Speaking for Ourselves

Deaths of neonates in Gorakhpur hospital: Do we wait for another healthcare tragedy or shall we learn some lessons?

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'Let a wrongdoing repeat itself at least three times: the first may be an accident, the second a mistake, but the third is likely to be intentional.'

—African proverb

The death of several neonates at Gorakhpur's government medical college hospital sparked fresh debates over the working of government-funded hospitals. At the outset, we confess that we neither know the actual reasons for the tragic deaths nor the realities surrounding the purported deficiency of oxygen. However, we wish to critically analyse the bottlenecks in the process of procurement. If oxygen supply—a critical hospital consumable—was exhausted, then the government needs to re-examine how purchases are made of such items. Of course, that begs the question: what is a critical consumable? Do only oxygen and life-saving drugs fall into the category of 'critically important'? Even a gauze sponge used as a tamponade can be critically important. Certain drugs and consumables should be listed as 'critical' if used almost exclusively in life-support situations. Having identified critical items, their purchase should be expedited.

When one of us was on a volunteer mission with a charity over a decade ago, the efficient inventory management of supplies was an eye-opener. An American nurse deftly managed operation theatre schedules with charts colour-coding logistic supplies and shortfalls. Her non-negotiable decision to cancel a surgery for missing supplies, ignoring the annoyed surgeon, remains deeply ingrained. That kind of authority appears unrealistic in our system. We wonder whether a ward worker in our hospitals would dare inform the hospital superintendent of a potential disruption in the supply of oxygen for fear of reprisals and for daring to breach the hierarchical 'layers' to be heard. Informal, unhindered communication is unlikely to happen in traditional public sector hospitals, especially those located in lesser educated, backward parts of India where feudal traditions are strong and fear of punitive measures or verbal reprimand is high. This obstacle to free communication is an Asian cultural trait that must be addressed; a cockpit voice-recorder analysis of a South Korean airline crash in 1999 revealed that the co-pilot, trying to be respectful, delayed pointing out critical errors by the senior captain until it was too late.[1]

Besides oxygen supply, there could be shortages of drugs, dressings, soap, disinfectant, surgical spirit, hand sanitizer, antiseptic, sutures and other consumables. Multiple factors may complicate their timely replenishment. These could be:

1. No death may be directly attributable to their shortage.
2. Patients' relatives are instructed to buy some items when hospital supplies are exhausted or in short supply.
3. Patients may choose to remain quiet if they can raise the necessary funds (i.e. they are either not aware of their rights or may be grateful for treatment received).
4. Patients may perceive the system as slow and non-responsive (i.e. bureaucratic) and realize the hopelessness of providing feedback about deficiencies.
5. Patients may be already exhausted and overwhelmed with the logistics of transporting an ill relative and a difficult stay in the corridors of a public hospital.
6. There may be a degree of apathy on our part.

This absence of feedback from patients about shortages suggests a fear that complaining about lack of hospital supplies would somehow lead to a compromise in care received. Nearly all our tertiary care centres and district hospitals have pharmacies, private pathology laboratories and X-ray centres in their vicinity. Obviously, business is good in their neighbourhood.

We must collect data from all discharged patients about out-of-pocket expenses incurred. Documenting these costs would highlight shortages in outpatient departments and wards. This valuable information is currently lost. Out-of-pocket expenditure is an 'alarm bell' for more serious deficiencies by drawing attention to inefficient procurement practices. Informal discussions about non-availability of hospital supplies with nurses and administrators reveal just that procurement processes are perpetually 'ongoing'. What then is the reason for lack of availability of these critical items?

The present process of procurement requires cumbersome paperwork, book-keeping and desk-to-desk movement of files. It is unacceptable for sanctioned posts to remain unfilled as day-to-day clerical tasks are hampered by limited time devoted to this paperwork by clinicians already dividing time between teaching, treating, research, ward rounds, travelling, besides administrative work and publishing. The fact is that the same system of purchase exists—moving bulky files and note sheets back and forth across offices—whether the item in question is stationery or oxygen, which reflects a worrying lack of priorities. It would be instructive to study the work practices of the network of military hospitals across India. They provide basic and complex medical care to armed forces personnel, operate within budgets and yet are unlike public-funded hospitals: their premises are clean, outpatients efficiently handle a large number of patients, personnel are in

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designated areas, inpatient care is good, and drugs and consumables (also awarded to the lowest bidders) are available. One crucial difference is the discipline with which military hospitals are managed, with punitive measures built into the Army Act for compliance with rules. There are problems too, but less of the absenteeism, no illegal private practice and no debilitating stocks that hamper the functioning of civil hospitals.

A solution may lie within the framework of the Digital India initiative by the Government of India. Digitization of purchase files and their subsequent electronic movement and tracking would add efficiency, security and speed. Barcodes or QR codes permit rapid scanning to replace data entry. These modern systems are already in use in retail, powered by India's formidable information technology (IT) industry. Why cannot our public sector hospitals adopt improved office procurement procedures from India's IT sector which is the world's preferred destination for back-office processes? Digitization is being applied to the process of obtaining feedback at public hospitals. This is done with SMS (short message system) response codes, allowing precise categorization of responses but eliminates details. Instead of merely coding patients' experiences, specific comments need to be captured. There are logistic challenges to data collection and analysis and no method is perfect; digitally recording responses may make patients fearful that a 'bad report' will be traced to them through a linked mobile number and bias the system against them. Commendable initiatives to discourage absenteeism such as Aadhaar-based biometric attendance have good intentions but cannot work with patchy availability of the internet.

