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CMJI

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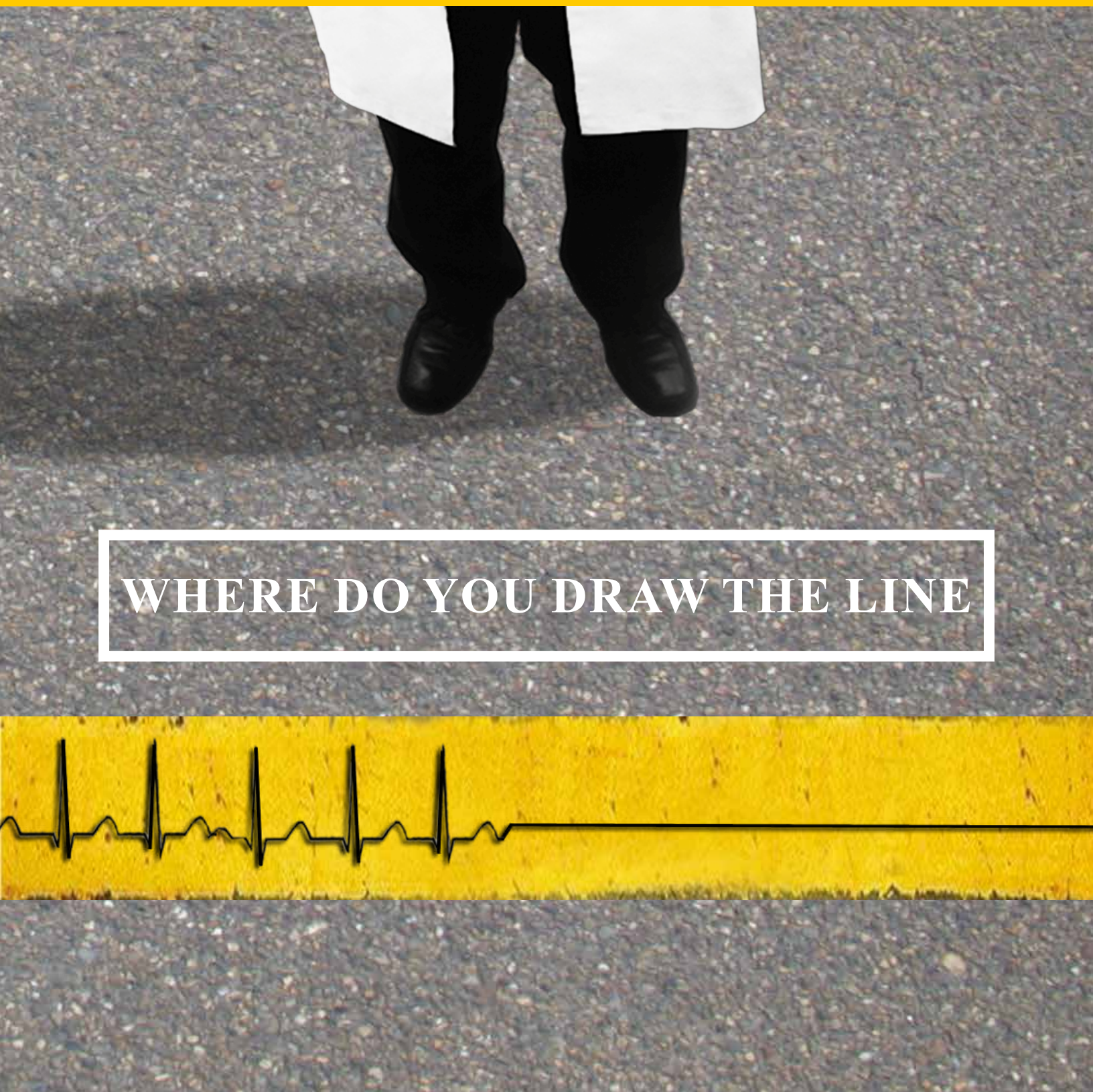
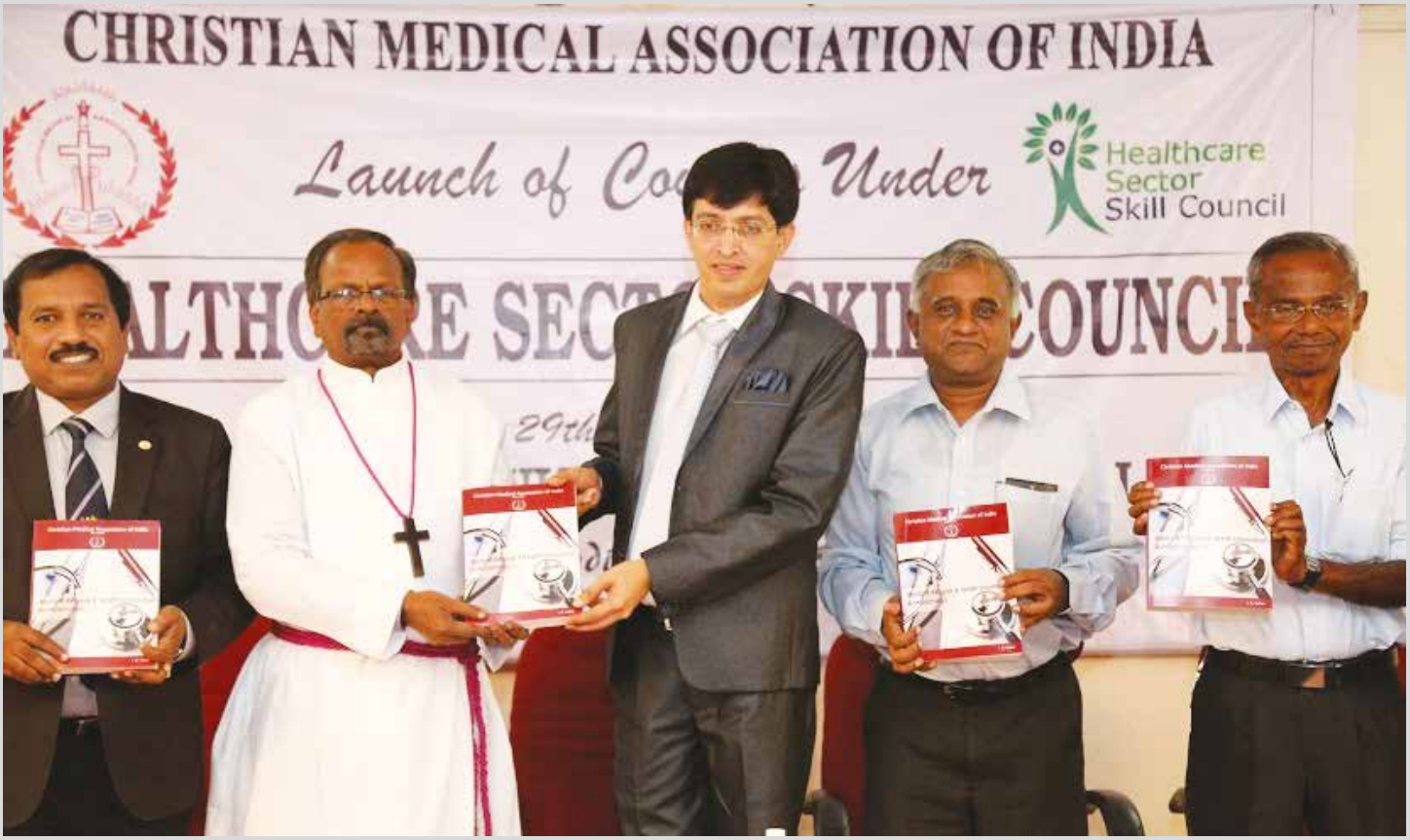


