QUARTERLY JOURNAL OF CMAI

CMJI

CHRISTIAN MEDICAL JOURNAL OF INDIA

Volume 35.2 | April-June 2020

VIOLENCE IN MEDICAL FIELD

Join Hands with us in the Healing Ministry

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

- CMAI has over 10,000 Christian health care professionals and over 270 institutions representing various denominations.
- CMAI builds individuals to be technically sound, spiritually alive, and socially relevant, in fellowship and with a Christian perspective on health and development.
- CMAI is the health arm of the National Council of Churches in India(NCCI).

WHAT DO WE DO ?

- Build capacity to respond to the current and future health care needs
- 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
- CMAI influences other networks and alliances on thinking change in health systems practices in India. We partner with national and international agencies to promote this objective.

OUR PUBLICATIONS

- Christian Medical Journal of India (Perspective)
- Life for All (Newsletter)
- Footsteps (Development) English & Hindi (A Tearfund publication distributed by CMAI)

COME JOIN US

The core of CMAI is its members- individuals and institutions. Individual membership consists of five professional groups - Doctors, Nurses, Allied Health Professionals, Chaplains and Administrators. Each section comes together for conferences, workshops, a time of fellowship to learn from, to share with and to encourage each other spiritually and professionally.

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Building a just and healthy society

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CONTENT

LETTERS / ARTICLES FOR CMJI

We invite your views and opinions to make the CMJI interactive and vibrant. As you go through this and each issue of CMJI, we would like to know what comes to your mind. Is it provoking your thoughts? Please share your thoughts with us. This may help someone else in the network and would definitely guide us in the Editorial team. E-mail your responses to: cmai@cmai.org

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.

GENERAL GUIDELINES

- 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

Improving or Deteriorating?

Rev. Dr. Arul Dhas T.

As a healing community, are we growing in relationships? Or deteriorating? Even though all of us are together, some of us are deeply involved in providing health and others at the receiving end. The dividing mark between these two group is not very clear physically and spiritually. In giving we receive; in receiving we give. Our lives and works are so intertwined with each other.

Time and again we experience breach in the trust between health providers and receivers. We, ministers of healing, take relationship for granted at times. Trust develops between communities and ministers of healing by giving – giving our time, energy, care, etc. Often we build this safety into our systems through the occasions of fellowship, discussions, conversations, and other methods.

This issue of CMJI comes with this burden. We rejoice and celebrate the trusting relationships. We are ready to identify when there is a deterioration or breach in our relationships. Any kind of violence is due to eroded relationships. Has there been violence in the medical context? How do we understand them and address them?

The articles “Healthcare Professionals and Communities”, “The Trust Quotient of Mission Hospitals”, “Legal risk for Medical Professionals”, “Interprofessional relationships: A Biblical Perspective” and “Role of Family in the Healing Process” and the Interview which are featured in this issue are put together with the intention of looking at the trusting relationships from different perspectives. Our prayer is that the reading and reflections due to this issue will facilitate and promote better relationships between the ministers of healing and the communities.

With best wishes and prayers,

Rev. Dr. Arul Dhas T.
Editor

5C'S OF PSALM 23

Rev. Paras Tayade

Psalm 23, without a doubt is one the most read, memorized and recited passage of the bible. No matter what our situation may be, Psalm 23 has something to offer to each one of us. The first five words of this Psalm are the foundation on which everything else hinges. David is affirming that 'Because God is his shepherd therefore he is not in want'. David highlights four blessings that are a result of his relationship with God.

1. Contentment (Vs. 2-3)

It is human nature to think that the grass is always greener on the other side. As a counter view David is saying when the Lord is our shepherd, we can be satisfied where we are, in what we are doing and in what we have.

2. Comfort (Vs. 4)

Christian life is not just about green pastures and still waters. It also involves walking through the valley of death. Yet God's assurance is that we are not alone as we go through difficult times, but he is our Immanuel; God who is with us, even in our darkest hour.

3. Confidence (5)

David expresses his confidence in God protection. God is more than able to protect us, so much so that we can sit with our enemies and yet know that they can't harm us.

4. Communion (Vs. 6)

David began this Psalm by stating his relationship with God and he ends it by affirming that this relationship is an everlasting one.

5. Challenge

The challenge this Psalm presents to each one of us is to know the Shepherd in an intimate way so as to share in the blessing that David expresses here.

"Yet God's assurance is that we are not alone as we go through difficult times, but he is our Immanuel; God who is with us, even in our darkest hour."

Rev. Paras Tayade
Faculty at Union Biblical Seminary, Pune
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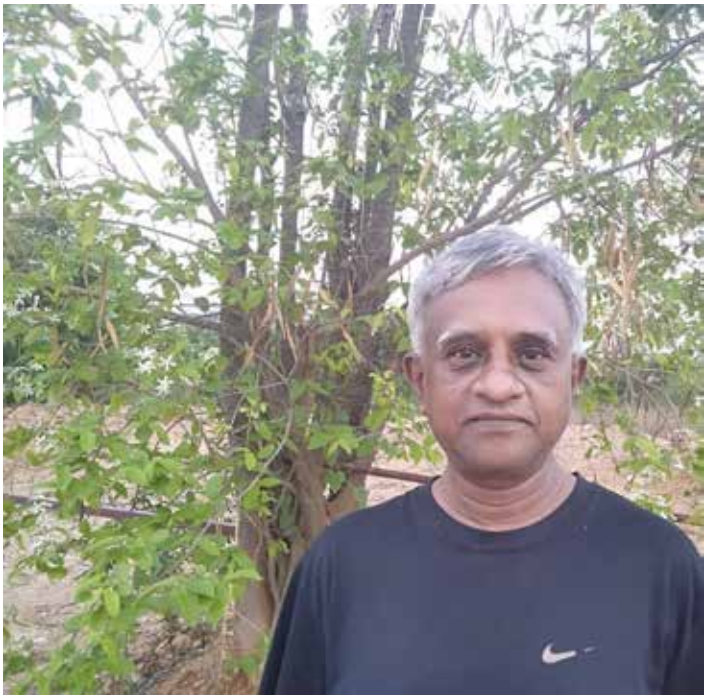

In this exclusive interview with Dr. Bimal Charles, former General Secretary of CMAI we speak about the effects, impact and challenges of Violence in Medical Field. Interview by Christopher N. Peter, Lead- Department of Communications of CMAI.

Q. Why do you think that the trust is lost?

A. Even today, GDP allocation for healthcare is less than two percent. Which means that while the Government is unable to provide quality healthcare to everyone, those who could afford went to the private hospitals. In late nineties, standards came in bringing insurance companies, NABH and all services of hospitals were to meet standards and quality. So we saw that the costs rose and unfortunately, it was the patients who began to suffer. Hospital which was a place of trust witnessed a massive change.

Q. When the trust is lost, what happens?

A. Healthcare and hospitals are a place and safe haven of trust. We are unfortunately headed in a wrong direction. It seems that it is tough to go back in time now. So when the trust is broken the manifestation is in many different ways.

