quietness is a state of mind rather than just remaining quiet, ie silent. Even in the midst of adverse circumstances, God's people have displayed a great sense of quietness. Paul and Silas displayed that kind of quietness. In Philippi the officials tore the clothes off Paul and Silas and ordered them to be flogged. After a severe beating, they were thrown into jail, and the jailer was ordered to lock them up tight. The jailer shoved them into the inner cell and fastened their feet between heavy blocks of wood. Their backs were bruised and bleeding but their hearts were not bruised. A heavenly quietness filled their souls and even at midnight they could pray and praise God singing hymns. God has called us to a life of quietness in the real sense. Isaiah pointed out that that quietness accompanied with hope can give us real strength (Isa 30:15). May God help us to enjoy that kind of quietness.

Stephen Victor, CMAI

"I f you don't know where you are going, any road will get you there."
Lewis Carroll

MBO Revisited

Management by Objectives (MBO) was first outlined by Peter Drucker in 1954 in his book The Practice of Management. The corporate world was enamoured by the concept of MBO in the 70s and 80s. Though MBO has faded from the modern management parlance, it still has relevance when applied in the appropriate manner. Of late, some organisations have tried to apply the MBO process to improve the quality and quantity of their services. This article attempts to present the MBO process and its application in a healthcare environment.

The principle behind MBO is to create empowered employees who have clarity in terms of the roles and responsibilities expected from them, understand the objectives to be achieved and thus help in the achievement of organisational as well as personal goals. Some objectives are collective - for a whole department or the whole company - others can be individualised. From a simplistic view, if you start out with a goal in mind, you are more likely to reach it or conversely, “If you don’t know where you are going, you’ll probably get there.”

In a 1991 comprehensive review of 30 years of research on the impact of MBO, Robert Rodgers and John Hunter concluded that companies whose CEOs demonstrated high commitment to MBO showed, on an average, a 56% gain in productivity. Companies with CEOs who showed low commitment only saw a 6% gain in productivity.

Theory X and Theory Y are theories of human motivation created and developed by Douglas McGregor. Theory Y assumes employees are likely to be ambitious, self-motivated and anxious to accept greater responsibility, exercise self- control, self-direction, autonomy and empowerment. It is also believed that if given the chance, employees have the desire to be creative in the workplace. McGregor’s Theory Y forms the basis for MBO and assumes that individuals within an organisation will exercise self-direction and self-control in the process of attaining the objectives and goals to which they are committed. MBO recognises that the intellectual potential of the average human is only partially used under the traditional managerial system with its threat of punishment or withholding rewards. Therefore, MBO proposes to provide an environment where the imagination, ingenuity and creativity of all employees are incorporated in achieving common goals (Levinson 1970).

Some of the important features and advantages of MBO are:

1. **Motivation** – Involving employees in the whole process of goal setting and increasing employee empowerment increases employee job satisfaction and commitment.

2. **Better communication and Coordination** – Frequent reviews and interactions between superiors and subordinates helps to maintain harmonious relationships within the enterprise and also solve many problems faced during the period.

3. **Clarity of goals** – With MBO comes the concept of **SMART** i.e. goals that are:

   a) Specific
   b) Measurable
   c) Achievable
   d) Realistic
   e) Time bound

The goals thus set are clear and motivating and there is a link between organisational goals and performance targets of the employees. The focus is on the future rather than on the past. Goals and standards are set for the performance for the future with periodic reviews and feedback. In some sectors (Healthcare, Finance etc.) some add ER to make SMARTER, The ER can have many meanings but the most relevant would be E=End-minded R=Reviewed and Resourced Goals.

Cautions while following MBO

MBO, to be effective needs a considerable amount of time. Every individual’s work has to be meticulously evaluated and measured in relation to the overall objective. This will require periodic review meetings which would reduce the amount of time spent for routine work.

MBO is not a substitute for a performance appraisal, because MBO talks primarily about organisational tasks while an appraisal system is related to the performance of an individual as a person.

The use of MBO needs to be carefully aligned with the culture of the organisation. While MBO is not as fashionable as it was before the ‘empowerment’ fad, it still has its place in management today. The key difference is that rather than ‘set’ objectives from a cascade process, objectives are discussed and agreed

to, based upon a more strategic picture being available to employees. Engagement of employees in the objective setting process is seen as a strategic advantage by many.

