CHRISTIAN MEDICAL JOURNAL OF INDIA

CMJI

Communicating Health
Since 1895

A Quarterly Journal of the Christian Medical Association of India

VOLUME 31 NUMBER 1 : JANUARY - MARCH 2016

Compassionate Care Towards Mental Health

Bangalore Baptist Hospital Nursing Institute

Bellary Road , Hebbal, Bangalore - 560024

www.bbh.org.in

Invites Application for

Basic Bachelor of Science in Nursing (4 Years)
General Nursing and Midwifery (3 Years)

Application form can be downloaded from the website www.bbh.org.in

Basic Bachelor of Science in Nursing

Last Date for Receiving Filled in Application Forms is 4th June, 2016. Entrance exam will be on 6th June, 2016 Shortlisted candidates will be called for the interview on 7th June, 2016

General Nursing and Midwifery Program

Last Date for Receiving Filled in Application Forms is 11th June, 2016. Entrance exam will be on 13th June, 2016. Shortlisted candidates will be called for the interview on 14th June, 2016

Contact Nursing Institute from Monday to Friday between 8.00am to 4.30 pm & Saturday 8am to 12.30 pm, Phone No: 080 – 22024399/ 22024400/ 23333557

EDITORIAL OFFICE:
Christian Medical Association of India,
Plot No 2, A-3 Local Shopping Centre,
Janakpuri, New Delhi 110 058
Tel: 011 2559 9991/2/3, 2552 1502
Fax: 011 2559 8150
E-mail: cmai@cmai.org
Website: www.cmai.org

BANGALORE OFFICE: HVS Court,
Third Floor, 21 Cunningham Road
Bangalore 560 052
Tel: 080 2220 5464, 2220 5837, 2220 5826
Fax: 080 2220 5826
E-mail: cmaiblr@cmai.org

PRINTED AT: New Life Printers, New Delhi

CMJI

Communicating Health
Since 1895

CHRISTIAN MEDICAL JOURNAL OF INDIA www.cmai.org

A Quarterly Journal of the Christian Medical Association of India

VOLUME 31 NUMBER 1 JANUARY - MARCH 2016

Compassionate Care Towards Mental Health

LETTERS TO THE EDITOR

Dear Sir,

I went through the articles of CMJI issue on 43rd biennium. I witnessed the conference and all the events are updated through overview of this journal. The article such as “Renew Our Strength like the Eagles” by Dr Bimal Charles has expressed innovative thought regarding future healing ministry in India. “The challenges of Healing Ministry in India” by Daleep Mukarji is very informative. “Being a nurse – reflections from the journey” by Mrs Mercy John is very inspiring to me.

Thanking you

Regards

Prof M Thanga Darwin
Guest Faculty, Sree Mokamika College of Nursing
Padanilam, Kulashekaram, K K District,Tamilnadu - 629161

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? The next 2 issues will be on **“Misson & Transformation”** and **“Ethics & Healthcare”**. 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: **ronald.l@cmai.org.**

Guidelines for Contributors

SPECIAL ARTICLES

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

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

LETTERS

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

GENERAL GUIDELINES

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

ADDRESS FOR COMMUNICATION

Head – Communication Dept.
CMAI
Plot No 2, A-3 Local Shopping Centre
Janakpuri, New Delhi 110 058
Tel: 011 2559 9991/2/3
Email: ronald.l@cmai.org

EDITORIAL

FROM BROKENNESS TO RESTORATION

Dr Nitin Theodore Joseph

One of the writers of our Healing Ministry Week Bible studies has correctly written, “The wounds of people living with mental illness are painful, not because of the stress, anxiety, depression and other emotional burdens they carry along, not because of the genetic and biological factors over which they have no control, not because of the social factors that are controlled by others, nor because of their inaccessibility to proper health care. Their wounds are painful because they need healing, encouragement and a feeling of living a fruitful life in society”. In India mental illness is still spoken in hushed tones and a lot of stigma is attached to it, with the result that a large number of patients go undiagnosed and their strange behaviour is attributed to “bad genes”, faulty upbringing and wrong company. A mentally disturbed person goes through a plethora of feelings from denial to desperation and sometimes suicidal attempts. Functional disorders like hysteria do not have a specific cure but organic disorders like schizophrenia, bipolar disorders, endogenous depression can be controlled by drugs that correct the biochemical changes in the brain and also by Counselling.

In Biblical times mental illness was classified as “unclean spirit” or “demon-possessed”. The story of *Legion* is mentioned by all the Synoptic gospel writers with slight variations, but they all mention that he was ostracized by society and lived in the cemetery. What is encouraging from the story is that Jesus who was working on a tight time schedule, found the time to go to Gerasenes, specifically in search of this man with compassion to heal him. Not only was this man healed but his position in society was restored.

We live in a world that is broken and full of people who need support. Substance abuse, alcoholism and other addictions are on the rise. Our youth who are caught up in the rat race are living a very unhealthy lifestyle. Rural and “Rurban” areas which were supposed to be stress-free have an alarming rise in suicides due to debts as a result of drought and subsequent crop failure. To us is given the mandate to reach out to help people who are struggling with mental and emotional issues. Jesus performed most of his miracles and did most of his teaching not in the synagogues or in the temple but in the market places and in the areas of real need. Like Jesus we too must reach out beyond the secure walls of our churches and institutions. Paul writes, “For God has not given us the spirit of fear, but of power and of love, and a sound mind” (2Tim.1:7, KJV).

As you go through the pages of this journal may I request you to think of how we as an individual, a church or an organization can address this issue of mental health and bring healing and restoration to those unfortunate people who suffer in silence and live on the fringes of society? Your valuable feedback will be much appreciated and will help us to develop a protocol for our network.

Dr Nitin Theodore Joseph

MENTAL HEALTH, DISTRESS AND ILLNESS: UNDERSTANDING, COMPASSION AND INTERVENTIONS

The Bible has many universal truths. It describes the lives of the people of Israel and has several examples of mental distress and mental illness. The social context of the region, the culture of the Jewish people and the understanding of human suffering of the time influenced the concepts related to disease and comprehension of life.

There are also numerous suggestions for improving one's mental health, reducing emotional distress and for reclaiming peace and contentment. Psalm 23 describes David's faith, his belief in divine guidance, his conviction of God's protection and his confidence in God's continued blessings, both in times of peace and in periods of discord. Jesus' promise of peace for those in turmoil is reassuring for the faithful (Mathew 11: 28). St Paul's advice of leaving our lives in God's hands has mental health benefits to those who believe (Philippians 4: 6-7). These strategies are good solutions to reduce emotional turmoil and are applicable to mental distress faced by many people today. Such distress seems to be part of the human condition and is seen across countries, cultures and contexts.

The complexity, contradictions and conflicts of human existence cause existential anxiety and demand solutions that are not only simple but also easily applicable in our daily lives. A study of the parables of Jesus shows his ability to focus on mental health. Turning the other cheek, walking the extra mile, and loving our enemies (Luke 6:27-29) are good examples of changing one's perspective and altering the frame of reference, which often results in a reduction of emotional tension and in peaceful resolution of conflicts. His examples of focusing on the road less travelled and of choosing the not-so-popular options help in enhancing mental health in the most difficult and distressing of human interactions. He challenges us all to choose perspectives, which relieve our stress, reduce mental tension and thereby improve mental health. The task before us is to examine our options and choose those, which give us peace rather than those, which increase our emotional turmoil.

A study of the parables of Jesus shows his ability to focus on mental health. Turning the other cheek, walking the extra mile, and loving our enemies (Luke 6:27-29) are good examples of changing one's perspective and altering the frame of reference, which often results in a reduction of emotional tension and in peaceful resolution of conflicts.

There are also descriptions in the Bible, which document mental illness. The story in the Gospel according to St. Mark is consistent with psychiatric diagnosis of chronic schizophrenia (Mark 5: 1-20). However, the cultural understanding of those times of the cause of such conditions invoked the concept of possession by evil spirits. Today our understanding of severe mental illness suggests that they are diseases of the brain. Such a view calls for the use of psychotropic medication, which have been scientifically shown to greatly improve clinical outcomes for many people with these conditions. However, different types of mental illnesses respond variably to treatment, producing varied clinical outcomes. These range from complete recovery and minimal deficits on one hand, to an episodic course, persistent symptoms, chronicity and deterioration, on the other. Consequently, a small but significant number of people continue to live with distressing symptoms, debilitating deficits, difficult livelihood issues and disabling side effects of medication,

The acceptance of people with persistent mental health difficulties, disabilities and handicaps calls for love and compassion.

despite regular and optimal treatment. This underscores the fact that the scientific understanding of severe mental illness seems to be partial and the impact of medical interventions variable.

Similarly, the understanding of mental illness employing other disciplinary frameworks and perspectives (e.g. psychological, social, anthropological, traditional healer and indigenous systems of medicine like Ayurveda, Unnani, Siddha, etc.,) also seems to be partial, with imperfect comprehension of the complexity of major mental disorders. Religious explanations and solutions also seem insufficient and inadequate for the task.

The partial, inadequate, incomplete and imperfect solutions on offer for many people with severe mental illness demands humility in our approach to their problems and a great degree of tolerance for those with such afflictions. The diverse problems demand the use of multiple strategies and different solutions. These options can be employed concurrently and in sequence. As no single causal account completely explains the complexity of different forms of mental illness and no simple interventions solve all difficulties faced by people with mental disorders, each explanation and intervention should be presented without dismissing or challenging other beliefs about causation and treatment. Consequently, this calls for the use of multiple strategies, not just medication but also the use of psychological, social and spiritual interventions. Regular involvement in religious activities for those with such inclination is known to help reduce distress. Similarly, social support networks within religious communities can also improve ability to cope and function.

The challenge is not just one of cure but of healing for those with severe and chronic mental illnesses. It demands not only compassion, but also empathetic understanding of the complexity of the issues facing individuals with mental disorders. Such empathy will not only allow for the reduction of social stigma associated with mental illness but will also allow for re-integration of people with such conditions back into life and into the wider community. It will help them find meaning in life, in spite of their disability. The acceptance of people with persistent mental health difficulties, disabilities and handicaps calls for love and compassion.

The complexity and contradictions of the human condition related to normal human distress, on one hand, and severe mental diseases, on the other, demand a variety of solutions. For those who hold religious beliefs and who experience distress because of the circumstances of their lives, their faith and counseling often helps reduce their distress and helps them find meaning in their lives. On the other hand, religious explanations, support and suggestions are also useful for those with severe mental disease, when provided as part of a package of interventions, which includes psychotropic medication and psychological and social supports.

The challenge for society is to view those with mental health problems with compassion and to unconditionally accept them. We need to focus on their humanity rather than on superficial characteristics of their illness and function. Such positive regard and an empathetic understanding of others, who may differ from us, will go a long way in helping them and will allow us to acknowledge our own precarious existence, understand our contradictions, reduce our distress and provide healing, peace and contentment.