Q. Trust is build when truth prevails. When there is no trust, how do we hold steadfast with truth as a value?

A. It is here that we can be different from other hospitals in the private sector. People generally know that we are not in this for money and our ethical values are better than any other institutions. Like I have always said that our mission hospitals have a bright future because over a period of time this truth has eroded. Now there is very little understanding what this truth is. Most often the truth is not told. Having said that, I would say that there is so much that can be done in our institutions on what is proper, correct and ethical. When you do that you will have to tell the truth boldly and then gradually people and the community will trust the hospital.

Patients come to mission hospitals because they trust us with their lives and most

importantly they know that we will not exploit them as we have been telling the truth. But the point is that we have to tell what is real without camouflaging it by stating assumptions that this may happen or not happen. We have to come forth boldly and share our limitations and how within those the hospital would perform medical duties. If this communication is given properly and documented, then I believe that people will begin to trust us more in days to come.

Q. Please talk about litigation?

A. The government has enacted laws to protect healthcare providers, property and the life of workers. Some organizations are aware of it and unfortunately there are many who are not. However, the law also needs to be enforced by the law enforcement agencies but small institutions in rural areas are not only unaware but also scared to approach the law.

Q. How can a mission hospital protect itself?

A. Create a standard operating protocol by the hospital management. Those in frontline like guards, the receptionists, the nurses on duty and junior doctors have to receive standard training programmes. They have to be prepared how to respond in case of a physical attack on the hospital.

Let's say if somebody dies at the hospital. In that case how to break the news? who breaks the news? whether a junior or senior doctor breaks the news and what all precautions have been taken and what precautions have been taken to protect oneself physically before breaking the news. These according to me are system issues. We can definitely learn from those experts who have created such systems and especially those who have experienced these type of challenging times. For instance, like a code could be developed which is known to the entire hospital staff and the management. So that when needed, immediately everybody acts accordingly in a time when one needs to protect himself/herself, the staff and the property from a physical attack.

Q. What legal process can protect the institution and what our hospitals should be aware of?

A. A legal person has to be involved to inform the hospital and guide on the processes to keep the hospital protected legally. So I would say that our institutions have to be well aware of what is happening but the best would be would say prevention. Most often we get caught in consumer protection act as well as in violence situations because our people do not communicate properly. So to start with someone should be responsible in giving proper communication to the patient and the relatives. The staff has to have a proper checklist of communication points like type of disease,whatis the condition, possible outcomes, how much would it cost, related consequences, etc. Additionally, every communication is properly documented. Like there are standard consent forms and you should ask people to sign them. Also looking at your location and language a translated copy of the consent forms also should be made available at the hospital. Lastly, there should be adequate back-up in case of any untoward case.

Q.Why are institutions unable to communicate effectively in this regard?

A. See, our mission hospitals are struggling and struggling even for survival. So very often they don't have the latest equipment, best expertise and resources. Sometimes they try to help patients themselves along with guiding them to go take a treatment from some other facility. We should try to refrain from that and just speak the truth and state if the hospital is not able to take care of a patient then refer to another hospital.

Q. In case of an act of violence, who bears the brunt at the hospital first?

A. In a violent situation, the front liners get affected first. Normally, it is the nurses and the junior doctor. It is not fair unless we prepare them properly so that we can protect them. Not only that it is important for people to be alert as well. Staff at entrance and at reception have to alert because in a given situation a group can enter the hospital premises and gather slowly.

Q. Please talk about the local relationships, reputation and goodwill of the hospital with authorities, political parties, media, administration, business community, etc.

A. In the past these relationships were maintained. Our leaders in the past were very good in creating and maintaining these relationships. The local community felt lot of pride in associating themselves with their mission hospital. However, the hospitals create a physical wall around the campus which converts into a mental wall distancing them from the community.

We have to interact with everybody and engage with the local culture of the location or region. It is crucial for the leadership of the hospital to interact with the local community. Invitations to various festivals should be respected and attended by the staff. Interact with the district superintendent of police, district collector and the local politician. The CEO or the chief manager of the hospital has to regularly interact with the outside community despite having or not having latest equipment and facilities. Once you have a relationship then trust follows and when there is trust then you are protected. It is then the objective and purpose of our healing ministry can be effectively communicated and understood.

Q. What about the role of patient's family?

A. The role of family is really important because when someone is sick and suffering in the hospital, then it is the family that takes a decision. They play a critical part as in case of an issue or a problem it is the family that brings involvement of other family members and the community. It is the family that influences those they are connected with outside and at times in order to avoid paying for the treatment. Therefore, the hospital has to keep their communication with those family members who are closely related to the patient and keep this documented and recorded for defense in the future.

Q. The role of media?

A. We have to adapt to the situation. Relationship with media comes as a part of mission hospital's relationship with the outside world. Mostly, the hospitals are not prepared to interact and engage with the media. There is a way you talk to the media. There is a way you tell the truth to the media. We should not feel shy from media, in fact, we should know how to address the media persons, present our case to them, respond to their queries without getting scared of them and tell the truth. We also have to be cautious of the media and share knowledge and wisdom with the media. All of these approaches does not come naturally and requires practice and guidance. In time, these efforts will be noticed and then the senior media persons and representatives will respect the mission hospital and support in the future.

THE TRUST QUOTIENT OF MISSION HOSPITALS-AN OBSERVATION DURING THE COVID-19 SEASON

Dr. M.C.Mathew

I remember hearing my parents talk between themselves, when I fell ill during my childhood, that 'There is no mission hospital close by to go to'. They both had vivid memories of going to the Thiruvella Medical Mission hospital in central Kerala, to which they went whenever they or their parents had any health need. That hospital was their first port of call for all their medical needs. They spoke highly of the care and conveniences the hospital offered. Since my parents relocated in North Kerala, they did not have access to that hospital during my childhood.

As a medical student, I had acquaintances with Achalpur Mission Hospital, where Dr. Howard Searle spent several years; Paddar Mission Hospital where Dr. Victor Choudharie spent his life time of service and the Christian Fellowship Hospital, Oddanchatram, where its co-founder Dr A.K.Tharien spent his life time, developing health care facilities for the rural community. Anna and I worked for a while at the Christian Fellowship hospital and N.M.Wadia hospital, Pune, in the late nineteen seventies after our graduation, which gave us an opportunity to get to know why a mission hospital is the spontaneous first choice of many, when they have health care needs.

I was on a phone call the other day with Dr Sedevi Angami of the Christian Institute of Health Sciences and Research (CIHSR), Dimapur. He told me the several COVID 19 awareness programme the hospital staff was engaged in, in the community and hospital. The fear and anxiety about contracting the corona infection was high in the community that they even stopped coming to the hospital for their regular health care needs. The awareness campaign by visiting homes, church groups, restaurants, public places, village gatherings, etc. by the hospital staff helped in building confidence in the community to return to the hospital for their health care needs. Now, although the hospital is offering care for the COVID 19 patients in the same campus, the regular patients have resumed coming to the hospital. They now know of the care and attention with which the hospital has prepared itself to contain the spread of the COVID infection. Even the government of the Nagaland has adopted the protocol of care advocated by the CIHSR for prevention and treatment of COVID 19 infection. I followed up this conversation by talking to a friend, to get a feel of the role of CIHSR in Dimapur and near-by places. His response was that, 'People feel secure and confident when they come to CIHSR. Many travel long distance even from the adjacent north eastern states to reach the hospital'. His reason for this was that, people have come to believe that the hospital practices medicine 'honestly, ethically and altruistically'.