Informal discussions with colleagues reveal widely varying awareness about various general financial rules (GFR) that govern procurement of hospital supplies.[2] There is fear of implication in financial irregularity and that audits could lead to the recovery of monetary amounts years later. If doctors need medicolegal training, it is equally important for them to have a working knowledge of GFR clauses to prevent unnecessary cancellation of bids in response to tenders floated for purchases. It is unrealistic to expect everyone to learn 'on the job' with no formal training. Stores officers at our hospital commendably take the initiative and guide doctors on intricacies of purchase. But is handling of purchases the task of clinicians or clerks? Equally important, procurement and finance personnel must periodically see wards and patients (a ward walk-through with consultants) to understand their requirements so that procurement does not become 'dehumanized'.

The media reported that payments were pending to the supplier of oxygen for the Gorakhpur hospital. Smaller hospitals do not have oxygen plants, requiring purchase from vendors. Delays in payments are known issues that hint at cumbersome procedures.[3] Suppliers require timely payments to run their businesses. It is noteworthy that financial rules mandate that suppliers be penalized (liquidated damages) for delays in delivery of goods, but there is no clause on vendors receiving interest on the delayed release of payment by the government! The crucial question is: was oxygen at Gorakhpur purchased with a rate contract with the timely release of payments? And were enough trained administrators and clerical staff in place to prepare and process purchase- and payment-related documentation?

The Gorakhpur incident would not have made it to national news if the problem related to suboptimal surgical outcomes instead of deaths. This raises the uncomfortable question whether treatment results are adequately audited across public sector hospitals. Are our wound infection rates on par with published data? Are vaccines stored properly? While it is commendable that academic meetings exist among doctors for exchange of ideas, morbidity and mortality (M and M) meetings need to be turned into morbidity and mortality and management (M and M and M) meetings by hospital administrators, who must understand suboptimal outcomes in a non-accusatory manner and identify obstacles to delivery of healthcare. Too many meetings are burdensome to the already stretched time schedules of clinicians so it is only logical that state governments take a call on private practice by doctors employed at government hospitals and discontinue the practice altogether. This will be realistic only with timely disbursal of salaries, attractive pay and perks, and punitive action including dismissal against defaulters who do private practice.

The media mentioned that the Gorakhpur tragedy occurred in the chief minister's constituency. This disturbingly implies that hospitals outside the state capital or a minister's constituency are expected to run poorly. By that logic, a primary health centre would be ramshackle and dysfunctional. The dichotomy of standards is unacceptable. Across the board, a minimum acceptable standard of primary health centres, government clinics and hospitals needs to be defined, publicised and adhered to. Where a hospital is located should have no correlation with the quality and reliability of care. If our administrators from the *panchayat* to district to state level seek healthcare at smaller hospitals instead of flying to New Delhi or abroad for treatment, it would infuse confidence and much-needed pride in the public healthcare system and set the stage for reforms. Our public healthcare systems have done well in delivering community health programmes such as immunization. New tertiary care hospitals such as the new All India Institute Medical Sciences (AIIMS) in many states are geared to deliver efficient, affordable and quality healthcare. However, are smaller district-level hospitals, urban health centres and primary health centres getting neglected in the race to deliver tertiary level care? Should not the fact that patients with basic diseases and ailments also report to AIIMS be a matter of concern and a warning sign that rural and district healthcare centres are failing? And are the government's poll promises to provide free dialysis, free cochlear implants and free cardiac surgery draining the exchequer of precious funds meant for more mundane purchases by our public hospitals? A sustainable financial roadmap for delivery of healthcare to urban and rural India is needed:[4] how much will the government-run and how much outsourced private healthcare will it fund? Will the focus remain on new tertiary hospitals or well-functioning small centres? To decide that, decision-making must include experienced clinicians, not only bureaucrats.

It is instructive to borrow ideas from sectors other than our own.

Conclusion

The Gorakhpur tragedy is a deranged vital sign of our office procurement systems. Instead of knee-jerk responses to such unfortunate incidents and succumbing to the media's baying attempts at head-hunting, it is time to accept that such incidents reflect a deeper malaise in procurement processes. No stronger reform is more urgently needed in India than in eliminating administrative obstacles to the delivery of public healthcare. Whether malpractice, inefficiency and corruption contributed to the deaths of neonates in Gorakhpur will become clearer with time; what we do know is that India's metrics for neonatal mortality rates are dismal.[5] Let alone the global average, we lag even lesser developed poorer neighbours such as Nepal, Bhutan, Bangladesh and Myanmar. The tragedy of neonatal deaths is

another wake-up call for public sector hospitals to review procurement policies. If the Gorakhpur incident were the culmination of a series of mistakes, then to permit another preventable tragedy to happen would be inhuman. Just three words can change the mindset that appears to plague our Indian system: Human lives matter.

Conflicts of interest. None declared

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