A Breath of New Life

Mure Memorial Hospital's OD experience

By Priya Raj Kumar (through the eyes of a staff member)

Early days

We are all products of our history. Mure Memorial hospital is the same. We were founded by a remarkable woman Scottish missionary Dr. Agnes Henderson who came to India in 1891 with a vision of serving the poor. She started a single bed clinic for mothers and children. Little did she know that this small beginning would grow over the years to a 125 bed general hospital with 150 staff (35 doctors, 35 nurses, 8 tutors, paramedical and administrative staff). In 1964, Dr. Agnes left the reins of leadership to Indian nationals i.e. Church of North India and left India. Our first Indian medical director Dr. S. N Mukherjee (from 1964 to 1999) had wide experience and initiative. He worked hard to develop the hospital, staff were content and we provided the best medical services.

Gasping patient

Soon after Dr Mukherjee retired, however, a crisis emerged. Morale of staff plummeted and patient numbers dwindled. Our credibility was at stake. Although the hospital management were seriously concerned and tried various options, nothing significant changed. It was like trying to revive a gasping patient. The hospital eventually ran into a deficit of almost $75,000. The gasping patient was sustained only through artificial respiration.

New Leadership

Five years ago, the Board appointed a new hospital director – Mr. Vilas Shende. He is not a medical professional and as staff we had mixed feelings about his appointment. However this new Director soon became aware of the prevailing situation and had tremendous energy to facilitate change. His experience of working in the social sector helped him to adopt a more people-centred approach. But he was not frightened to make important decisions. We appointed full-time senior medical staff, reviewed and developed our existing systems and revised our protocols for medical staff. The most important change, however, was the shift to a more participatory management approach. Staff were given many opportunities to contribute to the change process by expressing their views and opinions. Over a period of time the Director also helped to re-establish good public relations through the media.

Quality OD

We then approached the Quality Council of India for accreditation. This required us to go through a more thorough OD process. We did further work on our protocols and systems which led to the

preparation of a quality manual. Staffs at different levels were oriented to new systems, procedures and ways of working in order to provide quality services. We developed participatory systems for appraising the performance of staff. This participative appraisal process also enabled us to better identify the learning needs of staff. While management took responsibility for implementing these initiatives, staff were involved at every stage of the discussion. We were part of the advisory committee set up to take administrative decisions. As staff we felt fully involved in this fresh OD process. We felt our opinions were valued. As a result, staff motivation improved and we felt greater ownership of the hospital.

We were further encouraged as the hospital gave greater emphasis to staff development and growth. This was a welcome change. We learnt a lot from a series of in-house training programs and exposure visits. Most of the staff came back from these visits full of inspiration and ready to take up their work with renewed initiative and creativity. However, I must admit that not all of these initiatives brought about miraculous change. Some of my colleagues resisted any form of change and preferred the old way of doing things. They were not willing to adapt to the changes in systems and functioning. In some cases we had to arrange psychological counseling to help people adjust.

We realised afresh that the hospital exists primarily for the patient and providing quality service to the patient is our calling. We adopted a strategy called “Patient People First” which gave first preference to the patients (now addressed as clients). Our hospital organogram even reflects our bottom up approach.

The spiritual commitment which we share has made a big difference. This shared committed draws us to each other, strengthening our professional and personal relationships. We organized spiritual meetings and discourses to renew our spiritual commitment and seek enlightenment. During these meetings we focused on common human values shared by people of all faiths. These were opportunities to renew our commitment to the vision, mission and values of the hospital and also in our personal lives.

Ripple effects

The changes made through the OD process had a ripple effect. Our annual turnover increased from $53,000 - $85,000. We have moved from regular deficits, to an annual surplus. We invested our surpluses in renovating infrastructure and giving a face-lift to the hospital. We purchased much-needed medical equipment. We were able to increase salaries by 60 %. The local media published news about the progress of the hospital which helped to bring the hospital in the public eye and improve public relations. Most important, the annual patient census went up by 20 %.

The gasping patient had received a breath of new life.

Lessons Learnt

- OD in hospitals require varied approaches to address the needs of people coming from diverse backgrounds, education and work experience, ranging from highly technical (such as medical doctors, nurses, paramedics, technicians) to unskilled staff (watchmen, cleaning and maintenance workers).

- There are complex dynamics in the functioning of a hospital. As well as dealing with the various levels of staff we also have to focus on: maintaining standards of medical services; complying with changing legislation; dealing with labour unions; operating with very limited finances; and facing competition from private doctors. The interaction of these factors makes the hospital a unique and challenging workplace. Understanding the influence of these factors is important in initiating and implementing the OD process in hospitals.
- Hospitals are complex entities, which makes them different from any other organization. Hospitals constantly deal with life and death issues. Handling medical emergencies, accurate diagnosis of disease and removing pain and suffering are at the core of the hospital functions. Legal complications in patient care, managing patient relatives, medical technology etc make the situation more complex. When emergencies arise an OD process has to take a backseat.
- This means that OD processes need to be flexible, but also well-planned. Hospitals are not able to close for a week to do strategic planning (as some NGOs do). Not all hospital staff can be released at the same time for collective learning.
- We see that if an OD process is well-planned, need-based and flexible, then it can be helpful for hospitals. As with all OD processes, it benefits from harnessing management commitment and staff initiative to contribute to organizational growth and development. As ever, much insight, patience and perseverance is required in facilitating the process of change.