During a recent conversation with Dr Ravi George of the Asha Kiran Hospital, Lamptaput, which welcomes patients from the tribal belt, he shared a fascinating story. As early as

in March, when the news of the possibility of COVID 19 outbreak reached the hospital, the hospital team decided to convert the training centre, which is a stand-alone building away from the main hospital, to welcome and admit the COVID 19 patients as and when needed. This involved financial outlay, which for a hospital that normally needs external support for the maintenance of the hospital looked too ambitious to attempt. The training centre needed partition, staff needed protective kit, the ward needed extra beds and patients needed subsidised or free medical care. That was when, Dr Johny Oommen of Bisamcuttack mission Hospital offered to share their resources to help them to get it started. He introduced them to a donor, who was looking for genuine hospitals wanting to upgrade their capacity for the care of the COVID 19 patients.

> **“The Nepal-Bihar border having been closed following the national lock down, the hospital anticipated the local community to approach the hospital for regular health needs, which meant that they needed a separate facility for the patients of COVD 19.”**

The donor having examined their financial statements and satisfied by the mission of the hospital, offered a generous grant to make all the provisions needed to run a COVID 19 in-patient service. Although the patients from the tribal community, who normally access the hospital by using the public transport or jeeps, could not come since the transport system was non-functional following the national lockdown, the hospital was reaching out to them through the wayside clinics and home visits. It is yet another story of trust. Even a new donor trusted a mission hospital unconditionally, to fund its project! The tribal community has confidence in the hospital, because they are familiar with the child care centres, literacy programmes, village health centres, women’s support initiatives, etc the hospital runs for the last 25 years now.

I was keen to know how the community around the Duncan Hospital, Raxaul, responded since the outbreak of the pandemic in that region. I got in touch with Dr Santhosh Mathew, who until recently was located at the Duncan hospital. He shared with me the efforts of the hospital to prevent the staff from getting infected and prepare a protocol of practice to offer affordable and effective care for the COVID 19 patients from the local community. The Nepal-Bihar border having been closed following the national lock down, the hospital anticipated the local community to approach the hospital for regular health needs, which meant that they needed a separate facility for the patients of COVD 19. The hospital took a proactive step well in advance that they would remain available to the local community. Seeing the abundant caution that the hospital was taking not to mix the regular patients and the COVID 19 patients, the local community, after a short while of staying away from the hospital, returned trusting the hospital in its intent to follow good practices. The Orthopaedic surgeon and the Managing Director of the hospital, Dr Prabhu Joseph seems to have mentioned to Dr Santhosh, that he had a heavy load of operations to do, apart from the accident and trauma surgery he was normally doing, during this period. This benefitted the hospital as the drop in the income at the hospital could be compensated

for through the regular services provided to the local community. The local patients did not get ostracised because the Duncan Hospital was looking after the COVID 19 patients. Instead they came to trust the hospital for their concern to protect them from COVID 19 while visiting the hospital. Dr Santhosh attributed these changes on account of the habit of prayer of the staff and the cordial consultation and collaboration between the staff to evolve a Duncan model of COVID 19 care for Bihar.

I was keen to get an overview of the way the community responded to the initiatives of a mission hospital located in a south Indian city. The telephonic interview with Dr Naveen Thomas of the Bangalore Baptist Hospital, gave me some significant impressions about the high level of trust the local community has bestowed on the Bangalore Baptist Hospital. The hospital was in a dilemma as to how they would manage the regular work load, when the government took away 50 percent of their beds for the care of the COVID 19 patients. This meant that the local patients 'feared' to come for their regular health needs to a 'COVID hospital'. This led to a drop in the number of patients visiting the hospital and the income. The increase in the salary for the staff, promised for April had to be kept in abeyance. Even the regular salary could not be paid in full to which the staff responded in a magnanimous way. Since all the steps to contain the infection from spreading beyond the COVID care area was made known widely, the patients for regular health care started to return. Dr Naveen talked about the team spirit he observed during this difficult time and commented his colleagues for their steadfast efforts to run a COVID service without disturbing the regular health care services too much. The local community knew the Baptist Hospital as their 'friend' at all times. A young consultant working in the hospital for a year, having observed the trust many patients have in the hospital told me, that 'The patients come to the hospital believing that, they have no other better place to go to'.

"Even the regular salary could not be paid in full to which the staff responded in a magnanimous way. Since all the steps to contain the infection from spreading beyond the COVID care area was made known widely, the patients for regular health care started to return."

The trust quotient is high among people who come to a mission hospital. This has been for fifty or seventy five years or more and continues to be so even now. The mission hospitals function across many geographical areas, both in the rural and urban areas. Wherever they are located, the community around a hospital finds it as a safe place to go to for their health care.

Late Dr K. N. Nambudiripad, a former director of the Christian Medical College, Ludhiana and a neurosurgeon of repute used to say that the 'X' factors which endear people to a mission hospital are, 'competency, communication and compassion'. I believe that the human resources in the mission hospitals are of high calibre. The professionals in the mission hospitals take considerable effort to listen to patients and share with them the details of procedures, out of due respect to their autonomy. I have some personal experiences of the hospital staff going out of their way to make patients and relatives feel comfortable by consoling them and offering practical help.

While talking to Dr. Christopher Moses of Jalna Mission Hospital, I discovered another dimension of this trust quotient which people repose in the mission hospitals. The local community gathered together to help the hospital, having seen the efforts of the hospital to create a separate ward for the COVID 19 patients. A generous gift was given by the local community to the hospital to subsidize the cost of care of those, who were financially burdened.

Even Dr Moses was surprised by this. He had not known that there was so much goodwill towards the hospital from the local community! The local community was perceptive of the fact that although Dr. Christopher and his wife Dr Shobha, are older in age, they ignore the risk they carry and are in the forefront, giving leadership to the team in the hospital.

The hospital is able to do the COVID testing in the hospital itself, which has enhanced people's opinion about the hospital's resolve to provide the best service for the local community.

Our mission hospitals have earned the trust of the people whom they serve, because the hospital staff live and exercise their mission of, 'not to be ministered unto but to minister' spontaneously and cheerfully.

Dr. M.C.Mathew, Emeritus Professor of Developmental Paediatrics and Child Neurology, was a former editor of the CMJI and president of the CMAI.

CMJI with this edition will engage with artists to commission them for creating the Cover Design. This work of art will add visual value to the theme. The original art piece will be available for purchase by an individual member or a member institution. For this edition, we spoke with Rajesh Kumar Gogu who created this painting on Violence in Medical Field.

CMJI: Dear Mr. Gogu, thank you the beautiful art work. Please tell us about yourself?

