CHRISTIAN MEDICAL JOURNAL OF INDIA

CMJI

A Quarterly Journal of the Christian Medical Association of India

VOLUME 32 NUMBER 3 : JULY - SEPTEMBER 2017

OPPORTUNITIES in Health Care Mission

Join Hands with us in Healing Ministry

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CHRISTIAN MEDICAL ASSOCIATION OF INDIA

CMAI is a national network of health professionals and institutions promoting a just and healthy society for all irrespective of religion, caste, economic status, gender or language

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- CMAI builds individuals to be technically sound, spiritually alive, and socially relevant, in fellowship and with a Christian perspective on health and development.
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- Advocate for innovations, create evidence and promote policy change
- Work closely with the churches, civil society and the government
- Build alliances for health action on a national scale

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- Christian Medical Journal of India (Perspective)
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The core of CMAI is its members- individuals, institutions and churches. Individual membership consists of five professional groups - Doctors, Nurses, Allied Health Professionals, Chaplains and Administrators. Each section comes together for retreats, workshops, conferences and campaigns to share resources.

For more information about our work and to download membership form visit our Website:

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We invite Christian health care professionals, join us as members

COME JOIN US AS MEMBERS

Building a just and healthy society

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OPPORTUNITY IN HEALTH CARE MISSION

LETTERS TO THE EDITOR

The CMJI issue is really good. Articles by Jaylal, MC, Ophelia & SP are first person experiences making it very authentic and touching. Personally, I could revisit Betul, Tirunelveli and recall those student days while reading and looking at the group photo in Betul.

While Anand's article provided theological framework, MC, Ophelia and Jaylal have shared about issues related to the government and private settings, influenced by the Christian leadership, marked by their humility and availability than the techno expertise. Good examples of how actions speaks louder, influences young minds to opt and find true meaning in their vocation and training. Articles by Mrs. John presents key elements in excelling at work. A feature on a Serkawn was very inspiring and defines the relevance of mission hospitals.

The whole issue explores beyond the boundaries and centres on the Mission. While Christ and His love remains the centre of the Mission, often our ownership begins to define the periphery and is confused with the Mission. I recall Dr Elsy Philip's words in one of the medical student's conference: A true place for a Christian health worker is the government hospitals where only the poor visit. Ophelia in her article has emphasized- Act Justly, Love Mercy, and Walk Humbly. What else is a Christian worker expected to do? Thank you for your leadership. I am truly grateful to CMAI for shaping my life.

Mr. Shailendra Awale

Thank you. Please congratulate Dr Nitin Joseph and his team for such an inspiring issue of CMJI. I especially liked Dr MC Mathew's insights into practicing our faith in Secular health care forums. His experience ranging from working with Greats like Dr Susheila Nayar, Dr Janet Goodall and with the MFC were illuminating. I too hope and pray that young Christian health care professionals feel called to practice their faith wherever they can; to reach those in need, keeping the words of Jesus in mind " life in abundance" and not "wealth in abundance" as their goal.

Regards

Dr Leila Caleb Varkey

Guidelines for Contributors

SPECIAL ARTICLES

CMAI welcomes original articles on any topic relevant to CMAI membership - no plagiarism please.

- Articles must be not more than 1500 words.
- All articles must preferably be submitted in soft copy format. The soft copy can be sent by e-mail; alternatively it can be sent in a CD by post. Authors may please mention the source of all references: for e.g. in case of journals: Binswanger, Hans and Shaidur Khandker (1995), 'The Impact of Formal Finance on the Rural Economy in India', Journal of Development Studies, 32(2), December. pp 234-62 and in case of Books; Rutherford, Stuart (1997): 'Informal Financial Services in Dhaka's Slums' Jeoffrey Wood and Ifftah Sharif (eds), Who Needs Credit? Poverty and Finance in Bangladesh, Dhaka University Press, Dhaka.
- Articles submitted to CMAI should not have been simultaneously submitted to any other newspaper, journal or website for publication.
- Every effort is taken to process received articles at the earliest and these may be included in an issue where they are relevant.
- Articles accepted for publication can take up to six to eight months from the date of acceptance to appear in the CMJI. However, every effort is made to ensure early publication.
- The decision of the Editor is final and binding.

LETTERS

- Readers of CMJI are encouraged to send comments and suggestions (300-400 words) on published articles for the 'Letters to the Editor' column. All letters should have the writer's full name and postal address.

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- Authors are requested to provide full details for correspondence: postal and e-mail address and daytime phone numbers.
- Authors are requested to send the article in Microsoft Word format. Authors are encouraged to use UK English spellings.
- Contributors are requested to send articles that are complete in every respect, including references, as this facilitates quicker processing.
- All submissions will be acknowledged immediately on receipt with a reference number. Please quote this number when making enquiries.

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EDITORIAL

MEDIMISSION

Dr Nitin Theodore Joseph

Mission and Evangelism express the outward impulse of the Christian faith. Mission is the heart of the message of the gospel. The word 'mission' comes from the Latin word *mitto* that means 'to send', the noun of which is *missio.* In the Old Testament there were several people of God who were selected to announce judgment or redemption to His people. Few, like Isaiah were eager to take on the role of God's spokespersons, while the majority that included Moses, Jeremiah, Gideon etc. had doubts about their calling. In the New Testament Jesus gave the simple yet profound message of salvation to very ordinary people who later literally "turned the world upside down". Luke was the prototype of a medical missionary.

In contemporary times we see several examples of godly women and men who left the safe and happy confines of their homes and travelled great distances and made their dwelling in some of the most inhospitable and hostile places to provide medical services and to preach the gospel. David Livingstone did this in the continent of Africa and suffered physical and mental anguish in doing so. Closer to home Ida Scudder in Vellore, Edith Brown in Ludhiana, William Wanless in Miraj, Frances Newton in Ferozepur, Pandita Ramabai in Kedgaon and several others pioneered the healing ministry across India. All of them had one thing in common- in response to Christ's Great Commission they were willing to leave their comfort zones, face challenges and establish institutions to provide healing and salvation.

Today the opportunity to be involved in missions is immense and the necessity to do so is unprecedented. The challenges in this area are also growing with newer legislations and regulations that seemingly threaten the very ethos of our institutions compelling us to take decisions that we perhaps never expected to take. But amid all difficulties, the mission must go on.

Signing off: This is my final issue of CMJI as your Editor and by the time you read this issue I would have handed over this responsibility to someone whom God has chosen. It has been a blessing to be the Editor, a role that I never expected and I have been personally enriched by it. CMAI is a unique organisation that brings all medical personnel- doctors, nurses, administrators, allied health professionals, chaplains and students under one umbrella. It is up to its membership to carry on its mandate of healing and wholeness. I wish to sincerely thank the leadership of CMAI for entrusting the responsibility of the Editor to me for the last 4 years and a resounding thanks to my Editorial Team for enabling me to carry it out.

To God be the glory great things He hath done….

Dr. Nitin Theodore Joseph

BACKGROUND TO THE GROWTH OF HEALTH CARE IN INDIA

Mr. D. Anand Peacock

It is common knowledge that Christianity came to India before it reached the West. Ancient tradition holds one of the Disciples of Christ, St Thomas who came to India in 52 AD. With time there was a flow of missionaries who disseminated the gospel in the subcontinent. Despite early missionaries from Denmark like Ziegenbalg who came here in the early 1700's the era of modern missions was ushered in by William Carey a few years later on. Throughout history it is clearly evident that missionaries had a holistic approach. They reached out in the areas of education, health care and planted churches. This was a focus that threw light on the social, economic and moral as well as spiritual health of the people. The effect of missionaries was transformative in society and this was evident in the lives of many. While they did their part in empowering women through education and opening up a world of opportunities for them in terms of the way they were treated in society, they also saw the need for health care in a country where the means to quality health care is only for those who can afford it. In other words if you cannot pay for it you perish.

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This gave birth to the concept of mission hospitals in India. Christian missions have had and continue to have a considerably impact in the healthcare sector of the country bringing quality medical facilities to the poorest of the poor. Now the Doctor began treating the patient with care irrespective of their caste or social status. Where earlier one would be denied treatment based on their social background on account of them being untouchables, Doctors broke this wall by touching the patient and accepting them into the social fold. A very Christ like practice where he too went about doing good and touching the outcaste and lepers of his time.

To address the issue of pregnant women dying on account of their husbands refusing treatment from a male doctor, Christian Medical College Vellore was founded by Ida Scudder in 1893. A year later Christian Medical College and Hospital in Ludhiana was formed by Dame Edith Mary Brown in 1894 and was the first medical school for women in Asia. Even more than 100 years later we are witness to the fact that these hospitals continue to produce doctors who serve selflessly in mission hospitals in remote locations around the country.

In the case of patients affected with leprosy, they were considered to be cursed by God and were even buried alive in many cases. In the Old Testament whenever a person was caught with leprosy they had to live outside the community. In fact, one of the laws that God gave the Israelites in the Old Testament says, *"As long as he has the infection [of leprosy] he remains unclean. He must live alone. He must live outside the camp."* Leviticus 13:46. Christian doctors and nurses in mission hospitals began caring for them. They were cared for as part of the community. We know of Dr Paul Brand who revolutionised leprosy treatment in CMC Vellore. These illustrations serve to highlight a historical progression in the story of the Christian and health care in India.

The Biblical view of health

John Wesley, founder of the Methodist denomination,

We know of Dr Paul Brand who revolutionised leprosy treatment in CMC Vellore. These illustrations serve to highlight a historical progression in the story of the Christian and health care in India.

wrote that man was created as "a well-working system." Wesley would say that "The perfect model or expression of health would be Adam before the fall, a balanced, harmonious, human organism designed for immortality.