K S Jacob
Department of Psychiatry
Christian Medical College, Vellore 632002 India
ksjacob@cmcvellore.ac.in

COMPASSIONATE CARE TOWARDS MENTAL HEALTH

Ms Geeta Mondol

In a world where people are constantly busy and seem to be always on the run, stress appears as part and parcel of one's job description. Mental health is one of the primary areas that takes the toll. A good industry has emerged in such a scenario with programs and reading materials on how to live a stress free life, but still number of cases with various types of mental illness is on the rise including a steep increase in the number of suicides among young people. Mental health therefore needs to be given much attention in the present scenario.

"Mental health includes our emotional, psychological, and social well-being. It affects how we think, feel, and act. It also helps determine how we handle stress, relate to others, and make choices. Mental health is important at every stage of life, from childhood and adolescence through adulthood"[1]. However, when we talk of mental health, it is important for us to know and remember that we all at some stage or another may experience poor mental health. The phrase itself however, brings to mind the stigma attached to it. Not many talk of mental illness, or mental challenges and still fewer acknowledge it. It is when one is unable to avoid the phrase and the condition associated with it, that people are forced to acknowledge it.

Working with those who have mental challenges, and their families, the consequences of social stigma becomes very obvious to us. Families hide their own member who has mental challenges or mental illness. We have even encountered cases where they have been kept tied to a peg inside a room. Hidden from the world outside and ignored by those at home, persons affected with mental illnesses often live as dependents, waiting on the goodness and charity of the families that live with them.

When you have poor mental health, you struggle not just in your relationships with others, but also within yourself. Your self-esteem takes a battering and one starts to question whether they are worth anything at all. Some thoughts that pervade are that perhaps the world is better off without them, leading to suicidal thoughts and sometimes action. Many a time's people who are suicidal also face the condemnation of others who think of them as weak, not realizing how strong they have tried to be. I know of a family where the woman of the house has a mental illness. However, she is unable to share about it, or seek help that she so crucially needs, for fear that she would be alienated from her family. So, while she struggles in the battles that only she knows about, others also are unable to reach out to her for addressing her needs. This may be for a variety of reasons. And we are not here to question the "Why's". It's about the "How", we as Christ's ambassadors are called to bring forth his love and personify his compassion.

All care has to be person-centred. “The person is more important than programs” is something we say very often. However, in a world which is very ‘doing’ oriented, there is little room, to stop and understand and reach out to those who are struggling, who may be experiencing difficulty in coping with their situation. In a fast paced world and an ‘instant’ culture, there seems to be little room for those who may be slower, or struggling for some reasons.

When we talk of mental health, we talk of wholeness - The overall development of the person. It therefore does not just include the physical need. God calls people to wholeness - Spiritually, emotionally, physically and mentally. Care therefore also needs to be well-rounded. We need to reach out to the whole person rather than just reaching out to the immediate issues that the person may be facing.

Some of the characteristics of compassion are empathy- the ability to put oneself in someone else’s shoes. It is then that you do not come up with solutions, but rather walk with them silently, understanding their struggle and feeling their agony. It is also about handing the controls in the hands of the person rather than keeping it in the doctor’s hands. It is about giving up, rather than losing your control, and let someone who may be struggling, have a say in his/her health care decisions. It is about informing the person the line of treatment to be followed.

Some ways in which we can provide this care is by providing dignity to the person we are helping. This could be in the form of consulting them regarding the medication they may need to take (explaining to them what the medication is for), helping them in their toilet needs without making them feel the loss of dignity, listening to them as they talk without judging, and working with their families to provide the best possible support. Judging alienates the person we are trying to help. Treating them as robots or just anticipating changed behaviour by giving medication cannot bring about lasting change. It is when

Following Christ's example, we should seek, not just to understand but also to eliminate the pain that someone may be going through.

we understand the underlying issues, give the control of their lives to them, and treat them with dignity that we see the changes that we hope to see.

However, our work does not end with just reaching out to the person. It is also about reaching out to the whole family. In a country, where a lot of struggles are linked to belief in 'karma', and where the family is judged for having someone with mental illness, it is common to see the family become introverted.

They hide their struggles and their pain, the condemnation they face on a daily basis, and sometimes taking out the brunt of their anger and pain on the person suffering from mental illness. We need to give them spaces- spaces to vent out, to display their anger at the circumstances, if need be, spaces to rethink, spaces to take a break and spaces to heal. Healing is not just for the person, but the whole family needs healing and we can and should provide that.

Looking at the Bible, we see Christ reaching out to all people, regardless of their difficulties, ailments etc. and gently holding their hands and leading them forward. Compassion was the key to everything Christ did. He met people struggling in their worlds, trying hard to cope, and He reached out in love. "When we talk about a compassionate society, what are we talking about? We are talking about how to see people behind the label. How to see that vulnerable heart."[2]

God calls us to step in such a scenario. To bring his love to those who struggle. This can only be done in gentleness, kindness, goodness, patience, love, and the other fruits of the Spirit. To gently urge and cajole people to be the best they can.

Following Christ's example, we should seek, not just to understand but also to eliminate the pain that someone may be going through. It can only be done, when we walk in their shoes, and choose, intentionally, not to judge, but to reach out and affirm. We need to take the example of Jesus. He did not judge the woman caught in adultery (he would have been justified if he did that). However, he chose to redeem her, by reaching out deep within her the reservoirs of her pain and condemnations that she had perhaps faced, and helped her come out it. We as Christians are called to be the same. To walk the road that is different from others.

As Christians we need to practice wholistic care, following the example of Christ. As we read the gospel accounts of various people with whom Christ interacted, whether they were the disabled, the socially ostracized, the demon possessed, Christ's first reaction to all of them was love. And in reaching out with compassion, he healed the whole person resulting in their inclusion and acceptance back into their families and communities. This is the model that we need to follow in our ministries of compassion and care for the people with mental illnesses.

Ms Geeta Mondol is the founder director of a special school which works with children and young adults with autism and other mental challenges. She is married to Raaj Mondol and has 2 children, one of whom has special needs.

REFERENCES

1. http://www.mentalhealth.gov/basics/what-is-mental-health/
2. Jean Vanier, Daily thought, 12 march, 2016

6 MONTHS DISTANCE LEARNING
CMAI CERTIFIED "ICD – 10 MEDICAL CODER"

Applications are invited from qualified Medical Record Technicians, professional Coders with 2 years experience, nurses and physicians for **6 MONTHS DISTANCE LEARNING CMAI CERTIFIED "ICD – 10 MEDICAL CODER"** Course.

Learning and Examination Centres will be offerred where there are a minimum of 10 takers. Cost of the course will be around Rs. 10,000 including guide and workbooks. Courses are likely to be started in July 2016. No age limit. There will be 2 batches in an academic year.

Apply with copies of certificates / diplomas to:

Mr I R Asher
Convener Secretary,
CMAI – Medical Record Training Committee,
"His Grace", 43, Nainiappan Street,
Kaagithapattarai,
Vellore – 632 012
Tamilnadu
Cell: 9952228026. E-mail: immanuel.asher@gmail.com

LAW COURSE ON HOSPITAL ADMINISTRATION
(Certificate Course - Distance Education Programmme)

Course Duration : 1 Year

Course Begins: 1 May 2016

Issue of application forms and registration: 1 March 2016

Course begins: 1 May 2016

Despatch of reading material: 1 June 2016

Completion of assignment: 31 October 2016

Completion of Second Semester: 28 February 2017

Result Declaration March 2017

DO ADOLESCENT SMOKELESS TOBACCO USERS HAVE A DISTINCT PERSONALITY? PSYCHOSOCIAL DIMENSIONS OF SMOKELESS TOBACCO USE

Tobacco is the only legal drug that kills many of its users. WHO estimates that tobacco use (smoking and smokeless) is currently responsible for the death of about six million people across the world each year.[1] The majority of tobacco-related deaths are expected to occur in developing countries, where tobacco use is on the rise.[2]

Dr Priya Raj Kumar

Oral cancer is the sixth most common in the world and areas of high incidence are in South East Asia. Comparatively, the Indian population incidence rate of oral squamous cell carcinoma (OSCC) is higher. Prognosis for oral cancer in India is poor due to lesser early detection and poorly trained clinicians.

Common forms of tobacco consumption in India[3]

In India tobacco is consumed in various forms. Smoked forms include beedis, cigarettes, pipe, cigar, hukka, chutta of which beedi is most common since it is affordable. Among the non -smoked forms – chewable tobacco is consumed in the form of tobacco lime mixture, kharra, khaini, gutkha, pan masala, kimam and in the inhaled form as tobacco snuff.

Dr Dipti Christian

Commercial betel quid substitutes: *pan masala and gutkha*

Betel quid is a combination of betel leaf, areca nut, and slaked lime. Other ingredients and flavorants are also added according to local preferences and customs (e.g., sweeteners; catechu; or spices, anise seeds, turmeric, and mustard).

Gutka or Gutkha is a concoction of crushed areca nut, tobacco, catechu (dye extracted from trees), paraffin wax (waxy substance distilled from petroleum), slaked lime (water is added to lime) and sweet or savory flavourings.

Pan masala is basically a preparation of areca nut, catechu, cardamon, lime and a number of natural and artificial perfuming and flavouring materials.

Betel quid and gutkha use is reported to have stimulant and relaxation effects.

Source: The Economic Times, 17 Sep 2012

With the emergence of commercial pan masala and gutkha about three decades ago, the Indian market witnessed massive growth not only in the sales of smokeless tobacco and areca nut products, but also a huge worldwide export market. The packaging revolution has made these products portable, cheap and convenient, with the added advantage of a long shelf-life. Many states of India have banned the sale, manufacture, distribution and storage of gutkha and all its variants. Enforcement of the law is generally lax and many shops still sell gutkha, although it may not be displayed.

Conditions and Cancers associated with using betel quid/ gutkha include precancerous conditions (oral precancerous lesions- erythoplakia, leukoplakia, oral submucous fibrosis), oral cancers, poor reproductive health outcomes and cardiovascular disease.[4]

Increasing Trend of chewable tobacco use among school children and youth

The prevalence of tobacco use among Indian youth (10,112 school going students aged 13 to 15 years) indicated that 14.6% students currently use tobacco – 4.4% smoke and 12.5% use other forms or tobacco.[5]

Chewable tobacco products are typically consumed throughout the day. A number of small surveys conducted in schools and colleges in several states of India have shown that 13–50% of students chew pan masala

and gutkha on a regular basis (Gupta and Ray, 2003). Influences to use tobacco included parental use, peer pressure, advertisements and colorful packaging.[6]

Factors associated with Tobacco Chewing

In the GATS Survey in India, the prevalence of smokeless tobacco use was nearly twice as high in rural areas compared to urban ones; it was higher in those without formal education (twice as high in men, eight times higher in women). The poorest people who are the most nutritionally disadvantaged and can least defend themselves from harmful chemicals in smokeless tobacco; are more at risk for tobacco related cancers.[7]

Some of the psychosocial factors leading to initiation of tobacco use include family history of tobacco use by elders, peer influence, experimentation, easy access to tobacco products, personality factors, underlying emotional and psychological problems and accompanied risk taking behaviours.[8]

Poor school performance, truancy, low aspiration for future success and school dropouts has also been found to be associated with tobacco initiation. Children and adolescents with anxiety and depression are also more likely to use tobacco and other drugs, as these products have anxiety relieving and mood elevating properties.

