CHRISTIAN MEDICAL JOURNAL OF INDIA

CMJI

A Quarterly Journal of the Christian Medical Association of India

VOLUME 35 NUMBER 1: JANUARY - MARCH 2020

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Building a just and healthy society

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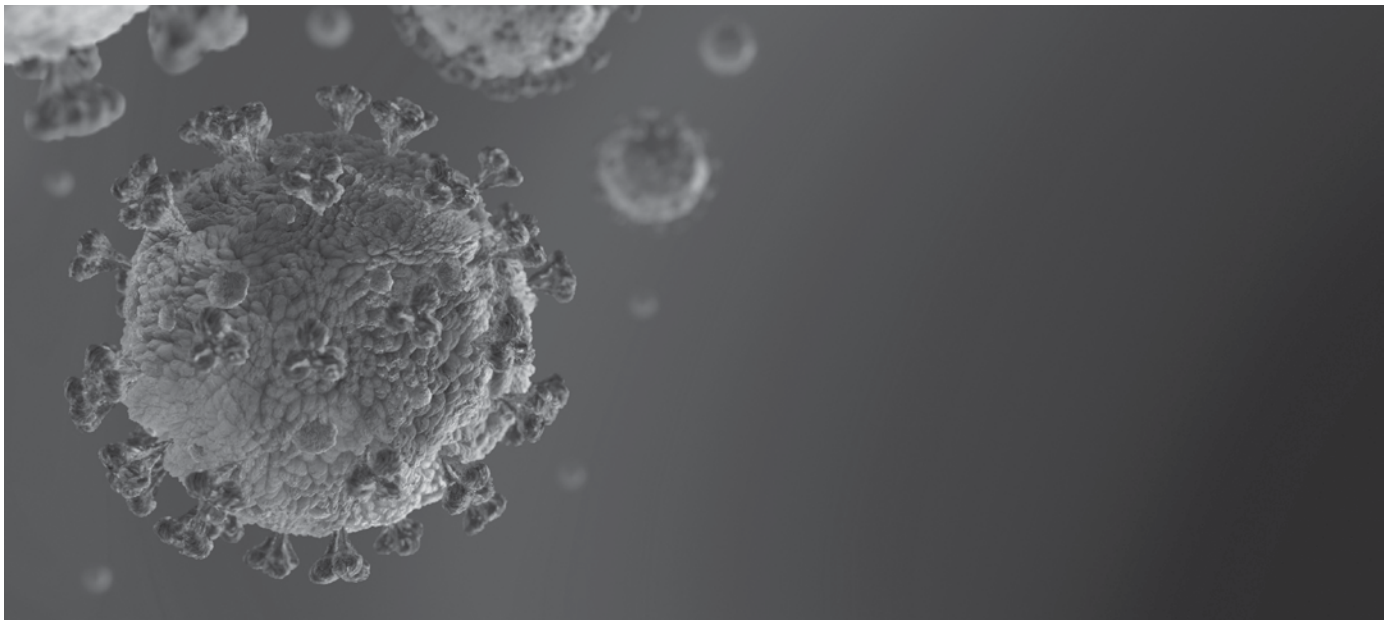

LETTERS / ARTICLES FOR CMJI

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

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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.
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- 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

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- 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

Eucharistic Approach to Life and Pandemic

Rev. Arul Dhas T.

In many Biblical passages, praising God and giving thanks to God are part of human experience even in the context of threats, dangers and calamities. We can find an example even as we read a very popular Psalm 34 which was written when David was running to escape from his enemy. "I will extol", "praise", "glorify" and "exalt" are some of his expressions in the midst of pain and danger. It is not new to stalwarts of faith in the Bible. Even our Lord Jesus Christ, in the midst of pain and betrayal, gave thanks to the Father (during Eucharist). One might wonder whether this is the pattern we need to face the Covid-19 situation in our land and in the world. Is there anything I can thank God for in the midst of calamities? Is there any reason we should praise Him when there is fear, death and loss of different kind? It looks as if this is the only way we can approach calamity in life: Beauty of approaching life and its struggles with gratefulness, An Eucharistic approach to life and pandemic.

Well, the plan for this CMJI is to focus on the theme of the Healing ministry Week this year: "Let us consider" (Hebrew 10:24). 'Let us consider how we may spur one another on towards love and good deeds'. We wanted to explore from different sections and representations of our network. The articles are coming from different perspectives and professionals highlighting what can be done in a pandemic situation to spur one another. We have two articles which are already published in Christian Journal of Global Health which will be so useful for our members and partners in the mission.

The devotional article by Rev. Paras Tayade talks about three different approaches to suffering drawing inspiration from John 9. Dr. Nitin Joseph emphasizes how Christian healthcare professionals and organizations can be beacons of hope during this crisis to bring forth healing and wholeness. Dr. Anuradha Rose highlights lessons we learn and the ethical dilemma and responsibilities of Christian healthcare professionals at the time of COVID 19.

Dr. Barbara Isely from her musical experience focuses on the way music plays pivotal role in our health and in the society's health. Mrs. Mercy John discusses different ways nurses can play an important role in approaching the Corona crisis. Mr. Sunny Kuruvilla would like to see the employees, patients, partners and local community and church as Missionaries of Pandemic. Dr. Vilas Shende highlights important ways of encouraging one another in a hospital setting. In the last article by Prof. TS Ravi Kumar is inviting the readers to arise and persevere in faith as soldiers of the Lord in the healing ministry. This journal also has a book review of a latest book "Beyond the Bougainvillea" by Dr. Glenn Kharkongor.

It is our prayer that all those who read this journal will be informed, strengthened and inspired to the healing ministry further during this times of pandemic.

With best wishes and prayers

Rev Dr Arul Dhas T
Editor

CHRISTIAN RESPONSE TO SUFFERING

Rev. Paras Tayade

Corrie ten Boom, a holocaust survivor, after her release from the concentration camp, became a world-renowned speaker. She spoke particularly on the theme of forgiveness, this, even though she had lost her father and sisters in one of the concentration camps. It is said that as Corrie travelled and spoke to various audiences around the world, she would often speak with her head down as if reading her notes. In reality, she would be working on needlepoint. At the end of her talk which described her hardships and the atrocities that she and her family had to bear at the hands of the Nazis, she would lift her needlework and reveal the underside of the fabric, which looked like a mess with no design or discernable pattern. And she would say, "That's how we see our lives. Sometimes it makes no sense." Then she would turn the needlepoint over to reveal the finished side and comment "This is how God views your life, and someday we will have the privilege of seeing it from His point of view."

So often, we judge life based on what we know and what we understand forgetting that we do not have the complete picture to fully comprehend what is transpiring around us. So often what we see in our life as tragic may be a part of God's larger plan for His Glory and our maturity.

The Gospel of John chapter 9, records for us a story with a similar theme. It is the story of a man who had been blind from birth. A tragic story of human suffering yet Jesus's response to the man's plight is "…this has happened so that the work of God might be displayed in his life." (Jn. 9:3) This story is a powerful reminder that human suffering is often multi- dimensional. Human beings with finite knowledge, at times, are not able to fully comprehend why we have to endure suffering. The Bible teaches however, to focus, not on the why but the what. What does suffering teach us, what should my response be, to my suffering as well as the suffering of those around me? This becomes pivotal, all the more, for those of us who are involved in the healing ministry. Be it medical professions, allied health professions or chaplains who encounter human suffering as a part of their daily routine. Furthermore, in our contemporary situation, as we grapple with the pandemic of the corona virus, the issue of suffering and our response to it becomes all the more vital.

John 9 not only highlights the wonderful work of God's healing amid human suffering, but it is also a reminder of our responsibility to those around us who are hurting and are in pain. The study of John 9 reveals three categories of responses to human suffering. These three responses stand in stark contrast to each other. It was Ann Lander who poignantly commented "There are only three types of people: those who make things happen, those who watch things happen, and those who say, what happened?" As those involved in healing ministry, John 9 presents to us, both, a word of warning and a word of encouragement. A warning not to be those who only watch and question things; and an encouragement to be doers who would put their faith into action. Let us look at the three responses from John 9.

1. The Shirkers

John 9 begins by telling us that as Jesus and His disciples were walking they saw a man who was blind from birth. On seeing the blind man, the disciples raised a question to Jesus asking "Rabbi, who sinned, this man or his parents that he was born blind?"(vs. 2) I am sure this was not the first blind man that the disciples had encountered in their life. However there may have been something very moving or pathetic about this man that promoted the disciples to raise this theological question. The tragedy is that the disciples only wanted to provoke a theological discussion without really doing anything about his situation. The first category of people that the passage presents to us, are 'The Shirkers', those who would happily pass the buck to someone else rather than take responsibility to make a difference. It is important to note that the disciples by this time had already seen Jesus perform many wonders. He had turned water into wine Jn. 2:1-12, healed the nobleman's son Jn. 4:46-54, healed a lame man Jn. 5:1-17, fed the five thousand Jn. 6:1-13, and had even walked on water Jn.6:16-21. They could have easily turned to Jesus and requested

him to intervene in the situation by healing the blind man. On the contrary they chose to analysis, scrutinize and even criticize the man's situation by saying that it was sin that had brought this suffering upon the man. Even though they had access to the greatest source of power to rectify the issues they chose to debate about it. This is a constant danger for Christian theologians. We chose to talk when we have the power to change. Theologizing has its legitimate place however, it can never compensate for action. True theology must lead to action. The challenge confronting the Church today, particular in the wake of the pandemic and the heart wrenching situation of the migrant workers and daily wagers, is to respond tangibly and not offer mere lip service.

2. The Questioners

The Pharisees are the second category of people that this passage presents to us, as those who questioned anything and everything that did not fit into their neatly worked out schema. The sudden and miraculous healing of the blind man displaced everything the Pharisees knew about God, sin, suffering and adherence to law. One of the key objections that they had against this healing was that it was done on a Sabbath. Their argument was "This man (Jesus) is not from God, for he does not keep the Sabbath." (vs16) They questioned the healing; raising doubts over the fact that the man was even blind in the first place (vs18). When that was established, they began to discredit the One who had healed him, all because this did not fit into their worldview. When the Pharisees encountered the blind man, we see a lot of questions being raised; his healing sparks a lot of debate. The missing element in this whole narrative is the excitement and the joy of celebration over a transformed life? Instead of rejoicing with the blind man, whose entire life had been radically transformed, the Pharisees are desperately trying to rework the facts so that their lopsided theology stays intact. The Pharisees completely misunderstood the purpose of the Sabbath when they used it as an excuse to justify their positions. We need to honestly ask ourselves this question - Are we guilty, at times, of using the scripture to justify our position? Of course we must not accept everything uncritically but neither should we reject everything just because it does not fit into our preconceived notions of how things should be. So often, we, as Christ's followers are known for our harsh judgment rather than our compassion and sensitivity to those who are hurting. The Bible exhorts us to rejoice with those who rejoice and weep with those who weep. (Rom 12:15) The idea is to empathize with the people around us, to connect with them at their level of joy or pain.

3. The Doer

Jesus stands in sharp contrast when compared to the disciples and the Pharisees. When confronted with suffering, He refused to stand at a distance and be a mere spectator. He also refused to be bound by dead traditions. Jesus, on the contrary, was moved by compassion, he exercised his authority to make a difference in the blind man's life. The significant aspect of this miracle is not what Jesus did namely the healing of the blind man but rather how he did it? Jn. 9:6 tells us that "…he (Jesus) spit on the ground made some mud with the saliva and put it on the man's eyes." Now, why did Jesus use this particular method to heal the blind man? The healing miracles in the Gospels clearly demonstrate Jesus' ability to heal the sick without even touching them. In Matthew 8 when the Roman centurion approached with a request for his sick servant, Jesus simply said the word and the servant was healed. However, in this case, Jesus deliberately performs an action to bring this healing to pass. Could it be, that Jesus was knowing and willingly violating the man-made laws and regulations pertaining to Sabbath, to demonstrate that in God's view human worth and dignity is much more significant than a dead adherence to the law? In the act of spitting on the ground and getting his hands dirty Jesus was setting an example for his followers. A reminder that the appropriate response to suffering often involves us getting our hands dirty as we strive to make a difference in the lives of people. There is always a cost to pay, at times someone or the other will be rubbed the wrong way. However, this is a part and parcel of our calling to be the salt and light of the world.