When we contend that the bible has a holistic view of health we derive this notion from the concept of shalom which is the nearest in meaning to health. An Old testament scholar Von Rad defines shalom as *well being* and quotes Judges 19:20 as well as 1 Sam 16:5 to underline the fact that shalom as a strong material side to it. In fact in both the poetic books we read of shalom of the wicked Job 21:7-13 and Psalm 73:3-5 which is no way can be inferred to be spiritual well being. In ancient Hebrew thinking health was understood in terms of longevity and strength. The idea of health in the Old Testament is carried on in the New Testament as well. But we need to understand that the New Testament has no specific term for health, it rather looks at terms for healing. We deduce three areas of healing in this relation:

1. Physical healing
2. Casting out of demons
3. Raising from the dead

Thus the New Testament understanding of health is seen as the absence of illness, and the exorcism of evil spirits which would comprise health both in the physical and mental realm. The bible in other words looks at health purely in physical terms.

The christian response to suffering in our country

My application for the Christian is a sense of ***involvement*** that is transformational. The key to having an impact in the life of the weak and ill is relationships. The second most important commandment to love our neighbour, determines that the way we treat one another is a reflection of our relationship with our creator. Relationships are crucial in effectively delivering heath care. Poor communication means that in the line of health

care delivery it could lead to ineffective treatment which will go on to have an adverse effect at the other end of the spectrum which is the patient. The bible is clear about the fact that individuals and the community as a whole have a responsibility towards one another. In the area of healthcare then, setting up good relationships is pivotal.

That is the clarion call for the Christian, involvement, since it means giving up the luxuries and comforts that one is entitled to and stepping out into the area of dire need. It also opens up one to vulnerability. But in it lies the power of the gospel. In fact I would underline that the Christian response to the issue of suffering is considerable in places like India where we form less than a mere 3%, an inconsequential minority. There are innumerable instances of Christians risking their lives to reach out to those in affliction. Since in many countries including our own, the State is uninvolved or shabbily involved in the lives of the poor, this has made room for the Church to step in and Christian NGOs to get drawn to human need in significant ways.

Even where there is little or none, they are to respond and have shared their five loaves and two fishes that have had a ripple effect in meeting the needs of countless people.

Such an involvement has had a transformatory effect in the community. The people he healed, Jesus often sent back to the community they belonged to.

This brings us to the concept of ***universality***. All who suffer are worthy of the Christian response. Anyone regardless of their social standing, or caste or creed is made in God's image and is worth serving. This belief reaffirms the fact that all of us possess dignity. So when we attend to the need of the leper or the victim of HIV AIDS, we are acknowledging that dignity through their pain. This means we go on not only to address ones physical needs, we consider the poor and those on the boundaries and outside, as one's sinned against rather than sinning. Our calling is to stretch and blur boundaries and break the walls that have kept people ostracised from the community and care; to be the helm of the garment that when people connect with us they will experience healing. Such universality is not necessarily a common feature of all religious groups.

It must to be understood that Christians do not wait to secure all the necessary resources to attend to someone's need. Even where there is little or none, they are to respond and have shared their five loaves and two fishes that have had a ripple effect in meeting the needs of countless people. No suffering is beyond address, no one who approaches us can be shown a closed door, despite our limitations. In other words there is not a condition that is beyond an empathetic response. It is our own conviction of hope that is diffused in our service. Only those with hope can respond to the hopeless. Only those who have been broken can be sensitised to respond to brokenness.

Nevertheless, the challenge to Christians to risk involvement with the poor and suffering is never going to diminish in priority for Christian mission. The poor are not to be considered objects or targets of the Church; rather they are a significant part of it. Because when they suffer all suffer. We cannot ignore the fact that special attention needs to be made to the suffering women and children as they are the ones who are the most vulnerable in community. Only when we turn the spotlight on them can we speak of responding in ways that are equitable and egalitarian.

With time it has become increasingly clear that our religion and the practice of it has lost its "we" ness. We have become more centred on the self and have created a God for the individual removing God out of the community. This has fractured relationships, paved the way for arrogance and increased a sense of selfish indifference. It is time we affirm our "we-ness" by being more accepting and tolerant in a rather hostile climate within our country today. By learning not to draw lines and rubbing off the edges. By realising that we always cannot be in control. Our attitude does not guarantee cure, but it instils and reaffirms the fact that it is the care of the sick and suffering into which we were baptized. Even though we do not have the words or understanding in some cases but we will continue to care and stand besides the suffering. In the end what we will weave is "our" story and not that of any individuals.

Mr. D. Anand Peacock is a State Program Manager for West Bengal Cure Clubfoot India

THE NEW SPACES FOR HEALTH CARE MISSION IN CHANGING TIME - A PERSPECTIVE!

A recent innovation in the state of Kerala in health care sector is converting some Primary Health Centres into Family Health Centres. Each family Health centre would have specialist doctors, offer longer hours of service, emergency services, mental health clinics, counselling, palliative care etc. There is an increase in alcohol dependence or substance abuse, suicide, family crises, chronic non-communicable illnesses needing long-term care. Obviously a conventional approach to health care would not address the emerging health needs of the vulnerable groups in the state of Kerala. This latest adaptation initiated by the government is an authentication of what the non-governmental charitable health care providers were engaged in during the last two decades in the state of Kerala

Let me make a few observations on the National Health care Policy framework proposed in 2017. Let me draw our attention to some gaps that I find in its current form.

There is no thrust on enlarging the scope of Family Medicine Practice which has been perceived as a viable model for providing optimum health care support at the first layer of health delivery in the community. Secondly, the Medical colleges which were proposed to be the referral centres do not have a network of active connections with the Primary Health Centres, which makes the Medical Colleges dissociated from the rest of the health care infrastructure at the community level. Thirdly, the tertiary care is getting more abdicated to the private sector under the justification that the insurance packages would cover the expenses, which is not real as only about 25% or less of population are presently under any form of private insurance scheme. The government sponsored insurance services are reserved for those in the low-income bracket. Fourthly, health care education is drifting more towards private sector where the cost of training taxes the students heavily and borrowing money is pushing them to a debt burden. Fifthly, there is an increasing incidence of unethical practice in the practice of medicine, whether it is diagnostics, therapeutics or interventions. There is a commercial angle to all of them, which makes health care profit driven!

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Let me elaborate on each of them.

1. Family Medicine Practice

A conversation with late Dr Mabel and Raj Arole in 1983 stays in mind even now because of the profoundness that their thoughts and work at Jamkhed conveyed. They referred to Family physician training as the central issue in making health care accessible and affordable for people in the urban and rural areas. It was a time then, when the specialty-based hospitals were surfacing in the urban setting and they feared that it would offset the perspective on health care. Their work at Jamkhed began with an approach to meeting the immediate medical needs and creating public health measures to promote health and to prevent illnesses. Their base hospital provided all the essential acute health care needs in the community and the need to refer elsewhere was only about 20%. They considered the mission hospitals to be similar in purpose and mission. A well trained Family Medicine practitioner is well versed to attend to the common medical, surgical, obstetrics, paediatrics and public health clinical

A well trained Family Medicine practitioner is well versed to attend to the common medical, surgical, obstetrics, paediatrics and public health clinical scenario which would consist of the 70% of the health care needs in a community.

scenario which would consist of the 70% of the health care needs in a community. There are only about forty five or so institutions in India from my knowledge, who offer family Medicine training. In fact the CMAI began the family physician training under its auspices thirty five or so years ago, the first such initiative in India. The National Board of Examinations subsequently offered it and the Medical Council of India soon followed it. About seventy five family physicians are trained every year in India, as against a projected need to have at least one family physician in each of the Primary Health Centres.

While on a visit to three rural hospitals, I observed that the family physicians conduct deliveries, perform LSCS, Hysterectomy, abdominal general surgeries, manage acute cardiac conditions in the intensive care and look after children and new born babies. In a hospital at a town, the family physicians did the same. I wonder why Family Medicine training is not fostered actively when they are immensely resourceful professionals.

It was the CMAI, which sensed the need for training family physicians and pioneered it. The CMC, Vellore runs a distance education programme in family physician training, which is attracting hundreds of general practitioners to update their skills. The distance education department has collaborated with some state governments to offer refresher course and formal training courses in family medicine to those who are in the government service. It is a space we can occupy if some more of the mission hospitals, who are equipped to get approval from the National Board of Examinations to run Family Medicine training programme can offer to start the training programme. We need to campaign for all the medical colleges who run post-graduate programmes in family medicine training and give it a recognisable status as a specialty.

2. Medical Colleges as referral centres

While visiting mission hospitals at Herbertpur, Raxaul and Oddanchatram, I observed the working relationships that have evolved with tertiary care centres situated in their region, for some reason the referral centres. But through the initiatives of doctors in these mission hospitals, there is a trustful relationship because of which the doctors at the Medical College receive referrals from the mission hospitals with consideration. There is a growing interest in private-public partnership and our mission hospitals can use this effectively.

It is another space that exists for mission hospitals to access the pathway of private-public partnership. It is possible for mission hospitals to develop academic and referral relationships to foster the evolution of three-tier system of health care practice in India. The mission hospitals with specialty departments or their equivalent hospitals can become a referral place for family physicians and the medical colleges to become referral centres for mission or equivalent hospitals. It is worth exploring if some medical colleges would restore their status to be referral hospitals through the advocacy we can generate on this issue.

The advantage of moving into the tertiary care sector is for the sake of offering a Christian witness in this technologically driven health care sector, where bench mark of good and ethical practices are desperately needed.

3. Mission hospitals in tertiary care

A few of our mission hospitals are almost in a tertiary care status at least in some specialties. The corporate hospitals are given the status to offer tertiary care services and the government seems to prefer to have it that way. What if some of our mission hospitals come forward to take this responsibility! I know that at the Mission hospital at Nadiad, Bangalore Baptist Hospital, St. Stephen's hospital, Delhi, Christian Fellowship Hospital, Oddanchtram, Christian Institute and Research Center, Dimapur, and some other mission hospitals, tertiary care services are provided at an affordable level with excellence in quality and outcome. I feel disturbed at the apathy of the churches to consider upgrading already well-established hospitals to move into offering tertiary care at least in some specialties. The advantage of moving into the tertiary care sector is for the sake of offering a Christian witness in this technologically driven health care sector, where bench mark of good and ethical practices are desperately needed.