CMAI - HSSC
Short Term Training Programme



The Healthcare Sector Skill Council (HSSC) is a Not-for-Profit Organization, registered under the Societies Registration Act, 1860. The Council has been promoted by the Confederation of Indian Industry (CII), National Skills Development Corporation (NSDC) and Healthcare Industry, under Quality Council of India. The key objective of the Council is to create a robust and vibrant eco-system for quality vocational education and skill development, and employments in Allied Healthcare Sector in the country. In addition, the Healthcare Sector Skill Council aims to serve as a source of information on healthcare sector with specific reference to Skill and Human Resource Development in India. The council has proposed to bring-in a major change in the recruitment pattern so as to give preference to HSSC certified trainees/workforce.

Christian Medical Association of India has signed a MoU with HSSC to be their training providers and promoters through their vast network across the country. In our maiden effort, 10 of the CMAI training centres have received HSSC's affiliation to provide training in 4 short term courses, namely (1) General Duty Assistant, (2) Medical Laboratory Technician, (3) Diabetic Educator, and (4) Vision Technician.

Now, Government of India has approved a sum of Rs.10,000 for all successful HSSC candidates as ex-gratia from the Prime Minister's PMKV fund. The Gulf Cooperation Council [KSA, Oman, Bahrain, Qatar, and UAE] has recently approved HSSC Qualifications for employment. This has opened a way for our HSSC certificate holders to get employed in GCC member countries.

The opportunity of conducting these CMAI training course is open to all institutions that fulfil the requirements designed by the Academic Committee under AHP section of CMAI and Healthcare Sector Skill Council (HSSC), subject to the condition that they are organizations committed to human resource development in the healthcare sector. These institutions are expected to abide by the rules and regulations of the CMAI/ HSSC who will then consider the recognition of training centres on receipt of a written request in the prescribed form from the centre.

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VOLUME 31 NUMBER 2 APRIL - JUNE 2016

Where do you Draw the Line?

LETTERS TO THE EDITOR

Dear Sir,

I enjoy reading CMJI from cover to cover. I also use the insights for my personal growth as I interact with others.

I will be grateful, if you could send the periodical by mail(post) uninterrupted. May the Holy Spirit stimulate you and your team as you strive to bring out issue after issue of our coveted CMJI journal for the benefit of all.

Blessings and peace!

Rev Percy K V Hirams
Andhra Evangelical Lutheran Church
Rajahmundry – 533 103
Andhra Pradesh

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 issue will be on **"Mission & Transformation"**. 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.

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EDITORIAL

GOD'S UNCHANTING ETHIC

Dr Nitin Theodore Joseph

Etymologically 'ethics' is derived from the Greek word *ethikos* and essentially pertains to rules of behaviour based on ideas about what is morally good and bad. Society therefore has its own ethic that gradually changes with passage of time. In the Old Testament God's ethic was the Mosaic Law. God selected the nation Israel and gave her the Law so that she would be a model for the heathen nations to follow. When we read the details of the Law in the book of Leviticus we would very soon realize that it was extremely difficult to fulfill. We have often heard that the Old Testament was about an angry God who punished the people for their wrongdoings and seldom showed any mercy, while the New Testament reflects the compassion, grace and pardon that Jesus embodied. While this may seem true on the surface we must not forget that God is unchanging and there is never a 'plan 2' that He unleashed through the persona of Jesus.

If we read the Sermon on the Mount we will soon realize that rather than putting to rest the strict Mosaic Law, Jesus has raised the bar of His expectations from us. He compares hate to murder, lust to adultery, makes divorce difficult and prohibits oaths (Matt.5). In Matt.5:18 He declares, "until heaven and earth pass away, not an iota, not a dot, will pass from the Law until all is accomplished". God's ethic is permanent and unchanging.

Health care that was a revered vocation has now sadly transformed into an industry and a business. The corporate has already eaten a chunk of the pie and are trying to consume it altogether. At the other extreme is the Government sector where corruption is rampant and health care barely percolates to the periphery. In the midst of this dull scenario are the "mission hospitals and mission minded health providers" who are battling to provide ethical, evidence based, sacrificial service to the impoverished and needy people in far flung areas of rural India. How can we continue to do that with our extremely limited resources and newer challenges? No easy answers here!

This issue is therefore devoted to this important subject and I do hope you find this interesting. Please pass this issue to someone else after reading and do give us your valuable feedback.