Similar to the blind man, our world is steeped in pain and suffering. Jesus' response reminds us that God does not cause suffering but in His sovereignty, every suffering can have a divine purpose. We often encounter people who lay at the intersection of affliction and God's preordained choice to turn those afflictions into occasions that reflect God's Glory. Healing ministry comprises not only of healing the body and mind but also healing the perspective; to help people recognize that in God's hand our tragedies can be transformed in celebratory moments of God's glory.

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THE COVID-19 PANDEMIC:
DEFINING THE CLINICAL SYNDROME AND DESCRIBING AN EMPIRICAL RESPONSE

Abstract

The novel corona virus infectious disease, COVID-19, is a pandemic now and is raging through several continents, posing a challenge to health-care systems of all the countries and disrupting lives and livelihoods across the world. The facilities for virus testing are available for only limited numbers in each country and each country excludes a large number of potentially infected subjects because the lab test is done for only certain categories. Nearly 80 % of those infected will, therefore, go undiagnosed. There is an urgent need, therefore, to define the clinical syndrome so that practitioners at the primary and secondary levels can make a confident, clinical diagnosis and proceed to manage patients early and effectively. Chloroquine and hydroxychloroquine, both antimalarials, have shown promise in limited trials in France and China. They are inexpensive, have been around for several decades in the prevention and treatment of malaria, have well-known side-effects and, in the short-term, safe for use. We propose that practitioners make a preliminary clinical diagnosis of the COVID-19 syndrome based on simple clinical criteria and lab tests and proceed to manage patients and protect other family members and contacts by using isolation measures and short regimens of these anti-malarial and other medications, anticipating results of more clinical trials.

Key Words: COVID-19, clinical syndrome, empirical therapy, hydroxychloroquine.

Introduction

The COVID-19 pandemic sweeping across the world is continuing to take a heavy toll in terms of human lives and is threatening the global economy. It is currently spreading rapidly across several continents, and the peak is yet to come. The variable sensitivity of the polymerase chain reaction (PCR) based tests employed, different criteria for testing in different countries, limited availability of the testing facilities, and the high cost of testing will result in under diagnosis.[1] Therefore, alternative approaches that do not rely on testing everyone with fever and cough with PCR are necessary in low- and middle-income countries.

Diagnosis

In clinical medicine, a syndrome may be diagnosed using specific clinical and commonly available laboratory criteria, especially when the situation is a medical emergency and treatment is urgent. To cite a common example, empirical use of antibiotics, pending culture reports, is standard practice in treating sepsis syndrome, and completion of a course of antibiotics is indicated if there is a clinical response, even if the cultures eventually turn out to be negative.[2]

In the face of a pandemic, the possibility of contact with infected patients (typical epidemiologic setting) is a very important element for defining the clinical syndrome. When a disease has a high, attack rate, a clinical diagnosis may provide a more sensitive approach than a lab test. Further, in the context of resource poor countries, only select patients are tested by PCR. Therefore, relying only on laboratory tests for a diagnosis of COVID-19 will grossly underestimate the true disease prevalence and incidence.

In view of this, it is reasonable to assume that every individual that meets the clinical case definition inclusion criteria is presumptively positive for COVID-19 and to treat as such. This will provide a more sensitive approach and ensure that most of those who actually have the disease are detected and treated. Such an approach will be in the best interests of both individual patients and the community as a whole. In the public health systems

of countries like India, where access to lab tests is more difficult than access to an outpatient consultation, this approach would be easier to implement.

While the WHO case definition[3] is simple to use, it does not give adequate importance to fever which is the most common symptom[4] and ignores smell and taste disturbances that appear to be unique to this viral illness.[5] In the COVID-19 clinical syndrome, fever is observed in > 95 % of individuals and selecting this symptom as a criterion will ensure that the clinical definition will have good sensitivity. Sudden, otherwise unexplained loss of smell and taste[5] occurs in about 34% of COVID-19 patients and including this unique symptom will confer greater specificity for the clinical diagnosis. In the light of these arguments, we recommend that the clinical syndrome be defined using criteria as listed below:

Mandatory criterion:

Fever of three or more days duration without other obvious localizing symptoms such as dysuria, skin, or soft tissue infections

Major criteria:

1. Dry cough
2. Sudden recent onset loss of smell and or taste sensation (anosmia due to nasal block and sinusitis to be excluded)
3. Physical findings of crepitations on chest auscultation
4. Chest X Ray showing peripheral patchy infiltrate (not lobar pneumonia or cavitating lesion)
5. Respiratory rate > 25/minute

Minor criteria:

1. Diarrhoea
2. Severe headache, body aches (myalgia)
3. Fatigue and lassitude
4. Normal or low normal total WBC count and lymphopenia (Lymphocytes < 20 % on differential count)

Epidemiologic setting:

(When there is community spread this criterion may not be useful):

1. Travel within the past four weeks to or from any other country or a big crowded city in the country.
2. Visit within the last four weeks to a crowded place such a bus stand, railway station, movie theatre, airport, place of worship, etc., without a mask and or without maintaining a physical distance of two meters
3. Contact with a case of COVID-19 at home or at work-place.

The clinical syndrome can be presumed if, in the presence of the mandatory criterion (fever), the following criteria are met:

1. Presence of one epidemiologic setting along with two major criteria or one major criterion and two minor criteria
2. Even in the *absence of the epidemiologic setting,* the presence of three major criteria and two minor criteria or two major criteria and three minor criteria

Where available, a positive PCR lab test, in combination with the clinical syndrome criteria, offers confirmation of diagnosis while a negative PCR test does not necessarily negate the diagnosis due to less than optimal test sensitivity. In fact, PCR and CT thorax combined have higher sensitivity than either test alone for diagnosing serious COVID-19 infection.[6]

Therefore, in resource poor settings, we can consider two groups of subjects:

a) those having the COVID-19 clinical syndrome (large numbers)

b) cases confirmed by PCR testing (smaller numbers)

For those with the clinical syndrome, if feasible, nasopharyngeal swabs, or even throat swabs can be sent to a regional laboratory for confirmation. In endemic malarial zones, malaria should be excluded by a rapid test and peripheral smear.

Isolation and Prevention of Spread

Pending results, clinical management should be initiated as set out below:

Isolate affected subjects at home for a period of 21 days (three weeks). Get a younger member of the family aged less than 45 to be the primary care-giver. A detailed isolation procedure at home, as spelt out below, has to be strictly followed to prevent within family spread. Other family members, in particular, the elderly, those with diabetes, and cardiac disease should also home quarantine for four weeks (to allow for incubation period and duration of viral shedding) to prevent serious disease in them. Younger family members can go out to get essential requirements but wear a mask when they do so and maintain a physical distance of two meters from others to prevent community spread. (See Appendix A for our example of home isolation procedure).

Any member of any family that develops a fever, cough, and cold should not panic and go to hospital unless there is significant breathing difficulty. Other respiratory viruses such as influenza (5-20 % of the population each year)[7] and the common cold are highly prevalent

and must be considered in the differential diagnosis. The hospital may be crowded with other sick patients who may have COVID-19. It is essential that every household has simple medications such as paracetamol for fever and an antihistamine such as pheniramine or cetirizine which may minimize sneezing and limit nasal discharge. These supplies are better issued to individual households by the local civil administration and or by local non-governmental agencies with instructions for use, so that crowding at hospitals and medical shops is avoided. The mobile phone number of an individual in the family can be made available to the proximate primary or secondary level hospital so that the lab test reports, when they arrive, can be communicated. A designated mobile number at the health care facility can be provided to the family. The family can contact this number in the event of any worsening or questions. The follow up information can be recorded on spread-sheet.

With the crowded living conditions in most middle- and low-income households, these quarantine measures will prove to be major challenges; isolation may not be possible in poor households living in one or two rooms. The local administration needs to face this reality and design isolation facilities near home, such as a school building, if possible. The Government and non-governmental organisations (NGOs) should ensure essential supplies to these quarantined families so that they can effectively practice what is recommended.

Treatment

The antimalarial drugs, chloroquine and hydroxychloroquine (HCQ), have shown some efficacy in *in-vitro* experiments. Limited observational studies using HCQ in infected subjects in France and China have been shown to reduce virus load and also hasten virus clearance from two weeks to six days.[8,9] The proposed mechanisms of action of these drugs[9], such as interference with adhesion of virus to cell surface receptor, inhibition of viral replication by increasing the pH in the endo-lysosomes, and an anti-inflammatory action (to reduce cytokine production and immunologically mediated inflammation), imply that the drugs may be of use early in the course of infection as well as in the delayed cytokine storm. [10]

However, in the absence of controlled clinical trials in severe cases of COVID-19 pneumonia, some suggest that these drugs should only be used in randomized controlled clinical trials.[11] Major clinical trials have just started, and the results will probably be available only after about 12 weeks by which time the pandemic may be waning.[12]

Physicians working in endemic malarial zones have good experience with these drugs. However, in non-endemic zones, HCQ is commonly used for rheumatological disorders and for malaria prophylaxis in travellers. In New York and other hot spots for COVID-19, physicians have started using these drugs on an empirical basis for treating severe COVID-19 pneumonia. In countries such as India, adequate supplies of chloroquine and HCQ are available, and the Government and NGOs can cope with the demands for these drugs during this pandemic without compromising supplies of the drug for patients with rheumatological disorders who need the drug.

In rural settings, for reasons mentioned earlier, physicians may need to resort to syndromic diagnosis and institute empirical management protocols for sick patients, and if there is good clinical improvement, complete the course of HCQ. Perhaps based on the safety profile of once weekly doses of the drug in malaria prophylaxis, the relatively short duration of time for which chemoprophylaxis may be required, the suggested dosage schedules, which are similar to doses used for malaria (treatment and prophylaxis), and the potential for reduction of infectivity, the Indian Council of Medical Research (ICMR) has recommended prophylaxis with HCQ for frontline health care workers and household contacts of SARS-CoV-2 positive subjects.[13]

When a physician chooses to use HCQ for either empirical treatment for COVID-19 or chemo-prophylaxis as per Government guidelines, due precautions are mandatory for the elderly, those with diabetes and cardiac disease, in whom dosing has to be modified to avert potential side effects of the drug. An outline of suggested empirical treatment, chemoprophylaxis, monitoring, and precautions is detailed below:

Empirical HCQ Treatment

(Effective dose for treatment derived from pharmacokinetics-based computer assisted modelling)[14]

Hydroxychloroquine 200 mg, 2 tablets, Q12h (total 800 mg) on day 1 followed by 200 mg, 1 tablet, Q12h (total 400 mg per day) for 4 more days.

a. Youngsters without any risk factors: Monitor progress of clinical illness daily (over mobile phone). Maintain a database on a spread-sheet, and avoid HCQ in mild to moderately severe disease.

b. Avoid HCQ in those with chronic renal or liver disease.

c. In subjects with diabetes mellitus:

- While on HCQ, treatment, reduce dose of anti-diabetic

drugs by 25 -30% in order to avert hypoglycaemia.

- Institute home monitoring or field monitoring of blood sugars by glucometer during HCQ treatment. Further dose adjustment of anti-diabetic drugs can be based on plasma glucose values
- Once the treatment course is finished, over the next 3-7 days get back to the previous stable dose of oral anti-diabetic drugs and or insulin

d. Those with cardiac disease on medication:

Look at the drug list, check for potential drug interactions, and make a considered decision in consultation with the attending cardiologist. Baseline ECG (focus on corrected QT interval) and ECG on alternate days until course is over would be useful; however, this may necessitate hospital admission. Monitor serum electrolytes and magnesium and correct hypokalaemia and hypomagnesemia when detected.

Zinc Supplementation

In vitro studies have shown that intracellular zinc, when present in sufficient concentration, inhibits viral replication and chloroquine acts as an ionophore, facilitating transport of zinc from extracellular to intracellular compartment. Therefore, elemental zinc of 50 mg per day, orally, once daily can be co-prescribed with HCQ.[15,16]

Use of Antibiotics

In order to treat secondary bacterial infection which occurs in about 50 % of COVID- 19 cases, Azithromycin 500 mg, once daily, for 5 days or Amoxicillin/potassium-clavulanate 625/125mg Q12 hourly, for 5 days (common antibiotics used for treating community acquired pneumonia) may be added at the discretion of the treating physician based on a persistent fever > 38 degree Celsius and productive cough persisting beyond 5 days.