4. Health care Education

Let me advocate that every mission hospital tithes its annual income by 10% and create an endowment fund towards educational interest free loan scholarships, for students from their region, seeking training in any health care discipline. I found out from a survey that sixty five percent of students studying in a medical college would have 20 to 35 lacs to refund with interest at the end of their course. This eliminates the able and motivated students from low socio-economic background to pursue

This eliminates the able and motivated students from low socio-economic background to pursue courses for which they have the skills and calling, but not the economic means. I wonder whether mission hospitals would set an example by creating an endowment fund to offer health care training prospects for deserving students! This is an investment for human resource planning in health care.

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5. Ethical Practices in Medicine

There is considerable emphasis on research ethics due to the pro-active steps taken by the Indian Council of Medical Research in the recent years. The government of India is taking some active measures to bring some good practices by standardizing hospital charges, introducing affordable costing of consumables, pricing of drugs, etc. all of which have exposed the deviant and corrupt practices currently in vogue. However, I feel terrible about the lack of voluntary ethical consciousness in the day-today clinical care and bedside practices. It is still not common for a patient to receive full information about the illness, treatment plan and implications of the illness, although we are under obligation to follow the approach of doing all things only with the informed consent of the patient. The initiative by the Center for Bioethics is a valuable initiative, which is taking efforts and offering learning modules to create awareness on ethical perspectives in the practice of medicine.

I struggle with it every time when I have to start a child on an anti-epileptic medicine. It takes an additional fifteen minutes to brief the child and the family all about the illness, drug, complications, follow-up plan, etc. Although it is done more than once and also by my colleagues, the parents go back with incomplete information. It is not the gross departures from standard ethical practices that happen often, but several acts of commission or omission that makes the practice of medicine less noble!

Let me conclude. We are facing an uphill task in our missionary vocation in the healing ministry. The health care practices have created some in between spaces where enough is not done. I have referred to five of them, which have a resonance with the National Health Care Policy of 2017.

I am certain that there is something more that Christian health care professionals and institutions can offer to health care practices in India at this transition time!

Dr. M. C. Mathew is a Professor of Developmental Paediatrics and Child Neurology, at MOSC Medical College, Kolenchery, Ernakulam, Kerala.

CHANGING VALUES AND MEDICAL MISSION IN INDIA

The failure of mission hospitals to adapt to the changed reality in post-independence India has resulted in a decline in Christian Medical Missions. Many factors have contributed to the decline. However, the changes in values within Christianity over the past century have had a major impact. They call for introspection within the Christian community in order to revive the mission.

It is widely acknowledged that the number of Christian mission hospitals in India has seen a sharp and steady decline over the past six decades. The reason have been debated and include (i) changed post-independence political reality, (ii) capitalism and a neoliberal agenda and their impact on medicine, (iii) inequity and cost of medical care, and (iv) tertiary care as ideal and standard.[1] This article focuses on the changing values and standards within Christianity and Christian communities. These are briefly highlighted.

Changing values

Interpretations of the Bible and of Christian beliefs have changed over time, influencing the metanarrative and frameworks of communities and societies. These include:

Christmas story and capitalism

The Christmas story, with its no room in the inn and birth in a stable amid sheep and oxen, is one of poverty. However, this subversive story of deprivation and self-sacrifice has been transformed by 20th century capitalism.[2] We now celebrate it with materialistic orgy, in malls and department stores, our temples of consumerism. Santas, snowmen, mistletoe, new clothes, expensive presents, good food and music take us away to a different world. This not-so-subtle change has transformed Christianity from its roots in destitution to one of material excesses.

Christmas story and inclusiveness

The Christmas story in the gospels according to Mathew and Luke focus on inclusiveness, albeit with major differences. Mathew argues that Jesus came not only for the Jews but also for the gentiles and includes the magi, wise men from the East, in his telling of Jesus's birth. Luke, on the other hand, focuses on the shepherds, the marginalized and outcasts of Jewish society, who were the first to receive the good news.[2] The gospels consistently present Jesus's interacting with people despised by the establishment - with "sinners", publicans and prostitutes. The inclusiveness seen throughout the New Testament contrasts with some within the Church who believe that they have a monopoly on truth; their self-righteous condemnation of others does not reflect Jesus' approach.

The inclusiveness seen throughout the New Testament contrasts with some within the Church who believe that they have a monopoly on truth; their self-righteous condemnation of others does not reflect Jesus' approach.

Liberation theology and the prosperity gospel

Gustavo Gutierrez, a Dominican priest and philosopher, described liberation theology based on his understanding of extreme poverty in Latin America. His advocacy of the solution to injustice is a return to Christian values; the theology argues that we need to apply these ideals in a way that dismantles the social structures that perpetuate poverty, hierarchy and structural violence.[3] It supports "preferential option for the poor, marginalized and oppressed". Similar theologies of liberation have been have been developed in other parts of the world including Black Theology in USA and South Africa and Dalit Theology in India.

Despite its inspiration from the Bible, Liberation Theology is not the preferred

option among the wealthy or within the church. Many people, despite their support for non-violence, refuse to recognize their role in maintaining social inequity and perpetuating structural violence.[4] In fact, many Christians subscribe to the Prosperity Gospel, which holds that financial blessing and physical health are part of God's plan and that faith, positive thoughts and donations to the religious causes will increase one's material wealth. Although many Christians do not openly subscribe to the Prosperity Gospel, they operate within their comfort zones and do not actively champion the cause of the poor nor attempt to reduce social oppression.

Personal salvation and social justice

Many Christians have struggled to integrate their response of service to humanity with materialistic ways of contemporary middle-class India. Many find refuge from the contemporary confusion in their quest for personal salvation, while the message of Christ's mission of social justice has few takers.[1] Social justice from a Biblical perspective is often incompatible with personal prosperity, while the message of personal salvation accommodates upward mobility much more easily. Walking the talk and serving the rural poor in "Bharat" presents huge challenges, with its lack of facilities, poor schooling, limited social life, and restricted remuneration and material rewards. Talking about mission service from the comfort of cities and tertiary care facilities is an easier option, as is superficial tinkering with existing approaches. The demise of the Student Christian Movement and the rise of evangelical approaches within student communities and among health professionals support such conclusions.

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These subtle and not-so-subtle changes in values in Christian communities and societies have a major impact on the functioning of individuals and institutions.

Milieu and mechanisms

The changed values affect the functioning of individuals and institutions through different mechanisms within specific institutional settings. These include:

Support within echo chambers

The diversity of philosophy, beliefs, attitudes and practice in pluralistic societies poses a challenge to people seeking support for their individual thinking and actions. Heterogeneity within Christian theology and approaches also add to the contemporary confusion. Consequently, individuals and groups tend to seek homogeneous environments in their local milieus, congruent with their philosophy and life style. Such metaphoric echo chambers result in information, ideas, or beliefs being amplified or reinforced by communication and repetition. Inside such figurative echo chambers, the dominant narratives often go unquestioned and different or competing views are disallowed, discouraged or underrepresented. Protestantism, which began as a reaction to medieval Roman Catholic doctrines and practices has splintered the Church over time with numerous smaller denominations and groups breaking away to form smaller and smaller homogenous environments, albeit echo chambers.

Power and prejudice

While financial corruption within many churches is an open secret, many Christian missions are also plagued by subtler form of non-material corruption. While people who lead medical missions claim roles of servant-leaders, many also believe that they deserve their power and position making them morally pliable and more prone to abuse their privileges. People with power feel a sense of entitlement; their sense of privilege becomes private law. The culture of entitlement results in double standards, one for themselves, their family and friends, and the other for the general population. Such use of divergent values and principles by the individuals involved results in hypocrisy.

Power and corruption seem to have a complex and bidirectional relationship. Corruption in its broadest sense is not restricted to financial irregularities. The abuse of religion, language, ethnicity, caste, kinship, privilege and position also comes under this rubric. Such misuse is also a form of moral fraud. However, these may be in the form of "softer" violations which, though equally fraudulent, are much more difficult to recognize, quantify, track and document. Conflicts of interest can directly or indirectly, influence decision-making, appraisals and can bias judgments. The intense desire to leave lasting legacies and to make

The benefits of consensus decision-making allows for collective leadership, sharing of power and for building communities. It is neither compromise nor unanimity but allows for weaving of everybody's best ideas, concerns and strategies while protecting minority positions.

significant changes in institutional direction and function often result in decision-makers short-circuiting standard procedures. The culture of sycophancy, common in our culture and society, aids and abets in such corruption. Double standards in public life are accepted; hypocrisy is tolerated and is the norm.

Decision making styles

Traditionally, many mission hospitals functioned with leaders whose leadership style could be described as benign dictatorships. Overtime many institutions have incorporated consensus approaches, fixed terms in office, and rotation of responsibilities. However, despite these changes, many institutions and departments continue to be led by individuals who impose their agenda resulting in frequent changes in directions with changes in leadership.

The benefits of consensus decision-making allows for collective leadership, sharing of power and for building communities. It is neither compromise nor unanimity but allows for weaving of everybody's best ideas, concerns and strategies while protecting minority positions. It also allows for sustained institutional efforts and enduring focus. Building consensus requires commitment, effort, practice and a change of institutional culture.