Kharra Addiction among children and youth in Nagpur

Among the anti-tobacco activists, Nagpur is known as the kharra and oral cancer capital of the country.[9] Youth and school children are increasingly addicted to tobacco- laden *Kharra* being illegally sold in paan- stalls and roadside shops despite heavy restrictions on tobacco products. There are few support services available to youth and children from lower socio-economic background to help deal with addiction to tobacco products.

The author conducted a study which compared the personality dimensions of smokeless tobacco users and non-users in Nagpur using Catell's High School Personality Questionnaire (HSPQ) in a sample of 432 males and females in the age group of 12 to 18 years. Users typically consumed one or more packets of gutkha and/or 1 pouch of kharra (--) on a daily basis. Non users were those who were not in the habit of consuming gutkha or kharra on a daily basis. The sample of users and non-users were drawn from local government schools, youth working in construction sites and those living in resettlement colonies in Nagpur.

The data was treated by Student's test to find out if there were significant personality differences among adolescent users and non-users of chewable tobacco and the selected significant differences between users and non-users follow.

Adolescent users of kharra and gutkha (9.49) had higher scores on the Obedient versus Assertive personality dimension as compared to Non users (8.74) indicating that users may be more assertive, independent, aggressive and stubborn as compared to the non-users who tended to be more mild and conforming. ($t=2.39$, $df=430$, $p>0.05$)

On another personality dimension (Expedient versus conscientious) users (9.74) emerged as more evasive of rules and feeling less obligated to act in socially accepted ways as compared to non-users (10.95) who tended to be more rule bound and persevere at tasks for longer periods. ($t=3.42$, $df=430$, $p>0.05$)

Another significant difference between users and non-users, ($t=4.59$, $df=430$,$p>0.0.5$) was the tendency of users (10.71) to be self-reliant, realistic and having a

tough attitude as compared to non-users who were more dependent, sensitive and overprotected. (12.26)

In other personality dimensions, users (10.27) personality profiles indicated higher levels of undisciplined self-conflict, impulsive and careless of protocol as compared as the non-users who were more controlled, self-disciplined and socially precise (10.94) (t=4.59, df=430,p >0.05).

However, users (9.00) also tended to be more relaxed and frustrated, lethargic as compared to their non-user counterparts who were more tense and alert in comparison. (9.69). It is possible that the relaxing effects of chewable tobacco tended to reduce high levels of tension and induce dullness.

Children and adolescents with anxiety and depression are also more likely to use tobacco and other drugs, as these products have anxiety relieving and mood elevating properties.

Implications for the Design of Tobacco Cessation Programs for Adolescents

In the India Global School Personnel Survey 2006, nearly one in five (16.3%) school personnel reported to have ever received training to prevent youth from tobacco use.

Alarmingly over one third of school personnel used chewable tobacco themselves. 66 % of the current student tobacco users wanted to stop but there are few if any effective tobacco cessation programs at the school level.

There is increasing interest in developing treatment approaches that match adolescent personality profiles.

Personality can therefore be a protective or risk factor and influences how adolescents deal with stressful situations, playing a role in self-regulation and influencing inadequate coping strategies such as addiction, violence and delinquency.

There is usually a decline in negative emotionality and impulsiveness and an increase in affability, conscientiousness and emotional stability in later adolescence. (McAdams and Olson, 2010). Older adolescent users will therefore be more open to carefully designed tobacco cessation programs than younger users and can be trained as peer leaders.

Tobacco cessation programs should focus on school personnel as well as students and equip them to understand the psychosocial dimensions and address tobacco use firmly and effectively.

Social and personality factors together influence the consumption of health endangering substances. Adolescents with adequate support from family, network of friends have a good chance of coping effectively with developmental challenges. Tobacco cessation programs should therefore incorporate strategies for strengthening supportive family and peer networks for adolescent tobacco users as well as robust educational support programs for under achievers and dropouts.

Social resistance training will help youth to develop skills to resist negative social pressure to use chewable tobacco products. Cognitive behavioural therapy will help existing users to reduce and even stop tobacco chewing habit completely.

To conclude, the personality characteristics of adolescent chewable tobacco users are significantly different from adolescent non users. Users tend to be more aggressive, evade rules, are more self-reliant, have a tough attitude and tend to be more impulsive and careless of protocol as compared to the non-users. The interplay of personality and socio economic factors influence the initiation and continued use of tobacco chewing among children and youth. A keener understanding of these dimensions is necessary in designing effective school based tobacco cessation programs for youth.

Dr Priya Raj Kumar is a consultant for voluntary organizations and Director of Rainbow Christian Academy based in Nagpur. She is also a part time psychology lecturer. She has a - Phd in Public Administration related to women's development programs.
Email: rainbow4us@gmail.com

*Dr Dipti Christian is principal of Hislop College, Nagpur as well as a psychology lecturer, counsellor and HRD trainer. She has wide experience in facilitating training programs for leaders and youth, leads psychology research on key issues, provides leadership to the Hislop college and Psychology Department in particular. She is also a Board member of several leading Christian organizations and educational institutions in India.(*diptichristian9@gmail.com*)*

REFERENCES

1. WHO global report on trends in prevalence of tobacco smoking 2015
2. The World Bank 1999; Warren et al. 2008
3. Textbook of Oral and Maxillofacial surgery – Rajiv M Borle, J P Medical Ltd, 28 Feb 2014
4. WHO International Agency for Research on Cancer (IARC) Monographs on the Evaluation of Carcinogenic Risks to Humans Volume 85 Betel Quid and areca nut chewing and some areca nut derived nitrosamines
5. Global Youth Tobacco Survey, India 209 - WHO and US Centre for Disease Control
6. **Review Article, Indian Journal of Public Health, Year 2011, volume 55, Issue 3, Pg 199-209, Smokeless tobacco: A major public health problem in the South East Asia Region: A review (Prakash C Gupta1, Cecily S Ray1, Dhirendra N Sinha2, Poonam K Singh2)**
7. Review Article, Indian Journal of Public Health, Year 2011, volume 55, Issue 3, Pg 199-209, Smokeless tobacco: A major public health problem in the South East Asia Region: A review (Prakash C Gupta1, Cecily S Ray1, Dhirendra N Sinha2, Poonam K Singh2)
8. Tob Induc Dis. 2003; 1(1): 8. Published online 2002 Jun 15. doi: 10.1186/1617-9625-1-8, PMCID: PMC2669568 Tobacco use by Indian adolescents, RK Chadda and SN Sengupta
9. Now, govt. bans mawa, kharra, Payal Gwalani, Free Press Journal, Jul 26, 2015, www.thehealthsite.com

FROM OUR ARCHIVES

The Journal of the Christian Medical Association of India, Burma and Ceylon

Vol. XVI No. 1 - JANUARY 1941

Public Health Nursing: A Review

Its Possibilities in Christian Mission in India

By Louisse Scott, R. N.
U.P.P Mission, Indore, C.I,

I am very grateful for the opportunity of presenting to you some of the possibilities of PUBLIC HEALTH NURSING. The chairman has been very kind in giving me the whole scope of the subject, and I may say I have taken advantage of this in not confining myself to any one phase.

About 1850 a rather pessimistic gentleman, a physician, writes:

'It is evident that the essential conditions of rational and successful sick nursing, such as good air, light, warm bedding, good food, etc. are altogether wanting in the homes of the poor. Of what use are the gratuitous supply and regular giving of medicines, if every necessary is wanting for ordinary living? It is not that the nurses shrink from the privations and injurious influences existing in the cottages and hovels, but it is the impossibility of being useful under such circumstances that renders home nursing unattainable for the poor. One can comfort them, give them food and medicines in the cottages, but to nurse them and heal them there with any prospect of success cannot be done.'

This was the general opinion of that time in England. Do we hear a slight echo of it where we are? Perhaps we do. Yet the courage and spirit which was theirs who began the first district nursing association is more than just echoing through this land, it is a reality.

Most of you are familiar with the history of Public Health Nursing yet I would venture a little repetition. The New Testament presents Phoebe as 'a succourer of many', and throughout the early centuries we find various religious orders caring for the sick in hospital and in home. It is interesting to note that certain monastic and military orders were dedicated to special diseases, as for example, the Order of St. Anthony cared for the disease known as St. Anthony's. Fire, known now as erysipelas. The Templars attended to the needs of the travellers, pilgrims, and soldiers afflicted with ophthalmia, scurvy and serious wounds, and the Lazarites specialized in leprosy, smallpox, and other fevers.

The Ancient Order of the Knights of Malta maintained something like a district nursing service connected with their hospital in Valletta. To Knights were deputed to each of the towns around the harbour with four 'elderly women' to assist them in their rounds.

Religious and Military Orders in Europe, the Early Social Reforms in England contributed much to the field of District Nursing. Nevertheless, it is to Mr W Rathbone, a Liverpool merchant, that we owe the first definitely formulated district nursing association. Illness had been in his family and he saw how much nursing meant to his household. His desire was that the poor of Liverpool should share in the benefits. The beginning was but an experiment and a somewhat discouraging one at first, yet Mrs Mary Robinson, the nurse who attempted it, asked after the first three months to be permitted to go on. The task which Mr Rathbone took upon himself was not an easy one. There were the sick poor but there were no nurses. Miss Nightingale had no nurses to offer but suggested a scheme which Mr Rathbone carried out. He erected a home for nurses on the grounds of the Royal Liverpool Infirmary, and made an arrangement whereby systematic training should be given to nurses in order that they might supply the Infirmary and also give care to both rich and poor in their homes. The care of the rich was to be done only after the needs of the Infirmary and of the poor had been met...

.....All over the world women and men are entering the homes of their country men to teach health, to care for the sick to instruct in prevention, and though methods differ yet the aim is a common one.

FROM OUR ARCHIVES

The Journal of the Christian Medical Association of India

Vol. XLI No. 1 - JANUARY 1966

Head Injuries and their management

R. Azariah, MBBS, FRCS(Eng)

Neuro Surgeon, Miraj Medical Centre

Violence applied to the head leads to a disruption of cerebral function which may be transient, prolonged or fatal. Head injuries are in all ways most disruptive events particularly to the peace of mind of anyone used to a relatively ordered clinical existence! A severe head injury is a disturbing factor in the efficient running of any ordinary Hospital ward. Apart from the continuous need for careful nursing the patient may be noisy, obstreperous, and a source of torment to other ill patients. Severe head injuries moreover require extremely skilled and devoted nursing care from nurses who have had special training in the problems of the unconscious patient. Such nurses cannot usually be conjured up at a moment's notice in a small hospital. It is therefore understandable that head injuries are not popular with every one.

