Patient-centric Approach through “Multi-Purpose Behavior Therapy (MPBT)” Room for Improving Patient’s Satisfaction And Decreasing Work Load in Hospitals: An Analysis from Available Evidence

Abstract
Many studies from India have documented that patients are not satisfied with their treatment provided in the hospitals. The common reasons of patient’s dissatisfaction are overcrowding, long waiting time to meet doctors, short consultation period (2 minutes), absence of a congenial environment, and communication gap. It is well known fact that there is frustration with systemic problems of government hospitals, from poor budgetary allocation to shortage of health care staff. It is evident from management studies that, if we have to give better output without changes in the input level we have to improve our existing processes. Improvement of any system is possible by proper system analysis, system design and effective implementation. In hospitals also, our aim is to design and implement a customized and comprehensive care plan, giving more emphasis on the patient’s problems than on their diagnosis. Person centered care is underpinned by values of respect for persons, individuals right to self-determination, understanding, empathy, tow way communication and eye to eye contact. Newer concepts like social prescribing in patient care have been implemented in the Multi-Purpose Behavior Therapy (MPBT) room project at PGIMER, Chandigarh for urinary incontinence, dysmenorrhea, osteoarthritis and polycystic ovarian disease patients. Our results indicate that it is feasible to impart health promotion orientation in gynae OPD and orthopedic OPD through counselling of patients for de-medicalization of management of their health problems. Doctors also reported reduced workload. However, this model can be adopted in any clinical department for improving patient satisfaction and decrease workload in hospitals..

Keywords: Behavior therapy room, patient-centric care, salutogenesis

Introduction
Many studies from India have documented that patients are not satisfied with their treatment provided in the hospitals. There are multiple reasons for that. Some of the reasons are controllable others are not.[1]

The common reasons of patient’s dissatisfaction are overcrowding, long waiting time to meet doctors, short consultation period (2 min), absence of a congenial environment, and communication gap. It is well-known fact that there is frustration with systemic problems of government hospitals, from poor budgetary allocation to shortage of health-care staff.[2]

India’s public health expenditure is among the lowest (1.02% of GDP) in the world, lower than most low-income countries which spend 1.4% of their GDP on health, according to the National Health Profile, 2018. Sri Lanka spends about four times as much as India per capita on health, and Indonesia more than twice. The shortage of workforce is also creating a problem for effective health-care service delivery.[3]

Only 106,415 doctors are employed by the Government in India, of the 938,861 doctors registered to provide healthcare to a population over 120 crore (1.2 billion). Similar scenario is observed in the cases of nurses also. The number of nurses is also 0.9/1000 inhabitants in India.[4]

Given the poor budgetary allocation for health in India, these problems are unlikely to change. With poor infrastructure and no increase in the number of posts for government doctors over the past many decades, despite an increasing population, the public health-care system is on the verge of collapse. Patient’s satisfaction is
decreasing day-by-day and communication gap between doctors and patients is increasing. It is one of the main causes of recently reported sudden increase in medical violence incidents.\textsuperscript{[4]}

In 2018, British Medical Journal reported that doctors in India see patients for barely 2 min. Such a short consultation adversely affects patient care, workload, and stress of the doctors. In Western countries, consultation crosses 20 min. Over the past 15 years, globally, new concepts have emerged about doctor–patient interaction, such as patient- and family-centered care, patient as person, social prescription, and information therapy. There is a focus on active collaboration and shared decision-making between patients, families, and providers.\textsuperscript{[3]}

It is evident from management studies that, if we have to give better output without changes in the input level, we have to improve our existing processes. The improvement of any system is possible by proper system analysis, system design, and effective implementation.\textsuperscript{[6]}

In hospitals also, our aim is to design and implement a customized and comprehensive care plan, giving more emphasis on the patient’s problems than on their diagnosis. Person-centered care is underpinned by values of respect for persons, individual’s right to self-determination, understanding, empathy, two-way communication, and eye-to-eye contact.

Doctors generally prescribe pills to make people feel better. In contrast to this, exclusively pharmaceutical approach social prescribing is relatively new holistic approach to wellness in which patients are encouraged to fit their lifestyle, interests, and special needs in ways that complement any medical prescriptions. This highlights the concept of patient self-care with “information prescriptions.” Here, patients are supported to take greater control of their own health.\textsuperscript{[7]}

The above-mentioned newer concepts in patient care have been implemented in the Multi-Purpose Behavior Therapy (MPBT) room project at PGIMER, Chandigarh.