The way forward

The complexity and contradictions of the human condition demand constant reappraisal of our framework and approach to life and to medical mission in India. The changes in Christian values and interpretations of Christianity today, working through mechanisms in the local environment, complicate the approach. Many

people, despite their good intention, miss the woods for the trees. They constantly search for God's plan while making choices, which make their individual and institutional worlds increasingly comfortable and far removed the original goals of service to the poor, the marginalized and the oppressed. Often, their original aims of service morphs into a sole quest for personal salvation and material comfort. If ordinary people want to make extraordinary claims, then they should continually refocus on Jesus' mission of peace on earth and social justice.

The infancy narratives in the gospels of Matthew and Luke are considered Midrash, a genre of Hebrew literature, which contains early interpretations and commentaries making connections between new realities and the unchanging sacred texts. Biblical stories are defined as something that happened once, and that they happen all the time. They reveal the underlying and timeless significance of an event. They are also programs for action; like all religious text, they tell the reader how to behave.[2] We will not grasp their full importance unless we put them into practice.

They reveal the underlying and timeless significance of an event. They are also programs for action; like all religious text, they tell the reader how to behave.

The ambiguities of life and the changing socio-economic and political climate mean a constant search for meaning. There is a need to reexamine the framework and perspectives and move out of our comfort zones. Christianity is a broad church with diverse beliefs and practices; Christians are also varied from fundamentalists who have literal interpretations of the Bible, through to liberals who believe in its principles, all of whom can contribute to building a just society.

Christian communities need renewal from within. We need to reevaluate our culture, which has normalized materialism, moral corruption and social inequity in its many different forms. The "Seven Nolan Principles of Public Life" — selflessness, integrity, objectivity, accountability, openness, honesty and leadership by example — should form the standards for holding public office.[5] There should be regular and independent reviews of individual and organizational functioning. The challenge is to inspire and change individual frameworks and perspectives and to transcend and transform institutional and societal norms.

The changed context demands different strategies. While there are no simple or single solutions, there needs to be a broader approach and a more radical and comprehensive framework and response, which is not yet within reach or even in sight. Otherwise, the decline in medical mission is set to continue.

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REFERENCES

1. Jacob KS. The decline of mission hospitals in India. Christian Medical Journal of India. 2016; 31 (4): 19-22. http://cmai.org/wp-content/uploads/2013/08/October-December-2016.pdf.
2. Armstrong K. A short history of myth. Edinburgh:Canongate Books; 2005.
3. Gutierrez G. A Theology of Liberation: History, politics and salvation. 15th Anniversary edition. Orbis Books, Maryknoll, New York.1988.
4. Jacob KS. Ahimsa at odds: Individual ethics and structural violence. Economic and Political Weekly, 50: 4; 3 October 2015 http://www.epw.in/journal/2015/40/web-exclusives/ahimsa-odds.html
5. Committee for Standards in Public Life, United Kingdom.1995 https://en.wikipedia.org/wiki/Committee_on_Standards_in_Public_Life

FROM OUR ARCHIVES

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1942

THE CREDO OF A MISSIONARY DOCTOR

Of Perhaps it had better be called 'The Confessio'

By Edwin C Cort, M.A., M.D., D.Sc., F.A.C.S, F.A.C.P* - Fatehgarh

The most precious thing in the world, it seems to me, is human personality. This was so infinitely precious in the eyes of Christ that He laid down His life for it. Yet in enormous areas of our present-day world, any value of individual personality has been denied and its rights ruthlessly and brutally suppressed...

Many guesses have been made as to the nature of the 'unpardonable sin', but it seems to me that brutal psychic trauma perpetrated on those who cannot help themselves and who cannot retaliate, approaches this type of sin-and this is one of the major sins of the Totalitarians. I can find a certain respect for a man who has the courage to stand up to an overbearing 'boss' and belabour him physically or linguistically but I have only pity and indignation for one who takes advantage of his position to hurt the spirit of those who are, because of economic dependence or social or official position, unable to protect themselves...

Even we who have come on a ministry of healing, following in the footsteps of the Great Physician, have *stooped* to heal. We have put gloves on our hearts as well as our hands (if such a mixed metaphor is pardonable) in order to avoid contamination, instead of imitating the loving compassion of Christ who, ignoring the Rabbinical Law, laid his hand on a leper and healed him. I am speaking, of course, of mental attitudes, not of essential medical and surgical technique.

In our hospitals and clinics we have, rightly, striven for the highest ideals and the greatest efficiency in the healing of our patients and the development of our staffs. Too often our methods have been coercive and arbitrary and we have used 'the big stick' instead of trying to understand the other fellow's point of view and acting with love and sympathy and a spirit of co-operation...

The efficiency obtained by the first method is very limited. The harsher method either inhibits the mind of the victim who then makes more and more mistakes or awakens a spirit of sullen resentment that makes the building of a real 'team' impossible. The second method, by winning the love and cooperation of the staff, gives constantly increasing dividends in efficiency.

What I have just said as to the methods of handling a hospital staff is not mere theory but has been hammered out on the anvil of experience...

Too many patients come to us after having wasted their substance, not in riotous living, but on many physicians-of sorts-and are, like the woman described in Luke 'none the better, but rather the worse'. In view of our very limited resources this is apt to be decidedly irritating. Then, too, so many show the most abysmal ignorance or disregard of the rudiments of hygiene, sanitation, and prophylaxis that we get very discouraged or even disgusted. But they are fellow human beings with all their hopes and fears-principally fears-and so are in need of love and sympathy instead of a scolding. ……Personally, I make rounds in my own hospital every night, not only to see the condition of the serious cases, to see that pain is relieved and that the patient gets much needed sleep, but also to give the friendly and reassuring word that is often all that is needed to send the patient off to sleep with a cheerful mind. I have seen many apparently hopeless cases brought through, not only by the unremitting labours of doctors and nurses but by the courage and hope built up by the assurance of the devotion and sympathy of a staff that will not let them down. …

It is also my long considered and definite belief that only as we continually strive-with 'toil and sweat and tears if need be-for better and better standards of diagnostic and therapeutic care of our patients, for ever higher standard of nursing care and training, for better diets, and for better and more adequate equipment in the wards, operating rooms, laboratories, and kitchens of our hospitals can we adequately represent Master whom we came to serve, 'that in all things He might have the preminence' .

But it is also equally true that until we learn to handle our contacts and relationships with our patients and their friends and relatives; with our colleagues, missionary and national; the nurses and nursing students; and the entire hospital personnel from top to bottom, with sympathy and patience and a love that ,is neither patronizing nor condescending -not condoning mistakes or neglect or mis-conduct, but handling the problem in a spirit of love-then and only then can we represent the Christ who died that men might have life and have it more abundantly.

FROM OUR ARCHIVES

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SPECIAL ARTICLE

A Surgeon Challenges Youth*

N. J. EVERARD, D.T.M. F.R.C.S. (Edin.)
Kachwa, (near Varanasi)

It is now clear that the Government of India has decided not to grant visas to new missionary doctors and nurses, except under exceptional circumstances. This presents a challenge to many young people in India.

For some more years, many mission hospitals may be able to continue because the ruling so far refers only to new missionaries. But the Government purpose is that all Christian institutions should be Indianised. This has been taking place more and more, especially in recent years; but in the rural hospitals Indian doctors may work for a time but later wish to settle down in cities.

Unless qualified and dedicated Christian doctors are willing to take the places of missionaries, who minister largely to the needs of the poor, then many hospitals will have to be closed.

In recent years, many mission hospitals have, in fact, ceased to function, sometimes because there was no suitable Indian Christian doctor willing to do the work. In some cases, a small amount of work is being carried on by sisters or nurses because no doctor is ready to sacrifice himself.

But is it 'sacrifice', when one realizes that Jesus Christ gave up all for our salvation and even shed His blood to cleanse us from sin? ...

...Surely for a doctor, money should always be a secondary consideration. To join the staff of an established hospital with hundreds of patients, an up-to-date operation theatre, with a laboratory and X-ray department, will be far more satisfying than earning a large salary in a position where skill is more or less wasted. When a Christian has felt the call to be a doctor, the thought in medical college should have been *dedication of life* to help the large number of sick people in this land, irrespective of reward…

...This decision is not difficult during first or second year at college; but after five years of hard work, the desire for more reward results in loss of the vision given by the Lord…

As a young house-surgeon in England, I became friendly with a Christian Ophthalmologist. After reaching India, I received a letter from him, in which confessed that his professional life had not been successful even from a financial point of view-and this he attributed to his not fulfilling an early desire to be a medical missionary.

On the other hand, doctors without definite experience of Jesus Christ should certainly not attempt the work of a missionary doctor in India. There are too many frustrations; and without prayer the work would be impossible-and certainly would not be pleasing to the Lord. But medical students and doctors who have experienced *'new life in Christ',* must hear the word of the Lord; 'Whoever of you does not renounce all that he has cannot be my disciple'…

All this is also addressed to parents. I have known of a keen young Christian who would work in a mission hospital if he had his choice, but his father insists on him making more money. Many years also, an earnest Christian from South India, hearing of the need in central India, promised the Lord that, if he were given another daughter, he would dedicate her to work among those very people as a doctor. A girl was born; she later studied and served in that very district with her husband (who is a pastor), with skill and love and self-sacrifice. Gradually a small hospital has been built up, and souls are being saved as well as the sick being treated...

...The only hope is that who have the necessary training experience will respond to the Lord's call with the approval of their relations and dedicate themselves unreservedly and the heartedly to the service of Jesus Christ irrespective of salary or prospects or possible insecurity attached to such a career.

BRITISH STUDENTS' GESTURE

New Delhi, July 10: Four students of Edinburg University have set out on an 8000 mile drive to India in a Landrover which is to be delivered to the Wadia Hospital in Poona.The land rover, converted as an ambulance, was purchased following a fund-raising campaign in Edinburg in November.

The students, who expect to take eight weeks to complete the journey, will travel via France, Belgium, Germany, Austria, Yugoslavia, Bulgaria, Turkey, Iran, Afghanistan and Pakistan.

They plan to spend some weeks in Poona working at the hospital.