Most cases of head injury require a certain standard of management rather than active treatment and relatively few need the surgical operations that are so properly emphasized in textbooks. One difficulty is that all are potential candidates for such operations. No head injury should be regarded lightly and no patient should be considered beyond recall, particularly children and young adults who can make surprisingly good recoveries after a seemingly mortal injury.

The important task of assessing a case of head injury and deciding along the line of management depends first and foremost on the history of the accident, and the sequence of events that have transpired in the neurological state of the patient since then.

Thus a patient who has been unconscious before and is conscious at the time of admission requires observation and routine nursing care. The patient who is unconscious at the time of admission but who appears to be lightening in conscious level as shown by the history will also require observation and more specialised nursing care whereas, a patient who is deteriorating at the time of admission from a previously known lighter level, will probably require active and urgent surgical intervention. It therefore becomes of prime importance to be able to answer at any time the question, 'Is the patient's condition improving, static or getting worse?' The only reliable way this question be answered with confidence by anybody looking after a head injury is by keeping an accurate record of the patient's vital functions and most important of all is his or her level of consciousness.....

.....When roused he is able to co-operate with the examiner in performing a coordinated act like gripping the examiner's hand to assess the power of the limb in question. The pupils are equal and react briskly to light at this stage. The pulse may begin to slow. As the conscious level falls further the patient can no longer be roused from his slumber to acts of cooperation. Speech it present may be reduced to vague mumbles or disjointed words uttered in confusion. The equality of limb movements and any oncoming paresis can best be noted by applying a central noxious stimulus. Thus firm pressure over the supraorbital nerve, or better still rub the sternum firmly with the knuckles of the hand after making a fist using the flexed proximal interphalangeal joints.

CHRISTIAN COUNSELLING

Psalm 62:5 says, *'And hope does not put us to shame, because God's love has been poured out into our hearts through the Holy Spirit, who has been given to us.'*

I recently visited Home of Hope run by New Ark Ministries in Bengaluru. They provide shelter, food and health care for about 450 inmates housed in three different locations. Almost all of them are destitute and have been brought in by some individual, police or other social organization. Most of them just eat, sleep and laze around. I asked the founder Mr. T Raja if any of them would be able to make themselves useful if trained in any simple task. He said that would not be possible. Half of them are mentally challenged (perhaps the reason why they were abandoned), and the other half are so distressed and filled with hopelessness that they cannot fathom the possibility of being of any use. This is not an isolated case. There were similar cases among families that I encountered in Bihar last May.

Mr Santosh Vennamalla

Aaron Beck's Cognitive Theory of Depression speaks of the crippling triad of emotions – hopeless, helpless and worthless. This theory has been and continues to be critiqued and scrutinized to see if the three emotions are distinguishable or are different faces of a common emotion. Personally I feel that of the three, the sense of hopelessness drives and feeds the other two emotions. The question 'What drives one to such a state of hopelessness?' may have many answers but what is of more importance is the answer to 'What will give them hope?'

Hal Lindsey, the American evangelist and writer, said, "Man can live about forty days without food, about three days without water, about eight minutes without air... but only for one second without hope." The dictionary defines hope as 'a feeling of expectation and desire for a particular thing to happen.' It also defines hope as a verb – a feeling of trust. When an individual approaches a friend or counsellor, religious or atheist, they would point them to money, material possessions, career and relationships among other things to be hopeful of a good future. When they all fail, they turn to God (this is where the atheists leave). A counsellor from any of the world's foremost religions would have one of these responses. 'Your own actions, present or past, determine your future, and thus no hope from any source should we make a mistake/s.' 'It is entirely in the hands of God irrespective of our actions or aspirations.' 'It is best to give up all desires (material or emotional) in the search for eternal bliss.' This is where Christian faith differs. It rephrases our earlier question from 'What can give them hope?' to 'Who can give them hope?'

Hal Lindsey, the American evangelist and writer, said, "Man can live about forty days without food, about three days without water, about eight minutes without air...but only for one second without hope."

Psalm 62:5 says, '*And hope does not put us to shame, because God's love has been poured out into our hearts through the Holy Spirit, who has been given to us.'* And thus the approach of a Christian counsellor differs from that of the others.

Considering that most counselling (read 'advising') across the world happens informally between family members, friends, acquaintances and workplace peers, we have all by now been a counsellor or a counselee in numerous instances. Not many of us are trained to be counsellors but as Christians we are all called to the ministry of counselling. Colossians 1:28 – '*We proclaim Him, admonishing every man and teaching every man with all wisdom, so that we may present every man complete in Christ*.' There will be many who may question that last bit about

Christ. They would probably say, “How can a God who is out there somewhere understand what I am going through? Ask him to spend one week with my husband / boss / teacher / mother-in-law?”, “He does not know what it is to be in my shoes.” But He does. Let us look at Hebrews 4:15 – ‘*For we do not have a high priest who is unable to empathize with our weaknesses, but we have one who has been tempted in every way, just as we are—yet he did not sin’.* Jesus, through his own experiences while on earth, knows all the difficult times we go through because of disappointment, rejection, betrayal, temptation and trials. Having experienced His redeeming grace how do we bring others to the same knowledge and experience. For those among us who are medical professionals who are able to bring healing to the physical body through the knowledge and wisdom that God has blessed us with, here are a few things that we could keep in mind as Christian counsellors to also help heal the soul and spirit of our patients/counselees and their families.

It is the ability to communicate to the patient/client the counsellor’s sincere belief that every person possesses the inherent strength and capacity to make it in life, and that each person has the right to choose his own alternatives and make his own decisions.

1. Unconditional positive regard:

This implies that we accept the client unconditionally and non-judgmentally regardless of what we know of them. Many times people may be ashamed of how they got themselves into a bad physical condition. They may share secrets of their life that they have never shared before. Sometimes they may be struggling with a sinful habit that they are not able to come out of. As counsellors we may not have gone through such problem behaviours ourselves. At such times, we run the danger of becoming judgmental. They probably believe that they are inferior in some way and thus the troubles that have befallen them.

‘Give me HOPE’

Anything less than unconditional positive regard will only reinforce the rejection they would have already experienced from others.

2. Respect

Respect for a person flows out when you see ‘dignity’ in man. It is the reflection of God in man. It is looking at a person as worthy since he is created in the image of God. Avoid seeing the ‘depravity’ and start looking at the ‘dignity’. This enables a person to see the potential for change and personal growth in a person. It is the ability to communicate to the patient/client the counsellor’s sincere belief that every person possesses the inherent strength and capacity to make it in life, and that each person has the right to choose his own alternatives and make his own decisions.

We should be sensitive to the unique differences arising out of social class, race, and gender. Respect the counselee and the counselee respects himself and others connected with the problem.

They may share secrets of their life that they have never shared before. Sometimes they may be struggling with a sinful habit that they are not able to come out of.

Communicating respect involves:

- Speaking in a warm tone
- Not criticising, lecturing, giving orders or using bad language
- Communicating your faith in the counselee’s ability to solve his problem
- Crediting the counselee for progress

3. Genuineness

Genuineness is at the heart of every relationship, more so a counselling relationship. Counsellors who are genuine are open, honest, sincere and connected. Most problems arise due to artificiality in relationships. Genuineness is shown by the people who are comfortable with who they are and what they feel and hence wear no masks.

This in turn makes counselees comfortable and allows them to be open and honest with the counsellor and with themselves.

To develop empathy, a counsellor must be able to understand the feeling and the reason a counselee is feeling that way. When this understanding is conveyed to the counselee accurately, the counselee feels empathized.

Being genuine involves:

- Being authentic in what you say
- Being as open and spontaneous as possible within the helping relationship

Empathy

We are all familiar with what sympathy means: Feeling sorry for someone. Empathy on the other hand is to share the pain. Feel the pain. It is to put oneself in their shoes and feeling with them, not for them. To develop empathy, a counsellor must be able to understand the feeling and the reason a counselee is feeling that way. When this understanding is conveyed to the counselee accurately, the counselee feels empathized.

Empathy involves:

- Observing the counselee's expressions both verbal and non-verbal
- Taking time to think, time to listen and understand the counselee's perspective
- Avoiding clichés or making interpretation or judgments

And before we get focussed on only 'them' let us remind ourselves of times when we would have experienced hopelessness at some point in our lives – maybe for a shorter period or lesser degree. This would probably happen to us in the future too. Let us pray that Christ be our strength and hope. Let us pray that we will be able to lead those who are not strong enough in Christ or those who do not even know Him into the hope that was bought for us by Christ through his resurrection. 1 Peter 1:3 – '*Praise be to the God and Father of our Lord Jesus Christ! In his great mercy he has given us new birth into a living hope through the resurrection of Jesus Christ from the dead, …'*

As you meditate on 'Compassionate Care Towards Mental Health' this quarter, may the compassion of the Lord shine forth in all your efforts for His kingdom.

Mr Santhosh Vennamalla is the Regional Manager - North, Person to Person - Institute for Christian Counselling

INDIAN DOCTORS IN DILEMMA

Mr D Samuel Abraham

A 45 year old man with hepatitis and features of hepatic encephalopathy was admitted to the Department of Gastroenterology and Hepatology of a teaching hospital in India; this happened during the year 2005. The attending physician ensured appropriate treatment to the patient immediately after getting a proper consent from relatives. Although he was diagnosed to have chronic hepatic failure, he was not treated as terminally ill and hence there was a discussion about the future course. Before being shifted to the Operation Room the patient was clinically "sick" but haemodynamically stable with a heart rate of 103 per minute with and blood pressure of 110/60 mm Hg, with administration of oxygen by mask at the rate of 5 liters per minute with a pulse oximeter continuously measuring the arterial oxygen saturation. According to the ward nurse staff who accompanied the patient to the Operation Theater (OR), he had signs of life while being shifted. When he arrived at the OR, Doctors noticed that he had no pulse and no signs of spontaneous respiration. Considering this to be a witnessed arrest, that is, an immediate event, an external cardiac massage was started and the patient was intubated and ventilated. After intra-tracheal and intravenous administration of drugs and resuscitative measures for four or five minutes, he had cardiac activity and after about 20 minutes he reverted back to sinus rhythm. After resuscitation in the controlled environment of the OR, Doctors discussed this critical event with the patient's relatives who were unhappy about the resuscitation and declined financial support for the resuscitation efforts as well as for further terminal care measures. The patient was transferred to High Dependent Unit (HDU) and was continued mechanical ventilation. After arriving at the HDU the inotropic support was withheld following the relatives request, and the patient died after 24 hours.[1]

Doctors in India face such grave, unhappy and hyper emotional situations every day. Especially for those doctors who are in Intensive Care Unit (ICU), and Clinical Care Units this situation is inevitable.