A saying around MBO — "What gets measured gets done" - is perhaps the most famous aphorism of performance measurement; therefore, to avoid potential problems SMART and SMARTER objectives need to be agreed upon in the true sense rather than set.

When this approach is not properly set, agreed and managed by organisations, in self-centered thinking employees, it may trigger an unethical behavior of distorting the system of results and financial figures to falsely achieve targets that were set in a short-term, narrow, bottom-line fashion.

A formal, highly structured MBO system implemented to serve administrators' needs will not work in a hospital setting. Only an informal MBO system that emphasises the participation as well as the autonomy of individual departments will be effective.

As years went on, MBO lost its relevance to other newer techniques of productivity improvement. In the 90s, Peter Drucker himself decreased the significance of this organisation management method when he said, "It's just another tool. It is not the great cure for management inefficiency".

Need For MBO in Hospitals*

MBO is as needed in hospitals as in any other organisation because recently, private entrepreneurs have entered into the healthcare sector and are offering competition. Secondly, the charitable hospitals are not getting as much grant in aid as they used to in the past. Thirdly, there is a change in attitude of the patients. They want quicker and more efficient services. Though hospital personnel are professionals, their actions are often not professional. Now the time has come when they will have to professionalise their functioning. Therefore, MBO is very much needed for strategic planning, which is primarily necessary for long-term development of the hospitals. Though some academicians in the field of hospital administration have been advocating the necessity of MBO for quite some time, there is hardly any hospital which is making use of this process.

Source: www.wikipedia.org
**Handbook of Hospital Personnel Management*
R.C.Goyal

Management by Objectives as a Motivational, Appraisal and Effective Management Tool

Experience of a Tertiary Care Teaching Hospital

This article shares the experience of Kasturba Hospital, Manipal, a tertiary care teaching hospital, in implementing management by objectives (MBO). Keeping up its position as one of the finest medical college teaching hospitals, the management had initiated the MBO concept in October 2003.

The policy of the hospital was evolved through a brainstorming session with employees and with the help of extensive feedback from the prime customers, that is, patients and medical students. Extensive awareness programmes were held to drive down the policy to each and every employee. Top-level objectives were fixed to measure the achievement of the policy. The respective departments in consultation with the top management defined individual departmental objectives. Review of the levels of achievement and newer actions to achieve these objectives were done in various meetings held from time to time.

A patient feedback form was used in order to know the customer's (patients' and medical students') perception. Table 1 shows common customer perceptions derived from these feedback forms, which are then converted into their requirements and organisational objectives in order to improve the existing system.

Table 1

Customer Perceptions and Requirements with the Organisational Objectives			
Sl.No.	**Customer perception**	**Customer requirement**	**Organizational objectives**
1.	Delay in service delivery	Quick service	Reduction in Average Length of Stay by 5%
2.	Services not affordable	Affordability	Improve utilization of diagnostic services and OT by 10%. Increase in Bed Occupancy Rate by 5%
3.	Poor attitude of staff	Positive attitude of staff	Staff empowerment through training. Increase Patient Satisfaction Index by 10%
4.	Inadequate number of patients for learning	More patients	Increase bed occupancy by 5%

Fifteen clinical departments were identified based on their utilisation and the revenue generated through them. Each department set objectives that aimed to increase service utilisation, decrease stay, increase bed occupancy etc.

Table 2 highlights the objectives for a few clinical departments and the results they achieved. It can be seen that the first three objectives are aimed at optimisation of services utilisation and meeting the customer requirements for quick and affordable service. The remaining two objectives are targeted towards increased patient satisfaction.

Table 2

Objectives for Clinical Departments and Results		
S. No	**Departmental Objectives (Clinical) Results**	**After Nine Months**
1.	Decrease in ALS by 5% in one year in each of the 15 selected clinical departments by 7%	12 out of 15 clinical departments exceeded the target; overall ALS was less; no change in re-admission rate
2.	Increase in BOR by 5% in one year in 15 selected departments	10 out of 15 clinical departments exceeded the target; overall occupancy increased by 5%
3.	Operation Theatres: Increase in operations by 10%	Operations per month per OT went up by 16 %
4.	Anesthesia department: Reduction in cancellation rate by 10%	OT cancellation reduced by 7%
5.	Nursing: Reduction in medication error (wrong dose, drug, time, route etc), self reporting was encouraged	Self reporting was unsuccessful

Notes: ALS = Average length of stay; BOR = Bed occupancy rate

Table 3 highlights the objectives set for a few support service departments towards customer requirements and the results achieved. The patient satisfaction index, derived from the analysis of patient feedback forms, did not show significant improvements over the period.