Convalescent plasma for severely ill COVID-19 patients

Encouraging observational reports in small numbers of patients have aroused wide-spread interest in the use of convalescent plasma for severely ill COVID-19 patients on ventilators.[17] Randomized controlled clinical trials have commenced with this treatment approach. In general, in viral illnesses antibody response is much brisker in those who have a clinical illness than in those with asymptomatic or subclinical illness.[18] Patients with clinically diagnosed COVID-19 syndrome may be the ones with the highest titres of antibodies. Utilising the syndromic approach may help identify potential plasma donors in resource poor settings. Since those with the clinical syndrome will be the larger number than those with PCR-proven SARS-CoV-2 infection, a physician can select willing individuals who have recovered from the clinical syndrome for checking on antibody titres prior to plasmapheresis and, thus, reduce costs.

Preventive Treatment

House-hold contacts of the subject with clinical diagnosis of COVID 19 syndrome (During the lock down period in India, household members will predominate), those working or interacting closely with the index case in the workplace (such as grocery store, post office, bank, etc.) and those in migrant groups amongst whom one individual has been presumptively diagnosed to have COVID-19 clinical syndrome or confirmed to have COVID-19 by PCR will be the contacts.

Regimen for household and other contacts (as per ICMR advisory[13]):

HCQ 200 mg, 2 tabs, twice daily (800 mg per day) for day 1 followed by 200 mg, 2 tabs, once a week (400 mg per week) for the next several weeks

Preventive treatment for contacts starts as soon as the clinical case is diagnosed. If not, it can be started any time up to day 14 of presumptive diagnosis in the index patient. Long-term side effects, like retinopathy, are dose and duration dependent and are unlikely during these short-term treatment protocols.

Conclusion

Protocols by the Kerala, Tamil Nadu, Maharashtra State Governments, and the guidelines from the All India Institute of Medical Sciences, New Delhi, adequately cover management of confirmed cases. We highlight the need to address the clinical COVID-19 syndrome, where PCR testing may not be performed because of the restrictive selection criteria for PCR testing or lack of availability. For such a syndromic approach to be effective would require a quick nation-wide implementation during the shelter or lock-down period.

Governments and NGOs in other middle- and low-income countries involved in responding to the health care challenge posed by COVID-19 should consider implementing the syndromic approach. They should mobilize material and human resources and medication to do this quickly through their networks of healthcare professionals.

We note the use of HCQ has not yet been established in clinical trials and in the results of the multinational and multi-centric clinical trial “Solidarity”[12] will probably not be available until after the pandemic. We should be closely monitoring the latest evidence for HCQ, but in the

absence of data from controlled clinical trials and given the expected burden of mortality from Covid 19, the treatment of the clinical syndrome and use of chemoprophylaxis for contacts of the presumed COVID-19 syndrome (rather than only confirmed cases and their contacts) seems important in countries and settings with resource constraints.

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Appendix A: Home Isolation Procedure (from Thirumalai Mission Hospital)

The clinically diagnosed COVID-19 patient should wear a mask, wear full sleeves, and cough or sneeze only into a disposable tissue or into the crook of the elbow and not into the hand. He should be in a well-ventilated single room preferably with an attached bathroom, not shared with others. Where there is a need to share a bathroom, the surfaces that the patient has touched should be cleaned with dilute bleach or soap and water and mopped dry after use by the affected person. The patient's toilet kit (tooth-brush, shaving kit, etc.) should be kept separate and other house-hold members avoid coming in contact with these items of personal use. The patient's clothes should be washed thoroughly with soap and water daily, dried, and kept separate for him/her to re-use. Bed linen should be similarly washed and dried at least once in 3 days and kept separate. If the patient is using a mobile phone, it should not be shared with others and the surface wiped clean carefully with tissue moistened with hand sanitizer 3-4 times per day. Other family members also use a mask all the time at home and maintain a physical distance of two meters from the patient, avoiding physical contact such as shaking hands, patting on the back, hugging, etc. The household members should avoid visiting others and not allow visitors until the quarantine period is over. Communication with others outside the family should be by phone or messages (SMS). If there are people above age 65 in the household, ensure that they follow all the precautions that have been advised for the affected patient. Only younger unaffected members of the family (Age <45) should go out for buying provisions, wearing a mask when going out to shops, maintaining the critical physical distance of two meters from other people on the road and in the shop, and avoiding standing in groups to talk. Children in the house can play indoor games with other family members, read, paint, and listen to or play music for pastime. Children should also wear masks and maintain a physical distance of 2 meters from the affected individual. Every member of the household should practice frequent and thorough hand washing with soap and water after they come in contact with door knobs, lift buttons, and other potentially contaminated surfaces. If there is a care-taker for the elderly, it is the responsibility of the residents of the house to instruct the care-taker to wear a mask all the time, to use a pair of gloves while working, to sanitize gloves at the end of the work, to practice thorough hand washing with soap and water after they have finished their work and before they help elders, to avoid unnecessarily hanging around in common areas, and to abstain from work for 3 weeks if the care taker or his or her family member has a febrile illness. It is important that care-takers are paid their wages when they or their family members fall sick.

HOSPITAL READINESS FOR COVID-19:
THE SCENARIO FROM INDIA WITH SUGGESTIONS FOR THE WORLD

Abstract

Lessons learned from Italy regarding hospitals and health care facilities as important sources of disease spread for COVID-19, and ways to mitigate this in India and other countries.

Key Words: COVID-19, hospitals, mitigation, low income countries.

We have learned that recently, in two hospitals in India, emergency surgical procedures were performed on patients and healthcare personnel got infected with SARS-CoV-2. These surgical patients developed COVID-19 pneumonia in the postoperative period, and succumbed. In these hospitals, a large number of health care professionals got infected. This had led to a lock down and containment situation of these hospitals. These incidents have provided many important lessons for the medical profession, other healthcare workers, administrators, and health ministries.

If asymptomatic individuals during the incubation period develop COVID-19 in the postoperative period, there are only 2 possibilities: 1. Their infection was nosocomial; or 2. They were already infected on presentation. In either situation community level spread is occurring. In option one it would represent silent infection in medical staff or other admitted patients.

The Experience in Italy

Italian doctors, after their heart-rending experiences with COVID-19, made a plea in NEJM Catalyst; their article carries the following messages for the rest of the world in the approach to COVID-19 pandemic1:

1. The virus is exploiting centralized health care systems of the current era in a large number of countries.
2. Once you keep admitting very sick patients with high viral load, the hospital becomes a reservoir of the virus. Health care personnel acquire infection and unwittingly become vectors, who spread the infection to their patients and this leads on to further community spread. So, hospitals become hot-beds of SARS-CoV-2 infection.
3. A good number of health care professionals contract and some succumb to the infection they contracted in the hospital.
4. Physicians generally are skilled in treating individual patients and often make decisions in the interest of the patient as a whole rather than one symptom or abnormality. For example, in a difficult to control diabetic the physician may accept suboptimal control of blood sugars in order to avoid hypoglycaemia which can be life threatening. Similarly, in a pandemic, the way the medical profession should respond is to do their level best to consider the population as a whole and keep the population healthy. They need to think differently in order to achieve this. This approach is likely to reduce overall spread of COVID-19 and reduce overall mortality.
5. If you do not follow this approach, the human toll becomes huge as in Italy, Spain, and the US.
6. They recommend home based care as far as possible (mild and moderate COVID 19 cases, including those who have early COVID-19 pneumonia who need oxygen with home oxygen if needed, under the care and supervision of the family physician. This will minimize potential for contamination of hospitals.
7. There is a place for a fully isolated, well-equipped COVID-19 centres with all tertiary facilities manned by a committed team to take care of those who need positive pressure ventilation.

An Approach to Hospital-based Mitigation

There is an old saying originating from the Bible (Luke 4:23) “Physician, heal thyself!” In the current COVID-19 context, this can be rephrased as “Healthcare worker, protect thyself.” If healthcare professionals are depleted because of COVID-19 or if the health-care force is demoralised because of personal risk and fear, the situation can become extremely difficult to handle.

How can we handle a catastrophe of this magnitude? How would a humane, caring person in the interest of community justice approach this problem?

1. Ensure alternative avenues of management for chronic non-communicable diseases (NCDs) and restrict regular out-patient department (OPDs). Patients with NCDs are vulnerable people who should not be coming to hospitals potentially contaminated with the virus — for their own safety – but need ongoing management to prevent other causes of morbidity and mortality. Reduce crowding in the hospital, and limit avoidable workload of an already stressed group of healthcare staff.
2. Mobile telephone/telemedicine-based counselling for patients with chronic illness through their usual caregiver with the understanding that if there is a medical emergency, they will have to access a safe hospital not frequented by COVID-19 patients.
3. Home delivery of medications to avoid elderly coming out of their homes. They should be cocooned (reverse quarantined). When necessary, physicians wearing personal protective equipment should undertake home visits — instead of patients coming to hospitals when their illness is of low/moderate severity and not life-threatening. For example, utilizing mobile services, community acquired infections can be managed at home without a hospital visit.
4. Multiple hot-lines should be manned round the clock by appropriate health personnel to provide medical advice and counselling. Tertiary level and medical college hospitals must serve as resource centres for practitioners in order to guide them in caring for complex problems, for example, complicated diabetes, hypertension, community acquired infections, etc.
5. Where there is a functioning and reliable system, samples for lab tests should be collected at home, in a dedicated community level blood collection facility, or in a well-equipped mobile van for remote villages. Samples are then transported to the lab and the results of tests communicated to concerned practitioners.
6. Use a syndromic approach to diagnose COVID-19.2 Then treat such patients and prevent spread to their family members using appropriate home isolation and other prophylactic measures.
7. PCR or Rapid tests used only for confirming diagnosis when it will affect care, or for well-designed and ethical studies, so that resources saved can be put to better use.
8. Dedicated ambulance services with adequately protected personnel to carry sick infected subjects to a dedicated COVID centre.
9. Have separate emergency facility for patients with acute respiratory problems. A dedicated team with appropriate personal protective equipment should see these patients. Those needing admission for respiratory failure should be admitted to a separate ICU facility for COVID-19.
10. Major hospitals in either private or public sector can be designated to take on the management of the town and surrounding villages and to set up a model system of referral and management in the surrounding areas.
11. Importantly, continue to manage emergencies in non-COVID patients, who need hospital-based care in a separate facility manned by a different set of healthcare personnel. In other settings people are dying from late presentation after being encouraged to stay away from medical facilities.
12. Every patient coming to hospital for any emergency should be considered to be potentially infected with SARS-CoV- 2 and all the staff strive to take suitable precautions (respiratory as for COVID-19 and universal as for HIV).
13. Where safe, non-urgent surgical procedures should be postponed Each patient going for surgery to have a screening PCR on a nasopharyngeal swab and Ig M antibody (as soon as it is available widely) and lab report to be seen before taking up for surgery, similar to the present system in place for hepatitis B, C, and HIV. As even this will miss out a proportion (~10 %) of SARS-CoV-2 infected patients3, respiratory precautions as for COVID 19 and universal precautions as for HIV infected patients will be mandatory for every surgical patient and procedure.

Conclusion and Future Hope

The pandemic will eventually wane when around 50-60% of the population have been infected and developed immunity.4 This may take a few more months. During these crucial months ahead, medical professionals

should ensure that they safe-guard their health and at the same time put in their best efforts to tend to the sick and suffering.

We make these suggestions based on our significant clinical experience and understanding of the evidence so as to inform the approach of hospitals in India to this pandemic. We also feel that the above suggestions could be applicable to other middle- and low-income countries which are trying to cope with this pandemic.

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QUO VADIS, TERRA?

