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LETTERS TO THE EDITOR

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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- The decision of the Editor is final and binding.

LETTERS

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

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- Contributors are requested to send articles that are complete in every respect, including references, as this facilitates quicker processing.
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EDITORIAL

RENEW AND RESTORE

Every day is a blessing from God. This is true both for the providers and the receivers of the healing ministry of Christ. We come to realise this so acutely during this 'post-pandemic' era. As a community of healing we thank God for all the protection and grace that sustains us as individuals and as institutions. As Christian Medical Association of India, we appreciate all the committed service our member institutions and the members are providing during this time for those who suffer both physically and emotionally. It is our prayer that God will use us further so that everyone will experience the abundant life which Christ has promised.

It is a constant struggle for many of us to keep our calling and the current scenario side by side. There are so many challenges for us as Christian ministers. However, we inspire one another through the ministry of the Holy Spirit to press on. Listening to others' experiences and insights will help us in this journey. This experience will renew and restore us for the healing ministry. Therefore, we are so glad to bring this issue for the reading of our members.

The current issue of CMJI carries articles of great importance for the ministers of healing ministry. Dr. Nitin Joseph writes about the need and importance of "Pressing towards the goal". Rev. Dr. Daniel Premkumar highlights the meaning of "Love thy neighbour in the raging pandemic". "Tele-health for the rural poor" by Dr.Vijay Anand Ismavel will give a timely needed perspective for our healing ministry. Our interview with Dr. Joy Mammen, Dr. Balu Krishna Sasidharan and Dr. Henry Prakash gives a practical glimpse of our way forward. The writings from the yesteryears: Rev. Hooper's 'Workers together with God' and Bishop R. D. Joshi's 'Dynamics, dimensions & relevance of Christian medical work in the seventies' will give great inspiration for us to do our ministry meaningfully. We thank God for the contributors for their time, insight and their willingness to share. We are also grateful for the committed efforts of Mr.Christoper and Ms. Lata to facilitate the publication of the issue now. We pray that this issue will be a blessing to every reader.

Rev. Arul Dhas T.

Rev Dr Arul Dhas T
Editor

PRESSING TOWARDS THE GOAL

Dr. Nitin Joseph

A goal may be defined as something that we want to achieve. If we do not have a goal, we will not have a direction in life. However, if we plan goals without careful consideration it may lead to undue stress and frustration.

Well Begun is Half Done

If a goal is the ultimate objective, then the vision or revelation is the starting block on which every runner places his feet, at the commencement of a race. If an athlete is unable to get that first thrust, chances of winning the race are bleak.

When Paul encountered Jesus on the Damascus Road, his life was transformed. He recounts in Gal 1:13-16 that though he had lived all his life as a proud Pharisee, he was given a revelation, a vision, to be '*the apostle to the Gentiles*'.

A divine revelation or vision is the key for working towards a successful enterprise. It gives us focus and direction for all our ensuing actions. It helps us to realise our strengths and opportunities. It also gives us clarity about our limitations and shortcomings. If a vision is carefully drafted and internalised by us and our co-workers, it can give meaning and purpose to our work. It is also a good practice to revisit the vision statement periodically and modify or refine it, if required. If we have no vision, we can be compared to trying to catch a black cat in a dark room where every little sound can make us dive in different directions and ultimately tire and give up.

If we have no vision, we can be compared to trying to catch a black cat in a dark room where every little sound can make us dive in different directions and ultimately tire and give up.

Paul had many difficulties in his quest for proclaiming the Gospel to the Gentiles, but he could endure all these problems because he had a clear vision. At the very end of his life, he could boldly say, I have fought the good fight, I have finished the race, I have kept the faith (2 Tim 4:7

S-M-A-R-T Goals

Goals have to be carefully and prayerfully developed in order for us to remain motivated and challenged, instead of getting frustrated and giving up midway. When Jesus started His earthly ministry, He internalised Isaiah 61:1, 2 as His mission, and we know it as the 'Nazareth Manifesto'- to preach the Gospel to the poor, to heal the broken hearted, to proclaim liberty to the captives, to open the eyes of the blind, to set at liberty those who are oppressed and to proclaim the acceptable year of the Lord. He could complete all this in three years and shout '*Tetelestai*' – It is finished – just before He died.

Goal setting involves a well thought out action plan which is formulated to motivate and guide a person or a group towards the desired objectives. Goals may be called the '*North Star*' that gives us the proper direction. A common acronym that is used to help us set goals for ourselves or for an organisation is SMART. Goals have to be Specific (well defined, clear and unambiguous), Measurable (have fixed criteria to measure their progress), Attainable (an achievable possibility), Realistic (Real and relevant to the times) and Tangible (objective and discernible within a set timeline). If our every goal is SMART, then working towards them becomes very exciting and interesting. Goals that are vague, subjective, impossible, irrelevant and without a set timeline can lead to stress and non-compliance. It's like attempting to perfect Handel's *Messiah* within a week!

Goals, if set well, make our lives and the lives of our organisation more enriching and rewarding. They serve as lighthouses to keep us on course and reach our destination in the optimal time frame.

Backward Goal Setting

Backward goal setting is a useful process in planning to reach our goal, where we start with the ultimate objective and then work backwards to develop a plan. This not only

assists us in defining our steps, but also enables us to constantly keep our focus on our goal.

In Gen 12, we read that Abram's response to God's command was almost immediate. He went in search of the Promised Land by faith. That was his ultimate goal. He built altars at Shechem, Bethel and Hebron probably thinking that he had reached the Promised Land, but continued as a sojourner all his life. Abraham was even ready to sacrifice his son Isaac at Mount Moriah, trusting God to raise him from the dead, since Isaac was his son of promise. He could do all this because he knew his ultimate destination was Canaan and so no setbacks shook his faith and confidence.

It is a good practice to keep our focus on the goals that we have prayerfully set and then plan backwards. By starting at the end, we can prepare ourselves to face anticipated challenges. We can also set milestones and evaluate our progress periodically to ascertain that we are on track. If we do that, we will not be distracted by doubts and worries and though there may be times of discouragement and setbacks, we can be sure that these are just temporary and that God will carry us through.

Stepping Stones

The goals that we set are of different types in terms of their timeline. When we decide on a goal, we must break it up into smaller components so as to ultimately fulfil the main goal. If I were to travel along the Mumbai-Bengaluru highway, the milestones will first indicate the distance to Pune, then to Kolhapur, then to Belagavi and then finally to Bengaluru.

The final words of Jesus before He ascended to Heaven were that His disciples were to be His witnesses. He wanted this bunch of 11 ordinary but empowered men to spread the Gospel to every corner of the world. But He knew that this task was difficult and so He broke it up into Jerusalem (community), Judea (society), Samaria (foreign lands) and then finally to the entire world. The disciples earnestly followed this plan and today the message of the Gospel has indeed spread to the uttermost parts of the earth.

The initial small steps that we take can be termed as *stepping stones*. Though these may seem unimportant and insignificant, they give us the impetus to go on. To reach our long-term goal, we must break it down into

several short-term goals that are time bound. As we achieve our short-term goals, it increases our confidence and gives us the needed boost to persevere towards our long-term goal which wouldn't seem so distant as before.

In the process, we must also remember the over arching life goals that define our character and purpose. As leaders, we are evaluated by such values and principles.

Press on

Goal setting is the process of deciding what you want to achieve over a particular period of time. While serving as cupbearer to king Artaxerexes in a heathen nation, Nehemiah was informed by Hanani, a Jew, about the miserable condition of the wall of Jerusalem. This greatly anguished Nehemiah, and after many days of prayer and fasting, he sought the king's permission to go and repair the wall. That, to him, was a God given goal. He prayerfully and meticulously planned the process to rebuild the wall, taking the help of the available people and resources, and, in spite of a lot of opposition and danger, was able to complete the job in just 52 days.

We may try to fulfil our ideas by using our own intellect and human effort and this is doomed to failure. But, if we spend time in fervent prayer asking for God's divine intervention, then He will direct us to the right people and lead us to take the right actions and this will certainly give us success.

A life without a goal is like a ship without a rudder. It goes across the sea without any purpose and direction. Its course depends on the wind and the waves that toss it in different directions, and very soon the sea consumes it and it is drowned. When God gives us a goal, He also provides His favour, the resources and the wisdom to realise it. We have to be attentive to His still small voice and as Paul said, *press toward the goal for the prize of the upward call of God in Christ Jesus (*Philpp. 3:14)

Risk Taking

Sometimes to achieve a goal we have to be prepared to take risks. These risks don't have to be irrational and foolhardy but can be well intended and increase our faith and dependence on God. As John Haggai quotes, '*Attempt something so great for God that it's doomed to failure, unless God is in it*.'