Dr Nitin Theodore Joseph

ETHICS IN HEALTHCARE

"You shall be perfect, just as your Father in heaven is perfect."
(Matthew 5:48)


Rev Arul Dhas T

In the context of healthcare, there are many issues which are unethical today. It is not only among the secular and non-religious establishments, it is also in religious institutions. We see more people talking about ethics in healthcare these days. Maybe this itself is an indicator that there are many unethical practices among the healthcare professionals.

In this paper, I would like to concentrate on the healthcare services more than the healthcare education and research. This enlists some areas where our healthcare should concentrate while desiring to be ethical. Ethics is not religion; ethics is not law; ethics is not even culture or a socially accepted norm. Even though religion, law and culture will inform the way one takes an ethical decision, they are not the same. Therefore, it is important to see how we can comprehend and practice ethical healthcare.

1. Theology and Ethics

What is the foundation of our ethical thinking? One's spiritual values play a foundational role in forming the ethical sensitivities. Jesus told his disciples, "You shall be perfect, just as your Father in heaven is perfect." (Matthew 5:48). In many of the Pauline Epistles in the New Testament, we read a section on theology (What is the nature of God?) and another section on ethics (What should be the conduct of the people?). This is very helpful for us since we want to be faithful to our Christian calling in the healthcare ministry. When we reflect on this issue, it is important to do this as individuals and also as institutions.

2. The Healthcare Scenario Today

Basically, the government of any country takes the moral responsibility to provide healthcare to its citizens. India has 35,416 government hospitals and 13,76,013 beds. An average population served per Government Hospital bed is 879. According to the World Health Organisation, India has 0.9 hospital beds per 1000 population. This is far below the needed beds to provide reasonable healthcare.

Under the auspices of the Christian Medical Association of India and the Catholic Health Association of India, there are thousands of beds available for the sick and the suffering. We have the added privilege of following our Lord Jesus Christ in the healing ministry as we participate in healthcare. Do our Christian presence, preferential actions, attitudes and advocacy reflect our commitment to the ethical healthcare in a land where ethical principles are compromised often?

In our healthcare ministry there are many loopholes. There are many unacceptable things in the sight of God. As the body of Christ, how do we address those things?

3. Healthcare and Ethics

Healthcare is the right and privilege of people. The country and the Church own the responsibility of healthcare of their people. In this process, it is important to note whether everyone gets access to healthcare. Many a times, the poor and the villages are not given importance as the rich and the cities. Our programmes and projects are not reaching the people as it is intended to reach.

In our healthcare ministry there are many loopholes. There are many unacceptable things in the sight of God. As the body of Christ, how do we address those things? There are some issues pertaining to healthcare professionals and others to the healthcare institutions.

It takes courage from the individuals and institutions to see the unethical things in our midst and to address them with care and sensitivity.

4. Some Issues in Healthcare

A. Beginning of life issues

Life is precious and God given. 'When does life begin?' is a frequently asked question in the healthcare scenario. The answer we give to this question determines the value and respect we give to life. The human body is only the outer form life takes in this vast universe.

There are many who do not have a child. Even though adoption is one option available to them, many prefer to use the expertise of Artificial Reproductive Medicine to get their own biological child. From a Christian perspective where we value marriage as a divinely sanctioned institution, a Christian healthcare institution may refuse to involve egg donation or sperm donation outside the bond of Holy matrimony. Scientific technology may open up some options, however, those who are guided by specific spiritual principles may refuse the options which are outside the religiously sanctioned area. Scientific possibility and technological feasibility do not make an action ethically sound.

Supernumerary embryos are the by-products of the artificial reproductive procedures. To reduce the cost of making viable embryos more embryos are created at a time. Only some are implanted. The remaining is kept for another occasion till the parents request for it. How do we donate those embryos to somebody else? Or use it for medical research? This has brought in another ethical dilemma in our healthcare setting.

Surrogacy is a phenomenon by which a woman agrees to rear the embryo of somebody who is not able to rear it for different reasons. Today, commercial surrogacy is also very common. In our healthcare settings, we need to see that nobody is exploited and our spiritual values are respected even in our services.