In this category, the patient's relatives and doctors opine that the patient cannot return to normalcy. But legally, even with these two positive conditions (i) Doctors consider that the chance of return to normalcy is extremely remote (ii) Patient's relatives opine that they are willing to take responsibility for the patient even though the moment lifesaving equipment is removed, the patient may instantly die. Can Doctors withhold lifesaving support? Legally **NO** - they have to get the permission from jurisdictional High Court for doing this.

He is unconscious – his relatives and care takers do not have enough money to pay the bill - what is the option available to the hospital to get their service charges

Where withholding the life support system by the Medical Professional is considered to be "active" to end the patient's life which is an "offence" in Passive Euthanasia, doctors are not actively killing anyone; they are simply not saving him. The latter is considered to be an "offence" and it falls under "breach of contract" as Doctors and the patient are contracting parties now.

The following are a few of the situations where physicians in India find no solutions legally.

a. The intubated and mechanically ventilated patient is admitted in a hospital and he cannot live without life-support. He is unconscious – his relatives and care takers do not have enough money to pay the bill - what is the option available to the hospital to get their service charges – As per available legal

provisions they cannot withhold the life support system even when the relatives opt for this.

b. There are two categories, i.e. "withdrawal" of treatment and "withholding" of treatment. In the first, withdrawal of treatment, following instructions of the treating physician, inotropic support was withheld after relatives opined so, which resulted in deterioration of patient's cardiovascular status and in his eventual death. Whereas when the treatment is withheld, it seems natural that the patient dies of the disease.

Present situation in India

Many of the medical professionals working in corporate hospitals withdraw further treatment that prolongs the life of the patient, or withhold life – saving equipment, but record it thus:-**"*Discharged the Patient against Medical advice*"**

By this the medical professionals and hospital escape from legal proceedings and they record as though the patient's relatives discharged the patient against medical advice.

Another section of medical professionals in India record this boldly that Life support system was withheld as per the request of the patient's relatives – this is unlawful as per existing legal provisions – but they are documenting exactly what they are doing, come what may, or by ignorance.

The orders issued in *Aruna Ramchandra Shanbaugh VS Union of India and Ors*[2] on 7 March 2011 by the Supreme Court of India have not answered the issues raised supra. They answered only one issue raised before it whether life support and medication can be continued to Aruna Ramachandra Shanbaugh or not. The method enunciated by the Hon'ble Supreme Court with abundant caution not to be misused to the disadvantage of the patient is well understood, but how can a hospital /near friend/relatives / doctors file an application for permission to remove life support of an incompetent patient, and await the courts orders, which may take at least 30 days; in that eventuality who will pay the ensuing hospital bills.

What other countries do in this situation.

Countries of the world especially Europe and USA have well – defined laws in place. The following methods are followed in a few countries.

In Europe 90% of the patients reported to have information about Cardiopulmonary resuscitation (CPR). When a patient suffers sudden Cardiopulmonary arrest, usually the decision whether or not to resuscitate depends upon the physician's professional appraisal of the likelihood of successfully restoring Cardiopulmonary functioning of a particular patient versus the probable futility of a resuscitative attempt. Patient and patient's relatives take part in the decision making process. The "**advance directives**" and "**living will**" or through "**Medical Power of Attorney",** is signed by patient beforehand. In some circumstances, the patient nominates a person as "surrogate decision- maker", to take vital decisions on his/her behalf.[3]

In a few countries "**NOT for Resuscitation**" orders are passed by the doctors in connection with the patient and patient's relatives as per legal provisions available.

In the State of Michigan, US, system protocols like "*Do – not – resuscitate Identification bracelet"*, a wrist bracelet that meets the Public Act 368 of 1978 is worn by a declarant while a 'do-not resuscitate' order is in effect. But there are safeguards before issuing this bracelet.[4]

It states that euthanasia and Physician - Assisted Suicide(PAS) are not punishable if the attending physician acts in accordance with the criteria of due care.

In UK, the *Mental Capacity Act 2005* makes provisions relating to persons who lack capacity to determine what is in their best interests and power, to make declarations by a special Court of Protection, as to the lawfulness of any act done in relation to the patient.

In Netherlands, Euthanasia is regulated by the *Termination of Life on Request Assisted Suicide (Review Procedure) Act, 2002*. It states that euthanasia and Physician - Assisted Suicide(PAS) are not punishable if the attending physician acts in accordance with the criteria of due care. These criteria concern the patients' request, the patients' suffering (unbearable and hopeless), the information provided to the patient, the presence of reasonable alternatives, consultation of another physician and the applied method of ending life.

In UK, Spain, Austria, Italy, Germany and France, 'Euthanasia' or 'Patient Against Discharge' is legal.

In USA, Active Euthanasia is illegal in all States. In the States of Oregon, Washington and Montana, enacted laws, such as *Death with Dignity Act, 1997; Washington Death with Dignity Act 2008 Barver Vs Montana*, the Supreme Court of Montana has permitted Physician – Assisted Death with very stringent conditions.

Very recently Canada has permitted Euthanasia and Physician – Assisted Death. Switzerland has an unusual

position on Assisted Suicide; it is legally permitted and can be performed by a non-physician. However, Euthanasia is illegal, the difference between assisted suicide and euthanasia being that while in the former the patient administers the lethal injection himself, in the latter a doctor or some other person administers it. Article 115 of the Swiss Penal Code, which came into effect 1942 considers assisting suicide a crime if, only if, the motive is selfish. The code does not give physicians a special status in assisting suicide. Switzerland seems to be the only country in which law limits the circumstances in which assisted suicide is a crime, thereby decriminalizing it in other cases; without involvement of a physician. Many persons from other countries especially Germany, go to Switzerland to undergo euthanasia.

Belgium became the second country in Europe after Netherlands to legalize the practice of euthanasia in September 2002. To qualify for euthanasia a person must be in "c*onstant and unbearable physical or psychological pains".*

The Hon'ble Supreme Court of India has made proper distinction between Section 306 and Section 309 of Indian Penal Code in *Smt. Gian Kaur Vs The State of Punjab*[5] *(1996 SCC (2) 648)*. Sec 306 prescribes punishment for abetment of suicide while section 309 punishes attempt to commit suicide. In some countries, attempt to commit suicide is not punishable, assisted suicide and assisted to commit suicide are made punishable for cogent reasons in the interest of society. An argument is advanced to support the plea for another person assisting in the commission of suicide or in the attempt. The author views this differently, in as much as he abuts the extinguishment of life of another person, and punishment of abetment is considered necessary to prevent abuse of the absence of such a penal provision. However, the Hon'ble Supreme Court set-aside the Judgement and Order of the Bombay High court which declared invalid the Section 309 of IPC.

The Initiative of Government of India

We should certainly appreciate the initiative taken by the Government of India (GOI) by referring this matter to Law Commission of India to study and recommend suitable legislation on this subject.

The Law Commission of India in its 196th report [6], had in its opening remarks clarified in unmistakable terms that the Commission was not dealing with "Euthanasia" or "Assisted Suicide", which are unlawful, but the Commission was dealing with a different matter, i.e. "withholding life support measures to patients terminally ill, and universally in all countries such as withdrawal is treated as lawful." Time and again, it was pointed out by the Commission that withdrawal of life-support to patient is very much different from euthanasia and assisted suicide, a distraction which has been sharply focused in Aruna's case. The Law Commission in its 196th report suggested legislation and even drafted a Bill entitled "**Medical *Treatment to Terminally ill patients (Protection of Patients and medical practitioners) Bill 2006***." In this legislation, a simple procedure has been prescribed, i.e. the attending medical practitioner will have to obtain the experts opinion from an approved panel of medical experts before taking a decision to withdraw / withhold medical treatment to such patients.

This method is very easy to follow. It would be easier on the doctors, patients and patient's relatives when compared to the procedure prescribed by the Supreme Court in *Aruna Case* (supra). Moreover, this will help the medical fraternity in India to save:

1. their valuable time which could otherwise be utilized to treat patients crowded at the hospital rather than spending time in the corridors of the High Court for permission.
2. money spent in filing the petition to obtain permission before the jurisdictional High Court, where in many States the distance between the hospital and the location of the High Court would be more than 600 kms.
3. medical expenses incurred towards the upkeep of the patient in **coma stage** or **vegetative stage,** from the application date and final order date of the Court.
4. mental agony of the dear and near ones who are to take care of the patient at hospital campus leaving all their routine work schedule.

The approved panel of experts may be from the District level and they can be easily approachable. The Government has to meet the expenses of the Expert Committee members towards their conveyance, stay and honorarium to be paid to them for their possible help. The State Government should constitute this Expert Committee in every District.

Suggestions

1. Super - Specialty Hospitals which are dealing with the similar patients described *supra* may form an association to represent effectively for converting the bill "*Medical Treatment to terminally ill patients (Protection of Patients and Medical Practitioners) Bill 2006*" into an Act of Parliament at the earliest.
2. The Medical Expert Committee shall be constituted as per Section 7 of the above bill at "District level" and not "State level".

3. The Bill is silent about conveyance, boarding and lodging facilities and honorarium to be paid to the medical expert who visits the hospital. It must be specific that the Director of Medical Services/ Education must pay these expenses which are fixed by State Government from time to time.
4. The Medical Council of India, Medical Association of India and all other similar associations, with one voice have to pass resolutions in their General Body, send the same to the Union Health Ministry and State Health Department and follow the matter at official and political level.

We all know that discontinuance of artificial feeding in such case is not equivalent to cutting a mountaineer's rope or severing the air pipe of a deep sea diver. But unfortunately Indian Laws, as available at present, do not make a distinction between the two. Only Judge-made laws now protect the medical fraternity.

The time has come for all the medical fraternity to rise up in one voice to get the Bill passed, so that the halter around the medical professional's neck is removed and they are at liberty to practice their profession without any restrictions and reservations just as other professionals do.

Mr D Samuel Abraham is Sr. Legal Consultant in Christian Medical College, Vellore, Tamil Nadu

REFERENCE:

1. Dr.Sanjib Das Adhikary, Dr.R.Raviraj, Do Not Resuscitate Orders, Case study published in Indian Journal of Medical Ethics, Vol III N0 3 July – September 2006.
2. Aruna Ramchandra Vs Union of India & Ors (Writ Petition (Criminal) No.115 of 2009)
3. Naveen Sulakshan Salins, Sachin Gopalakrishna Pai, MS Vidyasagar,and Manikkath Sobhana :Indian J Palliat Care. 2010 May-Aug; 16(2): 66–69.
4. Michigan, US, system protocols like "Do – not – resuscitate Policy"
5. Smt.Gian Kaur Vs The State of Punjab (1996 SCC (2) 648)
6. 196th Report of Law Commission of India

First South Asian Regional Conference of International Medical and Dental Association (ICMDA)

27 - 30 October 2016

The Christian Medical and Dental Associations across the globe are members of ICMDA (International Medical and Dental Association). ICMDA has 12 regions. Each region comes together for Regional conferences for times of fellowship and support.

The South Asia region, which has members from India, Nepal, Sri Lanka, Bangladesh, Myanmar, Pakistan and Bhutan, is having the first SA regional conference at Kolkata from 27 - 30 October 2016.