The life of queen Esther is so inspiring because she was willing to put her neck on the line in order to save her people. Taken into the palace of a heathen king, she was initially hesitant to intercede for the Jews who were going to be eliminated. However, she was prodded by her cousin Mordecai and she finally risked her own life for her fellowmen.

In a secular and pluralistic society, it is comfortable to '*go with the flow*' and be safe. We can set simplistic and safe goals for ourselves. We may be guilty of not using all our spiritual gifts. But we must be ready to take risks after conducting due diligence and weighing the pros and cons. We can pray about it, consult with people who we can trust, identify the possible pitfalls, strategise effectively and go ahead. Sure,

there will be hiccups and criticisms, but as someone rightly said, '*The one who was never criticised was the one who never did anything*.'

When Goals Elude Us

Many a times in our lives, we may experience failure or may find a particular goal elusive. It is natural that this may cause us pain and hurt. We can handle this situation in two ways. We can either get bogged down which will bring us more discouragement. Or we can evaluate and find out where we went wrong.

Joshua started his ministry with the great promise that God would be with him at all times and that the Promised Land was theirs for the taking, if they obeyed Him. The miraculous crossing of the Jordan and the victory at Jericho further strengthened their faith. However, the shocking defeat at a small place called Ai made Joshua plead with and question God. He soon discovered that sin in his camp had caused the debacle. Joshua dealt with this sin decisively and then they could easily capture Ai the second time.

All of us have faced failure in our lives. Failure in examinations, at the work place, in our families, in our ministry, and so on. We all fail and, as someone said, we cannot fully comprehend the sweetness of success without failure. What is our response to failure and when goals seem to elude us? We should not allow negativity to set in because it leads to self-pity, hating others, blaming our situations and destroying relationships. All this leads to troubling ourselves which adversely affects our health and peace. Instead, it would help if we introspect and try to find out the reasons for our failure. And then, we will also see the possible ways by which we can overcome our mistakes and take corrective steps that will eventually lead to success.

Dr.Nitin T. Joseph is the Director/CEO of the Rural Gospel Medical Missions of India, Nashik, Maharashtra & Chair, Doctor's Section, CMAI.

LOVE THY NEIGHBOUR IN THE RAGING PANDEMIC? YOU MUST BE JOKING!

." The scribe said to Jesus, "Right, Teacher; You have truly stated that HE IS ONE, AND THERE IS NO ONE ELSE BESIDES HIM; AND TO LOVE HIM WITH ALL THE HEART AND WITH ALL THE UNDERSTANDING AND WITH ALL THE STRENGTH, AND TO LOVE ONE'S NEIGHBOR AS HIMSELF, is much more than all burnt offerings and sacrifices." When Jesus saw that he had answered intelligently, He said to him, "You are not far from the kingdom of God." Mark 12. 32-34

Rev. Dr. R. Daniel Premkumar

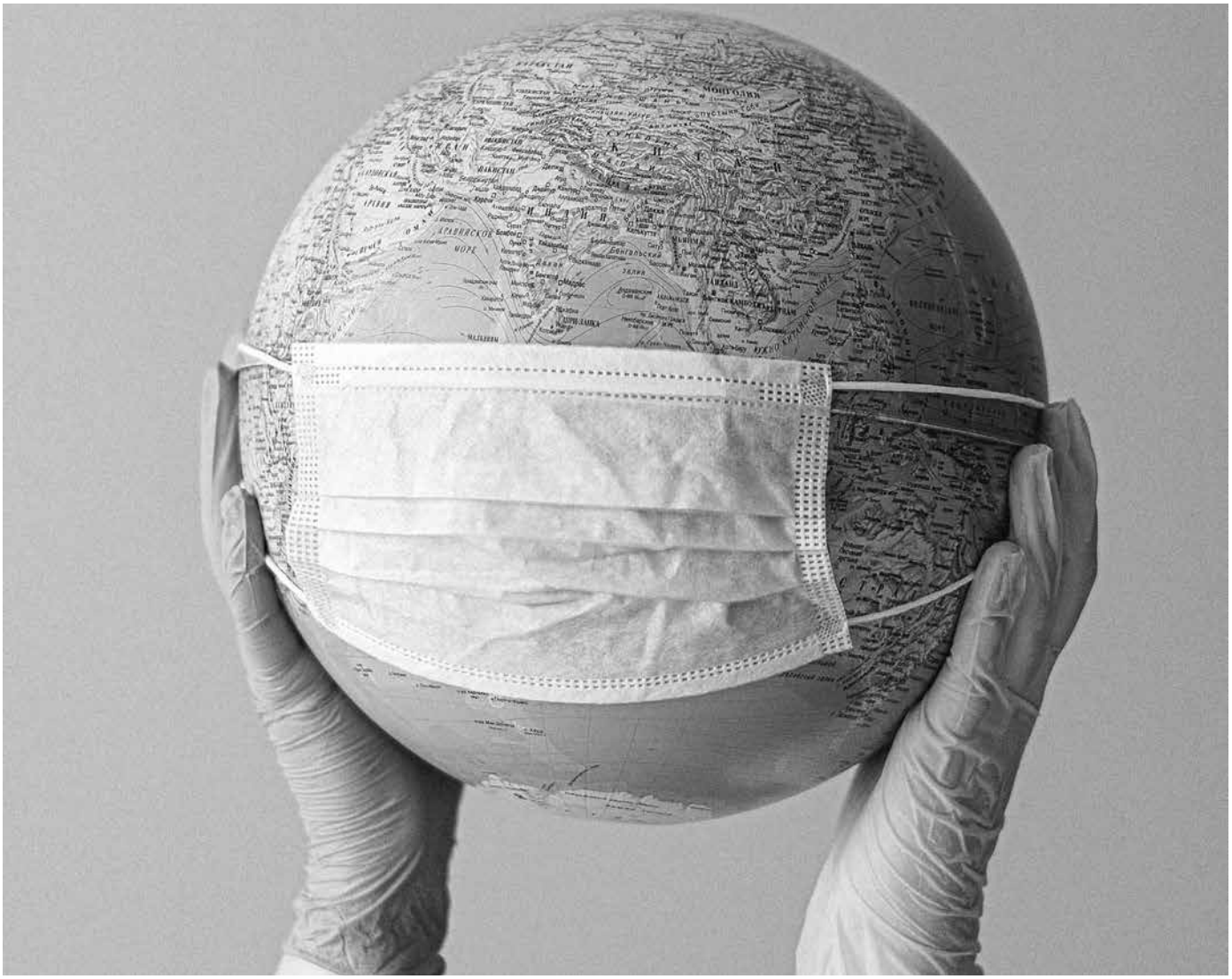
Introduction:

As the vicious Corona Pandemic spread her deadly tentacles across a billion people in India and the number of the dead started rising and even higher in the Second Wave into hundreds of thousands until we really lost the count. In India we are good at many things but not with numbers. Unfortunately, we are yet to count our dead, as some studies state that the dead due to the Corona Pandemic may run into many times more than what is acknowledged by the establishment. Even so, flood gates of human compassion and personal sacrifice irrespective of religious strands and communities began to gate-crash in unlikely places and quarters. There are stories of auto rickshaw driver who sold his wife's wedding jewelry to convert his three-wheeler- auto into a free ambulance for the Covid sick and the dying as well. Sikh religious houses called Gurudwars not only served a million meals a day for the affected and the impoverished because of pandemic stricken the devoted Sikhs also served free oxygen for the needy. Similarly, the church in different pockets did extend a Samaritan's hand. With such millennial human catastrophe engulfing the wide human family, with no respite in sight we need to enable the church at large in India and elsewhere as an organic body of the Risen Lord to respond to this Pandemic in a befitting and able manner by anchoring her acts of compassion and care basically as a faith response and with greater perception of Jesus' mandate- 'love God and love neighbor as yourself and as the Scribe in the above text added– 'It is much more than all burnt offerings and sacrifices',

What is more precious than Burnt Offerings and Sacrifices?

Mark states that it was a Scribe who asked Jesus the question-*"What commandment in the Torah is foremost of all?"* Scribes surely were the official religious establishment of the day. Religion is surely can become the opium of the people. People who are religious in any given persuasion tend to settle in their comfort zone in temples, churches and mosques and in their traditions. But Jesus re-interprets the traditional ***Shema*** *(Deut. 6, Hear O Israel, the Lord your God is On , you shall love him with all your heart etc.)* with Leviticus injunction (Lev 19.18- *You shall love your neighbor as yourself)*. At the end of this memorable conversation Jesus appreciates the Scribe's response and honors him with this divine compliment- *'you are not far from the kingdom of God',* Jesus who normally held a very critical opinion about these teachers of the Torah and the Pharisees (Mt. 3.7,12.34,23.33; Lk 3.7) and called them as brood of vipers and whitewashed tombs) of his day but, had greatest admiration for this Teacher of the Law.