Dr.Nitin T. Joseph

Who would have ever imagined when we sang our favourite Christmas carols last year that we would not be able to meet for a corporate church celebration of the glorious Day of our Lord's Resurrection? When we exchanged our New Year greetings of good health and prosperity with our friends and relatives would we have believed if someone were to say that these wishes would be vanity? Worship that was restricted to the confines of a church building is now not possible at all. Innovations in worship services are now common place. Online worship services are erroneously called "virtual" by some and I don't agree that is a good description. When people have gathered together in one spirit and one purpose to worship the living Lord can only physical separation justify it to be called unreal or virtual? These and so many other questions come to our minds during these times of uncertainty. We have realised that very few things actually are urgent and we may actually have to redefine "emergencies". Acronyms like ASAP and STAT that are so part of our medical jargon seem redundant. As someone correctly put it that "the world is closed for repairs", as if rebooting to factory settings!

We have realised that very few things actually are urgent and we may actually have to redefine "emergencies".

The pandemic of Covid-19 and the subsequent lock down has resulted in manifold inconveniences. While most of us must be in the security of our homes with a fairly reasonable stock of our necessities, the plight of daily wage workers, migrant labourers and those in the unorganised sectors is phenomenal. Being separated from one's families for extended periods and more so in such a time of crisis and uncertainty and with no guarantee of their wages and livelihood in the days ahead the lives of several thousand brethren looks very bleak. The world leader and the country with perhaps the best health care in the world USA, is unable to come to terms with this virus and at the time of writing this article, the cases of Covid-19 are climbing towards the 9,00,000 mark with nearly 46,000 people dead already. In our country the numbers are increasing at an alarming rate and people are talking of the "avalanche ahead" after the lock down is lifted. One can only speculate the consequences of this period of industrial inactivity. Our economic growth which was already limping in the last 3-4 quarters before the pandemic is projected to further nosedive in this fiscal year.

I don't think anyone has experienced such times in the past. Even during the World Wars, the pandemic of Spanish Influenza, the Great Depression and recently the pandemics of SARA and H1N1 the mortality and fear were not so intense. The enemy was known and there were weapons and ammunition available to combat the enemy. However, today we are faced with an enemy that is visible only with ultra-magnification and we yet have no vaccines or drugs against it. Most people are of the view that people will suffer either from the result of the economic depression or mental depression due the virus itself. The idea of trying to develop "herd immunity", especially among those under 50 years of age who have the capacity to fight the virus fairly effectively, by gradually opening up those areas that are not designated as "hot spots" and continuing with social distancing, prohibiting social gatherings and maintaining safety of the elderly and those with co-morbid conditions sounds logical and encouraging, but is it practical in a country like India with all its challenges?

As health professionals we have been traditionally taught the "cause and effect" of illnesses. We are aware of microorganisms that spread tuberculosis, leprosy, malaria, polio, cholera, typhoid etc and we can advise people of how we can stay away from these infections and also tackle infected cases. We can also educate people the causes and prevention of non-communicable diseases like diabetes mellitus, hypertension, heart disease and also mental illness. Even the dreaded HIV can be prevented by education against sexual promiscuity, drug abuse and safe blood transfusions.

But the Corona virus has added an entirely different dimension. It has not even spared monarchs, heads of governments, politicians, film stars and the affluent class of society. While the debate of whether the origin of the virus was in the Wuhan Institute of Virology or the Huanan Seafood wet market will continue, we must be ready for the long haul.

There are also many theorists who send/forward their opinions of whether this pandemic is the doing of the Devil or the act of God. Suddenly there is a lot of interest in those portions of the Bible that are otherwise conveniently ignored by preachers. Is this the beginning of the 7 seals mentioned in John's Revelation? Is this the Tribulation? Are we close to the Rapture? All the opinions seem very convincing and that leads to a lot of doubt, debate and division. I am sure you will agree that Psalm 91 has become the "Psalm of the Season"! While the religious philosophers and enlightened theologians can continue to debate, we as Christian healthcare professionals need to look for ways and means to address the effects of this pandemic, to alleviate the suffering and to be soldiers at the forefront. We read of so many cases all over our country of violence against doctors and nurses who are involved in the management of this disease. This is just obnoxious and inexplainable. Reports of doctors who are turned out of their rented homes and even not awarded a decent burial are shattering to say the least. We certainly don't expect claps, clanging of plates or even the status as martyrs.

We as healthcare workers must support our government agencies to address this issue. I am happy that the Christian Medical Association of India is dialoguing with the government leaders at the very top to formulate policy and protocols. The hospitals and personnel in our network can be excellent places for quarantine of mild cases and as Covid-19 care hospitals. There are several encouraging reports of how our mission hospitals are responding to the crisis. Many are providing meals and dry rations to those in need. Masks are prepared and distributed to people. One hospital is also preparing Personal Protection equipment in-house and using them while treating patients. CMAI is helping coordinate the purchase and distribution of PPE kits etc. Counselling services to those who are affected by the disease and its effects is also a need of the hour.

Christian healthcare professionals and organisations must be beacons of hope to provide holistic health in this supposedly hopeless situation. The WHO definition of health that we studied, "the state of complete physical, mental, social well-being and not merely the absence of disease or infirmity", suddenly seems so true in this time of physical and mental sickness with social-distancing added to it! As we live through these times of uncertainty I am reminded of a hymn by Frances "Fanny" Jane Crosby who became blind in her infancy and then went on to live to the ripe age of 95. She wrote nearly 8500 hymns in her lifetime and this hymn is perhaps one of her less popular ones:

Rescue the perishing, care for the dying, snatch them from pity from sin and the grave;

Weep o'er the erring one, lift up the fallen, tell them of Jesus the mightysave.

Though they are slighting Him, still He is waiting, waiting the penitent child to receive;

Plead with them earnestly, plead with them gently, He will forgive if they only believe.

Down in the human heart, crushed by the tempter, feelings lie buried that grace can restore;

Touched by a loving heart, wakened by kindness, chords that are broken will vibrate once more.

Rescue the perishing, duty demands it, strength for thy labour the Lord will provide;

Back to the narrow way, patiently win them, tell the poor wanderer a Saviour has died.

In the midst of this gloom and despair let us look upon this situation to live out our faith. Put our faith in action, not just hearers but doers of our faith. The Jesus model was of reaching out to the poor, the needy, the marginalised, the ostracised, the have-nots of society. Let us reach out to our neighbourhood who are beyond the walls of our churches and institutions with much needed help, support and hope. After all,"our hope is built on nothing else than Jesus' blood and righteousness".

"Then the King will say, 'I'm telling the solemn truth:Whenever you did one of these things to someone overlooked or ignored, that was Me- you did it to Me'" (Matt.25:40, The Message)

The hospitals and personnel in our network can be excellent places for quarantine of mild cases.

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LESSONS FROM SURREAL TIMES.....

Dr. Anuradha Rose

It has been a surreal time for the world. Across continents cultures and beliefs, the world is for once united, facing a common threat. Every day the news is filled with stories of new numbers of people infected with the n-COVID 19 virus, deaths of fathers, mothers, uncles , aunts grandparents and sometimes children reduced to mere numbers. Many have become numb to the countless stories of human tragedy and suffering experienced by mainly the poorer sections of all countries. Through this emerge stories exhibiting the best and the worst of human behavior.

In the medical profession, all we have strived for in the field of ethical care of patients has broken down in the current pandemic. Much of this is due to the methods used in implementing the Epidemic Act which is in force and the directives issued periodically by the Government, with the intention to prevent being overwhelmed by the pandemic.

There has been a complete loss of autonomy, shared decision making and confidentiality in the doctor patient interaction. Many hospitals practicing ethical medicine have always tried to include patients and their families in deciding the best options for treatment and prognosis. Gone were the days when paternalism was the prevalent practice and patients were instructed. Now in a matter of days, patients diagnosed to have COVID 19 have no choice on testing for the disease, confidentiality of test results and the post-test treatment. Patients with other diseases have very little choice on where they seek treatment, choices now governed by availability of transport and availability of doctors. As much of the situation is evolving and the response of the medical community is heavily affected by the directives announced by the Government.

The dignity and respect of the dead has been compromised due to family's inability to respect the wishes of the dead and inability to carry out religious and funeral rituals.

There is a complete loss of rapport building mechanisms, conventional communication methods, and ways to reassure patients. Medical isolation of patients to protect others has meant that patients go through this illness entirely alone and sometimes die alone without family by their side. Doctors traditionally try to communicate with patients and relatives with compassion to reassure them and help them to cope with illness. Several teams such as social workers and chaplaincy help patients cope. With the advent of the pandemic all these methods are restricted. COVID 19 patients cannot even see the faces of their health care providers which dehumanizes the whole patient health care provider interaction, increasing anxiety, distrust and sorrow. Coping mechanisms are severely compromised in this current situation.

Cost of care and resource allocation mechanisms are being reconsidered. In mission hospitals, many patients are middle class to poor. The current economic situation has made health care even more inaccessible financially to patients. Hospitals are also facing a huge financial crisis making subsidizing health care a difficult option. Doctors are forced to rethink what would have been routine concessions for the poor. Resource allocation is in danger of being favorable to the patients able to pay for services.

The news reports and the reports from the medical community about health care workers getting infected and sometimes dying has changed the way the health care workers interact with patients. In many hospitals fear is a daily presence in the doctor patient interaction, compounded by fact that the administration of some hospitals are insensitive to protection needed by the health workers in the front line. It has changed the way the community treats the hospital workers, with distressing news reports of doctors being the new "untouchables" in society. All this has added the distrust between society and the health care workers.

The most distressing aspect of this COVID 19 illness is the inability of health care works and family members to provide sufficient comfort for the dying due to isolation needs. The dignity and respect of the dead has been compromised due to family's inability to respect the wishes of the dead and inability to carry out religious and funeral rituals. After the advent of respiratory support for the sick, the way we face death has changed from being in the presence of family, in the familiarity of one's own home, to a cold clinical ICU. Many efforts have been made to allow the dying as much comfort from family members, clerics and counselors. In the COVID situation patients die alone.

Societal tragedies are heart breaking. Families separated by the lack of transport, some walking or cycling hundreds of kilometers to reach their families, leaving behind uncaring cities and irresponsible employers.

In the face of this rather dismal situation there are stories of love, sacrifice and the indomitable human spirit. An Italian catholic priest offered to be allowed to die, to enable a younger person to obtain a ventilator. Doctors and nurses all over the world willingly working long hours, putting themselves and their families at risk to tend to the sick. People have been generous to provide for basics like food and medicines for those not fortunate enough to have an income in this time. A family in Kerala sold their property to feed the sick. Young people who have never made a meal for themselves are now cooking for whole communities of stranded patients and laborers and unfailingly delivering packed food, and miraculously the funds to sustain these activities are available in answer to the sincere prayers of those who care.

Young people who have never made a meal for themselves are now cooking for whole communities of stranded patients and laborers and unfailingly delivering packed food, and miraculously the funds to sustain these activities are available in answer to the sincere prayers of those who care.

How do we as Christians respond to this situation?

We need to pray. In no other time has the world needed our prayers as now. As Abraham pleaded to God to for the city of Sodom to be spared, we have to pray for Gods mercy and grace on our sinful world. As is in 1 Corinthians 2:5, our faith should rest not in the wisdom of men and science, mathematical projections of the future, but in the power of God. While we are called on to be prudent to avoid infection and infecting others, we should not allow irrational fears of infection and death govern the way we behave with others, especially patients. 1 Thessalonians 4: 16-18 holds a glorious promise for those who believe in Christ.

The pandemic has not changed the way Christians ought to behave. We are called to exhibit the love of Christ through our lives, to feed the hungry, cloth the naked and tend to the sick. For centuries Christians have been known to care for the sick and suffering, and Christian missionaries were the first to care for people with the dreaded diseases of old such as leprosy and HIV.

The pandemic has given us an opportunity to examine our way of living, to reach out beyond our selfish wants and to make a difference in the lives of others. There are many who are hungry, unemployment making it impossible to feed their families. There are many who are hungry for a caring voice, a human touch, separate from their families far away. There are many in the line of duty, fulfilling the duties placed on them by the government and society who will also like to be safely in their homes with their families. We are called to be the ones providing food for the hungry, comfort for the lonely and reassurances for the anxious. For those of us in the medical profession, we are now called to be the family of patients alone in COVID wards, the son or daughter for the elderly, the parent for the child, the priest for the distressed or the doctor for the suffering. Let us rise to our calling and be a blessing.