B. Medical investigations

Investigations are done to diagnose the deficiency and address them. It is important to note today that many individual clinicians and even healthcare centres practise a 'defensive medicine' where investigations are ordered not just to diagnose, but to safeguard the doctor or the hospital from legal proceedings.

Many healthcare settings acquire expensive medical equipments over time. It is painful to see that some patients are subjected to certain investigations even though it is not warranted, just to get some income for the centre. We who are in Christian healthcare settings need to keep ourselves under heavy scrutiny keeping our conscience clean.

It is painful to see that some patients are subjected to certain investigations even though it is not warranted, just to get some income for the centre. We who are in Christian healthcare settings need to keep ourselves under heavy scrutiny keeping our conscience clean.

C. Organ Transplantation

When organs like kidney and liver are to be transplanted, clear guidelines are to be followed. There are many precautions we need to watch out to avoid any misuse or commercialisation of the procedure. With the advancement of scientific technology, more types of transplantations are to come in the future. For example, cadaver transplantations have come into vogue in recent times. It is very important to see that the clinicians of the donor do not interact with those of the recipient. This is to make sure that the conflicts of interests are addressed in a professional manner. There are many who are willing to sell their organs to address their precarious situations. There are many who like to run a business around this dire need of the people.

D. Scarce Resources & Medical Futility

In healthcare institutions we have limited beds. We also have limited ventilators or other critical medical equipments. In such situations, using Christian principles and values, the question arises on how we are to make sound ethical decisions to discern whom to treat and whom to discharge. In some situations it is predominantly a question related to finance. There are situations when, the healthcare team is convinced that further treatment of a particular patient will not bring any further health outcome.

However, the family members might insist on providing intensive care. It is a dilemma for the healthcare professionals to make an ethically sound decision given the fact that our resources are limited.

E. Withholding treatment and withdrawing treatment

Our ethical dilemma gets intense when we are in a situation where we need to withhold a particular treatment knowing that this will not help in the long run. Similarly, our dilemma intensifies when we have already started a course of treatment and we see that it is not beneficial to continue this treatment due to poor prognosis or due to the financial burden the family experiences. We are pressurized to withdraw the treatment.

F. Palliative care

When it becomes clear that some patients are not going to improve further, we still care for them and provide love and care for them. Palliative care symbolizes the fact that we value the person irrespective of what he or she would contribute to the family or to the society. Till the end of life we are committed to show respect and love to the fellow traveller in life. The temptation today is to pay no heed to the people based on the material benefit they bring to others. Our course of treatment reflects the value we give to the elderly and the terminally ill patients.

G. Medical Errors

We in healthcare are aware of many instances of wrong procedures, wrong surgeries, no proper sterilization of surgical devices and even hospital acquired infections. In such situations, what do we do? How do we admit and face the consequences? Or how do we manipulate to justify or safeguard ourselves? It is very important that we in healthcare are sincere, honest and truthful in all our dealings.

H. Pharmacy and ethics

Cost of medicines is a major issue in our healthcare institutions. There are many generic medicines that are prescribed in many of our settings to avoid the monopoly of some pharmaceutical companies. Added to the problem, many individual professionals are bribed by many companies through different means – household articles, holiday trips, equipments, even cheques.

5. Approaches to Ethics

Commonly the following four principles are considered crucial when we make an ethical decision. 1) Do good, 2) Do not do harm, 3) Be Just, 4) Give respect. When any decision is taken, they are checked against these four principles. However, it is important to note that there is an overemphasis on this principle based approach in recent times.

In addition to this principle based approach, there are other models available and worth looking at. A "*Utilitarian"* approach looks at the consequences – an action that brings most good and least harm. The "*Rights"* approach focuses on the moral rights of an individual – right to make one's own choices, right of privacy, right to be justly treated, etc. The "*Justice"* approach focuses on equal and fair treatment – all equals should be treated equally. The "C*ommon good"* approach focuses on the community life where we emphasise the actions which

A *"Utilitarian"* approach looks at the consequences – an action that brings most good and least harm. The *"Rights"* approach focuses on the moral rights of an individual – right to make one's own choices, right of privacy, right to be justly treated, etc. The *"Justice"* approach focuses on equal and fair treatment – all equals should be treated equally.

would bring common good for the society. The "V*irtue"* approach pays attention to the values and virtues which are considered as good for the development of the humanity – compassion, generosity, fidelity, integrity, self-control, etc.