I am Rajesh Kr Gogu, currently heading the exterior design team at Maruti Suzuki. Painting has been a hobby for me since childhood. After joining the corporate world, I had stopped painting but picked up the brush again to inspire my daughters to paint.

CMJI: What inspires you?

Bringing a canvas to life reminds me of how God created everything out of nothing. So, when I sit in front of a canvas it reminds me of my creator and his creative act. Similarly, every painting I make is an act of worship, however big or small the subject maybe.

CMJI: The artists love the beauty of Canvas and colors. It has it own space and yet the digital world embraces and promotes art more effectively today. Your thoughts please?

Paints on canvas is a traditional medium which has been there for hundreds of years. It has its own charm and has timeless beauty. Along with time and advancement in technology, art has also been embracing the new media that are available. Both traditional and digital art have their own unique way and advantages in expressing the artists' creativity. It's upto the artist to choose which medium best represents his creativity and ideas. In these changing times, the artists often need to embrace digital medium to reach and promote their art.

CMJI: So looking at the painting you've created for the cover page, tell us what came to your mind?

The brief that was given to me was "violence in the medical field". There are many doctors in my family. In fact, when one of my cousins was studying medicine I used to visit him quite often and spent a lot of time in the hospitals and

with other medicos. I saw first-hand how they treated the patients and their commitment to make the patient live and get better again. They don't give up.

The first thing that came to my mind was how delicate life is and how the doctors are life savers who dedicate themselves for that cause so that out light continues to glow for another day. I hope people can see that in this art and my prayer is that violence against doctors would reduce drastically.

CMJI: CMAI is trying to promote artists through this publication. What would you like to tell your fellow Artists?

It's wonderful to see that CMAI is using art to highlight the relevant issues or causes of the medical field. It's a good initiative and I commend you for that. I encourage artists to engage with CMAI and use this as a stimulus to not only bring out your creativity but also to make people think.

A picture is better than a thousand words. But in today's world the attention span is just few seconds even for that picture. I believe a painting can grab the attention of the viewer for few more seconds from the visual chaos we experience on a daily basis. We have that power to stop the eyes moving on to another visual content. So, I encourage artists to use it for a good cause like this.

CMJI: What does your process involve? Does the work evolve or your start with an idea and take it to the finish?

It depends, sometimes I have an idea before even I start painting and I use the Digital medium to compose and try out different options before I actually paint it. Other times, I paint and then repaint to improve. With this cover page, I was very clear what I wanted to paint, even the colours and the mood I wanted to capture. Sometimes, it's not that easy. It's a creative struggle and I love that process. I often run the ideas by my wife and kids (10 & 6 years), they are my first critics and based on their feedback I do changes. For us, art is a family affair :-)

CMJI: Where can we find more about your work?

You can find my art on Instagram @gogu.art.

Note: Those interested in buying the art work kindly write to us at cmai@cmai.org

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LEGAL RISK FOR MEDICAL PROFESSIONALS

Mr. Abraham Mathew

Which doctor (or any professional, for that matter) has not had a friend ask for medical advice through a text message on Whatsapp? It is almost commonplace nowadays for friends and extended family to borrow your expertise. But are you liable for advice that was given gratuitously, without physically examining the patient, or considering their medical history?

While the law doesn't not permit recipients of free treatment to sue medical service providers, these lines could be blurred with tele-health becoming more prevalent; a 'patient' could claim consideration for services in many ways. But for this article, we will look at traditional medical services, and the legal risks faced by doctors.

Patients can potentially proceed against doctors in several ways – a complaint with the Medical Council, criminal proceedings, and much more commonly, a complaint before the consumer courts.

Consumer complaints against doctors are becoming much more common. However, it is important to point out that unlike in most other cases, where courts are pro-consumer, in medical negligence cases, courts are typically more protective of doctors. It has been held repeatedly by the Supreme Court that if a doctor has adopted a practice that is considered "proper" by a reasonable body of medical professionals who are skilled in that particular field, he or she will not be held negligent only because something went wrong.

> **"It has been held repeatedly by the Supreme Court that if a doctor has adopted a practice that is considered "proper" by a reasonable body of medical professionals who are skilled in that particular field, he or she will not be held negligent only because something went wrong."**

In a recent case, surgery was performed on the lower back area of a patient. She continued having back-pain, and six months later, a different hospital conducted a scan to discover that there was a cyst on the upper area of the spinal cord. Now, the relevant question was whether the cyst developed subsequent to the first operation; and simultaneously, whether the surgery on the lower portion, L4 & L5, was actually successful, which is why, it did not show abnormality. In such a case, the judge decides by analysing the doctor's recommendation for the scan which formed the basis for the first operation. (That still leaves the question of whether the cyst at D5 existed at the time of the first operation, but one has seen that in such cases, doctors get the benefit of doubt).

This, and so many other episodes, show how proper

documentation – with regard to symptoms, suggested treatment, information about side-effects, etc - can come to the aid of the doctor. Equally important is adherence to well-established procedures.

The kind of adventurism exhibited by the protagonist in the beginning of the Malayalam movie "Ayaalum Najaanum Thammil' where the doctor operates on a minor without parents' consent is best avoided. Unless, of course, it can be justified why the doctor had to act in haste – such as the treatment of a victim of a serious accident. Again, the test is whether a reasonable doctor would act the same way in a similar situation.

Courts are also alive to the different sinister motives behind filing of cases. In another recent case, it came out during cross examination that an ayurvedic 'doctor' who had treated the patient subsequently had offered to conduct a case against her former (allopathic) doctor, in exchange for 50% of whatever compensation was awarded by the Court. It cannot be underlined enough that medical professionals should take adequate care (but definitely not encroaching on paranoia – you are only expected to prove a reasonable standard of care).

So then what are the cases that typically land doctors and hospitals in trouble? These are, broadly speaking, cases where on the face of it, it can be seen that there was negligence on the part of the doctor. A prominent case from Delhi comes to mind, where the doctors allegedly operated on the left leg, when the surgery was required on the right leg.As it turned out, the Medical Council gave a rap on the knuckle for the junior doctors, while exonerating the senior

doctor. However, the patient appealed to the High Court which then interfered in the case.

Another example comes from Calcutta where a patient was refused treatment for not depositing money, even though he was covered by insurance for a sum higher than what was demanded. While being taken to another hospital, the patient expired, and the hospital was found guilty of negligence. One shouldn't forget the case of Dr Kunal Saha, who lost his wife, a psychologist, due to a serious case of negligence – the hospital had given an excessive dose of steroids during treatment. The Supreme Court finally awarded over Rs 11 crore in compensation, including interest. All these cases are examples of consequences that flow from gross and palpable negligence. They shouldn't be seen as the norm in such cases, but doctors must be vigilant against giving room for such instances.

Doctors may also be exposed to criminal liability – mainly under 304 of the Indian Penal Code for having caused death due to their rash and negligent act. The Supreme Court has clarified earlier this year that this section cannot be invoked against doctors unless there is a high order of negligence. In addition, Sections 80 (accident while doing a lawful act without criminal intention or knowledge) and section 88 (act done in good faith for the benefit of another, and where the patient has given consent) protect doctors in a majority of cases that come under this section. If a doctor opts for a riskier procedure, but which has a higher chance of relief for the patient (after explaining the nuances to the patient, and obtaining consent), the mere fact that the procedure was unsuccessful does not give rise to liability.