Table 3

Objectives for Support Service Departments and Results

Sl.No.	Departmental Objectives (Non Clinical)	Results (After Nine Months)
1.	IP Billing Department: Reduction in billing time by 25% without any compromise on accuracy	Billing time reduced by 30%
2.	MRD: Reduction in file retrieval time from 45 to 20 minutes	MRD file retrieval time reduced by 40%
3.	Stores: Reduction in inventory by 15%; stock out to remain the same	Reduction in inventory by Rs 2.6 million
4.	HRD: 6 hours of soft skill training to technical staff	Only 50% could be achieved

Notes: IP = In patients; MRD = Medical records department

After nine months, findings showed that there was substantial improvement in overall performance. Thus, performance is better when people work towards specific objectives than when they are simply asked to do their best. Further, MBO makes the staff work in a particular direction, with well-defined objectives. It encourages them to think, plan and achieve. It promotes teamwork and improves communication.

However, despite all its advantages, the MBO system has its own weaknesses. First, it needs a thorough commitment from the management at all levels. Next, health managers at top levels should be capable enough to see that the policy and objectives percolate down to all levels of the organisation. Difficulties are also faced in defining objectives—they may not address real problems; they may be too difficult or too easy to attain in the fixed time- frame; they may not be fully under the control of that particular department. However, notwithstanding all these limitations, goal-oriented management should be one of the most widely practiced managerial approaches in healthcare during the next decade.

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LEGAL WATCH

Several CMAI member institutions have received government orders asking them to join the government's admission process for professional courses, carry out appointments as per guidelines for other non-government institutions, etc. Faced with such GOs, there is often uncertainty on what is the legal position and how to respond.

Mr Samuel Abraham, Legal Officer, CMC Vellore, who is author of the CMAI publication Laws Related to Hospitals released by B I Publications, and one of our leading resource persons on legal issues, has prepared this tabular overview of rulings of various courts on issued faced by minority institutions, especially those related to the admissions process.

Sl.No	Case Title	Issue Raised	Decision
1.	State of Bombay Vs. Bombay education society	The Government of Bombay issued a circular directing no primary or secondary school shall from the date of this order admit students to a class where English is used as medium of instruction including minority institutions	The order / circular was declared unconstitutional by the Supreme Court of India ***(AIR 1954 Supreme Court 561)***

Sl.No	Case Title	Issue Raised	Decision
2.	IN RE Kerala Education Bill 1957	State of Kerala proposed to bring a law to take control of all the educational institutions established and administered by minorities in the state of Kerala who receive state aid – the bill was referred to the Supreme Court of India for their opinion by the President of India under Article 143.	It was declared that the Kerala Educational Bill contains many sections which will be declared ultra vires by the Supreme Court of India and hence the bill was not assented to by the President of India to make it a law. ***(AIR 1958 Supreme court 956)***
3.	Sidhrajbhai Vs State of Gujarat	i) The Government of Bombay ordered all private training colleges in the state to reserve 60% seats for government candidates who are working in the state boards. ii) On refusal, grant was withheld and affiliation was withdrawn.	1. Any interference should be for the development of minority institutions and **not** detrimental to the institution. 2. The circular and orders issued by government were quashed. ***(AIR 1963 Supreme Court CASES 540)***
4.	The State of Kerala etc Vs. Very Rev. Mother Provincial etc	The Kerala University Act 1969 brought the stipulation that prior permission of the Vice Chancellor should be obtained to issue final orders on the employees of a college including colleges administered by the minorities.	The appeal by the minority institutions was upheld and the sections affecting the minority rights in the Kerala University Act 1969 were struck down by the Supreme Court. ***(1970 (2) Supreme Court cases 417)***
5.	Ahmedabad St. Xavier's College Society Vs. State of Gujarat	The State of Gujarat brought laws in the state which was likely to violate the fundamental right of the minorities' educational institutions.	By majority judgment, section 33 A, 40, 41, 51 A, 51 A(1), 51 (B), 51 A(2) and 51 (B) of Gujarat University Act 1949 was declared as not applicable to institutions established by minorities. ***(1974 (1) Supreme Court cases 717)***
6.	Lilly Kurien Vs. University Appellate Tribunal.	Can a teacher employed in a minority institution claim promotion as a matter of right as she is the senior-most?	No. The minority institution has every right to promote any person of their choice provided they fulfill other conditions. The senior most teacher cannot claim promotion as a matter of right. ***(1977 (2) Supreme Court cases 240)***
7.	The All Saints High Schools Vs The Government of Andhra Pradesh and others	State of Andhra Pradesh and the University introduced regulatory measures in the administration of minority institutions.	The provisions contained in Andhra Pradesh - recognized Private Educational Institutions Control Act 1975 were struck down by the Supreme Court as invalid. ***(AIR 1980 Supreme Court 1042)'***