CMAI and EMFI are co-hosting the same along with their National Doctors and Students conferences. If you are a Medical or Dental Graduate or a Student, kindly block your dates. Watch this space for more details.

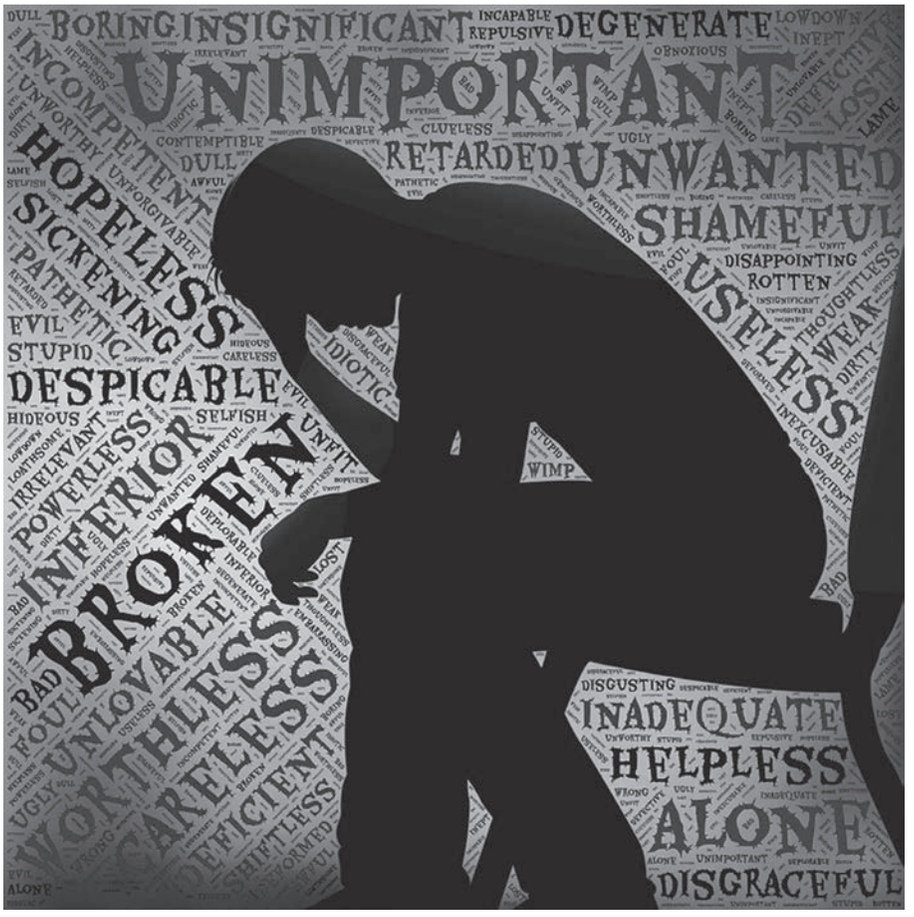
MENTAL HEALTH AND YOUNG ADULTS

Rev Sharath C David

Young adult is a stage when someone moving from youth to adulthood, he or she settles mentally ready to enter into the long term hauls of life and relationship. They are also at a vulnerable period where emotions, feelings, and stakes are at a high pedestal. A young person can easily be made or broken and as it's a break or make stage of the life. A little topsy-turvy in life can spin them out of the purpose of life and its meaning and dump them into deep confusion.

A young adult needs lot of appreciation, guidance, supervision, approvals and help from time to time when they get stuck in life. What this stage signifies is uncontrolled speed or raw power, rapid excitements and disappointments, spirit of adventurism, fearlessness, ready to take risk and the ability to learn new skills and want to achieve something that is difficult and rarely accomplished.

This is also a stage when young adults search for life partners and prime reproductive stage in one's life, when hormone levels are peeking for courtship, love and search for a potential person to settle in life for a long term relationship to build a family.



Depression and help

A simple bad experience can destabilize them and can cause flutters that would make the situation complicated. It is like a thread when it gets entangled with each other, it needs lot of patient work to untangle it. Only a professionally trained and experienced counselor who respects other human being as the image of God can help such individuals.

A young girl Rosy (name changed) who is 26 years of age came in with a lot of frustration and was depressed too, Rosy was in love with a boy Abraham and they both were in a relationship for more than four years and soon they had misunderstandings which finally led to their break up. Rosy said " I have stopped going to work the past week and am not able to eat, crying bitterly over what had happened, I am pulling on the days with sleeping pills and I give up, it is too much, this is the second time this has happened to me, first time

somehow I managed to come out of it after six months and this time I know that I am going to end my life, I can't bear this I still love Abraham and I am not able to forget him."

Rosy was counseled for three sessions and over a period of time with follow-up calls, the very next day she started going to work and also started eating food and now she is able to rest without any sleeping pill. As she left the very first day she promised she would not think even of ending her life. Rosy is now preparing herself to give competitive exams, she found it hard to come out of this situation but God has healed her wounds. Rosy is stable now.

Depression can be triggered due to disappointments, constant failures and criticisms, complications of love affairs, stressed relations and loss.

What is depression? It is a situation where the human mind goes in to a shock and non-responsive condition where the individual loses control to take cognitive decisions and have struggle to face the next hour/ day.

Depression is a common but serious mood disorder. It causes severe symptoms that affect how you feel, think, and handle daily activities, such as sleeping, eating, or working. To be diagnosed with depression, the symptoms must be present for at least two weeks. Source www.nimh.nih.gov

Hurts and fear

These hurts of the past or present differs from individual to individual which are harbored and stored to make a person react, or deal with situations differently. There is a lot of hurt piling in the background for them to behave abnormally or awkward. There are permanent scars and temporary scars depending on the individual's personality to get it erased or remembered as hurt. My lecturer in pastoral counseling class used a case study of a girl who was abnormally afraid of Dogs and this behavior was analyzed later in her life and she was helped. This was due to her bad childhood experience with a dog that bit her badly and the scar remained in her which made her abnormally afraid of dogs even the ones which are docile. She was counseled and helped to face her own fear which slowly helped her overcome her fear of dogs.

There is a lot of hurt piling in the back ground for them to behave abnormally or awkward. There are permanent scars and temporary scars depending on the individual's personality to get it erased or remembered as hurt.

Most childhood bad experiences are manifested in different ways or it starts affecting life. Some hurt if not dealt or resolved can linger in life for a long time and can be an irritant or nuisance. It is better to throw these unwanted bags and baggage from life and move forward for a better tomorrow.

There can be many scars that people carry or push under the carpet thinking that it may not affect them. Every response a person carries out can be related to his or her past which can be addressed and resolved.

There are raw wounds of the mind which needs immediate attention or wounds of the mind that once in a while cause abnormal behavior.

Conflicts and peer pressure

Conflicts are part and parcel of life which interferes with ones interests and goals in life**.** *The Webster dictionary defines it as a difference that prevents agreement: disagreement between ideas, feelings, etc. Competitive or opposing action of incompatibles : Antagonistic state or action (as of divergent ideas, interests, or persons) mental struggle resulting from incompatible or opposing needs, drives, wishes, or external or internal demands.*

The struggles are both internal and external factors that affect life at a time where it becomes a state of confusion of idea and action. Clarity and clear vision is blocked and makes an individual go biased and blind. How does one handle conflicts of interests, mental struggle that brings confused decisions or action? If a young adult learns to be more objective in life, conflicts need not confuse or distract them.

Conflicts can be a constant irritation in day to day life. Jesus himself experienced this in this life with the religious leaders and Pharisees in the world. The important lesson is, focus on Jesus who is the author and finisher of this life we can overcome conflicts and difficulties of life with Him. “But be of Good cheer: I have overcome the world” in John 16:33 as Jesus says.

Confidence and ability to complete tasks

The translation of life’s confidence to build and complete tasks is the litmus test for healthy minds. Half done and incomplete works are signs of less confident and confused individuals and minds. When an individual tastes success, it makes them more confident to achieve more. It also helps them to take risks in life; to be achievers.

Some time back a parent of a young adult called me over the phone saying my son who is intelligent and educated is not responsible and able stay in one job and is not able to be consistent. He goes to work sometimes regularly and at times he does not go to work for a long time and invariably loses his job. He is talented but that does not reflect in his life and at times he goes in to a shell and does not come out of it. It is usually that something that bothers a person at the back of the mind that causes behavioral change and inconsistent behavior. How do we help people in such condition? They need a lot of understanding, support, listening and counseling with love. They are to be treated with lot of tender loving care till they rediscover their worth and value to be successful in life.

Discovering and experience God

It all begins here as this is central to one’s life as to how one is mentally stable to handle situations and resolve problems in a matured way. Our life began with God and He should be the centre of all that happens in our life; to allow God to lead and be our shepherd will be a good discipline.

This life God wants us to live in abundance and enjoy our relationship with Him and our family and friends. It is the work of the evil to cut short the joy of this as the outcome of the beautiful relationship with God, family and friends.

We have a choice to either accept the world and all that goes with it or displace God and be our own shepherd or to recognize, accept and commit our ways to God which needs to be the priority in one’s life. Discovering God, knowing Him as our source and shepherd is the key to the success in life.

If God is experienced then most of the priorities are set so the person knows whose life is in control and what is expected of the individual. The earlier we seek the face of God, life becomes enjoyable though there are challenges but one is always above the problems and the issues that confronts us; with their head above the waters.

God is our maker it is he who makes our life pleasing, successful and He can help us when we are stuck or not able to move forward. God knows our innermost being and it is he who can make us well and put us back on the road. Nobody can make us whole as our creator for each one of us is fearfully and wonderfully created.

Knowing God and experiencing Him is the ultimate height a young adult should aim in life for better perspective at every situation of life.

Relationships and the elders

Though our life is centered in God it all summed up in how we deal with neighbors, elders and family members.

This life need not be limped with hurts and conflicts and depression. This life God wants us to live in abundance and enjoy our relationship with Him and our family and friends. It is the work of the evil to cut short the joy of this as the outcome of the beautiful relationship with God, family and friends. The doubts on people, hurts we

With God at the centre of life, with all the expectations from family and society, we are called to fulfill every purpose and plan of God in this life.

harbor, and conflicts we live with needs to be brought at the cross of Christ where acceptance, forgiveness and restitution for our broken minds and life are discovered and we become complete in Christ who is our redeemer and source of our life and healing.

Looking after parents and siblings and helping them in their old age and sickness is a responsibility of every successful individual. It is not a matter of shirking responsibility and saying 'I will be selfish and look after my life' which is not the wish of God. Even Christ on the cross asked his disciple to look after his mother. We can never receive God's blessings by being irresponsible but receive His blessings by taking responsibility of one another. God has not designed life to be lived alone or in solitude but by sharing and caring for one another. It is in that we find meaning, fulfillment of life and abundance.