Today Christian religion has turned heaven ward expecting the Return of the Lord and awaiting the End Times. So, who bothers about loving the neighbor or the climate change or the abuse of the created Planet Earth? There is an Evangelical Sect in the US who desire expending the fossil fuels and earthly resources quickly so that Jesus would return soon to meet these faithful in the mid-air to rule with him in heavenly places. If so, why bother about t either the Pandemic or the rise of sea levels or be concerned about everybody including the



poorest of the poor getting vaccinated across the globe against the Pandemic.

What more, imagine the virus infection making the person unclean and need to be quarantined. Surely, the medical fraternity has prescribed Covid appropriate behavior in dealing with the Pandemic. But still, one could find ways to comfort and care for the Infected! I am reminded of how the general public used to treat HIV Infected persons 20-30 years ago or that matter even Covid infected today!

Magic Word is Love that Binds Even Almighty God with the Neighbor

We have always known that there are many kinds of love in the NT and *agapaō* refers to 'the love of God' while *phileō* refers to 'brotherly love. But, surprise of surprise the Christian Scriptures never commanded to 'love' with the word *phileō*. Even when husbands and wives are instructed to love one another, the word *agapaō* is used, for it is impossible to command that kind of love which can arise only from intimate association. It may come as a surprise to many that the love with which we are called to love God (Agapao) is the same kind of love with which we need to love (agapao) our neighbor and the Corona Virus Infected. In NT love (agapao) and faith (pistis) are closely associated (*See Gal 2:20; Eph 6:23,24; 1 Thes 1:3,4; 2 Thes 2:13; Js 2:5; 1 Pet 1:8,9,21,22.).* Consequently, we begin to learn that followers of Jesus see essentially loving God and loving neighbor as a faith response!

Agapáō is to act for a neighbor's highest good which is always and only defined and revealed by the Lord. The God-centered and directed nature of true (agapáō) is illustrated for example in the two greatest commandments. (Mk 12:30,31) we just discussed.

Our Text says- and you shall love (agapáō) the lord your god with all your heart, and with all your soul, and with all your mind, and with all your strength.' The second is like unto this, 'you shall love (agapáō) your neighbor as

Meeting human needs is important, but this can only really happen by sharing God's love. Genuine love is always God-inspired and God-empowered. The Lord must inspire an action and empower it for it to qualify as genuine love.

yourself.' There is no other commandment greater than these".

In sum, agapáō for the believer is living out the preferred-will of God. Accordingly, to love (agapaō, agapē) is directly connected to preferring "God's preferred-will" (See: 2 Cor 8:5-8; Eph 1:4,5) .

The "holy triad" – "faith, hope and love" in 1 Cor 13:13. Love is the greatest because (by definition) it includes faith and hope. Agapáō ("to love, prefer") in its biblical sense means to prefer what the Lord prefers, so (agapáō) originates with God and is empowered by Him (1 Jn 4:7,10,19). It means actively partnering with the Risen Christ (Rev 1:5, 3:9).

That is why in the NT the agapaō occurs over 250 times compared with philéō) which only occurs 38 times.

No wonder then, that Jesus concludes that on 'these two commandments depend (hang) the whole Law and the Prophets' (Mat 22.40). The word hang or depend is so critical and picturesque that the same word is used for hanging a millstone around the neck (Mt 22.40) or for the hanging of criminals hung on the cross (lk. 23.39).

Meeting human needs is important, but this can only really happen by sharing God's love. Genuine love is always God-inspired and God-empowered. The Lord must inspire an action and empower it for it to qualify as genuine love.

Let us note the important ordering (relating to love) in the two great commandments: we are to love God first – before people (Mk 12:30,31). Agapaō ("to love") and agápē ("love") act out God's preferences. ("love") is never neighbor-defined nor self-defined. Rather, love (in the biblical sense) is always God-defined. Biblical (real) love begins with the revelation of God's preference (faith) – and shown in action as Christ lives His live through ours.

Finally, Jesus commends the Scribe as having great understanding (sunymi), (Mk 12.33). The (understanding) is a union or bringing together of the mind with an object'. In modern parlance this refers to praxis.

Some Concluding Overtures

- Covid appropriate behavior and precautions prescribed by the WHO and the local medical fraternity have to be followed by all care givers of any religious or secular persuasion.
- For a Christian believer caring for the Covid sick is not merely an act of charity but as intense as loving God and aspiring God's utmost good and preference for the neighbor.
- As Covid infected and affected are in greatest need today, many digital churches cannot continue their sanitized worship without the other dimension of Christian worship is the care of the Covid affected.
- For a follower of Jesus caring for the Covid affected is basically a faith response.
- Caring for the neighbor who is Covid affected is a serious business as serious as offering 'all burnt offerings and sacrifices',
- As a believer in God of the Bible who raised Jesus from the grave, may the Christian Care Givers around the world become the Front Runners and Champions in instilling hope and love in a devastatingly hopeless context as well!

(Note: The above Biblical Reflection on Church's Response to the Covid-19 is written for the Global Ministries of UCC, Cleveland, USA.)

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TELE -HEALTH FOR THE RURAL POOR

Dr. Vijay Anand Ismavel

With India spending so little of its Gross Domestic Product (GDP) on healthcare, medical expenditure in the form of "Out of Pocket" (OOP) expenditure drains household savings, with a single major healthcare incident being the commonest cause of catastrophic expenditure leading to destitution. The rural poor are handicapped by non-availability of affordable quality healthcare within reasonable geographical limits. This combined with poverty, leads to delay and denial of access to appropriate healthcare and to preventable morbidity and mortality, which is unacceptable, especially when it occurs in the prime of youth.

Many of our mission hospitals exist in geographical areas where they have high potential for transformational impact because the rural poor are their target communities. Hospitals can provide high quality affordable healthcare on a sustainable basis even if they are focused on the poor and do not rely on external financial support by lowering in-hospital costs. (1,2). Several innovations have been made by our hospitals to make this a reality. However, out of hospital expenses continue to remain high – this involves the avoidable expenditure of travel and loss of wages to attend hospitals. Often, a patient from a distant village who attends a hospital for treatment of a chronic medical condition like diabetes or hypertension spends more on his travel and loss of wage than on the actual review and refill prescription.

Often, a patient from a distant village who attends a hospital for treatment of a chronic medical condition like diabetes or hypertension spends more on his travel and loss of wage than on the actual review and refill prescription.

In the current Covid situation, this scenario is exacerbated. Lockdowns, hospitals being converted to Covid care centers and fear of being infected lead people to avoid hospital visits with non-compliance causing preventable complications. Patients who have had emergency surgery or deliveries or medical admissions also hesitate to report to hospital for reviews.

Electronic health, or Tele-Health initiatives appear to be an attractive solution. The Government of India has released a number of draft and final documents from 2013 on these initiatives, including the Electronic Medical Records guidelines, the National Health Stack and the National Digital Health Blueprint. (3,4,5) Some of these relate to medical records, their interoperability so that they can be transmitted and read across different platforms by different stakeholders. Others relate to safety and confidentiality standards for patients, recommendations for digital health cards and a 5-year plan for roll-out.

The advantages of tele-health are many. If a patient's paperless health records are online and can be instantly and securely accessed by the patient or his/her trusted healthcare professionals, there is no need to carry documents during visits. Healthcare visits can take place remotely when physical examination and diagnostic or therapeutic procedures are not required. Electronic prescriptions can be generated and filled by local pharmacies with cashless transactions. All this can be done securely from the comfort of home. When a new hospital is visited, longitudinal health records are updated and the patient's updated reports and treatment are available online.

Several challenges appear before us when we consider this promising scenario. The patient must give consent to his/her records (which may contain private or stigmatizing information) to be read by trusted professionals. The healthcare workers accessing the records should be able to confirm the identity of the patient securely and confidently treat the patient without having to examine or administer tests. The data should be secure, it should not be accessible to employers, insurance companies or

rogue elements who can use it to profile individuals or malign their reputations. Some level of basic infrastructure should be available in a reliable realistic manner close to home to produce the least disruption to a patient.

An ideal situation could be one where a patient logs into a hospital's website or App, registers himself/herself on a smartphone or tablet using biometric ID (fingerprint or face ID), locates a department of his/her interest and adds one or more doctors as 'trusted'. He/she is then provided a detailed online consent form which is read and accepted. If previous healthcare records are already available online, these are now accessible to the doctors selected. An appointment is booked, the patient appears online through a tele-conference, answers questions and if the only requirement is for drugs to be refilled for a chronic medical condition, the doctor issues an electronic prescription. If tests are required, they can be done through the hospital's local franchisee or any approved laboratory or imaging center and if a hospital visit is required, this can also be booked with a firm appointment fixed. Once an electronic prescription is generated, online payment is done and the hospital's pharmacy franchisee brings the drugs to the patient's home at a convenient time, confirms the ID using a QR code on the patient's smart device and delivers the drugs with instructions on how they should be administered. Legally, there are qualification requirements for the person who prescribes and dispenses medication. If all this can happen seamlessly, most of the issues of privacy, confidentiality, security, reproducibility, audit and quality will be met. Costs of travel and potential loss of wages are avoided. All service providing entities – the hospital and its staff, pharmacies, diagnostic labs and imaging centers as well as the software hosting companies get a share of the profits.