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SINGING: A PATH TO LOVING

Music is an often underutilized gift from God. Two aspects of singing can help us follow Jesus more closely in our loving:

1. The act of singing, especially singing in groups, and
2. The words of songs that are sung.

Dr. Barbara Isely

Singing in a Group

The very act of singing makes us feel good. It energizes and makes us happy to be singing with other people.

Physiological Effects

Many researchers have worked to identify what happens physiologically when we sing together. The research is from wide-ranging disciplines – music therapy, psychology to neurology. Because of diverse approaches, few of the tantalizing results are well replicated. Tracing original research is limited by no access to a professional library, and few refereed articles are online. See limited references below.

The act of singing has several positive physical effects that appear more in group singing than in singing alone. Most of us have experienced feeling joyful or relaxed after a good session of singing with other people. Research indicates physiological effects such as increased endorphin levels and improvement of the immune function.

Other physiological effects of singing together, such as synchronized heart beats lead to strong group cohesion that can strengthen other activities by the group. Singing together informally and forming or joining a singing group or choir are enjoyable, easy, and powerful ways to build loving teams and families.

Include Everyone – A Loving Act

Music groups can negatively impact excluded individuals. Competition and the myths of talent and non-singers lead to exclusion of some persons. NEVER tell a person, especially a child that they cannot sing; even professional singing teachers have been mistaken.

Making the blessings of singing available to all is a first step in loving through music. Desire and effort to learn can overcome "talent" or "lack of talent." "Talent" is often merely what was learned from previous exposure to music.

A seeming inability to sing can be overcome by experience with music and good teaching. Unloving labeling by other persons and lack of opportunity, not lack of talent, leads to "non-singers." Take the first step to help a person sing by believing they can, and you will have taken a step to be more loving.

The very special sound of group singing does not depend on solo quality voices; every singer adds to the overall choral sound. A group of weak singers can produce a very special, unique sound that can be far more beautiful than a single good singer. A strong, overly loud singer, no matter how good, can spoil the group sound. Persons who are firmly convinced they cannot sing can be included on guitar, drum, bells, tambourine, or clapping. Inclusion of the weak or supposed "non-singer" is an exercise in loving, in accepting every child of God. As we include everyone in our singing, we grow to recognize that in all situations every child of God has some gift that contributes to the whole.

Improve Singing in Your Group

Strong singers can gently and easily help others improve their singing. Know that ability to sing well is a gift from God to be lovingly shared.

Some weak singers are not aware of pitch – the high and low of the sound of music. Use "God Is So Good" to teach pitch: in the first three word repetitions the

pitch has the same pattern (note, repeat, skip up, step down). The whole pattern rises in pitch on the second and third repetitions. The fourth repetition does not follow the pattern. Help weak singers by calling attention to the pitch and/or accurately moving a hand up and down with the pitch. The same song is useful to teach how to change volume, increasing or decreasing volume with each repetition.

Echo songs help improve singing by focusing listening. "God is Everywhere" is a song where the group echoes the leader. It is online with excellent karaoke videos; search *"New Hope Music God is Everywhere."*

Words of the Songs

Most of us have had music and words suddenly, without apparent reason, go around and around in our head. This phenomenon has a great potential for good or evil, so pay close attention to what is sung or heard. Words can comfort, energize, and focus on what we are called to do, or distract and lead us astray.

The Familiar

Singing Amazing Grace is wonderful and comforting. I played it for my grandmother a week before she died. And she wept with joy, remembering her father, whose favorite hymn it was. This hymn linked across four generations in a special moment. I happily remember my pastor father singing it in the pulpit, rocking up on his toes on "When we've been there ten thousand years." Each of us has special memories and feelings of comfort stimulated by singing familiar songs. This is good.

Awareness of limits of familiar songs is not a criticism of the actual words themselves, but of how comfort and habit may cause us to miss important ideas.

However, good memories and comfort may also limit how a song guides our journey in following Jesus. If I focus only on my good feelings and family memories of Amazing Grace, I miss much meaning, and my singing may be far from praise and a focus on discipleship. While being strengthened to love by the warm feelings of comfort and in assured salvation, I may miss the challenge to think on how I may now be blind and in need of seeing some new aspect of my following Jesus.

The familiar, the habitual can comfort us to face difficulties. However, if familiarity keeps us from fresh thinking about how to love as we face daily challenges, we may also need to step into the unfamiliar. Awareness of limits of familiar songs is not a criticism of the actual words themselves, but of how comfort and habit may cause us to miss important ideas.

The New

Well-chosen, new or unfamiliar old songs can move us from a self-absorbed rut. Many recent songs speak specifically to today's real situations that challenge our loving – homelessness, the environment, drug abuse, greed and unnecessary consumption, thoughtless aping of popular culture, especially the focus on self. Unfamiliar songs can catch our attention to the depth that loving requires as we strive to follow Jesus.

As new songs are chosen, some singers may resist, especially if they do not read music. However, new songs can be easily learned from online sources. A few links below lead to songs that provide fresh insights on how to love as we strive to follow Jesus in our daily lives.

Links to Songs

Here are a few old and new songs and websites with many songs. Simple URLs or easily typed words in italics are links. A search on the typed words gives the intended link as the first suggestion, unless stated otherwise. If you want to learn a song, also searchYouTube.com to see if someone has posted a video.

Sound the Bamboo 2000 cca.org is an amazing, multi-cultural hymnal with hymns from Asian and Pacific cultures, including 39 from India. *The Christian Conference of Asia* website posts many of the tunes in their music gallery. The physical hymnal must be purchased and is not available during the COVID-19 crisis. Nevertheless, it is worth buying,and is a valuable, and uniquely Asian resource.

Hymntime.com provides audio accompaniment, words, printed music for 14,200 old and new hymns. You can search by words, writer, tune names, or topic. Here are a few:

- *O Young and Fearless Prophet, hymntime.com*
- *Father Make Us Loving, hymntime.com*
- *God of the Strong God of the Weak, hymntime.com*

Several current lyricists make available their contemporary texts to familiar tunes.

- *carolynhymns.com leads to words and audio on the COVID-19 crisis among others.*
- *New Zealand Methodist hymns With Heart and Voice nwhymns.com*

Ralph Merrifield is a generous composer/lyricist who makes his many songs available in print, audio, and karaoke video files.

God is Everywhere NewHopeMusic.com
The Fruit of the Spirit is Love NewHopeMusic.com
God Made You NewHopeMusic.com
I Will Walk in the Ways of the Lord New HopeMusic.com

Colin Gibson is another generous composer/lyricist. In the first and third suggestions that come when you search on the next words, you will find words and a lovely video.

Dunedin Nothing is lost on the breath of God Colin Gibson.
Love is a miracle Colin Gibson
Dunedin New Zealand Colin Gibson hymns

The *New Zealand Hymnbook* Trust published several excellent hymnals with inspiring new hymns in recent decades. Digital copies of the hymnals and some audio files can be purchased online. *https://pgpl.co.nz*

Dr. Barbara Isely

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THE YEAR OF THE NURSE-MIDWIFE AND THE YEAR OF CORONA:

A NURSING PERSPECTIVE PROVOKING ONE ANOTHER TO LOVE AND GOOD DEEDS

Ms. Mercy John

Dear sisters and brothers, my nursing colleagues and all my fellow health care workers; especially those who are at the front-line in combating Covid ; those who are weighed down with the burden of caring for people suspected or confirmed to have Covid; and those of us who worry for our families back home; and worry for ourselves …

At times like this, the Word of God stands only too clear and it is our privilege and right to take hold of it - for ourselves, our faith and our need to encourage those around us.

We stand on the brink of something unprecedented. When it was war, it was something far away, on the borders of the country, affecting limited people. When it was a flood or an earthquake, it was sad, but affecting somebody else. When it was malnutrition or malaria, again it was not for people like us. Even in December 2019, it felt like faraway China which is affected by the Corona virus. And then some European and American nations far away. But today it is staring us in our faces! The distant enemy is here, before each and every one of us. We are dealing with a different kind of world war – not with guns, bombs or nuclear stuff, but something unseen to the human eye - 0.06 micron size! Even the countries with the biggest armies and defense budgets are finding themselves vulnerable and exposed. Now it's lockdown, job-losses, disruption in education, anxiety, fear, hunger. But it is also a time of coming together, forgetting old differences; creativity and innovation, sharing ideas, preparations for the unfamiliar!

We are a 200-bedded hospital (CHB – Christian Hospital, Bissamcuttack) in a relatively remote part of south Odisha; 200 km from the nearest ICU and 400 km from the nearest Covid testing facility. So it is all between us, God and our patients! On the one hand, we have to prepare for Covid; on the other hand, we have to care for hundreds of other patients coming to us for delivery or emergency surgery or Tuberculosis, Dengue, Malaria, Diabetes, Hypertension etc. Any of them (and us) could also potentially have the infection, and so neither can it be business as usual, nor can we shut our doors to the needy and sick. I would like to share with you some small things we have done in our hospital in our CHB Covid Preparedness and Response approach; and some of the lessons we are learning in the process.

The CHB COVID-19 Preparedness & Response Initiative includes the following :

A. Hospital Preparedness and Response : As of date, this includes :

1. A 13-member CHB Task Force that leads the initiative was set up in mid-March 2020.
2. Education and Training of all Hospital Staff on COVID – including classes for all staff, and Webinar-based education for Health professionals
3. Procurement of PPE and other needed hospital supplies for the management of general and COVID patients, in the context of the epidemic
4. Production of CHB-made PPE materials : The following items have been researched, designed and are being produced in-house :
    a. Face Masks including Cotton Cloth masks for patients and their relatives and CHB Cloth and Polypropylene Masks for staff in patient care areas
    b. Individual Pouches for each staff : to submit masks for sterilization daily : 20 x 15cm of 25 gsm Polypropylene
    c. PPE Hood, Gown, Apron and Shoe Covers made of Polypropylene
    d. PPE Face Shields made transparency sheets

5. Re-organisation of Hospital Services for Patient Care in General Zone and Isolation Zone :
   a. Setting up of a Patient Triage at the entrance and a fast-track Fever & Cough Clinic for those with zrespiratory illnesses
   b. Re-organisation of the Emergency Dept, OPD and Wards to continue to serve the regular patients
   c. Setting up of a defined Isolation Ward with 2 beds, expandable to 24 beds.
   d. Setting up a Staff Care Center – where staff members come to change into scrubs and then at the end of duty have a shower and change back into street clothes to go back home clean

B. Mask For All Campaign to decrease community transmission pressure around us :

CHB launched this idea on 30 March 2020, about a week before WHO, CDC, GoI and others recommended it. It made common sense. Cloth was procured, about 50 local tailors were recruited and trained and masks were produced and are now being distributed. For the town, it is undertaken in partnership with a local club, AFSA.

As of date, over 22,000 masks have been distributed with instructions for use and 50 tailors have become experts at stitching masks and can now earn their livelihood with this. The aim is that it becomes a people's movement - if all the infected, known and unknown, are wearing masks, the risk of transmission from them decreases. From the 6th of April, we made it compulsory that anybody entering our hospital campus has to wash their hands with soap and wear a mask (a mask is available at the triage for Rs 10).

What are the lessons we are learning through this process?

Preparedness and Team Work :– Whatever was occurring in China, was spreading from person to person very fast and there was a high mortality associated. So early in January 2020 we had a general staff meeting to inform all staff and to discuss what little we knew of the new disease. Subsequently it reached India. We realised that even though we had some knowledge, we were not ready with equipment to face the onslaught. The CHB Covid Task Force meets almost daily to re-assess and lead the response. In the nursing department – we changed the uniform from white sarees to salwar-kurta with coats. We also decided to produce our own Personal Protective Equipment (PPE) using locally available materials, mostly cotton cloth from local shops and polypropylene from a defunct bag-making factory. So we have been researching, innovating, designing and making our own PPE for all our staff who will be involved in the care – doctors, nurses, lab techs, ward aides and cleaning staff. It is wonderful to see the camaraderie of the staff and willingness to pitch in and do whatever is needed – in terms of cutting, designing, stitching, cleaning, fixing, etc. We even do our testing of materials made through washing machines, autoclave, microbiology cultures, and looking at pore size through microscopes, etc.