-UNI

NATIONAL HEALTH POLICY, 2017 - A SUMMARY

Ms. Anuvinda Varkey

This paper attempts to summarise the National Health Policy 2017, for basic information and to recognise the opportunities for mission hospitals to partner with the government so as to enable the country to achieve the stated goals in the policy.

Aim: Government's role in shaping health systems in all its dimensions.

- Inform
- Clarify
- Strengthen
- Prioritise

Goal: ***To work towards achieving the highest possible level of health and wellbeing for all*** by

- Increasing Access
- Improving Quality
- Decreasing healthcare delivery costs.

Principles: The health policy is based on the following principles

• Professional Standards, Integrity and Ethics • Equity • Affordability • Universality • Patient Centred quality care	• Accountability • Inclusive Partnerships • Pluralism • Decentralisation • Dynamismand Adaptiveness

Objectives: Emphasis on quality "preventive, promotive, curative, palliative and rehabilitative service" which will be delivered through the public health sector.

General objectives

Progressively achieve Universal Health coverage

The policy envisions achieving Universal health coverage through a three pronged approach:-

- Free primary healthcare services for all.
- For access to secondary and tertiary services with an

emphasis of those of the not-for-profit sector along with the improved public sector services.

- The reduction of out of pocket expenses.

Reinforcing trust in the Public Healthcare System:

National Health Policy, 2017, would like to see the Public Healthcare system, be "predictable, efficient, patient centric, affordable and effective", so as to build the public's trust in the system.

Align growth of private healthcare with public health goals

The policy encourages the private sector to use medical technologies and work towards aligning with the public health goals of making systems "effective, efficient, rational, safe affordable and ethical".

Specific Quantitative Goals and

- Increase Life Expectancy at birth from 67.5 to 70 by 2025.
- Reduce Fertility Rate to 2.1 by 2025.
- Reduce Infant Mortality Rate to 28 by 2019.
- Reduce Under-Five Mortality to 23 by 2025.
- Achieve the global 2020 HIV target (also termed 90:90:90 global target).
- To reduce premature mortality from cardiovascular diseases, cancer, diabetes or chronic respiratory diseases by 25 per cent by 2025.
- Reducing the prevalence of blindness to 0.25 per 1000 persons by 2025.
- The disease burden to be reduced by one third from the current levels.
- Elimination of leprosy by 2018, kala-azar by 2017 and lymphatic filariasis in endemic pockets by 2017.

Policy Thrust

Ensuring Adequate Investment

- To achieve the policy target of 2.5% of GDP.
- Expects states to allocate adequate resources.
- Taxation would be the means of financing care.
- Taxes on specific commodities would be considered.
- To utilise funds under CSR.

Preventive and Promotive Health

The policy keeping in line with the "Health in All" to complement "Health for All", it hopes to be able to do this by

- Constituting bodies that have representation from non-health ministries.
- Identifying various areas of improving the environment.
- Recognises early detection and response as critical to this policy.
- The use of ASHA's as assisting frontline workers.
- The use of AYUSH like yoga at the school level.
- Recognises the risk of workplace hazards and has emphasised occupational health.
- Working with excluded sections like the poor, geriatric and differently abled.
- Strengthening the VHSNCs. It has recommended the same for urban areas as well.

Organisation of Public Healthcare delivery

The policy lists 7 key areas where there has been a shift of focus from the old policy.

- In primary care the shift is from selective to assured comprehensive care.
- Input based orientation in secondary care.
- Free Assured drugs, diagnostics and emergency services in Public hospitals.
- Targeted approach to reach underserved areas in infrastructure and HR.
- Health system strengthening through National health programmes.
- Emphasis on National health programmes and how they can be used in health system strengthening.
- Working towards mainstreaming AYUSH.

The policy thrust

- Free primary healthcare envisages the public and NGO sector to fill in gaps as a strategy of "assuring healthcare services" on a *pro-bono* basis.
- Purchasing of secondary and tertiary services with preference from not-for-profit private sector on well-defined quality criteria.
- Special needs of vulnerable sections of society like the tribals and socially excluded populations to be met.
- For needs during natural disasters a provisioning for infrastructure, HR and technology to be able to be mobilised at short notice is envisioned.

Primary Care Services and Continuity of Care

The focus of the National Health Policy, 2017, is on "Health and Wellness" centres.

- Provide comprehensive packages for primary care.
- It envisions a health card for each family, which will

enable them to access primary care anywhere in the country.

- Leveraging the potential of digital healthcare.

Secondary Care Services

The aspiration that the policy states are

- Basic services such as caesarean sections made available at the sub-division level.
- Short term measure for govt. to purchase these from non-government hospitals.
- 2 beds per thousand populations.
- Resources would be allocated as per case load.
- To fill in FR gaps of HR and specialists.
- To fill gaps of blood shortage by expanding the network of blood banks.

Urban Health Care

- Harness the huge number of private healthcare players.
- Development of NHUM and an urban health strategy.
- Use preventive methods to be an integral part of this strategy.
- Tying up with the various government schemes/ projects.

Tertiary Care Services

The policy looks at

- Organisation of tertiary care. Recommends government to set up new medical colleges, nursing institutes and AIIMS across the country.
- Standardisation of fee structure and its periodic review.
- Operationalization of a mechanism where a referral system from public health system to charitable hospitals to the designated free beds.

Human Resource in Health

- Recognises the need for appropriate financing for technical training.
- Proper professional orientation and the right professional ethics and attitude.
- Pedagogy that is located in proper training institutions.

Medical Education

Opening AIIMS like institutions across the country, use of technology to have a steady flow of faculty, NEET for UG Entrance at the all India level and a common all India exit exam, appropriate practical based entrance exam for PG courses.

Attracting and retaining Doctors in Remote Areas

The policy proposes a mix of incentives, financial and non-financial to attract and retain doctors in remote areas they are by creating medical colleges in remote areas, giving students from remote areas a priority in admission and mandatory rural postings.

Specialists Attraction and Retention

Recognition of a "National Board of Examinations and college of physicians and surgeons", Suitable pay scales, enhancement of training which is short-term, performance linked payments and distance education modules are some of the methods suggested.

Mid-Level Service Providers

The policy recommends a cadre of "mid-level care providers" for the growth of the primary care from a selective care system to a comprehensive care system. This cadre would be trained in courses like Community health, BSc nurses and pharmacists as well as GNM nurses could be incorporated into this cadre along with the AYUSH doctors.

Nursing Education

The policy recognises that to support the primary healthcare agenda it would need improved quality management and regulation of nursing education and Nurse practitioners and Public Health Nurses to increase the availability of these nurses in most vulnerable areas.

ASHA

The policy also looks into training and certification of ASHAs with preferential treatment for the ANM course. NGOs could support and train the ASHAs and could be learning centres/laboratories and revival of the multipurpose male healthcare work cadre.

Paramedical Skills

The policy envisions the development of training courses for super speciality paramedical care professionals. Due to the shortfall of the paramedics it looks at a planned expansion of technical skills. It also looks at the possibility of multi skilling so as to enable a more efficient use of HR in remote and peripheral areas.

Public Health Management Cadre

A Public Health Management Cadre has been proposed. State to develop its cadre and attract medical and health professionals as well as humanities graduates to be trained in public health to join the cadre.

Financing Healthcare

The policy's emphasize 2/3rds of the allocation of funds

to go to primary care followed by secondary and then tertiary care and formation of a robust National Health Accounting System which would work on building efficiencies in resource allocation.

Purchasing Of Healthcare Services

- Purchased from public not-for-profit and private sector in this order.
- Purchases of services will be on the basis of quality services and adhere to strict standard treatment protocols along with a mandatory disclosure of treatment.

Collaboration with Non-Government Sector/ Engagement with Private Sector

The policy suggests that the NGO sector should be engaged with for primary healthcare on a "give back to society" initiative. NGOs would be engaged where major and critical gaps can be plugged.

Role of Immunisation

The policy looks towards the continued role in immunisation of the private sector.

Disease Surveillance

The policy looks to strengthen disease surveillance with the private laboratories for pooling and sharing data. Furthermore it would engage with private clinical establishments to notify diseases that have a public health importance.

Tissue and Organ Transplant

The policy looks to building awareness and about organ transplant where the private sector could be engaged to assist the government and the government could ensure that the private sector complies with all the rules and regulations concerning organ transplant.

Make in India

The opportunities for Indian firms in medical device manufacturing to plug into the "Make in India" schemes is encouraged by the policy. Indigenous medical device would be encouraged by assured purchases by government health facilities.

Health Information System

The policy is looking at an integrated health information system where there would be private and public partnership.

Incentivising Private Sector

Subject to the quality standards Private sector has been incentivised in this policy to participate in the attempt to provide health for all. The incentives are reimbursement/ fee, preferential Treatment to Collaborating Private Hospitals/institutes for CGHS empanelment and non-financial implications like recognition/acknowledgement / felicitations and skill up gradation to the private sector hospital/practitioners for providing public health services.

Regulatory Framework

The policy is looking at major reforms in the area of regulation by the strengthening of six councils such as Medical, Ayurveda, Unnani & Siddha, Homeopathy, Nursing, Dental and Pharmacy. It further will encourage states to adopt the Clinical Establishments act.

Health surveys

The policy looks at health surveys for the scope of health demographic and epidemiological surveys as well as those regarding cost of care, financial protection, evidence based policy and planning reforms etc.

Health Research

The policy sees health research as a key role in the development of the nation's health. It therefore looks at the strengthening of knowledge for health and advocates for public funded research for the various government agencies as well as both public and private medical colleges. It also looks at research for TB HIV/AIDS malaria etc.

Research Collaboration

India should leverage its cost effective technologies to collaborate with international agencies

Legal Framework for Health care and Health Pathway

The policy examined the fundamental question as to whether there is a health rights act to make health a fundamental right. It felt that the country had not reached that level of economic and health systems strengthening to make health a fundamental right.