The government guidelines mentioned above require standards to be followed for laboratory testing, drugs, disease nomenclature and data sequence. These require compliant machines (especially in laboratories), expensive software and the manpower to install and run the entire system. This idealistic situation is easy to imagine in a major Indian city with one of the large corporate hospital chains and their franchises, involving middle class or rich patients. Their already comfortable lives have just become more convenient and healthcare costs lower.

When we consider the rural poor in the neediest parts of the country, we are immediately struck by major limitations

to this solution. Internet services, smartphone penetration and even electricity itself is not easily available. Hospitals do not have an IT network with overworked staff still managing all documentation using paper records. It is difficult for illiterate patients to understand the nuances of online consent, they will probably give consent without understanding what it involves, because they cannot proceed with the registration without giving consent. In the absence of smart devices, confirming identity is not going to be easy.

India has progressed in leaps and bounds in technology. Cell phones are available across the country and internet costs are among the lowest in the world. Electricity will soon reach all the corners of the country. However, healthcare provision will continue to vary immensely between states, the southern states which have lead the way will be far ahead of those in central, north and northeast India where most of the country's poor rural people live. With rapid progress, the idealistic solution envisaged should become reality in time, already Aadhar cards and Ayushman Bharat services are available everywhere but the full potential will take time for our target population, the rural poor for some more years – they are always last in the queue.

When we consider the rural poor in the neediest parts of the country, we are immediately struck by major limitations to this solution. Internet services, smartphone penetration and even electricity itself is not easily available.

What we need is to avoid unnecessary travel. Can this be done realistically in the current scenario, before the idealistic solutions become available? If we can enlist the services of local pharmacies and doctors (many pharmacies have a local doctor attached in rural areas), train them in ethical healthcare (using material like the PGDFM course run by CMC Vellore) and refer patients to these tested healthcare providers many problems are resolved.:

The patient attends a large hospital, gets investigations done and diagnosis established and a treatment plan is made. If this is for a chronic medical condition requiring lifelong review and medication, a plan using drugs that the patient can take within his/her budget is made and entered into a patient held health record.

The patient is then referred for follow-up to a hospital-approved doctor in his/her neighborhood who will provide all the follow-up care. When further investigations are required, they can be done locally or if major interventions are required, the patient can be referred back to the large hospital. Drugs are dispensed by a certified hospital approved local pharmacy.

This ensures that the patient is seen by a doctor who is qualified to examine and prescribe drugs according to the treatment plan and the drugs are delivered by a registered approved pharmacist. The patient saves a lot of expense and inconvenience (not to mention risks in this Covid situation), the large hospital avoids being crowded with patients who have come simply for refill prescriptions and instead gets larger volumes of high value patients who now come for interventions and the small village doctor / pharmacy gets their share of income.

The greatest benefit in this suggestion is that we now include the village doctor into our network. These are the people to whom most of our target population go on a regular basis and winning them over to the cause of ethical medical practice will lead to transformation of healthcare in remote rural areas. It will not be an easy task as it will require engagement to earn their trust but since the large hospital has a good brand name, they are likely to accept the conditions for being empaneled with a large institution that is popular and trustworthy in the eyes of our target people.

This could be the best way to reduce non-hospital expenditure related to healthcare for the rural poor at this time. In a few more years, the benefits of tele-health would have percolated to rural grassroots but till then, this will keep them going. When the full tele-health setup becomes realistic, there will already be a well-trained network in place on the ground to make best use of it.

Dr Vijay Anand Ismavel is a Surgeon at Makunda Christian Hospital, Assam

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A NOT-FOR-PROFIT TELE-HEALTH REPOSITORY

Anuvinda Varkey

Covid19 has been a harbinger for healthcare to be front and centre for government and policy makers across the world. The call for Universal Health Coverage became even more important. One of the policy decisions taken was to notify guidelines for the practice of Tele-medicine. On the 12th of May 2020, the Board of Governors in supersession of the Medical Council of India published a notification, which effectively makes telemedicine permissible by a registered medical practitioner. The new regulation is called the "Indian Medical Council (Professional Conduct, Etiquette and Ethics (Amendment) Regulations, 2020. The guidelines were set up to counter the Covid19 restrictions. The guidelines are meant for Registered Medical Practitioners (RMP), it provides the norms and standards that a RMP is guided by, and it states that telemedicine covers all modes of communication that can leverage telemedicine platforms including, voice, audio, text and digital exchange.

The Christian Coalition for Health (CCH), while preparing its Strategic Direction Plan, brought together representatives of its members, CMAI, CHAI, EHA, CMC Ludhiana and Vellore, to form a Technical Advisory Committee (TAC) on Tele-Health (TH). This TAC-TH came together to identify issues that would enable healthcare to be accessible to remote rural areas and in semi-urban areas. They have come together to formulate a strategy to engage with policy makers and inform them as to how through the medium of tele-medicine, healthcare could optimally reach rural areas and marginalised people of this country.

To engage with policy makers the TAC-TH felt strongly that we need to demonstrate that we possess an adequate number of healthcare institutions practising tele-health. To this end the TAC-TH has advised the setting up of a Tele-Health Repository for Not-for-Profit organisations. The aim of the Tele-health Repository will be to

They have come together to formulate a strategy to engage with policy makers and inform them as to how through the medium of tele-medicine, healthcare could optimally reach rural areas and marginalised people of this country.

1. Documenting the variety of Tele-health practices in the CCH network to begin with and then offer it to other not-for-profit healthcare institutions.
2. Formulate appropriate standards for the practice of tele-health that will not only comply to the requirements of the legal system but to also uphold the privacy rights of patients and to formulate appropriate practises to protect doctors practising tele-health.
3. Collect evidence-based data to enable CCH to engage with government to make sure healthcare is accessible, affordable and compassionate.
4. Provide expertise to formulate tele-health policies for healthcare institutions appropriate for them.
5. Provide the required training for doctors as part of the government requirement.

It is important to note that the TAC-TH has provided other innovative interventions for CCH to take forward as part of its Strategic Direction Plan. The Tele-health Repository would be an important aspect of the plan going forward.

https://www.mohfw.gov.in/pdf/Telemedicine.pdf

Anuvinda Varkey
Executive Director
Christian Coalition for Health

LESSONS, POLICIES, PLANS, CHALLENGES WITH TELEHEALTH

DR. JOY MAMMAN, DR. BALU KRISHNA SASIDHARAN, DR. HENRY PRAKASH

FROM CMC VELLORE, IN A VIRTUAL INTERVIEW SPOKE WITH CHRISTOPHER N. PETER FROM CMJI EDITORIAL TEAM

Dr Henry:

I personally have worked with Physical Medicine and Rehabilitation Department and did expect lot of tele consultancy enquiries. However, to be very frank I think people are much happier to meet their doctors personally. So a few came, many did not, some of them actually made their way to the hospital even though it was difficult for them to reach because they wanted to the medical teams. But then again, other doctors had varied experiences and probably a person like Balu who is also being following up lot of patients on tele consultancy got better response.

Dr Balu:

So from the telemedicine perspective Henry has mentioned how things have happened and evolved at CMC Vellore. Though it was started as a pandemic response we learnt and then developed the programme as went along. Now it has become a standard service that is offered by most of the clinics. During April 2020 to end of March 2021, we were able to conduct 21,381 teleconsultations, because there was total lack of access to care for patients and it was a necessity to connect to us. During the second wave, the total consultation dipped to 7,960 (April - June) and that is because second wave was patchy and because physical connectivity was active. Some people would still come to meet the doctor in person. In teleconsultation mostly chronic disease patients approached are like rheumatology is one of the top performing department who had done 6,229 consultations.

In CMC, we have total 137 clinics which are offering teleconsultations. Around 494 doctors' services are available as our tele consultation. As Dr Henry told earlier it is a very simple programme. The essence of the programme was to emulate how a patient is seen in person in clinic the same workflow was duplicated for a remote consultation. So, I think that was one of the success of the software also because the learning curve was very small in that case. But even with that we have had multiple sessions training each and every doctor to introduce them to the software as well as to the laws governing tele medicine in India which came out in March 2020 the telehealth policy. Also, we developed etiquette for video conferencing for our doctors and this was done through our programme. The other unique factor of our programme is that it is integrated to our electronic medical records so that means the doctors don't have to go outside of our usual computer platform to connect to a patient so the other advantage of that is that the medical record. The telehealth policy suggests that the hospital or the service provider have to maintain records of consultation with the patient. It can be in video form or in a document. So in CMC we are not recording videos but we are actually storing a medical report

The other unique factor of our programme is that it is integrated to our electronic medical records so that means the doctors don't have to go outside of our usual computer platform to connect to a patient so the other advantage of that is that the medical record.

because we are following the same procedure for the in person consultation and it is simplified and automatically get stored in the same way as we do it for in person recording.