Another area that can be litigated more harshly in the days to come is the violation of patients' privacy. With the advent of tele-health, doctors may have to take additional steps to ensure the confidentiality of patients records (including being alert to the possibility of their devices being hacked). The new announcement of Health IDs for patients could bring in further complications. With patients entire medical history available to the treating doctor, it will (hypothetically speaking) be presumed that the doctor has studied it all before suggesting a treatment.

"If a doctor opts for a riskier procedure, but which has a higher chance of relief for the patient (after explaining the nuances to the patient, and obtaining consent), the mere fact that the procedure was unsuccessful does not give rise to liability."

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INTERPROFESSIONAL RELATIONSHIPS: A BIBLICAL PERSPECTIVE

Mrs. Priyadarsini John

In the Bible we find God revealing Himself as a relationship nurturing God. The opening pages of the scriptures point to God finishing off the first surgery and seeing the outcome of His surgery called out it is "good". Further He enjoyed the communion with the first man and woman in His eco-system and perhaps set the framework for relationship building between different stakeholders. Maintaining good interprofessional relationships with co-workers is an integral part of work satisfaction and retention of health care workers.

Healthy Work Environment: A healthy environment is essential for hiring, performing and retaining high calibre staff. As the word gets around of the culture of the organisation/ hospital good staff either gravitate to or away. Thus, hiring best in class talent is impingent on ensuring a healthy environment is cultivated. A work context that is surrounded by people who are concerned about each other, willing to cover for each other, lift each other up, ensures an effective work ethic and together a high quality service is emergent for the patients who are under the care of the hospital staff. An enabling and positive environment in turn leads to minimal attrition and higher retention of staff as it contributes to a sense of staff wellbeing which ranks highly alongside the monetary benefits. In fact, studies have shown that the atmosphere and significance of nurse- physician relationships determine nurse satisfaction and retention.

> **"A work context that is surrounded by people who are concerned about each other, willing to cover for each other, lift each other up, ensures an effective work ethic and together a high quality service is emergent for the patients who are under the care of the hospital staff."**

Conflicts and its adverse impact: Relationships need to be cultivated, nourished, weeds removed and watered with care to foster a long-term bond. A healthy relationship is a pre-requisite for a productive outcome in any area of life. Where two or more individuals work together conflicts are bound to arise. Disruptive behaviours ranging from verbal abuse to physical and sexual harassment[1] are known factors that adversely impact effective relationship within the hospital eco-system.

Very often it's our desire for power and position, pride or jealousy towards our co-workers that create conflicts. This is true of nurses and physicians and such conflicts often leads to poor teamwork/ inhibit effective collaboration,

result in poor attitude towards patients and delivering poor quality of patient care. It affects the accuracy, safety and outcomes of care causing frustration among health care workers. It hampers interprofessional effectiveness; lead to lack of cooperation and collaboration among co-workers, diminished teamwork, decreased creativity and adversely impact productivity.

Perhaps, the best way to deal with conflicts is to confront it constructively rather than allow it to fester that runs the risk of blowing out of proportions.

Gleaning the scriptures point to 5 Ps that are perhaps crucial to enjoy meaningful Inter-professional relationships:

1. Principle
2. Peace-loving
3. Politeness
4. Privacy
5. Prudence

I Principle:

Biblical readings present a basic tenet that is fundamental to building and nurturing relationships. When this principle is followed it leads to relationships flowering and when this is flouted it invariably results in relationships souring.

Honesty: Every relationship is to be handled truthfully, without guile. The Bible admonishes us to speak the truth in love. Honesty calls for speaking the truth; there is no compromise on the truth; during the day-to-day conversations within the nurses or between the nurses and doctors there are numerous opportunities for resorting to lies. Lies breaches trust and erodes relationships. While the truth is to be spoken it is to be spoken in love; the intent and the intonation while speaking are equally important and needs to be clearly expressed. The need is to be authentic, frank and candid. Wounds

when they arise because of speaking the truth needs to be nursed with care and love lest it turns septic. The Scriptures say:

Ephesians 4:15 Instead, speak the truth in love, we will in all things grow up into Christ Himself, who is the head.

Ephesians 4:25 Let each one of you speak the truth with his neighbor

Proverbs 10:9 Whoever walks in integrity, walks securely

II Peace-loving:

When conflicts arise and they will, the question is do we react or respond? Reaction is operating in the natural where we invariably retort without thinking through and often this is an emotional outburst. The need is to defer the natural reaction and temper it down with a response. The response is a thought through rational rather than emotional revert. Here we benefit as the situation does not aggravate but gets alleviated. The driving force here is the precedence of peace and harmony over conflict and hatred. Often conflict arises owing to a high sense of competition. Competing does not help but collaboration does; synergizing the strengths of each other and functioning as a team ensures we make ourselves as channels for the peace of God to flow through. Deal with differences peacefully. How do we deal with it?

1. Prayerfully: We have a God who is ever ready to listen to our cries, address our plight and intervene on our behalf. He can do things beyond what we can imagine or ask for. Taking our challenging situations to Him in prayer will ensure we are not dealing with the difficult situation at hand from a human standpoint but are leveraging the divine strength.

2. Discern the spirit and deal with conflicts: Often conflicts stem from ulterior motives, hidden agendas or incompetence. Recognising the reasons behind is fundamental to addressing them effectively. Sense the primary reasons and you should be able to handle them appropriately. E.g. if the conflict is a function of hidden agenda exploring the issue with the concerned individual in love will help progress towards resolution. Should this not work raising it to the relevant authorities may be the option to resort to. The Scriptures say in:

“Taking our challenging situations to Him in prayer will ensure we are not dealing with the difficult situation at hand from a human standpoint but are leveraging the divine strength.”

Colossians 3:15: "Let the peace of Christ rule in your hearts, since as members of one body you were called to peace.

Ephesians 4:3: Unity of spirit through bond of peace

III. Politeness:

It is to be considerate of others. In a world where often, my interests override others' interests the Bible admonishes us to hold others of high esteem than ourselves. Consideration for others is expressed in our dealings in the form of respect for and holding others' perspectives with the same level of dignity that we hold ours. It is to treat everyone equally; nurses treat each other equally; doctors treat the nurses as equals in terms of standing although functionally the nurses may take orders from the doctors. Often in a high paced, high stressed environment such as the ICU or OT's there is every possibility for tempers to rise and one often can end up losing one's cool. It is imperative that we exercise politeness and soon this will be noted, and others will reference us as role models as we

exercise restraint in all our dealings. Remember the scriptures:

Colossians 4:6 says Let your conversation be full of grace, seasoned with salt so that you may know how to answer everyone.

Proverbs 22:11 speaks about speaking graciously

Mathew 7:12 talks about doing to others what you want others to do unto you.