Implementation framework and way forward

A policy is only as good as its implementation. So a good implementation would be key to the achievement of the National Health Policy, 2017.

Ms. Anuvinda Varkey is the Executive Director
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"A COMPARATIVE STUDY OF THE EFFECTS OF THE EXISTING AND A NEW NURSING DOCUMENTATION SYSTEM ON NURSING PRACTICE AND SELECTED PATIENT OUTCOMES IN THE PAEDIATRIC WARDS OF CMC VELLORE"

Mr. Vinay John

Abstract:

This research investigated that "The newly devised documentation sheet will improve nursing practice and patient outcomes." (Appendix-1) The study was a comparative study to test the effectiveness and impact of new nursing documentation on nursing practice compared to the present system in the Paediatric wards of Christian Medical College, Vellore. The current documentation in place allowed for interventions but there was no documentation of assessment, planning and evaluation. The research design chosen for this study was an experimental design. The existing documentation was chosen for the control group and the newly devised nursing documentation was chosen for the experimental group. 100 children who satisfied the inclusion criteria of the study were selected randomly. 50 samples were randomly allocated to the control group and 50 samples to the experimental group. Data was collected through two observational checklists, an attitude scale and a time-recording sheet. The study showed marked improvements in nursing practice and outcomes, as measured in the percentage of adequate documentation in all the aspects of the Nursing Process Approach compared to existing documentation.

Introduction:

Documentation is a vital aspect of nursing practice. It records significant events, vital measurements and observations, and treatments administered to a patient. Nursing documentation must be accurate, comprehensive and flexible enough to retrieve critical data, maintain continuity of care, track client outcome, and reflect current standards of nursing practice. (Potter and Perry, 2005) Effective documentation enables continuity of care, saves time and minimizes risk of errors. (Yocum, 2002)

In the Christian Medical College, Vellore the current documentation has been used for several years. There is duplication in recording, while the nurses record many interventions; there is no documentation of assessment, planning and evaluation. A new documentation system was designed, and this study assessed the possibility of replacing the existing system.

The Study -- the Problem, Objectives, and Research Hypothesis:

The study undertaken was a comparative study to test the effectiveness and impact of a new nursing documentation approach on nursing practice and selected patient outcomes, compared to the present system in the Paediatric wards of Christian Medical College, Vellore. The objectives of the study were:

- To assess the nursing practice before and after introducing the new documentation system.
- To assess documentation of selected patient outcomes before and after introducing the new documentation system.
- To assess the nurses' attitudes in using the new documentation system.
- To compare the time taken for completion of documentation in the existing and new documentation systems.

The research hypothesis for the study was: "The newly devised documentation system will improve nursing practice and patient outcomes, compared to the existing documentation system."

Review of the Literature:

The literature contains a number of discussions on the need for and problems in nursing documentation. The Nursing and Midwifery Council (2002), stating that good record keeping protects the patient and client welfare, listed requirements for good documentation, and suggested that good documentation would demonstrate good nursing care. Edelsterin (1990) pointed out that continuity of care is more evident in simplified documentation and suggested that improving documentation would save time, assist in auditing, establish continuity of care and help to maintain standards.

Picogna and Lirutti (2001) advocated a continual assessment of the documentation process to modify and improve nursing care. Ammenwerth et al. (2006), in their study showed that the documentation of the Nursing Process is an important, but often neglected part of clinical documentation.

Scharf (1997) stated that complex documentation forms place unnecessary burdens on nurses, and a revision of the patient care forms can contribute to positive outcomes by enabling nurses to spend more time in caring for patients. She found that, on average, nurses spend 31% of their time with patients, and 69% spent on other activities, 11% was spent on charting.

In general the literature shows that documentation is a legal and vital part of nursing care, but it needs to be less time consuming.

Study Design and Methodology

Methodology:

The research design chosen for this study was an experimental design, with the existing documentation system being used for the control group and the new nursing documentation system for the experimental group. This study was conducted in the Christian Medical College, Vellore, a tertiary care centre with 2234 beds. The paediatric unit, has seven wards and a total of 135 beds.

Study Population and Sample:

The study population included all children and their documents, who were admitted in the surgical ward, isolation ward or medical ward of Paediatric Department of CMC, Vellore. A sample of 100 children and their documents that satisfied the inclusion criteria of the study (admitted with general medical and surgical condition in hospital for more than 24 hours) were selected randomly. Children requiring intensive care, chemotherapy and emergency care, those with special needs, and children admitted in private wards were excluded.

Data Collection Instruments:

Data were collected through two observational checklists, an attitude scale and a time-recording sheet. The first observational checklist was used to record the adequacy of the documentation of assessment, planning, intervention and evaluation. Scores above 75% were classified as "adequate documentation"; 50-74% was considered "moderately adequate" and 49% and below was considered "inadequate". The total scores for the outcome documentation were classified in the same way. The Nurse Attitude Scale comprised 13 questions (8 positive, 5 negative) to assess the attitude of the nurses towards the new documentation. Items were graded from 1 (strongly disagree) to 5 (strongly agree), with reverse scoring for negative questions. The time taken to document vital signs, Nursing Process, intravenous fluid, positioning, basic care and health teaching was recorded in minutes on the recording sheet. The reliability, feasibility

and validity of these tools were tested in a pilot study with 10 patients, resulting in some refinement of the instruments.

Data Collection:

The data were collected over a period of six weeks. The first three weeks was spent assessing the existing documentation system (50 Children, the control group), and following an orientation program for the new Nursing Process documentation over the next three weeks were spent assessing the new documentation (50 children randomly selected in the experimental group. The time record sheet was completed for each subject in both groups on the first observation day for the subject, with the investigator timing the nurses' completion of the patient's documentation sheets. At the end of the three weeks of using the new documentation, a questionnaire was administered to all 40 nursing personnel who had participated in the study.

Data Analysis:

Descriptive statistics (frequency, mean, standard deviation, percentage) and inferential statistics (t-test) were used to analyze the data collected. P values of 0.05 levels or less were considered as statistically significant.

Results of the Study:

Change in Nursing Practice:

The study showed there were marked improvements in nursing practice, as measured in the percentage of adequate documentation in all the aspects of Nursing Process Approach (assessment, planning, intervention and evaluation) using the new documentation as compared to existing documentation. These results, with the statistical measures of the difference in means ('t' test and 'P' values) are shown in the table below:

Table 1: Comparison of "Adequate" and Mean Scores of Nursing Practice as Documented

Aspects of documentation (Nursing Practice)	Existing documentation system			New documentation system			't' test value	'P' Value
	% rated "Adequate"	Mean	SD	% rated "Adequate"	Mean	SD		
Assessment	36	9.56	2.712	98	25.18	5.773	-17.17	0.001*
Planning	96	7.98	0.141	100	8.000	0.000	-1.000	0.322
Intervention	76	3.58	1.341	98	7.200	2.449	-9.808	0.001*
Evaluation	24	0.22	0.582	98	7.000	2.070	-20.710	0.001*

*p< 0.001

Table 1 demonstrates that there are significant statistical differences (p<0.001) between the nursing practice performed with the existing documentation and the new nursing process documentation sheet.

Table 2: Comparison of Documentation of Nursing Practice.

Sl. No	Aspects of documentation (Nursing Practice -- assessment, planning, intervention, evaluation)	Existing documentation system		Newly devised documentation system		't' test value	'P' Value
		Mean	SD	Mean	SD		
1	Cardiovascular system	5.08	1.35	8.020	2023	-8.281	0.001 *
2	Respiratory system	3.52	1.90	8.70	4.15	-9.304	0.001 *
3	Gastrointestinal system	4.20	1.14	9.44	1.26	-21.53	0.001 *
4	Genitourinary system	4.06	0.998	5.92	1.00	-8.858	0.001 *
5	Neurological system	1.10	0.364	2.78	1.54	-7.325	0.001 *
6	Musculoskeletal system	1.00	0.000	1.88	1.42	-4.372	0.001 *
7	Integumentary system	1.36	0.802	5.60	1.92	-12.69	0.001 *
8	Pain	1.02	0.141	4.84	0.62	-42.95	0.001 *

*p< 0.001

Table – 3: Documentation of other Aspects of Nursing Practice

Sl. No	Aspects of documentation (Nursing Practice)	Existing documentation system		Newly devised documentation system		't' test value	'P' Value
		Mean	SD	Mean	SD		
1	Health Education	0.30	0.463	1.00	0.000	-10.69	0.001 *
2	Interaction with child	0.000	0.000	1.00	0.000	-	0.001 *
3	Comfort level	0.000	0.000	2.00	0.000	-31.66	0.001 *
4	Special Procedure done	0.90	0.291	1.00	0.000	-20.73	0.001 *
5	Basic Care record – Weight checking, bath, medication, tepid sponging, mouth care and back care.	2.64	0.851	5.00	0.000	-19.66	0.001 *
6	Document – Clarity, legible, signature and arrangement.	2.18	0.522	4.90	0.303	-31.66	0.001 *

*p< 0.001

Documentation of Patient Outcome:

The table below compares the documentation of selected patient outcomes. There were significant differences ($p<0.001$) in the documentation of patient outcomes in relation to respiration, elimination, safety and comfort and nutritional status of the children with the new documentation

Table 4: Comparison of % Documents rated "Highly Satisfactory" and Mean scores of Selected Patient Outcomes as documented

Physiological Components	Existing documentation system			New documentation system			't' test value	'P' Value
	% rated "Highly Satisfactory"	Mean	SD	% rated "Highly Satisfactory"	Mean	SD		
Cardiac	12	1.8200	0.69076	36	2.2200	0.67883	-2.746	0.008
Respiration	20	1.0400	0.60474	74	1.7200	0.49652	-6.263	0.001*
Elimination	12	1.1000	0.36422	82	1.8200	0.38809	-8.887	0.001*
Safety and Comfort	6	1.2600	0.80331	88	3.4200	0.97080	-10.349	0.001*
Parents/ children satisfaction with nursing care	96	1.1600	0.65027	100	1.8800	0.38545	-6.292	0.001*

Attitude of Nursing Personnel to New Documentation System:

Nurses generally reported favourable reactions to the new documentation. Of the 40 nursing personnel, 27 had a favourable response to the attitude questionnaire, while only 8 had an unfavourable attitude. Items which showed a high number (38 or 39) of people who strongly agreed were:

- Assessment of children is made easier in the new system. , (39)
- Progress of the children's condition is assessed early compared to the existing system, (39)
- Documentation system is well organized in the new system. (38)
- Documentation on the new system promotes auditing.
- New documentation provides resources for patient teaching.