In conclusion it is important to succeed in life, reach our destination that God has set for each one of them. With God at the centre of life, with all the expectations from family and society, we are called to fulfill every purpose and plan of God in this life. It is the responsibility of people to help each other succeed and make a difference in life. An individual can make lot of plans to succeed but he should depend on God and his resources to take life forward. If he or she tries to build life with their strength it can end up in disaster. It is important to remember God as a young adult to be successful in life; there is no shortcut or any other alternative to Trust and depend on God to succeed (Eccl 12:1).

One major problem everyone faces in life is to forget God and backslide in life. Yes life is full of ups and down, we go through difficult passages and trials, suffering come only to make us strong.

Rev Sharath C David is the Secretary of Chaplains Section, CMAI

MODERN MIGRATION AND MENTAL HEALTH

Introduction

Industrial Revolution with all its glory resulted in not just pretty gadgets and clothes but also into something darker. According to R Lousome and R B Bhagat (2001) 30% of the total population in India are migrants and this must have drastically increased over the last 15 years.

Ms Saharsha S Jacob

Though internal migration is recognized as a major factor that influences the social and economic development of a country, especially in developing countries, modern migration has men and women move to cities for work or education to maintain the symbol of a resurgent India with malls, metros, BPOs, IT services, industries, research and educational institutes. In all the chaos and confusion of the city with different cultures, habits and upbringing, one wonders about the mental health of the people in their fight to survive the madness of the city, strive for success or establish their name in a place they are invisible. WHO has statistics that shows that the highest percentage of people who fall victim to depression and suicide are young adults from 15-29 years.

Mental health is a vast subject that has shades of grey way more than fifty. It moves from severe mental retardation, schizophrenia and depression. This article describes the mental issues faced by migrants, the environmental factors and the coping mechanisms that young adults can use during such difficult times.

WHO defines Mental Health as *a state of wellbeing in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully and is able to make a contribution to her or his life.* Every psychologist is made to learn this definition by heart to help those who come to them to *cope* with the difficulties of life. The definition explains that if a person's environment is disrupted or disturbed and she/he cannot cope with the environment, then their mental health is at risk.

WHO defines Mental Health as *a state of wellbeing in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully and is able to make a contribution to her or his life*

Mental health among migrants

Being a migrant, every city brings its set of fears, challenges and coping mechanisms. They can be cultural differences, language barriers, acceptance/rejection of the society towards the minority group, alienation and loss of cultural identity leading to identity crisis. Since most of us migrate because of the motivating factor of a job or education, the initial stages of migration is not as stressful as the later stages when we begin to understand our potential, adjust with our peers of different cultures while working towards the goal or field where we can contribute the most. These factors are strongly influenced by the social support networks and cultural congruity which alleviates and even eliminates any kind of negative thinking.

A short survey was taken on young adults who have been away from home for the purpose of studying or working. The findings were similar – cultural barrier and shock, language barriers and especially racism for those who look physically different. And those who responded to the cultural changes being barriers also spoke about problems related to low self esteem and change in emotions (being quieter and, angry often in the beginning). But they were capable of coping with such stress and used it to make them stronger and more confident in their daily tasks in life. An interesting observation was that most of the people had friends who they could count on mostly from the place they belonged to.

A migrant entering a city goes through a flow of emotions. "It is not surprising that immediately after migration, individuals may be optimistic and hopeful, and thus show low levels of depression and anxiety, which may change as they start to settle down.

They may feel let down by the new culture and perhaps their own culture and start to ruminate over losses they have faced, thereby leading to depression. Some studies show that the rates of common mental disorders among migrants are higher than among the members of the new culture, but others show either no difference or lower rates"

Cultural changes lead to mental health issues where the "stress include culture shock and conflict, both of which may lead to a sense of cultural confusion, feelings of alienation and isolation, and depression. Then new society's attitude, including racism, compounded by stress of potential unemployment, a discrepancy between achievement and expectations, financial hardships, legal concerns, poor housing and a general lack of opportunities for advancement within the host society, can lead to mental health problems in vulnerable individuals." (WPA guidance on mental health and mental health care in migrants, 2011)

There is a mention of *vulnerable* individuals. Vulnerable individuals are those who are not capable of coping with the disrupted environment. Those that were interviewed were persons who went through disruptions in their environment but were able to overcome and cope with mechanisms unique to them.

Environmental factors

There are environmental factors that majorly influence a person. The negative factors begin with the interpersonal factors which include experiences of victimization, family conflict, family/peer rejection, social isolation, poverty and housing instability. Other external factors include school, neighborhood safety and stereotypes. The grave factors include stigma, discrimination, social and economic marginalization, criminalizing or disenfranchising public policies. This results in negative coping mechanisms which lead to higher vulnerability of mental concerns like depression and suicide.

The resilient factors begin with intrapersonal traits or characteristics of the social environment that protect young people from harm and reduce the likelihood of mental health disorders among the vulnerable youth. It includes high self esteem, positive self image, spirituality, hopefulness, positive expectations of the future and participation in support or advocacy networks.

Interpersonal factors include family and peers who play an important role in youth development. Social support is generally hypothesized as a protective factor that buffers individuals against the potential negative consequences of stressful events. However, social support from family and peers may have differential effects for the youth including positive or no effects at all. Family connectedness and positive family acceptance have also been associated with positive mental health outcomes, particularly gender minorities.

Availability of support systems from caring adults including teachers, mentors, access to youth social groups, anti-bullying and non-discriminatory policies in colleges and work places and church.

Coping strategies

The reason most of the participants that were surveyed had good mental health was due to their coping strategies. Few of the coping strategies were painting, singing, studying, reading, talking with friends, involvement with institutions like the church, a drama or theatre club, part of a band and exercise. They are few but effective all the same and are also advised by medical psychiatrists.

Importance of good parenting

When you step out of the intrapersonal periphery you move to the interpersonal that includes family and friends. Unlike friends and spirituality which are uncontrolled environments, the family is a controlled environment, and as a family (siblings and parents) there is a responsibility that leaves a lasting effect on your child's mental health, especially as Christian parents, there is a bountiful duty to shepherd your children.

As parents it is necessary to understand a child's potential (strengths and weakness) that will help them cope in the future. It is important to encourage children in the areas they are good at and support them in their weak areas.

Coming back to the WHO mental health definition, *a state of wellbeing in which every individual realizes his or her own potential.* As parents it is necessary to understand a child's potential (strengths and weakness) that will help them cope in the future. It is important to encourage children in the areas they are good at and support them in their weak areas. Pressurizing, over-expectations, being authoritative, being too indulgent or even being indifferent to a child can result in low self-esteem, aggression or both. It is said that a young adult's behavior can be easily traced through the family dynamics than their peer influence.

With the bright lights of the city, with people continuously moving in and out, with no time to look or talk to each other, something unnatural to the human species is occurring, that is, there is no space for venting emotions. Family, which is the basic unit in society, is an essential component that can make a huge difference towards a person's mental health. The core issue of mental health is aptly addressed by C S Lewis, *"Mental pain is less dramatic than physical pain, but it is more common and also more hard to bear. The frequent attempt to conceal mental pain increases the burden: it is easier to say "My tooth is aching" than to say "My heart is broken"."*

Ms Saharsha S Jacob is the Project Officer in Community Health Dept, CMAI

REFERENCES

1. Bhugra, D., Gupta, S., Bhui, K., Craig, T., Dogra, N., Ingleby, J. D., … Tribe, R. (2011). WPA guidance on mental health and mental health care in migrants. *World Psychiatry*, *10*(1), 2–10.
2. Kirmayer, L. J., Narasiah, L., Munoz, M., Rashid, M., Ryder, A. G., Guzder, J., … Pottie, K. (2011). Common mental health problems in immigrants and refugees: general approach in primary care. *CMAJ : Canadian Medical Association Journal*, *183*(12), E959–E967. http://doi.org/10.1503/cmaj.090292
3. Harper W, Gary, Mutumba, Massy. (2015). Mental Health and support among young key populations: an ecological approach to understanding and intervention. *JIAS: Journal of the International AIDS Society*. Volume18, Supplement I. http://www.jiasociety.org/index.php/jias/issue/view/1472
4. Dr. Francis, C.M. Dr. Joseph, George. George, P.O. (1992). Proceedings of the Workshop on Promotion of Mental Health with Community Participation. *Centre for Health Care Research and Education*. Kerala. Print.

THE JOURNEY OF SALVATION ARMY EVANGELINE BOOTH HOSPITAL AHMEDNAGAR

Ahmednagar is a city with a rich historic heritage dating back to the 15th century. It was a kingdom ruled by the Nizam Shahs. The city itself was founded in 1494 by Ahmad Nizam Shah and named after him. It was his seat of government for the kingdom. A large fort was erected from 1553 to 1565 and the walls remain today as a historical monument. Close to this fort and on the edge of the city lies the Evangeline Booth Hospital. The local people called it "Dagadi Dawakhana" meaning "Hospital of Stone ". The reason for this is evident when one looks at the original buildings which are made from granite stone.

Major John Rohmingliana

"The hospital was founded in the year 1904 by Dr. Ruth Hume and others of the American Marathi Mission .It had a long period of useful and successful service, the greater part of the time as a Women's and Children Hospital staffed by Drs Ruth Hume, Eleanor Stephenson, Clara Proctor, Harriet P. Clark and Maria Korchagina among others during this period. Under Dr D O Sendel in 1932 it became a General Hospital, until, owing to necessary retrenchments, it was closed down on the 31st December 1934. The suggestion that it be re-opened by The Salvation Army was made even before it was closed down and negotiations were begun in 1934-35 by the former Territorial Commander, Lt. Commissioner (then Colonel) A H Barnett. They were, after a lapse, renewed again in 1936 under the present Territorial leader. When General

Evangeline Booth visited India in that year, her personal interest was aroused and shortly afterwards the property was acquired and renovated after its period of disuse. There was a further unavoidable delay in opening, as the staff was not at once available, but in March 1939 the present Medical Officers in London were appointed to the Hospital, and by May 1939 had arrived in Ahmednagar, and the Hospital was opened again on June 26th 1939 by W G Hulland, Esq., ICS. The present Hospital owes much to the established reputation of the Nursing Staff of the American Marathi Mission in previous days and gratefully acknowledges this background to our present effort."(From First Annual report: 1940)

Evangeline Booth Hospital began in 1939 with 50 beds and expanded to approximately 170 beds by 1976. Currently the capacity is 100 beds. Soon after opening, the need was seen to start a training school for nurses to meet the problem of lack of adequately trained nurses. In 1943, the EBH nursing school was established and was approved in 1944 by the Bombay Nursing Council. A dream was fulfilled with the building of the Nurses School and Hostel in 1949. This achievement was made possible because of the interest and support of Lady Colville. Mrs. General Orsborn opened the "Lady Colville Nurses Home" on the 8th February 1949.