This also helps in accreditation. The accreditation policy tells us that the institution or whoever is offering telemedicine services should have; a telehealth policy and also we should show the evidence to adherence to that policy and we should show evidence of maintenance of teleconsultation records as well as prescription. When we introduced this, we have completely turned into an electronic format, the prescriptions are in an electronic format which is already there in CMC which telemedicine made it 100% compliance. At the end of a consultation along with having spoken to the doctor through a video call the patient is also getting a medical report and a prescription automatically to their email. This is probably one of the success stories of our teleconsultation work flow that we developed inhouse. Our second top performing department is Dermatology and Oncology also do a lot of teleconsultations. Our initial policy was to offer tele consults to only our regular patients and not to new patients. But our current data show that some of the departments have opened up for fresh consultations. In the last six months, we have seen 1,500 fresh new teleconsultations in the entire CMC. Last month, we launched two new teleconsultations which is Ophthalmology and peripheral services from Shalom family medicine clinic.

Dr Joy: We made sure that we are able to respond to a problem in a contextual manner and give the patient a sense that they were not left out. Most of the time when Covid and lockdowns came so suddenly, there was a sense that there was no place for the patient to go to, that was one of the feedbacks we received. So, the telemedicine service was one of the ways in which we had restarted the operation to reassure them that we are still with them. Many different people had different experiences.

Some of the consultations happened in different situations. Some of them did from home where the kids running, there were other noises. Some did it from open fields. In some situations, it was youngsters standing around the elders to help the patients to get on to the video calls and to talk to the doctors. It was a different experience for all of us, but it also showed us the from which background the patients come and what needs to be done to reach out to them. I will say - "It is not everybody's cup of tea". The minimum requirement of a smart phone is still there. Connectivity is still an issue in many places, calls get disconnected in between, those pragmatic problem notwithstanding. I think lot of people had enjoyable experiences too. We have received positive feedback from many of our patients.

That was one of the ways through which we promoted this and then maintained connection with the patient during the first lockdown which is more strict than the second lockdown.

Dr Henry: I personally thought that the demand will be much more people will be coming in line from my department and my follow-up patients, but it didn't happened. When we look at Balu's statistics citing almost twenty thousand, probably, more people would have reached us. Probably one of the issues was getting those appointments through tele consult as it was dependent on the people in the department like the secretaries. If they were little more proactive in opening the slots, taking the call and helping the patient to get through tele consult that probably could have brought more positive significant numbers and care. So how does a patient respond to this technology and its adoption? Initially we thought the learning will be huge on the patient side but I personally have seen that they have learned very fast and it is only a bit of facilitation that should happen with the first time and once a patient learns how to do tele consult then every time he will demand for the same. I have seen patients consulting twice in one week because he finds it easier, getting the doctor immediately, don't have to spend time of money travelling. So in many ways it has helped. Technology learning curve is very small in current India. So much of mobile phone penetration call drops have been less and connectivity has been better with the kind software we have been using is very light. Overall, I feel it is a success story with the current software and how it has been taken up by our patients. Transfer of telemedicine services through our software where the doctors can look at their OPDs list and see who has not come in that day because the lockdown was announced immediately who had already booked their appointment. They could actually send a message with a simple click send a message to the patient and offer a transfer of this consult from in person mode to a telemedicine mode and if they go to the website and say ok to it , automatically that consultation gets transferred to a telemedicine consultation. That was one of the ways through which we promoted this and then maintained connection with the patient during the first lockdown which is more strict than the second lockdown. In case if the doctor is not in India, then, the service is there you need not have to come down to Vellore because communication is easier nowadays, if I am not available in the hospital the technology will enable me to contact you from anywhere but according to the policy of CMC the doctor can't give appointment from outside the country.

All the facility of which was there in person is now available through telemedicine also. Instead the patient can connect us from their home through the website and get an appointment from doctor who is available in the hospital.

Example: I am a radiation oncologist treating cancer. So once the treatment is over there is a long recovery period for the patient during which the I ask the patient to go home after recover and come back after three months so that I check the cancer status. But nowadays, I would tell them go home after two weeks then connect with me by telemedicine so that I can see the status of recovery. He would be on feeding tube I would assess his feeding through video call and suggest according the status and would take decisions and monitor his recovery. Suggest earlier follow up, suggest earlier referral all these facilities are now possible through telemedicine. Telemedicine was not a necessity because of lockdown, telemedicine launch was the necessity because of the lock but telemedicine pursue is now enabler for a better patient service for doctors across the country. It doesn't take away the in person consultation relevance, but it augments and it assess the in-person services that the clinicians provide to their patients.

Dr Joy: 10 years ago we thought about telemedicine and we started it in 2006 or 2007. But even though infrastructure existed we didn't well connect around the country. In the beginning it was mostly used for teaching and training, but it was difficult to do consultation. There were few departments like PMR used to do a consultation service between Duncan hospital, Raxaul and PMR. Some of the Oncology centers would use it for consultations were discussing cases. But largely it was used for training purposes. It was very hard to get a doctor to come and sit in front of a computer and wait for the appointments to open and get call. Everyone was busy because they had their outpatients, regular rounds, academic session. If he is a surgeon then he must go to OT. So everyone was busy with their regular schedule and no body thought of spending some time with the computer and wait for a call to come. Mostly it was addressed that whenever they waited call wouldn't come. But with the pandemic it precipitated something and made some alignments right. So, finally we are kind of caught up in the ground. On a national scale the roles came in suddenly and the regulatory framework was also activated with some help from IMA and other national organizations of health care.

Dr Balu: Prior to the first lock down telemedicine in medical community it was generally referred to consultation between the hospitals and probably some private hospitals used to use it as tools to get patients from abroad. Countries like Africa to get them for tourism to our cities but after the lockdown with the tele health policy rolled out by the Govt of India there was a sudden need for it. Also several society e.g, CAHO & Telemedicine Society of India started offering courses to doctors and immediate training to all the doctors to adapt the telemedicine services. So under the telehealth policy of Government of India any kind of electronic communication with the remotely located patient or a health worker is considered as telemedicine. It means if

I as a doctor respond to you through whatsapp on your child's condition that is a telemedicine service for which the doctor can charge from the patient while document and give prescription. All those have been made as a law right now. In CMC we decided that our telemedicine services would be related to audio calls as well as video calls which would be documented and would be accompanied by a medical report as well as a prescription. This will happen within the walls of the institution following the rules of the country and the institution. So that's how it is standardized. So that we are now complained with the guideline for the accreditation also. We also have the required benchmarking that is done by NABH.

Dr Henry: In continuation with what Balu said Dept like hematology have a large clientele in Bangladesh, so initially there was a bottle neck. Like how to help people living abroad and would like to meet and have a follow-up in person. Because this present system was based on cell phone, the patient would get an SMS and quickly touch that link and start speaking on the cell phone. Initially we denied and agreed to see patient within our country later we did extended to our service and started connecting with patients from Bangladesh and it worked through their email. They were able to get the link and the time in their email and they could with the doctor and get medical report. These were applied for pre-existing patients not for new members.

Dr Balu: The telemedicine policy of India pertains to only practitioners registered in India and it is applied only for only the people of India. So if somebody is taking a consultation from outside, we should have the disclaimers for them to accept our policy and the law of India. No foreign doctors can do consultants of India. So there are some restriction for outside of our country. That agreement has to be signed. So are bound by the law. Eg - In natural law if you are making a payment and you are initiating it and going through with the consultation agreement with me then you are bound by the rules I am setting it.

Christopher: Let us discuss about the guidelines set by the Government and are they helping us to be efficient or do they restrict treatments for our patients and community?

Dr Balu :- I am the one who trained all the doctors during the first lockdown regarding the laws of the country and I felt that was well written well compiled and well thought of and it had its own checks and balances. We could also work within the polices. It was the need of the hour to standardize the teleconsultation across India. For a first document I would say it was a good job by the govt.

Dr. Henry:- We never had any problem. In north India what application was floated and the govt itself was carrying out some teleconsultations I think those did well. There was some interview on TV how Apollo did lot of teleconsultations. They did it a little more seamlessly they had much larger clientele compared to us. They did without much restriction. In India Apollo was one of the biggest groups who could hold onto their clientele and have a large teleconsultation compared to any other institution.

Christopher: With the number of increase in patient how did you manage stress & time?