Sl.No	Case Title	Issue Raised	Decision
8.	TMA Pai Foundation Vs. State of Karnataka	Various issues	1. A minority institution may have its own procedure and method of admission as well as selection of students but such procedures should be fair and transparent. 2. Admission of students to unaided minority educational institutions viz schools, undergraduate colleges and where the scope for merit-based selection is practically nil cannot be regulated by the concerned state or university except for providing the qualifications and minimum conditions of eligibility in the interest of academic students. 3. Like any other private unaided institutions, similar unaided educational institutions administered by linguistic or religious minorities are assured maximum autonomy in relation to their (eg) method of recruitment of teachers, charges of fees and admission of students. They will have to comply with the conditions of the recognition which cannot be such as to whittle down the right under Article 30. ***(AIR 2003 Supreme Court cases 355)***
9.	Islamic academy of education and another Vs. State of Karnataka and others	Various issues	Government cannot fix a rigid fee structure for unaided institutions including minority institutions. ***(2003 (6) Supreme Court cases 303)***
10.	PA Inamdar and Anr Vs. State of Maharashtra and Ors .	Various issues	1. The policy of reservation cannot be enforced by the State, nor can any quota or percentage of admissions be carved out to be appropriated by the State in a minority or non-minority unaided education institution. Minority institutions are free to admit students of their own choice including students of non-minority community as also members of their own community from other states, both to a limited extent only and not in a manner and to such an extent that their minority educational institution status is lost. 2. The state cannot interfere up to the level of undergraduate education. The minority unaided educational institutions enjoyed total freedom. 3. So far as the minority unaided institutions are concerned, to admit students being one of the components of "right to establish and administer and institution", the State cannot interfere therewith. Up to the level of undergraduate education, the minority unaided educational institutions enjoy total freedom. ***(CDJ 2005 Supreme Court cases 595)***

What is meant by informed consent?

Consent is consensus of mind between two persons and in this context, between the doctor and the patient. Legally, both the doctor, who is to provide treatment to a patient and the patient have a similar understanding about the treatment/test proposed.

Informed consent is permission obtained from a patient to perform a specific test or procedure. It means the patient gives the consent in writing (signs the written consent form) after being informed in detail about the proposed treatment/procedure.

Informed consent is required before performing most invasive procedures and before admitting a patient to a research study. Informed consent is voluntary.

A valid consent form shall have the following features:

a) Details of the proposed operation/treatment/diagnostic procedures
b) The possibility of performing another operation if the first operation ends in failure; this decision will be taken by doctors while they are in the operation theatre itself
c) The approximate cost of the operation/treatment
d) The risks resulting out of failure of the operation and the type of disability arising out of the failure, with example
e) Proper witnesses (two in number) with signature, name and address so that they can be identified later, perhaps even after a lapse of 5 years
f) Signature of the patient; if he is less than 18 years of age, signature of his parent/guardian/relative.

The consent form can be produced in court in support of the medical practitioner/hospital.

From: Laws Related to Hospitals by Samuel Abraham (B.I Publication).

Clipboard goes electronic

Clipboard has been a well-appreciated publication. In order to reach more people, we will be sending it ***only*** by email from now on. However, if you would prefer to receive a printed version, please send a donation of Rs 100/- by DD to CMAI, Delhi, towards cost of publication and postage.

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A CMAI publication focussing on issues related to hospital administration

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