IV. Privacy:

Inevitably when working with colleagues in a professional environment, personal relationships of friendships gets formed. Such relationships are founded on trust and must be maintained sacrosanct. One of the ways trust manifests itself is through privacy/ confidentiality. Matters shared in private by colleagues need to be kept confidential. Any attempts to publicise privately shared information will lead to breach of trust and result in strained relationships. Maintaining confidentially shared information under wraps helps co-workers to bond, share problems and enhance professional working. Thus, keeping the sanctity of such confidences is important. However, note that that the confidences do not breach integrity. The Scriptures say:

Proverbs 11:12-13 a man of understanding holds one's tongue, does not gossip and betray confidence but a trustworthy man keeps a secret.

Proverbs 10:9 the man of integrity walks securely.

V. Prudence:

The quality of being prudent, or wise in practical affairs as by exercising caution, demonstrating discretion while dealing with others in a professional environment ensures that we do not jeopardise personal relationships. Prudence is a hallmark of maturity. Relationships can be brittle and if they are not handled with caution they may very well slip and break. Thus, considering if what we are to say are examined in the light of the following three questions:

1. Is it the right thing to say?
2. Is it the right time to say it?
3. Is it the right way to say it?

Ensuring these questions are answered will enable us to exercise restraint on things not to be said or employ skill in saying it the way it is to be said and ensure the timing is just right.

The Scriptures say in:

Mathew 10:16 Be wise as serpents and harmless as dove

Proverbs 13:16 In everything the prudent acts with knowledge but a fool flaunts his folly

In closing remember what you do not want done to yourself, do not do others. Albert Einstein who said, " only a life lived for others is a life worthwhile" Let us nurture professional relationships that are mature, that weathers the storms and that edifies and builds each other. May God grant grace!

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ROLE OF FAMILY IN THE HEALING PROCESS

Blessed is he who has regard for the weak; the LORD delivers him in times of trouble. Psalm 41:1

Ms.Rogina Savarimuthu

Family is first institution that God created to have communion with (Genesis 1). He created a man and a woman put them together and said “This is good". God himself longed to have relationship with man and he visited them daily in the Garden of Eden. Violence was not God’s intent of creation or emotion. It was an outcome of man’s sin.

Ms. Jemimah Jayakumar

Family is not just a physical association it is a complex emotional union. Family is the bond that we are born with. All of us love to belong to someone. There is peace when the complex is undisturbed. This complex is currently undergoing a process of profound change, due to continuing global changes that have occurred in recent decades, these changes threaten structural stability, bringing consequent changes in patterns of health and wellness to the family life cycle. Violence: Violence means the actions or words that are intended to hurt people. There is use of extreme force. The use of force on people or objects. But Bible call us to be messengers of peace and portals of love. In James 1:19-20 Paul urges every fellow believer in Christ to be swift to hear, slow to speak, slow to wrath.

Sickness and Family role disruption: Each family member plays a vital role in maintaining the harmony in a family, be it child or a responsible adult. Sickness is never an anticipated event in a family. When a member of a family falls ill and is hospitalised. First of all, the family is traumatised along with the patient. It is a nightmare when the person is critically ill.

Family The pivot

1) Family Vs illness

a) Acute or short-term Physical Illness

Family has been already described as an integral system. So, illness of a member can threaten the system. The result of threat of this system can include fear, distress, feeling of weakness, and lack of hope, which can lead to physical and emotional exhaustion. For this reason, each intervention that decreases the effect of these pressures, benefits family. Even a small illness like a respiratory infection or a fall disrupts the role of the sick member requiring role changes with in family. The degree that family is affected by illness of one of its members depends on:

- The role of the sick person in the family.
- Age of the sick individual as well as the family members
- The emotional bonding among family members.
- The financial stability.
- Perceived severity of the illness
- Availability of treatment options
- Physical suffering and pain

Presence of family during a person’s sickness strengthens the positive emotions enhances a

holistic approach which brings the best outcome.

b) Chronic or Rehabilitation requiring Physical Illness

When a person is hospitalised for a long-term or has a debilitating illness, the family encounters profound stress. Much so when the outcome is expected to be fatal. Family constitutes an important source of psychological and emotional support for hospitalized patients. The most important activities family can carry out during hospitalization of one of its members are as follows:

- Maintaining communication with patient and relatives.
- Providing spiritual, emotional psychological and financial support.
- Collaboration with health care professionals in therapeutic process.
- Participation in the planning and provision of patient care

c) Psychiatric Illness

In any psychiatric illness, along with the stress of chronic illness the family faces the stress of social stigma. Apart from managing the stigma the family is expected to play a vital role in recovery of the individual. According to the National Institute on Drug Abuse (NIDA), there is a correlation between the amount of social support a person has and their potential for relapse; those with less support are more likely to relapse. Hence family undergoes a lot of role changes when a person is under psychiatric care.

d) End of life Illness

End of life care is a novel concept with historical approach. This enhances individual and family preparation not just involving emotional, social or financial preparation but also role change adaptation of family members e.g. a son assuming father's role in family taking care of family needs.

2) Family Vs Sick Person

Illness debilitates the person's ability but presence of family provides an important source of psychological stability for the sick person, as well as a source of support for better recovery. The role of family, friends, and relatives is of vital importance for the maintenance of quality of life in hospitalized patients with chronic problems because family can satisfy basic needs of the sick person in the hospital to a large extent.

3) Family Vs Health Care Providers

It is a routine for a health care provider to be in hospital but it is a one-time incident and a dread for family. Patients and family are exposed to a place consisting of medicines, tubes, injections, blood, sorrow, pain and fear that cause utter confusion. Only positive hope that keeps them going is the hope that they are in the best place of care under the skilled hands. The family always looks forward for people who offer a positive outcome. This places the Medical team in a vulnerable position that even a small spark can burst out into big flames. Building a positive trust and friendship helps the medical team to overcome the positive expectation and to present reality to the family.

4) Family Vs Role disruption acceptance

As the patient is recovering, this is only the beginning of the journey for the family. They have questions, thoughts, and concerns about how the life they once knew has now gone on standby. Including the family in the treatment plan is important, and just taking the time to listen to the questions and concerns from the patient and family means so much. Even if an answer cannot be given, just the fact that their concerns were listened to and addressed goes a long way with the healing process. Providing realistic expectations helps build trust.

Violence

1. Violence within family

Family first struggles with in itself with the demands of sick person and later acclimates to violence as a method to compensate the role disruption. Chronic stress due to role disruption leads to blame game. Obvious physical violence may be absent within health care setting but a subdue emotional disconnect is noted among the family members due to inability to accept reality. With any chronic incurable illness, it is not just the family but even the extended family suffers emotionally because of the pain noted in patient's family. Each family member often is at different stages of grief. And they respond to others be it their own family member or an outsider in a manner influenced by the grieving stage which further complicates the family dynamics.

2. Violence with others or Health care Members

Each member of in the family anticipates a speedy recovery, while it might be a slow or bad prognosis they might become frustrated. Even trivial issues can result in violence and most often displaced onto the health care provider.