Dr Balu: It is another skill that we developed as a physician. To talk to a person in stress in a remote place without seeing him feeling him or in his presence, it is a learning. Today, I did 8 teleconsultations of which 2 are from Bangladesh. Many of them who can't access medicine it does add to the stress but within CMC we have added it as a new service which happens within our working hours. So, I have allocated time for this on particular day. Many dept has done that. There are certain depts that which have found it as stressful and I know few department who has full doubtful of this service because they felt that they are not able to do justice to the in person patient itself with the current available time so they don't want to offer an additional service. Another way to put it is that even if we don't offer a teleconsultation service, we still get telephone calls, emails etc which we have to reply. In my dept our secretary is instructed to answer all these remote communications to convert them into teleconsultation because firstly it is documented and secondly the patients get much more satisfactory due to direct communication with the doctor. Thirdly they get a documented reply. Many a times they get telephonic calls, I am more distrust to attend telephonic calls rather than doing teleconsultation. Because in teleconsultation I know it is more authentic,

The telemedicine policy of India pertains to only practitioners registered in India and it is applied only for only the people of India. So if somebody is taking a consultation from outside, we should have the disclaimers for them to accept our policy and the law of India.

it is a service, it is documented and much more legally safe. I will also make sure that I will advise within the perimeters of the teleconsultation guidelines. In an audio call you might have said something and forget what you have said that adds to your stress. I think once we learn this, it is a better and a safer platform and we will learn to handle this stress too.

Thanks to CMC administration when the first lock down happened 2 months of teleconsultations were done free to whoever wanted to do because it was unprecedented situation it is a response to that so we never charged for the first lock down tele consultation. The other reason is that it was a new service which we were launching, and we were learning from that so we didn't charge for that. Later it became service for which we started charging and it is not more than what we charge for an in-person consultation. So, no additional expense.

Christopher: Legally, what did you do to safeguard yourself or any other mission hospital which is already doing this work?

Dr Balu: Teleconsultation or remote consultation by law is not an excuse to say that I made a poor judgement you are as much pulpable by telemedicine as an in person consultation. So this is the foremost message that we give to our training clinicians when we launch this platform. So, if you are not able to make A judgement on the patient's conditions through remote process you don't commit to treatment or advice on that which will keep you legally safe. Secondly, proper documentation, finally the prescriptionS on telemedicine has been cleverly categorized by the telehealth policy into category A,B & C. and this is based on the mode of teleconsultation, the manner of teleconsultation and the type of drug. Eg/ If I am doing a video call with a patient I have more rights to prescribe drugs than I am responding by email. If I am doing a first tele consult vs repeat tele consults I have more right in the repeat consultation. Certain drugs like Narcotics, schedule X drugs cannot be prescribed by telemedicine. Chemotherapy etc So these are certain legal framework that are within the telemedicine in telehealth policy of Govt of India and we strictly follow that in our institution.

Dr Henry: The website has a disclaimer which they had to tick and accept before they get a consultation. So once the patient is done that and paid for the consultation they are eligible to opt for it.

So it is the consent form for taking a consultation. Many doctors refused to do tele consultation because they are not comfortable and they thought that it might get recorded and they might get into trouble.

Dr Balu: Additional legal requirement required in any telemedicine consultation is data privacy and data security. Firstly when you are doing a video consultation you have to ensure that it is one to one. On my end I cannot display it to 10 other doctors unless patient and consented to it. They are trusting me with their call so that privacy is important and on patient's end that room is to be private while you are conversing with them. Secondly, data privacy and data security, so WhatsApp calls and WhatsApp video leaked are not acceptable. So we have a disclaimer which is based on trust and we request the patient to not to record. While training we tell the doctors that it is a universal precaution, as the patient may record even after telling them not to record be aware of that and your conduct has to be suitable for that.

So that push back is always there at the time of launch. But with time doctors have realized that it is a necessary service, and many people have accepted it. CMC policy of making assured that consultations are provided within the walls of the institutions ensures that the etiquette is maintained. These consultations happen in our working hours and most of us have allocated time for that. It's not only doctors who do entire work but we enable the secretaries to do the prior communication and fix the consultation etc. We come in only for the medical advice, so once prior communication is sorted our most of our stress is over.

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Christopher: Lets talk about the telemedicine helpline?

Dr Balu: Telemedicine is the first response to lockdown, I would call the helpline as the second wave challenge that we took on virtual help platform. Because in Vellore in the beginning of May we found that our emergency rooms were not able to take in patients and we had to send away patients to other hospitals. One patient came in the night and couldn't get bed and we had to send him to the nearby govt hospital and they couldn't find bed finally they drove all the way to Kerala and got admitted. So there are similar stories shared by concerned

clinicians across the hospital and then we thought we need to have a wave within which handle this and direct them in stressfull situation direct them somewhere. Deliver some kind of service, even if we are not directly takecare of them.

At that point the same sentiment was echoed by other doctors in the city outside CMC Through the Indian Medical Association, Vellore chapter. So, we all found that common goal of taking care of the people of the city during the second wave of the pandemic and we have also learnt from what happened in Delhi. Through CMAI we know the helpline that was launched in Delhi and we found that it was very useful. We had multiple consultations with that group. They guided us directed us. This process also we made it very simple, firstly we decided to launch the helpline, called UDAVI (Tamil means Help). We also thought it should not be too CMC focused or institution focused rather it should be city focused, that means other doctors should be part of it. So, we trained the doctors of Vellore in regarding to the protocols of Level 1, Level 2, care in Covid patients on how to take care of them.

The IMA of Vellore launched the helpline called IMAI (means eye lid which protects the eye). We used to similar tech platform wherein it is a call in, and it is directed to the appropriate channel. At CMC we developed 4 channels for the helpline. It had IVR in Tamil and in English. Tamil IVR is used by all the callers. Helpline was started on 15th of June after almost two weeks of deliberation. There were stakeholders because we had to train people. The doctors who were participants in the helpline were not direct Covid doctors. We had doctors from all specialties because we wanted the Covid doctors on the ground as there was lack of doctors in the ground. So we got Sr. faculty who could communicate well from various specialties like physiology, bio chemistry came in. They were trained on the common platform by our covid consultants that to in virtual platform. We had secretaries and other non-medical people who are trained about the general information regarding covid, vaccination etc.

We had a group of volunteers, research professionals who were working on the ground with people to do our logistic part they were trained on that. We had our palliative care team led a group of chaplains to develop a counselling wing. So finally, under UDAVI CMC had 4 channels where:

- Patients could call in and ask for general information regarding covid, vaccination, isolation etc.
- They can directly talk to a doctor regarding home care programmes.
- If they found themselves in distress they could talk to a counselor, doctor, palliative care person, chaplain, physician, psychologist and a psychiatric counselling was also offered.
- Finally we had the logistic channel which help the patient to locate a bed in Vellore if CMC doesn't have a bed. Also to help them with homecare kits

We had ready 700 free homecare kits ready for the city of Vellore which included pulse oximeter, sanitizers, thermometer etc. which is needed for homecare of covid in a symptomatic situation.

And we also arranged around 30 Oxygen concentrators which could be delivered at home. Later around two weeks into the programme when the peak was settling and when we found that more patients needed homecare we also had a small logistics team for oxygen delivery. So when one team identifies the need of homecare kit and then this team deliver it and another team will teach them how to use it and the third team would monitor their progress. Under UDAVI, we continued to train the other doctors of Vellore who ran the calling and directly speak to the doctors. From their data we found that they had around 2000 calls over a period of 6 weeks which would probably 1000 meaningful calls. In our vertical in UDAVI helpline we had total 681 meaning full calls of which 25% were for general enquiry 55.7% was to directly talk to the doctor. Only 15 calls came for direct counselling and 20% calls were for logistic purposes like locating a bed , we even offered services to deliver food to people on quarantine through 3 NGOs (PISCES, hope house, etc) all of them came together for the city of vellore.

CMC was the center point which hosted it and directed it but we didn't own it but we are happy to shared with them. All of us together ran 2 helplines which reached around 1700 callers. The information helplines queries were mostly on vaccines. If the person in the call is not able to answer we had the mechanism to take it further to a doctor find the answer and revert back to them. The doctors' lines were quite busy we received around 181 level 1 calls where a symptomatic patient wanted to be taken care at home. Level 2 calls were around 61- it is the level much more sicker patients who had to get admitted. In the interim our doctors over the phone tried to help them and advise them on medications. We made in an advisory service not a prescriptive service because we thought without seeing the patient giving prescription is difficult. But if at all a patient needed a prescription, we arranged teleconsultations through the IMAI platform. So the IMAI and UDAVI were constantly in touch with each other we had multiple WhatsApp groups which used to

share details and communicate with each other and the institution walls were broken at this point. I think IMAI was also generous in offering services to patients who called UDAVI and they had to be followed up and IMAI meticulously followed up and everyday our doctors used to get feedback on what is happening to the patients on home monitoring programme. We kind of closed the programme on 15th of June when the peak was down but we found that the home oxygenation services were quite useful for people who are getting discharged from the hospitals for post covid care. So we continued that service till the end of June. On 30th June we stopped the home oxygen services also. Total 17 oxygen concentrators were delivered, the only regret the team feels about the whole programme is that we would say that we started around 3 weeks later than what was supposed to be and that is probably why the number was low but we feel that this was a good lesson to bring everyone together to respond to this situation. If, however there is a third wave we are prepared to take it head on from the beginning itself.