Care for your staff : This is one thing which is most important especially at this time. It will be the doctors, nurses and paramedics who are at the forefront of the action – especially for the patients who will come to the casualty, labour room and OPD. As administrators and leaders, it is our bounden duty to ensure that our staff (and also their families) is protected to the best of our ability. Care involves spiritual, mental, cognitive, physical, and psychological (for once these are not just a string of words in the health definition – they are real and stand out starkly). We have been talking with them, encouraging them to discuss their fears and doubts, praying with them, encouraging them – these are just some ways to help boost their (and our) morale.

Lead from the Front: What are we called to do in this situation – for us, as nurse leaders, educators and practitioners. This is the time to stand up and be counted. Not with fear, but in the strength of our Lord. Can we put our money where our mouths are? Can we translate our classroom teaching into practice? Or do we think that the bedside care is “only for the staff nurses, but I am a tutor”? That is cowardice. A teacher or administrator of nursing must be more deft in practice and brave. With our students at home, all the tutors along with other staff are involved in cutting, stitching, trying on PPE etc. Now that we have finalized our design and created a checklist, the next step will be to train all our staff to don and doff PPE – nurses, doctors, nurse aides and cleaning staff.

Do we know how to lead from the front? Are we involved in preparation by way of things, skills and intelligent systemic changes? Do we care for ourselves and each other? Are we resilient or crumbling under the pressure? Dear ones, if God is for us - on our side – who or what can be against us? Go forward in that faith – that whatever be it – we are in God’s hands!

Secure the right equipment, ensure training and set aside fear. These are essential points which we will have to constantly keep at. Be responsible for oneself and for others.

Powerful Will : As nurses we should have a powerful will. A will to get things done; a will to make sure things are set right to face any situation. In the existing pandemic, we cannot accept a ‘chalega’ attitude. We should be reasonable, intelligent and thinking two steps ahead and do the best we can.

Professionalism, Selfless devotion and great resilience: We have learnt considerable theory in our student days. Much is practised and some is laid under the carpet. Shortcuts can lead to disaster for us and our colleagues. We need to spruce up our isolation techniques, of course hand-washing, cough/sneeze etiquette, etc ; in short, we have to be more professional in our approach.

We have had classes, discussions, small group discussions with regards to procedure / system change, prayed with them, etc. We have involved the staff in preparation of the PPE. All the staff has been provided masks and now we are covering their families too. It is critical to hold the team together, and we are unable to do that without prayer. So until Covid actually gets here, we have a brief, ten minute devotion every morning together in our spacious auditorium, with a 20-minute update on Covid and our response activities and responsibilities. This helps keep everyone focused and tuned in.

I would ask each of you to please read the piece by Aaron Mishler entitled ‘There is no emergency in a pandemic’. We need to stay safe to be able to continue to serve. Let us encourage each other, be compassionate and provoke each other to stand firm in the love of the Lord. God bless us all through this historical period.

Ms. Mercy John, Principal, College of Nursing, Christian Hospital, Bissamcuttack, Odisha

MISSIONARIES OF THE PANDEMIC

Auto Raja, the founder of Bangalore's *New Ark Mission,* once told me about a church which participated in his large mission of supporting the destitute. The pastor asked each member of the congregation to carry one vegetable each to church the following Sunday. The next Sunday, as requested, parishioners arrived each carrying a vegetable. One brought a potato, another brought a carrot, some brought bhindi and so on. Each parishioner brought just one item each! At the end of the three services that Sunday, the church had collected several cartons full of vegetables for the mission. Everyone experienced the joy of giving. Each person gave a very small amount, but together as a family of God, they were able to say "mission accomplished". While the church carries on its mission, individuals too, are doing their missions with the church. A church filled with missionaries!

Mr. Sunny Kuruvilla

It is very common for people to feel drawn to institutions with great visions and missions. It is also possible for individuals to work with a *mission hospital* without having a sense of its mission. This Covid pandemic has taught us some important lessons on carrying out our mission as individuals involved in the healing ministry. It also showed us how to network with others to ensure the mission. Covid posed questions like "Who else is interested in our mission? "Who else's mission have we been involved in over the years? Are there other models to accomplish the same mission?"

This pandemic calls us to reengineer our mission as healthcare providers both at the individual level and at an institutional level. As staff at mission hospitals we are often comfortably placed under the blanket vision and mission of our institutions. This is because there is no reason to find a personal meaning for the traditional mission that is there for a long time!

This pandemic brought many unknown or less known individuals and organizations to the limelight. We saw many unusual faces step up to inspire others with ingenious thoughts and ideas.

This pandemic brought many unknown or less known individuals and organizations to the limelight. We saw many unusual faces step up to inspire others with ingenious thoughts and ideas. Individuals who were not part of active missions proved their solidarity through leadership, comradery and kindness. A strange situation such as this has brought us together for a higher purpose and with God's grace we will overcome it.

This is the time to embrace changes and finding new 'missionaries' in our mission. This is the time to redesign the future of our hospitals with this rich experience. Bringing in new leaders and networks, involving community and church are the new vistas of inclusiveness for an effective mission.

This pandemic will help us find likeminded individuals to align with us to make our healing ministry more effective. Therefore as mission hospitals, this is an opportunity to review our mission, objectives and strategies.

I have listed out some instances of the most impacted groups proving their power of influence and innovation.

Employees

This pandemic has reminded us that our employees are our biggest asset and investment. During this unusual period, they have carried out our mission by forgoing their privileges and benefits. They stood with the institution to face the challenge. I was told that a senior consultant from a mission hospital decided to bear the cost of a ventilator by paying his salary in monthly instalments to the vendor till the price of the machine is met. In another hospital, a group of doctors jointly financed protective gowns for the entire clinical staff. The mission hospital staff have worked multiple duties, taken up additional responsibilities and played unusual roles to provide the best possible patient care in these times. Our

people have proven that each of us is a missionary; ordinary men and women with extraordinary life missions!

We should maintain this momentum and stand tall with this zeal. Let our missionary staff take the institution forward. Let them review, redefine and rejuvenate the mission of the institution so that we can be relevant to our generation. This will be a paradigm shift from the institutional driven mission to the individual owned mission!

Mission hospitals found partners or sponsors to work within the community and the links we have developed in this period will be the roots for the coming days.

Patients

One patient recently called to offer funds to buy some PPEs! Another patient called and offered to come and cook food for the staff on hospital premises! We have experienced the solidarity of our patients in understanding the kind of missions we are involved in and have developed a new perspective on healthcare services especially in the non-profit sector.

We heavily depend on our patients for our revenue. Though our revenue model relies on cross subsidies, paying patients ensure that our mission is sustained. In this period we were not able to have the usual number of patients. Therefore our revenue was also affected. Our patients reminded us once again how important they are to us.

When some of our hospitals opened new platforms such as tele and e-consultations, there were many takers. Home-based sample collection and home delivery of medicines too have been ongoing. With increasing numbers, post this pandemic, we will see our patients in greater roles.

In addition to hospital-based care, community outreach and mental health support are going to be major areas of need.

Mercy drops opened for the community

Training the police

Partners

Covid provided a reason for networking with government agencies, service providers, vendors and contractors. Sharing the mission through partnership did wonders in most places. Mission hospitals found partners or sponsors to work within the community and the links we have developed in this period will be the roots for the coming days. I am sure some of us found they are interested not only in business but also in partnering for a cause. Corporate social responsibility (CSR) of business firms have reached out to healthcare organizations by supplying personal protective equipment or sanitizers or funding for medical equipment.

Local community and Church

What was the response of the local community towards us during this season? India, along with other countries have appreciated the excellent work of their healthcare staff through various interesting methods. We saw an increased awareness about our commitment and the risk healthcare staff takes was widely acknowledged during this period. Longstanding challenges like attacks on hospitals and healthcare workers were discussed, even leading to changes in statutory provisions.

We in turn, must thankfully acknowledge the joint initiatives by local communities and churches to support mission hospitals. This incredible manifestation of the mission must continue.

The post Covid days offer promising opportunities to strengthen the role of the church in mission hospitals. This is an area that we need to develop further. The opportunity also holds true for networking with the neighbourhood and in the community at large. Volunteers from the community are effective catalysts in establishing our mission.

Lessons

To be effective in our institutional mission, we need people to own it and the community to work with us. There are several people and agencies interested in our missions when we share it with others. Empowering others is the key. Introspecting on our stand as an institution is necessary in the light of Covid experience. This will help us be more inclusive in carrying out our mission and also influence our strategies while reaching out to the community.

We have a lot to do in the post Covid days. Wherever necessary, strategies have to be reviewed, priorities have to be changed and networking has to be strengthened. The role of other partners in our mission should be recognized and their missions aligned with ours for an effective way forward.

Mr. Sunny Kuruvilla
Associate Director
Bangalore Baptist Hospital

"LET US CONSIDER..."
BEING PROFESSIONALLY COMPETENT, SOCIALLY RELEVANT AND SPIRITUALLY ALIVE

"Let us be concerned for one another, to help one another to show love and to do good."

Hebrew 10:24

Christianity is a faith which God intended to be lived and practiced by caring for others, encouraging others and to be encouraged by others are both central to the life of an obedient Christian professional.

Dr. Vilas Shende

The book of Hebrews encourages Christians to be strong as rock in their faith. When persecution and fear put pressure on us, our response should be to "hold fast" to the truth. This is not a blind faith. On the contrary, most of the content of this letter is evidence supporting the fact that Jesus Christ is, in fact, God's ultimate plan for our salvation. Our own personal faith is crucial to that endurance, which is why the writer has time and gain warned readers not to be lazy or careless about their spiritual growth (Hebrews 3:13). We should not respond to difficult times with fear or doubt but we should embrace a confident faith and look to encourage fellow professional Christians to do the same. This means proactively calling other Christians to not just "believe," but to act out in love and good deeds.

Have you ever ***considered*** how you can do this? (To consider means to think about, decide, or keep in mind.) To spur one another toward love and good deeds, or to encourage someone can a big impact in their life. I think often we don't realize what a huge difference some small bit of encouragement can make in someone's life.

The following are few easy Ways to encourage and Spur One Another on Toward Love and Good Deeds

- Call someone just to tell them that you remember them
- Speak life-giving, positive, uplifting words to person going through difficult situation
- Tell someone how they inspired you
- Let someone know you are praying for them
- Give a sincere compliment
- Tell the janitor/maid/cleaning professional/ maintenance worker that you appreciate them
- Show appreciation to your co-worker and particularly subordinate
- Visiting neighbor when he/she is sick and or lost someone dear to him/her
- Taking leadership in helping someone who is in problem/difficulty and needs help from others
- Requesting someone you know who can help someone in need due to his/her position

What does it means to be professionally competent?

It is the habitual and appropriate use of communication, knowledge, technical skills, clinical reasoning, emotions, values, and reflection in daily practice for the benefit

of the individual and community being served. Competence builds on a foundation of basic clinical skills, scientific knowledge, and moral development. Competence depends on habits of mind, including attentiveness, critical curiosity, self-awareness, and presence. Professional competence is developmental, impermanent, and context-dependent.

How it is important to be professionally competent?

Maintaining **professional competence** allows individuals to continue to learn throughout their career, to develop their technical skills, and to keep pace with creativity and innovations.

How one should be socially relevant?

The need for *sociology* to become socially relevant is now being articulated by professional sociologists that the discipline should be *valuefree* allows sociologists to serve and promote the *social values* of others, a vital sociological endeavor requires more. To be socially relevant, it is essential that the discipline become consciously valuerelevant, not valuefree.

What does it means to be spiritually alive?