"During the early years of the Hospital, tuberculosis and leprosy were seen as pressing medical problems in the community and another dream was fulfilled with the opening of the new TB wing and on 2nd February 1952 by Hon'ble Minister of Health for India, Rajkumari Amrit Kaur. The main ward was named after the late N M Wadia whose trust gave the most generous donation towards the construction. The goal of the hospital then was to check expansion of disease in this area, and then to limit it and in time to defeat it "(Annual Report -1951). Extension work of the hospital was concurrently going on at dispensaries in Pathardi, Ghodnadi (near Shirur), Hanga and Parner."

The next step of the hospital was to tackle the problem of the Out Patient Department. Even the first Annual Report of the hospital records the importance of Out Patient treatment with the following report: "A visit to the hospital is sometimes in the nature of a village outing, as on one occasion when about a dozen people came from one village.

After being examined and receiving each of their medicines, they sat in a group under a tree outside and passed each other pills and potions round for mutual inspection and finally just as we were leaving, the headman came to say that they had now got them so mixed up that they had no idea 'which belonged to whom'. Adjustments were quickly made".

The patients in those days had to wait in a cramped area and there were only two consultation rooms. In the late 1950's a new Out Patient waiting room and Research Laboratory were added. Also a men's ward was added.

INSTITUTIONAL FEATURE

A dream was fulfilled with the building of the Nurses School and Hostel in 1949.

The Hospital also runs the Community Health Development Project (CHDP) for Diabetes and Hypertension and it covers the villages of Pathardi, Shrirampur, Shevgaon, Satara, Ahmednagar and the outskirts of Pune.

In 1958 the Nursery Ward was built for healthy children under the age of 2 years most of whom were orphans. The children were kept until other arrangements were made for them. To meet the growing demands of the hospital, a new X-ray Department was constructed in 1960 and named after Dr Picken, whose Trustees generously gave Rs.10,000 towards the project. The Norwegian Scheme of 1965 provided a grant of Rs. 2,00,000 towards assisting the on-going tuberculosis work, the purchase of a portable X-ray unit and the construction of new doctors and staff quarters. General F Coutts broke the ground for the new quarters.

Oxfam came to the hospital's aid by helping donate equipment for the Physiotherapy Unit which was established in 1967. Also, during this time extension work was going on at the dispensary at Rahuri, a village 37km from Ahmednagar.

Sudden and unexpected changes occurred in the year 1972 with the untimely deaths of Captain (Dr) Murray Stanton and Mrs. Captain Shirley Millar. Their loss was a severe blow to the work of the hospital which was at a stage of expansion and growth. They were loved by many and their lives were exemplary of the Christian Life. Even today the memory lives on of their great work and God-fearing lives. Today the male medical and surgical ward is named in honour of Dr. Stanton. Following those crisis was a period of getting the hospital back on its feet, and the next few years saw much struggle as the Administrator, then Captain T K Wylie, overcame many obstacles to return the hospital to a position of development and financial stability. The Out Patient Department was again expanded in 1978 to meet the growing need of space for treating out patients.

Again in 1973 a need was realized and fulfilled with the opening of the Private Ward and Intensive Coronary Care Unit by the Municipal President Shri N Barshikar and then International Secretary for South Asia, Commissioner A W Hook, thus providing new services to the community. The ground floor was completed with plans to add on more floors in the future.

In 1979, with the partnership of CBM (Christoffel Blinden mission) an Ophthalmic Project was launched to provide services in the district. The project has been struggling due to the short stay of qualified Ophthalmologists.

A long awaited dream came true in 1985 when the Shirley Millar Memorial Hall was completed. The cornerstone has been previously been laid by the then General Arnold Brown during his visit to the hospital in 1980. For a number of years the then Mrs Captain Iris Wylie worked hard raising funds for the building. Today it is a joy to be able to worship in a lovely building rather than make -do places or nurses dining room as was previously necessary.

The Evangeline Booth Hospital at present is a well-functioning Secondary Hospital catering to the needs of the People in and around Ahmednagar with Medicine, General Surgery, Orthopedics, Gynecology, Pediatrics, Urology, Ophthalmology, ENT, Psychiatric care.

Under the State Government Insurance scheme the Hospital also runs the Rajiv Gandhi Jeevandaaye Arogya Yojona (RGJAY Scheme) and this helps the hospital to serve the suffering humanity at its best.

The Hospital also still runs RGNM course with 20 intakes per year and the course is recognized by Indian Nursing Council (INC) and Maharashtra Nursing Council (MNC)

The Hospital also runs the Community Health Development Project (CHDP) for Diabetes and Hypertension and it covers the villages of Pathardi, Shrirampur, Shevgaon, Satara, Ahmednagar and the outskirts of Pune. Free Diabetes Screening is done regularly by the Team in the above mentioned areas.

It is my earnest request to all the readers and members of CMAI to continually uphold us in your prayers as we serve the Suffering Humanity with the Love of Christ.

Major John Rohmingliana is the Hospital Administrator of The Salvation Army Evangeline Booth Hospital, Ahmednagar.

MUKTI IS IN NEED OF THE FOLLOWING COMMITTED STAFF ON SHORT/LONG-TERM BASIS

Residential Doctor/Doctor Couple to serve the Mukti Community of 600 people and the village outside.

Minimum Qual. MBBS. Additional qualification and experience in gynaecology/paediatrics desirable.

Pandita Ramabai Mukti Mission was started in 1889 and is still serving the needy Community as a Beacon of Light. The founder, **Pandita Ramabai**, was a pioneer in several ways. Against many odds, Ramabai was the first in many unexplored fields and has changed the image of India for the better. Her vision of transforming and empowering women and children is still very much part of Mukti today. Mukti has multi-faceted ministries. Our medical facilities include ICU/OT etc. We also have a dental unit and a nursing home. Interested candidates will have an opportunity to serve the abandoned, abused and ostracized with Christian compassion.

Our ministry include : Homes for the Destitute Women and Children, Care for the Elderly, Care for Women and Girls with Special Needs, Care for the Visually Impaired, Nursery and Infant Care and Community Development Programmes. We also have an English medium school & Junior College in campus.

Emoluments will commensurate with qualification and experience.

Accommodation with partially furnished staff quarters will be provided on campus.

For those couples who have younger and school going children, we have a baby care centre and an International Standard English Medium School up to 10th Standar`d.

Recently retired couples/doctors in good health may also apply. This is an ideal set-up for individuals/couples who want to make a short/long term commitment to Missions.

Kedgaon is 60 kms. away from Pune City and 245 kms. from Mumbai with good rail connectivity going North or South.

'But for all who fear my name, the Sun of Righteousness will rise with healing in his wings. And you will go free, leaping with joy like calves let out to pasture.' Malachi 4:2

Please contact:

The Mission Director
Pandita Ramabai Mukti Mission
Kedgaon, Pune District - 412 203
Maharashtra
Email: superintendent.prmm@gmail.com

CHRISTIAN MEDICAL COLLEGE, VELLORE

DEPARTMENT OF DISTANCE EDUCATION

Admissions now open for Distance Programs 2016

Course I

"POST GRADUATE DIPLOMA IN FAMILY MEDICINE" (PGDFM) - 2 Years

Motto: "Refer less, Resolve More!"

'A Family Physician is a multi-competent specialist who not only provides the point of first contact, but also patient-centred continuum of care.'

Are you interested to become a Family Physician as per the definition?

CMC Vellore offers you a unique opportunity to become one, right from where you are!

ELIGIBILITY

Doctors with MBBS Degree with State/MCI Registration or Pass in MCI Screening test for FMGs. Preference for Candidates working in Mission Hospitals. Foreign National can also apply.

HIGHLIGHTS

1. 100 Problem based interactive modules, in Self Learning Format.
2. Video-lectures and live Video - Conferencing sessions with Expert CMC and International Faculty.
3. Eight Regional Study Centres across the Country.
4. Three Contact Programmes of 11 days each during the course period of two years.
5. Assignments and Project work.

Course Fee

Course Fee is : Rs.68,000/-
Foreign Nationals, NRI : US $1900

For Details Contact us at : dedu@cmcvellore.ac.in

Cell: 9790311199, 9790311188, 9003461291

Last date for submission of online application is 31st May 2016

Course II

"DISTANCE FELLOWSHIP IN DIABETES MANAGEMENT" (DFID) - 1 Year

Diabetes Mellitus has become a public health problem with more than 15% of the Indian urban population above the age of 30 years afflicted with this disease.

You can be trained in the management of diabetes, to be able to offer a "single-window integrated diabetic care", through distance mode, right from where you are.

ELIGIBILITY

MD/DNB (General Medicine) / DNB (Family Medicine) / M.Med, PGDFM (awarded by the Christian Medical College, Vellore). MRCGP, FCGP, MD (General Practice) Mission Hospital Doctors with any Post Graduate Degree can apply.

HIGHLIGHTS

1. 25 Problem based interactive modules, in Self Learning Format.
2. Ninteen DVD Lectures by CMC experts on Diabetes management
3. Two Contact Programs during the course period of one year, at CMC, Vellore (1st Contact Program consists of clinical and class room teaching and 2nd Contact Program offers intensive hands-on training).
4. Assignments and Project work

Course Fee

Course Fee is : Rs.65,000/-
Foreign Nationals, NRI : US $1900
SAARC Countries : US $1100

For Details Contact us at : dfid@cmcvellore.ac.in

Cell: 9790211166, 9367985537

Last date for submission of online application is 20th May 2016

Scholarship for Mission Hospital Doctors:

Candidates working in any Mission Hospital applying for either one of the courses will be eligible for scholarship in the course fee, on submission of a letter of recommendation from their Hospital.

Applications are now available online for the admission to both courses.

Log on to http://admissions.cmcvellore.ac.in

The Coordinator, Department of Distance Education,

3/1 Arni Road, 1st floor, Above Shalom Clinic, CMC, Vellore 632 001. Tamilnadu, India.

CMAI NEW GUEST HOUSE FACILITIES IN DELHI

Enquire and book your accommodation through telephone and email

WHO CAN STAY?

CMAI Guest Rooms are available to its members, member institutions, staff, official visitors, sister agencies and friends of CMAI for temporary stay.

- Provision of 14 beds accommodation
- 5 rooms with 2 beds each and one with 4 beds
- Additional folding cots can be provided if required

OTHER FACILITIES

- 24 - hr security and services of a care taker
- 24 - hr power supply
- Coffee/Tea can be self made
- TV with cable network
- Huge drawing and dining room with sofa
- AC Rooms
- 24 - hr running water

LOCATION:

1. Located in Pratap Nagar, opposite to Harinagar DTC Bus Depot and Tihar Jail,New Delhi
2. Connectivity: Situated close to the Tilak Nagar Metro station (1.5 kms) and New Delhi International airport (10 km). It is well connected by bus/ taxi/ auto, etc services.
3. Neighbourhood: The place is close to shopping malls, markets, good hotels, hospitals, etc. The area has parks and gardens which offer a pleasant & peaceful environment to stay.

For further details
Please contact CMAI Administration

Tel: 011-2559 9991/2/3, Fax: 011-2559 8150, Email: cmai@cmai.org, admin@cmai.org
Ms Elizabeth Mathew, Mobile: 9868142622