Time Required for Documentation:

The study showed a statistically significant improvement in the time required for documenting the care and condition of the patient, with the time required declining in all shifts from 3.3 to 5.1 minutes.

Table 5. Comparison of Time Taken for Completion of Documentation in Three Shifts

Time Period	Existing system (Time in minutes)		New system (Time in minutes)		't' test value	'P' Value
	Mean	SD	Mean	SD		
Morning shift (7:30 am -12:30 pm)	14.05	3.988	9.040	1.328	8.772	0.001*

Afternoon shift (12:30 – 4:00 pm)	9.070	2.007	5.790	1.015	11.393	0.001*
Evening shift (4:00 – 7:00pm)	9.280	1.720	5.440	1.057	14.080	0.001*

* $p < 0.001$

Discussion:

The study demonstrated that the new documentation engendered a significant improvement in nursing practice, documentation of selected patient outcomes, and time required for documentation, compared to the existing documentation. The majority of nursing staff had a favourable attitude towards the new documentation.

Objective 1: to assess the nursing practice before and after introducing the newly devised nursing documentation sheet

The study showed that there is significant statistical improvement ($p< 0.001$) in nursing practice when performed with the new documentation in all the areas. The Nursing Process Approach in nursing practice ensures comprehensive care to patients. Omission of any of the steps (assessment, planning, implementation and evaluation) can lead to less than optimal care (Smith, 1991). Baccoli et al., (1998) showed that 32% of the nurses' records did not have any assessment of the patient's condition, a minority had nursing care plans and only 5% had the evaluation of the interventions.

Objective 2: to assess selected patient outcomes before and after introducing the newly devised documentation sheet

Scharf, (1997) suggested that a change in a hospital's patient care forms contributes to positive outcomes. In this study the patient outcomes (as documented) in relation to respiratory, elimination, safety and comfort were significantly improved ($p<0.001$) after implementation of the new documentation. The cardiac component did not show a significant difference.

Objective 3: to assess the nurses' attitudes towards using the newly devised nursing documentation system

Results indicated that the nursing personnel generally had a good attitude towards the new system, with two-thirds having a "most favorable attitude

Some nursing staff interviewed about the new system made the following comments:

1. It provides child centered care and helps us to carry out assessment, planning every time, implementation of care and evaluation of care provided.
2. Assessment of children is made easier in the newly devised documentation system.
3. Progress of the children's condition is assessed early in the newly devised documentation system.
4. Less time consuming and omits irrelevant data and unnecessary information.

Four nurses (10%) felt that the medication documentation should also have been included.

Objective 4: to compare the time taken to complete the documentation in existing and newly devised documentation systems

It was found that the mean time of documentation was less for the new documentation system (6.75 minutes) compared to the existing documentation (10.8 minutes) and there was a significant statistical difference in time spent ($p<0.001$) for documenting an eight hour shift.

Research hypothesis

The research hypothesis was that the newly devised nursing documentation would improve nursing practice and patient outcomes. The study revealed that the implementation of new documentation showed an improvement in terms of nursing practice and documentation of selected patient outcomes, thus supporting the hypothesis.

The study has a number of implications for nursing practice;

- The Nursing Process Approach improves patient care and is less time consuming to complete.
- Selected Patient outcomes can be assessed and monitored more effectively using the new documentation..
- Nursing personnel responded favorably to the new system, so there should not be any resistance in implementation.
- The time required for documentation was less, leaving more time for patient care.

Suggestions and Recommendations for Further Research

This study suggests that there are benefits to be obtained, in nursing practice, efficiency and patient outcomes, if the Nursing Process was to be adopted in the Paediatric department of CMC Vellore. However, further research should be undertaken to validate and expand the results of this study:

1. The same study can be performed with a larger sample and for a longer period.
2. Follow up studies after periodic intervals to evaluate sustainability of the improvement, and continued nursing compliance.
3. A study to compare the effectiveness of nursing practice and selected patient outcomes.
4. A study involving all the nursing personnel at different levels (supervisor and senior staffs) to assess the time taken for retrieval of information from the newly devised documentation system.
5. A descriptive study to assess the knowledge, attitude and practice of paediatric nurses regarding documentation.
6. The same study can be replicated after computerizing the documentation system in the Paediatric Department.

Conclusion:

The study was conducted to test to suitability of a new nursing documentation system. It assessed nursing practice, documentation of selected patient outcomes, the time taken to complete the documentation and the attitude of nursing personnel towards the new system. The new system records specific care rendered to the children and was less time consuming to complete. The study also showed significant improvements in the documentation of selected patient outcomes occurred with the new system, and nursing practice was significantly improved in the aspects of assessment, intervention and evaluation.

Hence this newly devised documentation system using the Nursing Process meets all the criteria to be successfully implemented in Paediatric wards and possibly throughout the hospital.

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Research guide – Dr. Ananthakumari Rajan
Clinical guide – Dr. Vinitha Ravindran
Medical guide – Dr. Indira Agrawal

REFERENCES:

1. Ammenwerth, E., Kutscha, U., Kutscha A., Mahler, C., Eichstadter. R., & Haux R. (2006). Nursing process documentation systems in clinical routine – prerequisites and experiences. Retrieved on May 20, 2006 from http://www.ncbi.nlm.nih.gov.
2. Boccoli E., Lavazza, L., Tomaiuolo, M., Brandi, A., Melani, A.S. & Trianni, G. (1998). The content and structure of nursing documentation in Careggi Hospital, Florence. Retrieved on July 10, 2006 from http://www.ncbi.nlm.nih.gov.
3. Edelstein, S. (1990). A study of nursing documentation. *Nursing Management.* 21, 40 – 46.
4. Nursing and Midwifery council (NMC, 2002). Guideline for record and records keeping. Retrieved on January 2005 from www.nmc-uk.org
5. Picogna, M., & Lirutti, M. (2001). Assessment and improvement of the quality of nursing documentation. Prof Inferm, 54 (4), 202–208 and 241-248. Retrieved on Feb 2nd 2006 from www.unboundmedicine.com
6. Potter & Perry, A.G. (2004). *Fundamentals of Nursing*, (6th ed) St. Louis: Mosby, 476 – 499.
7. Scharf, L. (1997). Revising nursing documentation to meet patient outcomes. *Nursing Management,* 28(4), 38 – 39.
8. Smith, J. (1996). Chart reviews made simple. *Nursing Management*, 27, 33 – 34.
9. Yocum, R. F. (2002). Documentation, for Quality Patient Care. *Nursing*, 32(8), 58-63.

FOLLOW-UP OF NATIONAL FELLOWSHIP IN PALLIATIVE MEDICINE (NFPM) GRADUATES

Introducdtion

Dr. B. Lalrambuatsaiha

Christian Medical Association of India (CMAI), New Delhi in collaboration with the Institute of Palliative Medicine (IPM), Calicut, Kerala has jointly run National Fellowship in Palliative Medicine (NFPM) for medical and dental doctors as a long distance education of one year duration since 2004. In order to assess the usefulness and effectiveness of this course, an online survey of the graduates from the year 2004 to 2017 was carried out using a self-administered questionnaire starting from the month of May 2017. Out of the total 160 students graduated so far, we were not able to established contacts with 58 of them through online. The survey ended in July 2017 and analysis was done subsequently.

Results

Demographic Characteristics:

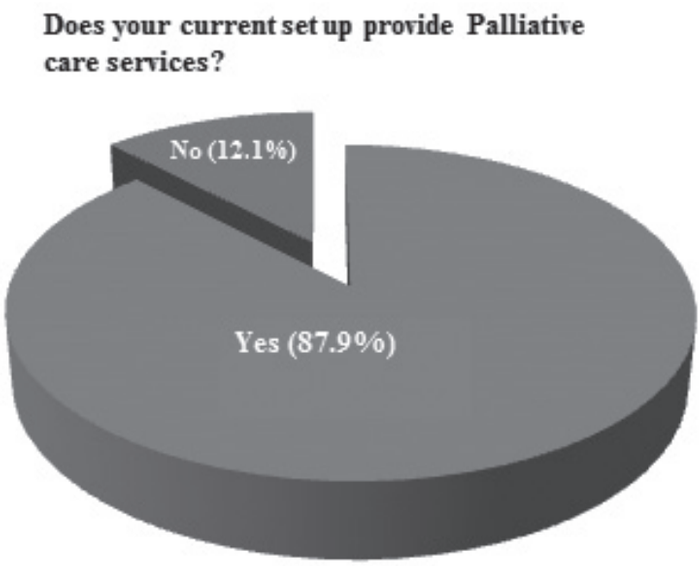
Male and female are almost equal in number among the respondents. Majority are 40 years and above and most of them are married. Graduates of NFPM come from all over the country and few students also come from the neighboring countries such as Bangladesh, Pakistan and African countries.