From the Christian point of view, we give much importance to the character of the individual and the community. We are concerned about how we become acceptable as individuals and as a community in the sight of God. The way we take ethical decisions will impact the witness of the individual and the community.

6. Process of Ethical Decision Making

In situations where we need to make ethical decisions in healthcare, we are confused on how to make them. It is good to have a disciplined way of ethical decision making. The following aspects should not be ignored when we make a decision.

After identifying the ethical issue, gather all the facts connected to the issue. What are the physical, psychological symptoms connected to the issue? How does the patient respond to the medicines and treatment? What is the financial and family background of the patient? How about the availability and affordability of the medicines and medical treatment? What are the legal issues connected to the situation?

After this process, it is important to identify and evaluate the different medical and therapeutic options available for the patient. Further, it is mandatory to identify all the stakeholders in the issue. Legal guardians, heirs, significant others and all the immediate family members should be taken into account.

Decision making should involve the sound ethical principles. Are we doing good? Are we doing harm? Is this decision just and fair? Have we shown respect to the individual irrespective of the financial background of the person? These are only some questions that we ask before we make the decision.

7. Some practical tips:

One dilemma many of us find ourselves in is that we are often alone when we need to make important decisions. Therefore, it is good to identify this dilemma and seek help by which we make those decisions ethically.

In a healthcare setting, it is good to have a clinical ethics help-group that can gather together on short notices to look at any critical urgent decisions that need to be taken. It helps the clinician to get insight from different schools of thought. It would be good to have professionals of different disciplines in that group – like a doctor, nurse, social worker, chaplain, lay person, etc. In an organised setting, it can even take the form of a committee if needed. A group is always better than one.

In a personal setting, when there is a context in which there could be a compromise on ethical principles, it is good to have a mentor for ourselves. This person could function as a sounding board to give a reflective feedback to our dilemma. In the presence of a mentor we get a chance to spell out our dilemma. This context also helps us to be open to divine guidance in making decisions.

These arrangements are needed for us so that we are able to handle the challenges that follow a particular ethical decision. By all means, since we are serving God and God's people, it is good to do this with humility, love and respect.

Rev Arul Dhas T, Chaplain
Christian Medical College, Vellore

PONDICHERRY INSTITUTE OF MEDICAL SCIENCES

A Unit of Madras Medical Mission

Ganapathichettikulam, Kalapet, Puducherry 605 014

(A Christian Minority Institution)

VACANCY FOR THE POST OF CHAPLAINS

The Pondicherry Institute of Medical Sciences, a Multi Speciality Hospital and teaching institute at Pondicherry (A unit of the Madras Medical Mission) is looking for a Chaplain who will primarily be working with the Medical and Nursing student community.

She/He should preferably be ordained and having completed at least a B. Div (A Masters would be great) with prior experience of working among a student / youth environment.

As a chaplain at PIMS you'll need to be:

- Willing to work with people of other faiths.
- Have the maturity to deal with students of various denominations and cultures.
- Able to relate to the medical professionals, both medical students as well as the doctors and nurses.
- Able to conduct regular morning devotions as well as Sunday service.
- Be involved with and organize various student activities (youth camps, retreats, mission trips) and work closely with the student council.
- Flexible
- Caring and compassionate.
- Able to work as part of a team with health care staff.

You'll also need:

- Good communication, including listening skills.
- Be proficient in English.
- Able to see things from another person's point of view.
- Good organizational skills

Please send your resume to the Director Principal at mmmpims@gmail.com at the earliest.

VACANCY FOR THE POST OF PURCHASE MANAGER

Candidate should be qualified in materials management with an MBA (preferable) or a Post Graduate Diploma with at least 5 years experience in a Hospital, preferably in a Medical College.