**Functions of multipurpose behavior therapy room**

After referral from main outpatient department (OPD), staff in MPBT room provides counseling including BT and exercises to antenatal women or those with dysmenorrhea, urinary incontinence, uterine prolapse, and menopause of infertility. The concept of diet-healthy lifestyle is explained to them. In MPBT room, women are counseled together with their family members. This way the husbands, the mother in law and other relatives can also understand her problems, especially in the case of infertility. Even adoption services were linked with MPBT room for those who cannot conceive. Queries of patients are resolved at leisurely pace. Sufficient time is devoted to each patient. Exercises and lifestyle changes (simple exercise/yoga) are also explained to the cases of such as morning sickness, backache, cramps, fainting spells, heartburn, and constipation the de-medicalization philosophy inherent in the MPBT room approach helps in empowering the women in self-care of their reproductive and other health problems. The latest addition is the use of mobile phone/laptops for video-based counseling.

In effect, MPBT room concept is operationalization of a multi-disciplinary teamwork in OPDs.

Unique features of MPBT room approach include a family-centered individualized as well as group counseling sessions, adoption of demedicalization approach for tackling the routine OBG problems of women, and integrated training strategies are used [Table 1].

### Impact multipurpose behavior therapy room in gynecology patients and doctors

It is proved that many of the problems of women reporting at gynecology and orthopedics OPD can be resolved by nonmedicinal interventions, for example, appropriate behavior therapy, exercise, and counseling. The results proved that they can be weaned off their dependence on medical cure. Human body’s power of self-healing was strongly emphasized. The concept of “Salutogenesis” was also popularized.\textsuperscript{[8]} Because of the enormous patient load in hospitals, the doctors in overcrowded gynecology and orthopedics department. OPD usually have no time to explain these things to the patients. Much of their time is wasted on routine queries of the patients. This can be avoided if we stress on conservative management of health problems of women through decentralized counseling in OPDs. MPBT room project did exactly that.

#### Example-1 Multi-purpose behavior therapy for Urinary Incontinence

This study was conducted to assess the impact of running a BT room for various categories of UI cases in different age groups in obstetrics-gynecology outpatient department of a tertiary care center. It was found that a total of 251 cases were registered in the MPBT over 2 years. Overall 126 patients got relief from UI and prolapse of pelvic floor organs after BT.\textsuperscript{[9]} Details of results are given in Tables 2 and 3.

#### Example-2 Behavior therapy for Dysmenorrhea

Few studies conducted by the authors have revealed that behavior therapy, exercise, hot water bottle, and use of ginger (tea or powder) led to a significant relief in the severity of pain and menstrual distress in the girls. In the exercise group, 28.3% of the dysmenorrheic girls became pain-free at the end of the 3\textsuperscript{rd} month of intervention as compared to 37.33% in the hot water bottle group. The benefit of behavioral therapy can be realized when we compare it with the drug therapy for menstrual pain.
Table 1: Strategies used in MPBT room

| Type of incontinence | Number of patients (%) | Reported relief |
|----------------------|------------------------|-----------------|
| SUI                  | 71 (28.2)              | Yes 36 (50.7)   |
|                      |                        | No 35 (49.3)    |
| UUI                  | 29 (11.5)              | Yes 14 (48.2)   |
|                      |                        | No 15 (51.7)    |
| MUI                  | 51 (20.3)              | Yes 29 (56.8)   |
|                      |                        | No 22 (43.1)    |
| Prolapse with SUI    | 58 (23.1)              | Yes 28 (48.2)   |
|                      |                        | No 30 (51.7)    |
| Prolapse with UUI    | 19 (7.5)               | Yes 10 (52.6)   |
|                      |                        | No 9 (47.3)     |
| Prolapse with MUI    | 23 (9.16)              | Yes 9 (39.1)    |
|                      |                        | No 14 (60.9)    |
| Total                | 251                    | Yes 126 (50.1)  |
|                      |                        | No 125 (49.8)   |

SUI: Stress urinary incontinence, UUI: Urgent urinary incontinence, MUI: Mixed urinary incontinence

Drugs may have side effects. Hence, BT should be considered as an initial step for the management of dysmenorrhea before considering medical intervention. The significant advantages of these regimens assume enormous dimension in countries like India where the majority of women do not get an opportunity for appropriate and adequate treatment of their reproductive health problems. In fact, such therapies will prove to be an empowerment mechanism for helpless dysmenorrheic girls who are rather forced to tolerate this easily treatable yet significant quality of life affecting malady, may be because of the fear of embarrassment, shame, or shortage of money.[10]

Example-3 Behavior therapy for Knee Osteoarthritis

Sharma M, Singh A. have conducted a Randomized Control Trial (RCT) as a part of her PhD work with an objective to compare the impact of two nonpharmacological intervention packages on quality of life in knee osteoarthritis (KOA) patients reporting at PGIMER Chandigarh. She used laptop/video/brochure/booklet/posters for training the KOA patients on exercises etc.; it was found that overall 123 patients (87 females and 36 males) were enrolled in the study. All except 4 patients (who had unilateral KOA) were diagnosed with bilateral KOA. There were 63 patients in mild grade group. Of these, 4 were lost to follow-up. Most (n = 49) patients complied with the instructions. Few (n = 10) were noncompliant. Sixty patients had moderate grade KOA. Here, lesser number (n = 22) were compliant. Rest (n = 38) were noncompliant. The response has been quite good. There was an improvement in the condition of many patients as measured by Visual Analog Scale (VAS) and Western Ontario and McMaster Universities Osteoarthritis (WOMAC) scale. In general, more of the compliant participants showed better improvement as compared to the noncompliant patients. The mean WOMAC scale decreased from 32.1 to 22.8 for the compliant patients. The mean VAS score decreased from 5.1 to 3.1.[12]