The health care setting serves a place to exhibit fierce emotions due to the vulnerable environment. Inability to trust the health care professional leads to violence. The Occupational Safety and Health Administration (OSHA) reports that in each year from 2011 to 2013, U.S. healthcare workers suffered 15,000 to 20,000 serious workplace-violence-related injuries; serious injuries are those that require time away from work for treatment and recovery. Indian Medical Association has reported that 75% of heath care professionals face verbal or physical abuse in hospital premises and fear of violence was the most common cause for stress for 43% doctors. The highest number of violence was reported in the department of emergency care and Intensive Care units. According to the findings, data of the past five years showed that the escorts of patient committed 68.33% of the violence. In India, 62% of doctors who answered a survey reported that they were unable to see their patients without any fear of violence, and 57% had considered hiring security staff at their workplace. This has increased anxiety among the health care professionals.

One of the authors of this article was taking care of a client who was on 2L of oxygen through nasal prongs. Due to the client's disease condition it was contraindicated to administer 100% oxygen. The father of the client said "you are stingy! My son needs oxygen. I will pay whatever it costs." Yet the nurse refused to administer 100% oxygen in benevolence to the client. There was tension in the air, the client's father pushed the nurse and increased the oxygen supply but at last we lost the Client in spite of all efforts to save him. The family members blamed the health care team and were in a rage to beat the treating team members.

As the data serves as an eye opener, the health care profession is in need of a plan to address this increasing violence with in the health care setting.

3. Violence with Society

Any sick person leaving the hospital either well or sick or dead leaves a greater impact on the society. The society forms an impression regarding the care at the hospital. During recent Pandemic time the health care setting is overflowing and there is heavy loss of human lives. Thus, giving an impact that the health care delivery is inadequate. The type of disease condition (contagious and stigma) determines the society's reaction towards convalescent client, family or the deceased. Continuing research with failure of breakthrough has also

led to frustration among the community. Such situations lead to violence not just with the hospital unit but with the Government system and within society.

Key to Resolution and Restitution

1. Communication

Isaiah 50:4 says The Sovereign LORD has given me a well-instructed tongue, to know the word that sustains the weary. He wakens me morning by morning, wakens my ear to listen like one being instructed. The Lord himself trains us when we wait on him. Also in Ephesians 4:29-32 we read "Let no corrupt communication proceed out of your mouth, but that which is good to the use of edifying, that it may minister grace unto the hearers". We are called to speak with grace in every situation. Patient's hospitalization is not a pleasant thing for any individual in family, since it can cause crisis in family due to dysfunction and instability. In order to avoid a crisis in family, it is important to estimate all the needs of family and address them. Main needs include needs of knowledge, emotional needs, and personal needs.

Assessing and connecting with family requires effective communication. Using the beatitudes of Christ helps us become better professional than others.

- Be open to discuss the needs of family
- Encourage behavioural flexibility in stressful environment
- Acceptance of physical changes of patient for e.g. Loss of a limb or disfigurement after burns
- Use illness as an opportunity to promote family bonding and resolve any disputes among members
- Therapeutic communication with Health team members promote overall well being

2. Co-operative Planning

Wright and Leahey assert that nursing care for the family can be seen from two perspectives:

i. The one that is focused on the affected individual and that is part of a family context from which it cannot be separated; seeing the individual the figure and the family the foundation.

ii. The one that focuses on the individual and the family simultaneously, under the premise that when one of their members is affected, the whole family is altered, and therefore requires care.

The second perspective proposed by Wright and Leahey is the one that today must be strengthened from public policies and health practice, in order to preserve the family unit as an integrated system. Once a health care professional strengthens the family, the need for reassurance from health care team reduces. This leads to trust and acceptance of the team. The family's norm in planning needs to be taken into consideration. In India mostly it is the family members who take the decisions on health care planning. While in other Countries the sick person themselves take part in decision making on their own health. When planning care it is vital to understand the family's decision taking pattern.

A middle aged man was admitted in the ICU, his admission into the ICU was out of visiting hours in the night. He had very less time on earth. His adolescent son approached and requested the nurse to allow him to be with his dying father. In-spite of varied opinions from the team members, the son was allowed to stay with the dying father. Less than an hour the father entered eternal life. His son stated "thank you for allowing me! I was near my father during his dying. I can be at peace. Considering the family as a unit yet focussing on individual needs by

going an extra mile helps the health care team gain more trust.

3. Enabling the Role compensation

As Bible guides in *Colossians 3:13,* we are called to bear with one another and, if one has a complaint against another, forgive each other; as the Lord has forgiven you, so you also must forgive. The lord asks us to bear with one another in times of good and bad. The family bonds are better explored when the roles are defined clearly. When the role of a member is lost due to illness, willingness to take up the roles and share the burden among each other should be encouraged. Also, when preparing a family for the role compensation we must ensure it is equally shared by members. This helps to promote optimistic outlook to the new role.

4. Community follow up

Even though the family role is disrupted due to hospitalisation the family ends up being part of the society and lives in a community. Helping them adjust to the roles at the community level helps in better coping and avoids violence. Many NGO's provide after care follow up and assistance to families in distress. Family can be introduced to NGO schemes like assistance in child education, monetary assistance in setting up self-employment with in the limited ability of family, cattle fund etc.

Conclusion:

Global changes and transformations in the family set up continue to provide new challenges every day to the health care profession. The important thing about all this is the degree of awareness that all the entities involved and the measures of action and correction that are taken along the way. We as health care professionals must address the needs of patients, their care givers and integrate the care into a dynamic and family centred one. Once we ensure the family is able to function at the lowest cost for the expected quality of life with satisfaction, we can proudly say we have competently cared for a family from the time of illness to the recovery. As stated in 1 Corinthians 12:26 If one part suffers, every part suffers with it; if one part is honoured, every part rejoices with it. It is our responsibility as health care professionals to help families be honoured and rejoiced.

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RELATIONSHIP BETWEEN HEALTHCARE PROFESSIONALS AND COMMUNITIES: *Urban and Rural settings*

Rev. Dr. Arul Dhas T.

86 year old Paediatrician Dr. Devadas from a place near Tiruchy, Tamil Nadu passed away in late July 2020. He was a very popular doctor and was loved by common people referred to as "Five Rupee Doctor" since he charged only Rs. 5/- for his consultations. When I made a search about in the internet recently, I came to know that there was a doctor in Kolkota and another in Karnataka just like Dr. Devadas charging people with very minimal and nominal amount as consultations.

Why do such doctors charge a small amount when so many are keen to charge a heavy amount? Many of them have justification saying that they have spent so much money for their medical studies. They have spent so many years of intensive studies and therefore they should be considered eligible to receive a huge amount as their consultations. This argument goes powerful in many corners, not only in the healthcare setting. People's worth is assessed based on the 'investment' they have made in terms of the years of study and the money they had spent to get to the position they have 'climbed'.

> **"He was a very popular doctor and was loved by common people referred to as "Five Rupee Doctor" since he charged only Rs. 5/- for his consultations."**

There seems to be a gap in the thinking of professionals – specifically healthcare professionals. In a community, different people are given different talents and opportunities. They make use of them and get to a position. In the midst of all these, there is an understanding of 'calling' for everyone of us. Every member of the community is called to be somebody and to do something for the betterment and health of the community. Accumulation of power and wealth at the cost of others' tragedies and misfortunes cannot be seen as right, healthy and God-given.