The characteristics of those who are alive spiritually and mature in Christ, as compared to those who are spiritually dead, are profound. The following are some of the salient characteristics of those who are alive spiritually:

1. They earnestly seek fellowship with God as well as with people in our society. These folks are easily recognizable for their zeal for all things pertaining to God and godliness. They epitomize the words of Jeremiah: "You will seek Me and find Me, when you search for Me with all your heart" (Jeremiah 29:13). They are those who "love God with all their heart, soul, mind, and strength. They love their neighbor as themselves" (Mark 12:30-31). They are known for their love for one another (John 13:35), and wouldn't hesitate "to lay down their lives for friends" (John 15:13).
2. They are highly sensitive to sin. The spiritually alive person is truly mindful of the sinful realities in their life. They strive to "walk in the Light as He Himself is the Light" (1 John 5:7). They "confess their sins" (1 John 1:9). They know that to live for God is to be holy (1 Peter 1:15-16) which means being totally devoted or dedicated to God. They know assuredly that they have been set aside for His special use and set apart from sin and its influence.
3. They're known for their strict obedience to the Word of God (1 John 2:3). Obedience to the commands of God produces assurance — the confidence "that we have come to know Him."

Some of the best examples in the bible regarding concern for others and showing professional competence, social relevance and spiritual alertness are as follows:

i) Good Samaritan Luke 10:25-37

The history of the feud between Jews and Samaritans is as old as 722 B.C. The year the Assyrians conquered Israel and took most of its people into captivity. Shortly afterward the invaders brought in Gentile Colonists to resettle the land. These foreigners brought with them their pagan idols, which the remaining Jews began to worship alongside the God of Israel. Intermarriages also took place. The Samaritans were descendants of these Jews who mingled with the Gentiles. Therefore the other Jews despised the Samaritans.

It was such a man that became the neighbor to the fallen Jew. Did he know the Law of Moses? Jesus didn't tell. But he said this, "But a Samaritan who was traveling came to where the injured man was, and when he saw him, he felt compassion for him." Then Jesus closed the story with another question. "Which of these three do you think was a neighbor to the man who fell into the hands of robbers?" The Lawyer knows the answer but he cannot even bring himself to mention the man's race. He is picky about his neighbors. He answered, "The one who had mercy on him." Jesus said, "Go and do likewise." By telling this parable Jesus wanted us to understand how one should be concerned for others with an attitude of being professionally competent, socially relevant and spiritually alive by sincerely completing the task of even helping a stranger in need.

- Eternal Life is an inheritance of God reserved for those who love him. But we cannot say we love him if we refuse to show mercy to people.
- Our love for one another truly reveals our love for God. To show mercy and be a neighbor to the needy is the act of that love.
- Be a neighbor to anyone in need. Don't divide people as neighbors and non-neighbors based on their race or behavior because God created everyone in his own image.

ii) Healing the paralytic at Capernaum is one of the miracles of Jesus in the Gospels in Matthew (9:1–8), Mark (2:1–12), and Luke (5:17–26). Jesus was living in Capernaum and teaching the people there, and on one occasion the people gathered in such large numbers that

there was no room left inside the house where he was teaching, not even outside the door. Some men came carrying a paralyzed man but could not get inside, so they made an opening in the roof above Jesus and then lowered the man down. When Jesus saw their faith, he said to the paralyzed man, "Son, your sins are forgiven."

"When they could not come near to him for the crowd, they removed the roof where he was" They chop a hole in the roof to lower their friend into Jesus' presence. In the typical house of that day, the roof would be flat, supported by beams laid across the walls, and composed of a mud/thatch mixture. People would sometimes sleep on the roof during hot nights, and the roof would provide a private retreat from a busy household. There would usually be a ladder standing outside to permit access to the roof. Getting a paralyzed man up the ladder would be no small task, and would require courage on the part of the paralyzed man. Chopping a hole in the roof would be a bold means of solving the problem of access to Jesus. Some scholars say that it is easy to repair a mud/thatch roof, but it is difficult to patch any roof so that it doesn't leak. This damage is not trivial. It involves "a major demolition job"

"Jesus, seeing their faith" The faith that Jesus sees is not simply intellectual assent or emotional feeling, but is manifested in determined, visible action. Jesus can read people's hearts, but he doesn't need to do so here. The faith of these men is out in the open for all to see.

Holistic health practitioners are **professionals** who provide **holistic health**-related services and can include counselors, doctors, nurse **practitioners**, nutritionists, therapists and other **healthcare professionals**. The health professionals need to carry emotional intelligence/ quotient (EQ)while performing their role of helping others in effective and efficient way. EQ is the ability to recognize and manage our emotions judicially and empathetically while dealing with others. It is a developed skill to manage interpersonal relationships. Although extremely important, this skill is not taught in schools and not considered as an integral part of education, unfortunately! The accepted notion is that EQ is only important for people pursuing administrative courses. Most of us learn this skill from our experiences during our life time. However, many of us don'tfeel the need to value it and then, when some unusual thing happens, a chaos of reactions ensues! Eventually everyone becomes aware of the importance of empathy and kindness towards others but we are caught totally off guard when it comes to reacting to a crucial or critical situation. Medical professionals are no less susceptible to this kind of reaction. While declaring a serious condition or death of a patient, some doctors just get overwhelmed with the stress and fail at open communication. Similarly, patient's relatives or close ones can have overtly emotional reactions and doctors/ other staff get distracted managing this psychotic or off the head type of behavior of that person. Many times sympathy wins over empathy! And when it comes to health, lending support whether physically, mentally, socially or financially, is jeopardized. So, do we have any solution for this? We can certainly follow the line of action taken by Jesus Christ while helping people in need and his teaching for being concern for others. We can also test our EQ by asking ourselves simple questions. For example, when I hear about any tricky or serious situation about our close ones, do I listen carefully and lend a helping hand or I cry, shout and get angry? Do I keep calm and look for the alternatives or do I get palpitations with anxiety? Do I extend support in any possible form to the actual sufferer or I find excuse to run away from the reality? Rather than showing empathy towards the victim, do I expect sympathy for myself from others? Good thing is comprehensive initiative of being professionally competent, socially relevant and spiritual alertness can be self-learned by mindful observation and keeping calm. We can let the bad news sink in the mind gradually, controlling the anxiety by prayer and meditation. We can get more empathetic, kind and resourceful towards others with self-control. Listening to your own mind and body without causing self-harm is the key!

In today's societal context health is complete physical, mental, social, spiritual, educational and environmental state of wellbeing of a person, family or community as a whole and not just an absence of disease or infirmity. This is respecting and considering holistic dimension of any individual or group for their sustainable development. As professional Christian health worker let us consider to see our goal of reaching eternal life for self and others in our society, understand the obstacles, create a positive mental picture, clear your mind of self-doubt be developing strong EQ, embrace the challenge/difficulties/problems, stay on track to conquer over them and show the world you can do it by following Jesus footsteps with God's blessing.

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ARISE, THOU THE SOLDIER OF THE LORD

Prof. T. Samuel Ravi Kumar

3 You therefore must endure[a] hardship as a good soldier of Jesus Christ.

4 No one engaged in warfare entangles himself with the affairs of *this* life, that he may please him who enlisted him as a soldier.2 Timothy 2:3-4 (New KJV)

It was 3 pm at the Emergency Room, another hour for the nurse to complete her shift. She was assigned in Triage area where one has to prioritize the patients according to the severity of illness and refer them for immediate care or to wait for further management. As the nurse glanced she saw a well-dressed person standing in the queue. The appearance did not give a clue as to the severity of the illness; for a moment the nurse was weary in feeling that this well dressed person who does not appear sick is delaying care for the other patients in the queue.

Meanwhile the nurse's mobile gave a vibrating sound, as she was not to use it on duty, she just silenced it remembering her kid whom she had left in her neighbor's house to be picked up after duty. By this time the well-dressed person in the queue had moved forward and was standing in front of the nurse. She was reluctant to see him first as there were more patients standing in the line. Besides she asked the person about the complaints, the presentation was head ache. With no obvious distress seen in the person she called for the next person to come in as she kept checking the Blood Pressure for this well-dressed man. The nurse was taken a back and asked her colleague to recheck the BP, yes it was confirmed the BP was 190\100. The patient was rushed in for further management to prevent hypertensive crisis.

Have you met such "well dressed person" in your life? With no signs on the outside but working under high pressure within. Have been like the tired nurse with many pressures around her causing "Weariness". We all rise up in the morning praying to do good for others but at the bedtime prayer we kneel with guilt in not having the opportunity to do good.

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Health care Team in a scenario of pandemic is at war. The war is between the Macro and the Microorganism. We at this occasion are called to serve as the soldier of Jesus Christ. The frontline care givers such as the Emergency personnel and many other critical care Zone personnel have to strategize themselves as soldiers in war. Let's look at some salient Biblical guidance in this regard.

1. Well-dressed person

Appearance is deceptive. Go by the system of care and love. Paul in his Epistle to Galatians states "And let us not be weary in well doing: for in due season we shall reap, if we faint not". **(Gal 6:9)** Goodness, being considerate of others, compassion requires perseverance and persisting relationship with our Lord and savior Jesus Christ. We live in a world of weariness, tired of environment, responsibilities, task fulfillment and accountability.

2. Hold fast the profession of our Faith

Let us hold fast the confession of our hope without wavering, for He who promised is faithful. And let us consider one another in order to stir up love and good works, Hebrews 10:23,24

Let us hold fast the profession of our faith **without wavering**; (for he is faithful that promised) And let us consider one another to provoke unto love and to good works.

Hold fast requires **commitment.** You cannot hold fast or be steadfast unless you are strongly convinced in, unless you are in strong relationship. The classic examples of Biblical personalities who were strongly committed and continue to good, in spite of hardships were, Moses, Esther, Nehemiah and so forth. They were considerate of people unknown to them, considerate to the people who even rebelled against them simply because there was a bonding between them and the people through the Love of God almighty. As a soldier our primary responsibility is to serve the commander who has called us to serve and for the purpose he has called us for. In this contemporary world do we have such bondage with Christ in order to love and do good in spite of our weariness?

3. "Without wavering"

Persistence is the positive way of looking at "without wavering". There is a narration concerning Rabbi Akiva (Akiba) on persistence.

Akiba was tending his flock in the hills of Judah. He became thirsty and went to his favorite brook in the hills to take a drink. As he was drawing the crystal clear water in his palm and putting it to his mouth, something caught his eye. He saw drops of water falling on a huge stone – drip, drop – and directly where the drops were falling; there was a deep hole in the stone. Akiba was fascinated. He gazed at the drops, and at the stone. "**What mighty power there is in a drop of water,"** the shepherd thought. "Could my stony heart ever be softened up that way?"

Every simple act that you perform in emergency, not as a ritual but with steadfast love fulfills the will of our Commander.

Philippians 2: 3 – 8 The Humbled and Exalted Christ

At this cross road in contemporary living the challenge presented to us through the word of God is towards

- Same mindset as Christ Jesus
- Humility
- No selfish Ambition
- Each of you to the interests of the others

Be persistent in doing good to your environment, people and to animals as well, such acts of kindness becomes your system of thinking.

4. "Consider one another"

The opening scenario saw a tired nurse, guided by experience in the field saw a life being saved simply because she performed what she was trained for, she performed what the system has directed her to do. Relook at the same from the perspective of our everyday living. A spontaneous response to consider one another is much more powerful than a deliberate effort to reach out to people. We saw in the life of our Lord and Saviour Jesus Christ, simplicity to reach out to people, lived among them, he walked around doing good as it was within him. The call for us today is the same mindset as it was in Christ that of love. Be it anywhere the response has such a call.

The act of consideration and doing good has few approaches

Points to ponder for the Emergency personnel (Tired soldiers)

a. Faith: He who calls you is faithful, who also will do it.1 Thessalonians 5:24

You are not a Vagabond but a pilgrim in his ministry, and you are not alone. If you want to sing do so with this hymn. No never alone, he promised never to leave me alone

Perseverance: Suffer hardship with me, as a good soldier of Christ Jesus.**2 Timothy 2:3**

But you, be strong and do not lose courage, for there is reward for your work."

2 Chronicles 15:7

Fellowship: Bear one another's burdens, and thereby fulfill the law of Christ.

Galatians 6:2

To conclude being considerate with concern is not an option, it is running in life with a purpose in Christ.

Philippians 2:16 Holding forth the word of life; that I may rejoice in the day of Christ, that I have not run in vain, neither laboured in vain.

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"LIFE LESSONS FROM CHAPLAINCY!"