Example-4 Behavior therapy for Poly-Cystic Ovarian Disease (PCOD)

We describe here eight polycystic ovary syndrome cases enrolled in an RCT. The study aimed to ascertain the impact of the lifestyle intervention for the management of polycystic ovarian syndrome among girls. Anthropometric assessments and biochemical parameters, including reproductive hormones and insulin resistance, were performed at baseline and after 6 months of intervention, change in their health profile was noted. After the intervention, menstrual regularity was achieved in all cases. The average weight loss was 4.07 kg (range 2.5–14 kg). The average body mass index reduced from 26.6 to 25.0 and waist circumference from 94.1 to 86.6. At the end of the intervention, five cases had normal ovarian size, luteinizing hormone:follicle stimulating hormone was normal in three cases. Out of six with insulin resistance, only one tested positive after the intervention.[12]

Conclusion

Our study indicates that it is feasible to impart health promotion orientation in gynecology OPD through counseling of women for demedicalization of the management of their routine health problems. Doctors also reported reduced workload since they did not have to spend...
time on routine cases. The burden on family caregivers also reduced. Simultaneously, this also helped to instill a sense of confidence among patients and their caregivers when they observed the positive results of their taking charge of their own health. Their concept of self-efficiency also improved.

This room has enhanced the level of satisfaction of patients and their relatives. Women are also happy that they are being listened to patiently.[13-20]

### Recommendations

The demonstration of the efficacy of the demedicalization philosophy inherent in the use of BT/counseling in MPBT room will help in empowering the women to control their reproductive health. This approach provides relief to them without resorting to any medication.

In this paper, we have described about gynecology and orthopedics OPD. However, this model can be adopted in any clinical department. As an example – same can be done in cardiology department for poststroke patients, neurology department for epilepsy cases, and psychiatry department for illicit drug use cases. As in these departments, adequate consultation is required (especially for chronic diseases/noncommunicable disease) to prevent any adverse outcome/readmission and to increase patient satisfaction. It is quite difficult for the clinicians in a busy hospital. It is quite possible to establish the counseling room to decrease the patient load as well as an increase in patient satisfaction.[13-20]

As the burden of noncommunicable disease is increasing in India, this is high time to incorporate this model in the National Program for Prevention and Control of Cancers, Diabetes, Cardiovascular Diseases and Stroke program for a better outcome in term of number of Disability-Adjusted Life Year averted or Quality-Adjusted Life Year gained.

Not only that but it will also improve the socio-medical environment of “pill of every ill” kind of medicalized life and mindset of citizens.

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### Conflicts of interest

There are no conflicts of interest.

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### Table 3: Trends of the impact of behavior therapy on various categories of urinary incontinence in different age groups

| Age (years) | Relief | Total | Odds of relief | P    |
|-------------|--------|-------|----------------|------|
|             | Yes    | No    |                |      |
| SUI         |        |       |                |      |
| 10-30       | 3      | 1     | 4              | 1.00 | 0.05*|
| 31-60       | 32     | 29    | 61             | 0.37 |
| >60         | 1      | 5     | 6              | 0.07 |
| UI          |        |       |                |      |
| 10-30       | 2      | 1     | 3              | 1.00 | 0.42 |
| 31-60       | 11     | 12    | 23             | 0.46 |
| >60         | 1      | 2     | 3              | 0.25 |
| MUI         |        |       |                |      |
| 10-30       | 4      | 1     | 5              | 1.00 | 0.03*|
| 31-60       | 23     | 15    | 38             | 0.38 |
| >60         | 2      | 6     | 8              | 0.08 |
| POP with SUI|        |       |                |      |
| 10-30       | 8      | 3     | 11             | 1    | 0.01 |
| 31-60       | 19     | 20    | 39             | 0.36 |
| >60         | 1      | 7     | 8              | 0.05 |
| POP with UI |        |       |                |      |
| 10-30       | 1      | 1     | 2              | 1.00 | 0.67 |
| 31-60       | 7      | 7     | 14             | 2.00 |
| >60         | 2      | 1     | 3              | 2.00 |
| POP with MUI|        |       |                |      |
| 10-30       | 1      | 1     | 2              | 1.00 | 0.24 |
| 31-60       | 7      | 8     | 15             | 0.88 |
| >60         | 1      | 5     | 6              | 0.20 |

*Significant difference. SUI: Stress urinary incontinence, UUI: Urgent urinary incontinence, MUI: Mixed urinary incontinence, POP: Pelvic organ prolapse
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