Dr Joy: I think this was an unusual experience for us. Some of the unique feature were that we worked entirely with volunteers for this service. It was not like getting instructions from HoD or directors. We sent of emails from directorate for volunteering and lot of people approached for it. Another unusual thing which also found it difficult to handle was that it was all virtual and new for us, we were ready to go and someone already stepped and it was already on and running. Because Dr. Balu was very much involved in the recording and sending recorded message and testing it etc. But when it when it went live. Numbers were there it was open to call and gradually started. So, it was a completely cloud based system, it was a virtual experience and it was new for us. So there was no real infrastructure cost for it. That was another unique feature. Where ever they are use their own phones and for 2 or 3 people we needed a computer, we provided the institutional device to use google sheet and share. These 3 were uncommon factors. As Balu said we engaged with the local communities seriously we never thought that it will work and Indian Medical Association as well as with other local NGOs. We continue to keep in touch with them. We are hoping that the volunteer recognition certificate will be given soon to all the people who volunteered for the programme. We are hoping that we will continue the relationship with IMA for vaccination and lot of more awareness programmes on vaccination in subsequent days.

Dr Balu: Our logistics vertical which were people on the ground and reaching out to patients on quarantine delivering homecare kits, food, oxygen concentrators was common for both the help line.

Even the IMA helpline was encouraged to use our logistic supply and they generously did that. Also all the services were free. From the entire group of people we didn't charge anything. We also got donors for oxygen concentrators. So it was only justice that we have given freely to the community.

Dr Joy: One of the feedback which came from the IMA was that fact that we had shared the protocols and had common training. Means there was no difference whether they call the IMAI helpline or they call the CMC – UDAVI helpline they will get the same answer because of the protocol do this for this type of question and answers which we used to answer were shared across the group and the Clinical training protocols were also shared. CMC medical team trained the IMAI group also. So, the other thing was that in our city we didn't find people running around for tossy for various anti-virus and oxygen because it was very clear from our protocol that there shouldn't those drugs …. So even if people call for these kinds of drugs they would get the same standardize drugs. In Vellore also had the luxury of our own district level control room. The collectorate was very proactive so they had a district level control room and a district level help line besides the state level helpline. So, we had choice, we had four option that they could call for help.

Dr Balu: We should appreciate our volunteers who are very competitively enthusiastic they were competing among themselves to do a better job. One of the funny things which I still remember is that the lady who recorded the Tamil IVR for me she actually called the helpline just to listen to her own voice and then disconnected. However, she shared with us that within seconds a volunteer who had recorded a missed call, called her back to check if she had Covid, to which she smiled.

Dr. Joy Mamman, Associate Professor, CMC, Vellore

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FROM OUR ARCHIVES
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DYNAMICS, DIMENSIONS AND RELEVANCE OF CHRISTIAN MEDICAL WORK IN THE SEVENTIES

(Introduction to the Conference Theme at the 21st Biennial Conference of the Christian Medical Association of India, on 28th October 1970)

BISHOP R. D. JOSHI

I feel privileged to have a part in introducing the theme of this Conference:

'Dynamics, Dimensions and Relevance of Christian Medical Work in the Seventies'. This is a theme well chosen and seems to comprehend the essential aspects of Christian Medical Work in India.

For group discussions, it seems helpful to divide the theme into dynamics, dimensions and relevance of Christian 'Medical Work. Dr Raleigh Pickard has well outlined some urgent issues around these aspects in his questionnaire. However, I find it rather difficult, in an introductory statement, to maintain

a clear-cut distinction between these three aspects of the healing ministry of the church. They seem to coalesce: dynamics leading to dimensions, and dimensions raising the question of their relevance.

Priorities in Healing Ministry

Dr Pickard, in his helpful questionnaire, limits the discussion of the theme to church-related institutional work. This, too, will be my primary concern. But I cannot stop there, for I am convinced that the most important concern of the church in the seventies should be to sustain and undergird the ministry of Christian medical workers who are engaged in secular institutions, and to make the church-related institutions an integral part of the witness of the healing congregation. The major task of the church in the seventies, it would seem to me, is to disentangle herself from the burden of inherited institutions, to bring them within the economy of the people they serve, to involve professionally competent laity in their administration, and to equip the Christian community, not for church work or the church's institutional work, but for the church's work in the world. A community actively engaged in worship, witness and service can alone provide the dynamics for the healing ministry of the church ' in the seventies.

Dynamics of Healing Ministry

Viewed as a divine institution, the church has institutional functions which are essential to her life. Among these necessary functions, is the ministry of the Word and the Sacraments. The sacraments of Baptism and the Lord's Supper are celebrations of Christ's reconciling ministry to man and the world. Pastoral care is another vital function of the church. These ministries the church alone can perform. They represent permanent institutional functions of the church. .

However, as a social organization, the church develops certain institutional structures in response to environmental needs and pressures. These needs and pressures change; so do the institutional structures of the church. These structures share features in common with secular institutions. They differ only in purpose and motivation. Christian medical work cannot claim any

monopoly of professional competence, compassion and sacrificial service. There are secular institutions and non-Christian doctors excelling in these respects.

The dynamics of the healing ministry of the church springs from our Lord's ministry of compassion and concerned response to the whole man and to all mankind. The Christian medical work cannot restrict itself to a hospital centered closed system of diet, medication and surgery. It must make man and the society whole. The healing works of the church must concentrate on persons rather than their diseases, provide motivations to unselfish expressions of love, and give assurance of supportive companionship of One who is in solidarity with suffering mankind. We are participants in both the mission and passion of our Lord. 'He came not to be ministered unto but to minister'-this is the mission. 'And to give His life a ransom for many' -this is the passion.

Healing Works as Symbols of Missions

The healing works of the church exist for mission. They are symbols or signs of Christ's mission in the world. They demonstrate God's redeeming love which binds and moves the inner life of God's people. This relationship is expressed in committed concern for the life for others and the sharing of divine gifts and realities with people everywhere. The questions we need to raise today are: (1) Does the Christian medical work in the seventies exist for mission? (2) What are the dynamics behind it ? (3) What are the resistances to renewal and reappraisal in Christian medical work?

The healing ministries of the church cease to be mediating agencies between the church and the world: (1) when they no longer remain signs or symbols of Christ's mission to the world; (2) when they are not valid expressions of the inner life of the church as the people of God and (3) when the concerns they represent and the services they perform are well or better taken care of by secular institutions.

When this happens, these institutions of service lose their relevance as facets of the mission of the church. The church may still cling to them without realizing that they have lost their symbolic and witness-bearing character.

They may actually become obstacles to effective mission. They may become like stockades which the primitive man built to keep himself in and the hazards of the jungle out. These stockades will not do in the seventies. They need to' be pulled down so that we may become what God intends us to be -- explorers rather than cowards seeking shelter in crumbling institutional structures. These are hedges which were raised to protect the young plant but now need to be lopped off so that the church may truly become free and responsible. We are called to be pioneers seeking new frontiers of concern in medical and health care, setting pace for new developments, rather than prisoners of institutions which have lost their relevance in the seventies, or which are limping on dwindling funds from abroad.

Danger of Institutionalism

The danger of institutionalism begins to loom large in the life of the church when questions of motive and purpose are not constantly asked, when institutions become props to bolster up the morale of an ingrown, introverted and encapsuled congregationalism. Institutionalism stresses wrong things in the life of the church. It is antagonistic to the spirit of reform and courageous action. It refuses to subject its institutions to periodic inquiry and evaluation. This studied refusal for reappraisal and renewal is largely responsible for the confusion in our midst regarding the motives and purposes of Christian medical work. This confusion is equally shared by those whom we seek to serve.

This is not so in the West where the Christian medical and health agencies have resources of their own with which to serve the poor and the needy. No one questions the genuineness of their motives or concerns. Being governed by independent trusts, which are in most cases not linked to ecclesiastical hierarchy, no ground is left for any misunderstanding.

What is the situation in India in regard to our institutions of service? Two things must be noted: (1) The institutions we maintain, in most cases, are -dependent on foreign funds or foreign personnel who are often valued because of their fund-raising abilities. (2) These institutions are administratively linked to church hierarchy. On both these counts, they are suspect in the eyes of the non-Christian world as Christianizing agencies, buttressed by foreign funds and administered by a church whose mission is to preach and baptize.