Rev. Alex Peter

There is an old saying, "*Life is so Uncertain*!" But which is more appropriate to say - Life is uncertain or Life situations are so uncertain? I think life situations are very uncertain and in midst of uncertain life situations God's life in us is still certain and must keep on moving forward. On March 3rd when I received Rev. Arul's email to write an article for forthcoming CMJI, everything was so certain. But in last one month our world has changed and we are living in an entirely different life situation.

All of a sudden life has become a ride in a giant roller coaster. All these years of my life in ministry I served as a chaplain – first as a student's chaplain, then as a youth chaplain and now as a Hospital Chaplain. And My friends jokingly say – Surely, I will retire as a Hospice Chaplain. But during all these years in Chaplaincy Ministry, has exposed me to some very uncertain life situations of Human existence and also taught me some very valuable lessons. Here are four of these lessons - small conversations between you and me:

Peaceful Pain:

None of us want to go through pain. But irony of life is – "*Pain will always be there. Its unavoidable.*" So, is it not better to get peaceful with pain? But is it possible? Yes!!!! It's very much possible. Only thing you need to know is the different types of pain.

Pain leading to Joy: This pain is caused by hard work or constant persistence to accomplish something, like an effort taken in exam preparation or labor pain of a mother. When you go through such pain then wait for the rewards and be thankful and enjoy that moment of achievement.

A Pain requiring Change: In our lives there are always some warning signs. When a pain demands change then take it as a warning sign and change. It's all a matter of making different choice.

A pain because of Loss: If you ask what are the most important 3 things in your life than the answer is "*Certain People*", "*Certain Moments*" & "*Certain Opportunities*". And what happens to you when you lose them? It's damn painful. If anything like that happens just remember that, that chapter of your life is over. Find peace in someone else, some other moment or some other opportunity

An Unexplainable Pain: But the most difficult ones are the pain which have no explanations or answers. If you are going through something like that than keep on searching for answers. If you get an answer than well and good. And if you won't, then also keep on searching without any grudge, bitterness or craving. One thing is guaranteed you might not get the answer for your question but you will surely get the answers for some other questions of your life, which you even never thought of. And that is your blessing.

Relationship Goals:

Now a days it's a big trend of setting goals. But it feels really weird when I hear – Relationship Goals – Friendship Goals – Love Goals…… And what types of goals are set? Wearing same colored dresses! Going out every week! ……. List is just endless. But can a relationship be achieved by setting some goals? By pursing such goals, you may get some good pics for Instagram and Facebook, but not a genuine relationship. Relationships cannot be achieved by setting goals, as they are not a task or a chore to be completed or finished. Any genuine relationship is formed only on 3 things:

Love: Love is an "*Intentional Decision*". And as per that decision whether you are happy or annoyed, Successful or failed, Growing or Fallen apart you are going to stick together. Love is growing together and accepting the truth that most of the things we are experiencing & doing in a particular relationship is first time in our life. So be compassionate to each other & be in love.

Trust: Trust has two sides

Accepting someone's trust on you and keep on proving that you still trust worthy even when you fall

Putting your trust on someone being patient and giving someone the chance to carry the burden of your trust. Sometimes it's damn heavy!

Honesty: Honesty is accepting two truths:

Neither me nor you are perfect, but together we can have a perfect life with all imperfections. Only two broken pieces of glass can make a single piece.

God's life is impossible without relationships. When you connect with someone, you are keeping them alive and when someone is connecting with you, they are keeping you alive. Together you and me are "*Ambassadors of God's Life.*"

Anxious Hope:

Have you ever had "*Anxious Hope*"? You might be thinking – "*Now what's that*?" How can be someone anxiously Hopeful? To be true in 99% of our experiences we are hopeful yet anxious. We desire the things to happen yet we are not sure. That is why instead of saying "*Damn Sure*!" we say "*I Hope So*!" Have you ever thought, "Why are you not sure?" Anxious Hope is always derived out of sum of possibilities & probabilities. It's a mere assumption and assumptions can go wrong anytime. The outcome is you are anxious even Hopeful. It's very irritating.

Don't connect your happiness with excitement; instead connect it with peace. If the ultimate aim of involvement in any experience is to get peace then you will end up being happy.

On the other hand, there is "*Sure Hope*". Anxious Hope is an assumption but the Sure Hope is a life Style and it requires 4 things in your day today living:

Finding God's Presence in every experience of your life.

Deriving meaning to stand straight out of every experience.

Getting purpose to move forward from every experience of life.

Being sure that things will happen in your life maybe not in a way you want but surely in the way God wants.

Bottom line is – "*Hope is not looking forward for your desires for your life being fulfilled, instead being completely sure of God's desire for your life being fulfilled.*" So Don't be anxious instead always be Hopeful.

Excited for Excitement:

Have you ever gone through anything like – You were browsing through Facebook and saw someone's pics and suppose they were looking very happy, enjoying every moment of life and you started feeling jealous and started thinking, "See that guy is also happy and I am not!" Have you ever thought why?

It's very true that, the ultimate aim of involvement in any life experience is to be happy. But then also happiness is either elusive or just momentary. Have you ever thought why? If you connect happiness with "Being Excited for Excitement" happiness will always be elusive and momentary. Because you cannot be excited for everything in your life and every experience of your life also not going to give you excitement. So what is the right Mantra?

Don't connect your happiness with excitement; instead connect it with peace. If the ultimate aim of involvement in any experience is to get peace then you will end up being happy. And for that three truths in life must always be followed:

Emotional Processing: There is a weird thing about our negative emotions. They are generated because of the outside people and situations but they cannot be processed by changing or removing those outside people & situations. Instead you have to process them inside yourself. Learn to face and process your damn negative emotions!

Relational Belonging: Our fear of "*Being Lonely*" tells us one truth: "Those who belong to us and those to whom we belong are the very foundation of our existence." Hang on to them for life & don't lose them on any cost!

Soulful Connection: We have only two things which connects us with God – Our Physical Body created by God and our Soul coming from God. And that soul has three promises from our God for our divinely created body:

Fret not – He Loves you!
Faint not – He holds you!
Fear not – He keeps you!

Peace be with you!

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THIS WAS SUPPOSED TO BE THE BIG YEAR, LORD

Dr. Lisa Choudhrie

This was supposed to be the big
year, Lord
2020, a double score
A year never seen
One like never before.
We made our projections
We made our plans
Did some number crunching,
Hmm, even asked for Your hand
Of wisdom and blessing
Insight and overseeing
To give You praise
In all we do
Lift our work
as an offering to You!

But now a quarter
Of this year is nearly o'er
We're wounded, dying
bleeding and oh so sore...
Covid 19 has taken
our world by storm
We're stunned and shaken
In agony and torn.
Lockdown measures
to 'flatten the curve'
Our plans are crushed
lying destroyed in the dirt.

What's the meaning, Lord?
Where do we turn?
Have we made our idols?
You, have we spurned?
Our work, our skills,
our knowledge, our selves?
Have we exalted them
Far above, Yourself?
It seems its time
for us to look deep
Into our hearts
for us to see
That what we've become
Makes You weep.

Our widows, our orphans
Our poor are broken
We've become robots
Bereft of Your compassion.
This time out, realign our beings
Back to you, our Source of living.
That we reflect Your heart of love
Execute justice and mercy from above
That we never forget
that ash to ash, dust to dust
There's no dodging,
Go, this way we must.

THE STORM

Dear Jesus
There's a storm brewing outside
Wind blowing, claps of thunder, grey clouds hanging low
Ominous..
And the wheat golden and ripe in the field?
All loss for the farmer? Again?

How can you sleep?
Don't you care if they drown?

There's a storm in the world today, Jesus
A tidal wave of craziness
Masked folks everywhere
Isolation, quarantine, triaging, lonely deaths
A pandemic like we've never seen before

How can you sleep?
Don't you care if we drown?

There's a storm in my heart today
Clouds of heaviness, winds of fear
It's so close to me now, Lord
My friends and my family
Not anonymous care givers anymore..
Some on the frontlines, some potential patients…

How can you sleep?
Don't you care if we drown?

But You care
You hear, You see, You love
You're in the storm with us

Lord, touch us with Your scarred hands
Hands that bring healing
Give us Your peace
Take over the wreckage and loss
And breathe new life into us
You are our hope
You are our peace.

Masks

They said, 'one layer is enough for now..'
Save the three layered masks,
for when the tsunami hits us..

What about masks for the ones who really need them?
Masks for the multitudes trudging wearily on their way home
Bereft of dignity, money, basic necessities...
Homeward bound for hours and miles- the end never in sight..

What about masks for the ones who really need them?
The mothers in labour, the ones in pain
The cancer patients breathing their last
one layer or three layered- who cares?

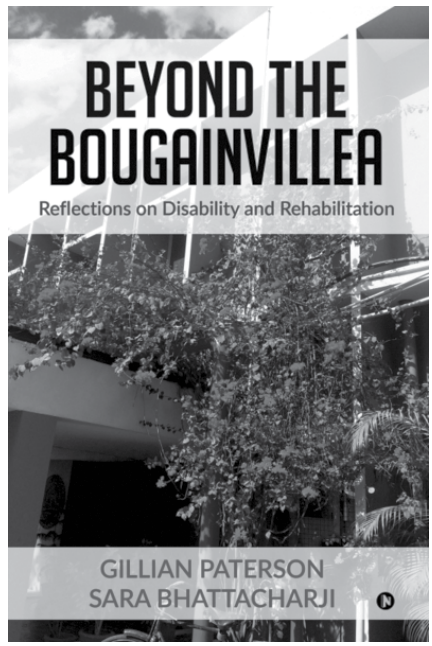
What about masks for the treating team?
A mask a -million layers thick
'Don't just protect me, dear God
Protect my loved ones too...
My little children innocent and sweet
My parents with so much life ahead of them to live...'

Dear Jesus,
Can I unburden myself at Your feet?
Get rid of my masks
Just be free to be me..?
You don't need PPE- you reassure
You've taken them all
My grief, hurts, pain,

So I drop them
here and now
Facades covering up cracks
Make up hiding scars

And I find rest for my weary soul
Comfort for my wounded spirit
In you and in you alone

TRANSFORMING THE LIVES OF THE DISABLED



Gillian Paterson and Sara Bhattacharji
Notion Press, Chennai, 2020
103pp. Rs 500.

This slim book says much more than it seemed to promise.

The story of 'Rehab' needed to be written. 'Rehab', for those who know, is the Rehabilitation Institute of Christian Medical College, Vellore. It is a multi-disciplinary centre, started in 1966, for the long-term care of disabled persons, once they are over the acute phase of their illness or injury. The mainstays of treatment are counselling, occupational therapy, and physiotherapy. 'Rehab' was the first institute in India for the holistic care of the disabled.

But there's much more to 'Rehab'. The authors narrate the stories of several patients whose lives have been transformed. There is Anna, a mother of four, recovering from a stroke, Meena a two-year old girl with polio, Saleem, paralysed from the waist down after a motorbike accident and many more (real names have not been used).

After being healed, some have found work or become entrepreneurs. Though paralysed, Edward set up an online mobile business with a small grant and tops up mobile phones. Kumaresan is a nationally known athlete and is internationally ranked in shot put and discus. Patients who have left 'Rehab' to continue their lives stay in touch with the Institute. One such occasion is the 'Rehab Mela', an annual three-day event of games, food and festivities. Accommodation, makeshift kitchens and a pandal are arranged by the Institute. The floor of the pandal is a thick bed of sand covered with colourful plastic sheets. In the evenings there are cultural performances, debates, literary competitions. Friendships are made and renewed, and confidence is boosted.

'Rehab' is not an ivory tower. It has an active community-based rehabilitation program (CBR), started in 2002. A team of volunteers trained in their communities, carry out surveys, refer patients, follow-up with home-based care, and support and educate families with a disabled person.

There is much more in this inspiring book. It is interspersed with Bible verses and motivational quotes. Here is one of them that I found to be deep with meaning:

"I thought that my voyage had come to its end at the last limit of my power, that the path before me was closed, that provisions were exhausted, and the time come to take shelter in silent obscurity. But I find that thy will knows no end in me. And when old words die out on the tongue, new melodies break forth from the heart, and where old tracks are lost, new country is revealed with its wonders." Rabindranath Tagore, Gitanjali 37.

Glenn C Kharkongor