The Purchase Manager will be responsible for the purchase department, especially to ensure that the process from indent to the receipt of materials is seamless and efficient. He/She will have to relate to departments and vendors and organize the department to keep all concerned informed of the status of indents. He/She will convene and facilitate the meetings of the Negotiation Committee and the Purchase Committee. Integrity and transparency in all dealings will be especially essential, apart from good management skills.

Please send your resume to the Personnel Manager at mmmpims@gmail.com at the earliest.

A USEFUL LINK IN HEALTHCARE DELIVERY

Introduction

In the past, trained Healthcare professionals used their moral compass to decide about treatment and the extent to which a particular patient should be treated. Currently, with the advancement of life sustaining technologies, healthcare professionals face ethical dilemmas pertaining to withholding or withdrawing ventilator support. This could be due to the differences in perceptions of healthcare team, patients or their relatives. At times the expectations and questions raised by patients and their relatives make it necessary for the treating physician to draw opinions from others in the team. Litigations against hospitals and healthcare professionals are on the rise. We also come across aggressive behavior of patients' relatives and communities when there are negative outcomes in treating patients.

Dr Jameela George

The reality is that apart from the varying standards of medical education in this country, medical professionals seldom have the training required to make complex ethical discussions. Also standardized treatment protocols are not followed across the nation. In other words, there could be differing opinions even among doctors of a hospital about how a case should be managed. It is in such situations that the Hospital Ethics Committee could be of great help to resolve ethical dilemmas and to promote good patient care, to their satisfaction.

Hospital Ethics Committee

The Hospital Ethics Committee (HEC) is a formally constituted committee by the management of the hospital. Such committees have been in existence as a useful resource for hospital staff in addressing ethical challenges. These committees are usually found in large tertiary hospitals, but are essential even in smaller hospitals. The HECs are vehicles for making difficult decisions and dispute resolution. *Clinical Ethics Consultation* could be an effective link between the hospital and the patients.

It provides a multi-disciplinary forum for the discussion of issues and thereby to support the decision making of healthcare professionals.

Composition of HEC

The HEC has representation from diverse departments of the hospital. The committee could have Doctors from different medical departments, Nurses, Social workers, Allied health professionals, Administrators, community representatives, Bioethicists, Chaplains and a Lawyer. These should be capacitated with knowledge and skills in applied ethics. They serve as a forum to promote and clarify ethical practices throughout the hospital setting, in order to enhance the quality of patient care.

Knowledge that will be essential for committee members are moral reasoning and ethical theory, typical bioethical issues in hospital settings, relevant healthcare systems and legal regulations, institutional policies and clinical practices, beliefs and perspectives of communities served, and relevant codes of ethics. These could be acquired by reading ethics literature, accessing web-based resources, participating in workshops, being an observer in HECs of other institutions and so on.

Role of HEC

The role of the HEC is the provision of support and advice to healthcare professionals and patients on ethical issues arising in clinical practice or patient care. It provides a multi-disciplinary forum for the discussion of issues and thereby to support the decision making of healthcare

professionals. The major functions of the committee are to provide clinical ethics consultation, to develop policies pertaining to clinical ethics and hospital policy, (advance directives, withholding & withdrawing life sustaining treatments, informed consent, organ procuring etc.) and to facilitate education on specific topics in clinical ethics.

HEC consultation

The traditional ethics committee model consists of the full committee to be involved in the review of the case and advisory process. When ethics consultation is requested by a patient, family or the attending physician, the nurse informs the HEC member (point person) who reviews the request, specifies the nature of perceived ethical problem and convenes the HEC meeting. The whole committee meets and reviews the case. The possible options and the justification for the same are discussed. Finally the reviewers select the appropriate option and recommend the same. This is communicated in writing to the concerned parties. The summary statement is placed on the patient's medical record. The progress notes are prepared by the HEC member on call.

Alternate models

The whole committee approach is recommended when the committee is new to ethics consultation or where there are only a few consults each year.

The alternate models to traditional committee structure are as follows:

- Dividing the traditional committee to sub-committees or teams
- Designating an ethics expert
- Linking institutional ethics committee through a network or academic institution
- Forming a multi-institutional ethics committee.