Relationship among the community members is an important aspect of life and fulfilment. Even though there are so many inequalities in the community with regard to our gifts and talents, the members of the community should not work towards widening the gaps, rather work for the oneness and togetherness.

The doctors, nurses and allied health professionals should be seen in the light of this backdrop. Are they not part of this community who have same responsibility of working for the health and wellbeing of the community? Sadly, many who do 'well' in their life/ are 'successful' in life do not see themselves as part of this community. People like Dr. Devadas definitely wanted to be part of the community and see the wellbeing of the community.

Hospitals began as establishments to care for the weak, sick and the suffering. They symbolised how hospitality should be in a community. However, when the ministers in the hospitals began considering themselves as more important than others, a division began emerging. Many even started building hospitals and started studying healthcare courses looking at them as great 'business' options. Slowly the oneness and trust people had on the healthcare providers and professionals began deteriorating. When I asked a patient who travelled nearly two thousand kilometres to consult a doctor, he said that he needed an honest opinion whether the surgery is needed or not. On the one hand it is good to have a second opinion, on the other hand if this is necessitated by lack of trust, there is something wrong fundamentally.

Healthy relationships are demonstrated by care, compassion, equal treatment, respectful consideration, mutual trust and so on. Focussing on profits, desire on embellishments, accumulating for oneself and lack of respect and care definitely are indicators of an unhealthy community. Commercially motivated health establishments are sign of a disintegrated community. In today's world we see many health care institutions making good 'profits' which benefit the owners and the founders.

The leaders of the community take responsibility towards the wellbeing of its members. In a community, people are together in all seasons. If there is a crisis, members gather around and try to help one another. Church is a body of believers who are united in different manners in

the pattern of Christ, the Lord and Savior. Church in general takes care of every part of the body. The health of the members is the responsibility of the church. This should be the scenario among the Christian community. Healthcare professionals are part of the community and they have a special responsibility to heal and work for the wellbeing of others.

Investigations in the healthcare setting:

When an institution buys an expensive medical equipment, it plans for its returns. Therefore even when a particular medical test is not indicated, since the equipment is available, since money is needed for the institution, sometimes since the professionals want to practice a defense medicine, they order for the investigation. The ordinary patient ends up paying a huge amount for the 'unnecessary' investigation. When the healthcare professional acts ethically that builds up relationship between the community and the professional. In today's mission context, the mission hospitals need to go extra mile, move against the normal current in the society to remain as the beacon of hope in the communities. The distinction between what is needed and what is not needed gets blurred due to our distractions – emotionally and spiritually.

Focus on the clinical examinations and the art of history taking:

Many of the health issues are handled well by examining the patient well and paying attention to what he/she says. Many do not understand that the cornerstone of clinical diagnosis is history taking. History taking also provides opportunity to build relationship, communicate care in the midst of listening. In our training programmes of the healthcare settings, as mission hospitals we need to emphasise the need for clinical diagnosis with careful history taking. This will definitely bring the trust back in our setting.

Communicating the plans about the future:

Often the elite do not see the need to communicate to the ordinary people what is in their mind about the future of the community. Every ordinary member of the community is a stakeholder in our health seeking society. The strength of the community is as good as the weakest member just as the strength of the chain is as good as the weakest link. Even though it is sometimes cumbersome, it is needed at the larger interest of the community to share our plans and the decisions. During the COVID 19 times, there was a good amount of cooperation between the leaders and the community. One reason could be that there was a good communication between the leaders and the community regarding the plan of action. Even in a context of uncertainty, good communication helps to build relationships.

Difference between urban and rural settings:

Because of the nature of urban contexts, the healthcare professionals face additional challenges. Trust level in the urban settings is normally less simply because of the enormous number of people in the urban settings. Migration of people towards the urban settings is common among the ordinary people and among the professionals. The reasons could be varied. We could see this operating even in the mission hospitals. The relationships in rural hospitals are different from urban hospitals. However, our attempts to understand the other person irrespective of the settings will pave a long way towards healthy communities.

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CLINICAL CRITERIA FOR DIAGNOSIS OF COVID-19

(By MS Seshadri, T Jacob John; 8-6-20)

COVID-19 is the disease caused by the infection with SARS-CoV-2.

In otherwise healthy adults the clinical diagnostic criteria are as follows:

Major Criteria

Group A:

1. Fever ≥ 3 days
2. Persistent dry cough
3. Sudden onset loss of smell with or without loss of taste

Group B:

1. On chest auscultation, crepitations
2. Resting respiratory rate of ≥25 per minute
3. Pulse oximeter showing oxygen saturation ≤ 94 % on room air

Group C:

CT scan or chest X Ray showing patchy peripheral infiltrates or bilateral ground glass appearance, without lobar consolidation or cavitary lesion

Minor Criteria:

1. Headache/body aches/myalgia
2. Severe fatigue/lassitude
3. Diarrhea
4. Conjunctival irritation -- pink eye with or without secretions
5. Skin lesions - maculopapular erythematous, urticarial or vesicular non-pruritic
6. WBC count: normal or low normal total count; but lymphocytes ≤20%

Diagnosis using the above criteria:

Either:

Three Major criteria, if they include at least one each from Group A, Group B and Group C.

Or:

In the absence of, or non-availability of, Chest imaging criterion (Group C), at least two Major criteria from Group A, at least one Major criterion from Group B and at least two Minor criteria

In elderly or those with co-morbidities, clinical features may vary from the above

These subjects may have any of the clinical features listed under Major or Minor criteria, or, may have only subtle features of low grade fever, delirium, postural instability and drowsiness. If any of these subtle features occurs, it is mandatory to do pulse oximetry (Major No. 6) and a Chest CT scan or X Ray (Major No.7) and if either is positive, to assume the diagnosis of COVID-19 and initiate treatment in a hospital.

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Christian Medical Association of India

BEYOND COVID-19

CMAI STORIES FROM FIELD & REGIONS

During COVID-19 lockdown and even much later, lack of employment opportunities made it impossible for Saraswati* and her husband Ramesh* (a *daily wage labourer*) to sustain themselves financially. They are meanwhile expecting a child. Saraswati is in her eighth month of pregnancy. Ramesh is unable to get any work.

They together visited Nireekshana (AIDS Care, Education & Training) Center accessible from their village. They met the officials and shared their plight.

The staff included them in the team which is locally creating innovative products at the center for COVID-19. Saraswati learnt how to make liquid soap and phenyl. She also received 10 liters of soap which she made herself in order to sell and generate some income. Saraswati and Ramesh are grateful to attain an income-generating skill and feel confident. Saraswati has also received nutrition support and medicines from the center.

Nireekshana (AIDS Care, Education & Training) Center, is a member of Christian Medical Association India. CMAI is the health arm of the National Council of Churches in India, a 100 plus year old network of more than 270 mission hospitals and 10,000 plus healthcare professionals.

To know more about CMAI's Mission Hospital (MI), please visit **www.nireekshanaacet.org**