Work related Characteristics:

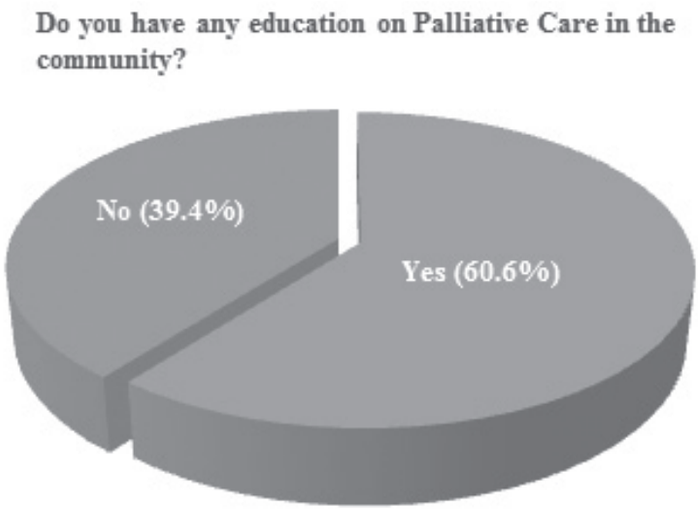
Majority of the respondents are in clinical practice mostly palliative care while few of them are currently working in research and teaching. Among the graduates, 75.8% have an MD/MS/DNB/Diploma degree besides MBBS and the

rest possess bachelor degree. It is interesting to note that while majority of the respondents (87.9%) provides Palliative care services in their current institutional set-up, only over half (56.7%) have a separate allocation of funds for Palliative care services.

More than 2/3rds of the respondents have a separate unit for Palliative care services in their institution and among those who do not have, majority of them are interested in opening a Palliative care Unit in their institution. Over half (51.5%) of the graduates started working in Palliative care services after finishing NFPM course and the rest continue to practice other clinical work.

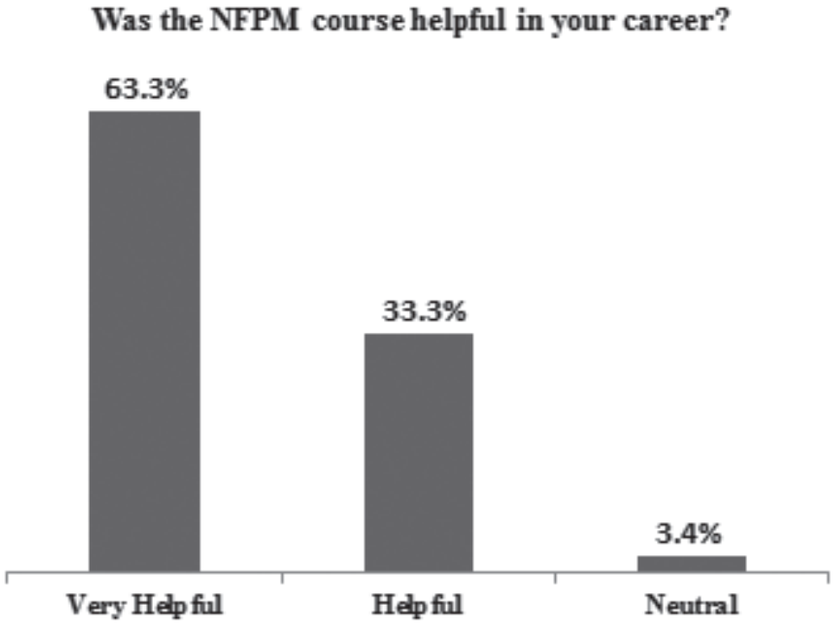


More than 2/3rds of the graduates find the NFPM course very helpful in advancing their career and over half (54.5%) finds the course very useful in their clinical practice. Almost half of the graduates (45.5 %) admitted that they charge for Palliative care services in their hospital which is mainly for medicines (28.6%). Majority (81.8%) responded that Palliative care services generated goodwill among the community they serve. 60.6% impart education on Palliative care services in their community which is important to generate awareness. However, a significant number (39.4%) of the graduates responded that they do not have any education on Palliative care services for the community.



Conclusion

Overall, the NFPM course was found to be useful and effective in enhancing knowledge and skill building among the graduates. The community they work with also benefitted from the Palliative care services. It was also found to be useful in progression of their professional career and in their clinical practice. Some of the graduates when asked for suggestions at the end of the survey questionnaire mentioned the need of palliative care services to be a free service provided by the government. This stressed the importance of policy advocacy at the State and at the National level. CMAI through its national coordinator for NFPM course has contributed to the National Policy on End of Life Care. Although the recent National Health Policy 2017 recognizes the growing need of palliative and



rehabilitative care, it does not specifically mention on how to implement and execute it nation-wide. There is also no mention of allocation of funds and resources for the same.

Some of the graduates are of the opinion that the contact period which is currently one month should be increased to at least 3 months. The reasons stated were; longer duration of clinical exposure in different aspects of Palliative care and also learning in multiple centres. However, the course is designed in such a way that working professionals will be able to complete the course without it being burden on their working schedule.

The course was also initiated with the intention to fill in the huge gaps of palliative care services in the country considering the resource constraints in a developing country such as ours.

Dr. B. Lalrambuatsaiha is the Programme Coordinator in Community Health Department, CMAI

HEALING MINISTRY

CELEBRATION

The Healing Ministry week and Sunday theme for 2018 will be

"Hope in Distress".

The bible study materials (Bible Study in English) will be available in

CMAI website from **December 2017**

The **Order of Worship** in the regional language will be available in

CMAI website from the **2nd Week of January**.

Please let everyone know about this celebration time!

Please note the dates of the Healing Ministry week and Sunday

Healing Ministry Week **11th – 18th February 2018**

Healing Ministry Sunday **11th February 2018 & 18th February 2018**

CMAI Day of Prayer: **4th February 2018**

MARY LOTT LYLES HOSPITAL THE ROAD TO REBUILDING A MISSION HOSPITAL

History

Dr. Shoba Katumalla

Mary Lott Lyles Hospital (MLL Hospital) has had the privilege of being one of the first few mission hospitals to be established in India. Located in a rocky valley along the southern border of Andhra Pradesh in a town called Madanapalle, this hospital has served the people of this region for over 100 years. The region was quite popular for its medical care in the early 1900s with MLL hospital and Arogyavaram TB Sanatorium serving as centres of healthcare and rehabilitation to patients from all over India. Visionaries such as Anne Besant, Jiddu Krishnamurti and Rabindranath Tagore have contributed to the history of this small town.

Medical work in Madanapalle

Medical work in Madanapalle was first started in 1863 by Rev. Dr Jacob Chamberlain, a medical missionary from the Reformed Church in America. He started to treat surrounding villagers from the verandah of his house. Due to the high volume of people seeking medical care, he started a hospital in Madanapalle with the help of the erstwhile government, which is currently the Government Hospital.

History of the hospital

MLL Hospital was established in 1911 with a motto "Called to Serve" by J.S. Atkinson, member of the

Dr Louisa Hart was the first physician in-charge of the hospital and worked for 42 years. She was also awarded the Kaiser-I-Hind, the Jubilee and Coronation Medals by the Government for her faithful dedication to her service.

Governor's Council, Madras and Dr Chamberlain's desire to have an exclusive hospital for women and children in Madanapalle was thus fulfilled. From 1911 to 2004, dedicated and selfless individuals had been at the helm of MLL Hospital's mission to serve the poor. Among the people who rendered their selfless services to MLLH were Dr Louisa Hart, Dr Mary Rajamanikam, Dr Alice Chorley, Dr Gibbons and Dr Vander Aarde. Dr Louisa Hart was the first physician in-charge of the hospital and worked for 42 years. She was also awarded the Kaiser-I-Hind, the Jubilee and Coronation Medals by the Government for her faithful dedication to her service. A teacher by profession and a trained medical doctor from Madras, Dr Mary worked at MLLH treating the sick and shaping the foreseeable future here. By the end of 50 years of operation, the hospital was proud to announce a 185-bed capacity with six doctors on the staff, a fully-fledged laboratory, and a nursing school. Missionaries from the Reformed Church in America worked in the hospital till 1986, at which point it was a 220-bedded hospital. After decades of steady growth, the hospital faced extreme challenges facing imminent shutdown in 2001. The hospital that was the birth place of many residents of Madanapalle and its surrounding areas was in a dilapidated state for over 15 years.

Rededication

On 2nd March 2014, with a vision to provide *high quality and compassionate care to all*, the hospital was reopened and rededicated to the service of God and the country under the aegis of Rt. Rev. B. D. Prasada Rao – Bishop in C.S.I. Rayalaseema Diocese by Dr Shoba Katumalla and Dr Naveen Khaja. The hospital now has a steady flow of patients from Madanapalle and its surrounding villages. With the help of the locals and the involvement of the congregation, buildings were renovated and basic operational activities were modernised. Apart from the regular hospital activities, community screening

Apart from the regular hospital activities, community screening programs are also conducted. Weekly school screenings and urban ward screenings are actively conducted not only to provide utmost care to people around but also to spread awareness of various medical conditions.

programs are also conducted. Weekly school screenings and urban ward screenings are actively conducted not only to provide utmost care to people around but also to spread awareness of various medical conditions.

We are now a team of six doctors namely:

- Dr. Naveen Khaja - Director, Orthopaedician
- Dr. Shoba Katumalla – Ophthalmologist
- Dr. Kamakshi Kartik – Pathologist
- Dr. Santosh Thomas – Gynaecologist
- Dr. Annie Thomas – Paediatrician
- Dr. Shaji Pankiraj - Orthopaedician

If you have had a connection with the hospital and are willing to invest either your precious time, expertise, donate to us or help us in any other way, please email us at mll.hospital.madanapalle@gmail.com or call us at +919849148777

We are also hiring medical professionals. If you are interested in finding out more about openings at MLLH, you can write to us at mll.hospital.madanapalle@gmail.com.

Dr. Shoba Katumalla is the CEO of Mary Lott Lyles Hospital, Madanapalle

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