What are the dynamics to resistance and change in Christian medical work in the seventies? This is the power structure in the church. All institutions generate power. This is especially the case with pyramidal structures. Institutions, centrally administered and controlled by church hierarchy, have a tendency to move within a limited range of interests and goals, to develop rigidity in attitudes and insensitivity to new roles in new settings, and to confuse organizational success with Christian excellence. These hazards are always present in the life of the church and her service institutions. They can thus run as 'Missions' buttressed by foreign funds alongside the mission of the church and defeat the very purpose

for which they exist. They become ends in themselves. Wrong ends encourage wrong means and attract wrong people to positions of power and influence in the church.

New Frontiers of Concern

Time was when the church was fired with a tremendous missionary inspiration. Her ardour poured forth into institutions of service to the world. These institutions provided unique facilities and met unmet needs. They became a protest to the environment, Vast sums flowed from the churches in the West to sustain them.

However, today in the seventies the situation has radically changed. The originating faith and dynamism behind the church's institutions has also suffered an eclipse. The state is taking its rightful responsibility for its own people. In many instances, the services rendered by government or private institutions are superior to those rendered by church-related institutions. Do we remain a protest today? Or, have we outlived our usefulness? Can we compete with the vastly superior resources of state and private agencies? Should we? 'To what purpose and with what resources?

We must also rethink our role in the context of the growing trends towards nationalization of educational and health services. These trends are clear in education. The same is a distinct possibility at a later date in medical work. There are growing restrictions on foreign funds, foreign personnel, and Christian institutions fed by Western pipelines or ecumenical oxygen. These restrictions seriously restrict the area of our manoeuvrability and our field of medical and health services.

These are disturbing developments. They can, however, become blessings in disguise, if they serve to arouse us from our complacency and false sense of security. It is good to know that others have followed where we led, that we are dispensable, that when others begin to do things as well or even -better than ourselves it is time to retire and search new avenues of service and witness.

The healing church is a servant church; her privileged position makes her a servant of all. She will not seek to build institutional empires but be content with humble structures of service which are flexible, adaptable and open to renewal and innovation. The mission of the church should draw us out into the world, sharing our national preoccupations, co-operating rather than competing with the state or other agencies engaged in the field of health and healing.

The Lord calls us to be pioneers rather than prisoners of institutions. He says to us, as He said to Moses; 'You have been around this mountain country long enough; turn northward'. The church has never to be afraid that she will have no frontiers of service at all. However, for a missionary church these frontiers will always .be found in the far horizons where, others have not gone before us. The church in mission blazes new trails, sets pace for new developments, lives on the growing edge of things, and serves in humility and with deep concern men and women everywhere.

The Healing Congregation

The new theological understanding of the healing congregation must provide the dynamics for the Christian medical work in the seventies. This congregation must become the agent of the healing ministry of the church. The development of a missionary vocation among Christian medical workers in secular and church-related institutions must become a priority concern of the healing ministry of the church.

Medical institutions of service will be relevant to the extent they contribute to this task and become expressions of the love and ardour of a community engaged in worship, witness and service. There is a serious question concerning the degree to which many Christian hospitals witness to the life of the total church. Generally speaking, the congregation looks upon them as concerns of the mission boards or church hierarchy rather than as expressions of their own inner life. This attitude must radically change, for ultimately it is the congregation which supplies the dynamics for the healing and reconciling ministry of the Gospel-- the community which partakes in Christ's solidarity with suffering mankind and fights against suffering in the world until He comes (Tubingen II, report p.28)

The congregation as a whole has a ministry- of healing. It becomes the mediating agency between the church and the world by its prayer which opens our eyes to the limitless health resources of religion, by its love with which it surrounds each person, by its acts of compassion which transcend all barriers, and by the opportunities which it offers for participation in Christ's mission. The care and nurture of this community of faith is the most strategic missionary frontier of the seventies.

Health Resources of Religion

We shall never fully understand the dynamics of the healing ministry, the resources available in the Gospel for this ministry and the dimensions in which to express this ministry relevantly, unless we are prepared to make a serious study of the interconnections of religion and health." The Tambaram Conference back in 1938 stressed this need: 'In the relationship of religion and health lies an imperative call for pioneering'. It went on to

say: 'We have scarcely' crossed the threshold of such a quest as this. We need fuller understanding of the inter-relationship of body, mind and spirit. We need continued study and development of the contribution that faith and prayer can make to the maintenance of mental and physical health and to the cure of disease. We ask the churches and hospitals to undertake together in selected centres continued inquiry into this significant field'. This' concern was expressed nearly 32 years ago. Have we taken it seriously? I very much hope that this Conference will consider it as one of the most pressing concerns of Christian medical work in the seventies.

Medical Work in Ecumenical Perspectives

Christian medical work in the seventies must be viewed in the context of *ecumenical* perspectives. The need for more effective mission calls for Joint Action for Mission and a multilateral approach to Christian service. An unilateral approach to mission lacks the inner power and dynamism of mutual service and is confusing to the secular world we seek to serve.

Limitation of resources, external pressures, the foolishness of divided service, and above all the demands of the Gospel require close co-operation in Christian medical work.

The establishment of the Co-ordinating Agency for Health Planning, with headquarters in Delhi, marks a milestone in the history of regional ecumenical co-operation. The Bangalore Consultation on 'The Future of Christian Medical Work in India' calls the churches to effect a functional co-ordination of all Christian medical work, to shift emphasis from hospital-centered approach to an integrated comprehensive community health care, to set up regional organizations to relate closely all Christian institutions, and to plan the objectives of Christian medical work within the context of the government's own planning for health care. These exciting developments must become dynamic forces in our own thinking and planning.

Divine Origin of Healing Ministry

The dynamism for Christian medical work comes from Christ's commission to love one's neighbour-the commandment which is so graphically illustrated in the story of the Good Samaritan. This story makes the healing work, not merely ancillary to preaching and teaching, but as a form of witness, a sign of Christ's ministry of compassion to the whole man and to all mankind.

This beautiful story would perhaps have never appeared in the New Testament, if the Good Samaritan had sat by the roadside, preached his faith to the wounded man, and converted him to Judaism. Instead he washed his wounds, applied antiseptic plaster over the wound (oil) put him in his ambulance (ass) and took him to a hospital (inn). This is the healing ministry to which we are called today. This ministry is not limited to any exclusive groups or any particular features or portions of man. It is a ministry which seeks to make man whole in the new settings in which he is placed today. This ministry represents the corporate witness of the healing congregation which is in the world in the person of boys and girls, men and women who are salt, light and leaven to the world.

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Dear Members,

CMJI as a quarterly journal and an official publication for Christian Medical Association of India, with its online presence today, brings a much wider reach, diversity, and a global reach. The print run of CMJI, for recent editions, due to the pandemic was held up by the editorial team and the leadership. We regret the inconvenience and wish to inform that we are working to provide our members with the printed copies of the editions.

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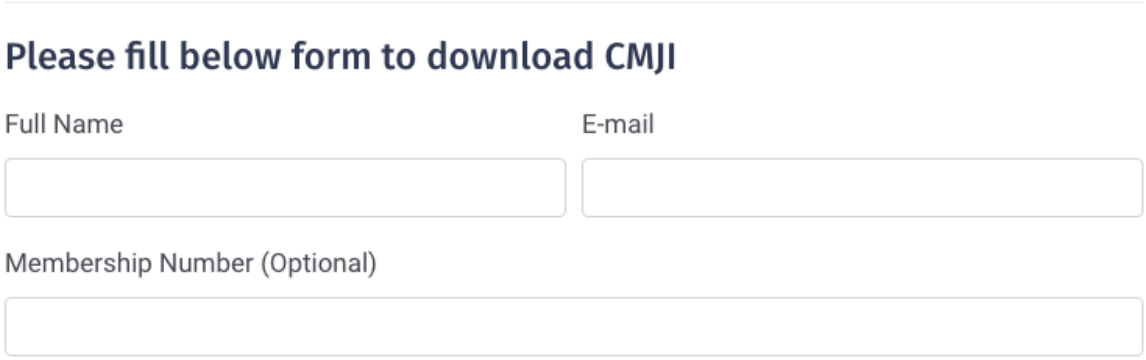

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We are excited as you view both new and old editions (2015-2020) of CMJI. In case you require older editions please send an email to communication@cmai.org

We on behalf of CMAI editorial team, thank you for being our support and helping us in building a just and healthy society.

Regards

Editor - CMJI
Head Communications - CMAI

Join Hands with us in the Healing Ministry

CHRISTIAN MEDICAL ASSOCIATION OF INDIA

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

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

WHAT DO WE DO ?

- Build capacity to respond to the current and future health care needs
- Advocate for innovations, create evidence and promote policy change
- Work closely with the churches, civil society and the government
- Build alliances for health action on a national scale
- CMAI influences other networks and alliances on thinking change in health systems practices in India. We partner with national and international agencies to promote this objective.

OUR PUBLICATIONS

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

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