Ethics consultation

The kinds of cases brought to the HEC are likely to be the most difficult and may often involve life-and-death decisions. Hence there is a sense of urgency to get clarity regarding the matter under consideration. Getting all the members of the HEC to deliberate on a case is not without challenges. Hence a person who is adequately equipped for the job is given the responsibility to provide the consultation. This "Ethics consultation" is a confidential aspect of patient care. It is done free of cost. Any member of the healthcare team, patient or patient's relative could request for an ethics consultation.

When a request is received, the person given the responsibility on a particular case reviews the request for appropriateness, gets basic information from the one who requested the consultation, identifies the nature of the

Depending on the type of cases managed in a particular hospital, the common ethical issues faced could be discussed with the healthcare teams and administration.

perceived ethical problem, discusses with the healthcare team, patient and or patient's relatives, considers possible options & justifications, selects the most appropriate option, and gives it in writing as recommendations. This is attached to the patient's medical records.

Medical ethics is a system of moral principles that apply values and judgments to the practice of medicine. The four cardinal principles of medical ethics namely patient autonomy (or respect for the patient as a person), beneficence (doing good), non-maleficence (minimizing harm) and justice (including the fair use of available resources) are applied in the consultation in addition to the patient's condition, prognosis of the disease and the beliefs of the patient in a sensitive manner.

Depending on the type of cases managed in a particular hospital, the common ethical issues faced could be discussed with the healthcare teams and administration. If some changes have to be brought about in the hospital's policy regarding end of life issues they could be done.

Conclusion

The Ethics committee consultation or Ethics consultation is an essential link in healthcare practice. But this service is on an advisory capacity alone. The final decisions are made by the patient, the family and the healthcare team. However, the consultation plays a unique role in promoting better understanding and acceptance of the treatment by the patient and their relatives, reducing friction, decreasing litigations, promoting patient satisfaction, resulting in better acceptance of the hospital by the communities.

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Manager Research & Bioethics, Emmanuel Hospital Association
Member Secretary, EHA Institutional Ethics, Committee
Ex Director, SHARE & Bhawan Community Health projects,
Ex IEM missionary

Jameela George graduated from Madurai Medical College; did a Certificate course on missions at All Nations Christian College, U.K; Diploma in Community Health at Jamkhed, India, Counselling training at Discipleship Training Centre, Singapore and Masters in International Research Bioethics at Monash University, Australia.

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FROM OUR ARCHIVES

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NURSES' AUXILIARY OF THE CHRISTIAN MEDICAL ASSOCIATION

1941

QUIET TIME : A Picture

It was drawing towards 8 O'clock in the ward. It was hot and the nurse-in-charge went round rapidly, giving out medicines, washing glasses and giving sweets. It still seemed queer to her, this habit of giving sweets and no opportunity for teeth to be brushed before they went to sleep; but she comforted herself with that there were many queer things in Hospital.

7:55 pm. Well, she had better have prayers first and then finish the report for the night nurse. A quick look round—everything was in its place and nobody looked uncomfortable, the junior nurses were all in the kitchen chattering and changing their aprons. She went and shut the door and then 'Prayers please'. She rather loved the Evening Prayer herself, and she knew that there were people in the ward to whom it mattered how the Prayers were read; so she read slowly and distinctly, and then, 'Goodnight all' and the returning answer, 'Goodnight Nurse'. It was funny how she enjoyed that.

She went to the table and pulled the shaded green night light down and sat down to the charts and report book.

When she had given her report to the night nurse she went away and did the oddments of sorting that she had saved up for this quiet evening time from the daily work. She could have gone, but there were bits of work that she preferred to do when she was quiet and undisturbed.

Having finished, she rose and wandered over to have her goodnight chat with some of the patients who were waiting for it. …To tell the truth she appreciated working with a fire-eating, hustling Sister who liked her patients to be happy but left her Charge Nurse to see to that part of the job. It was nice that Sister went out most evenings after a hectic morning's work. Funny old thing! But she trusted you, and trained you well. After working with her no nurse would be afraid of taking responsibility…

First patient, an Anglo-Catholic Nun, so good and uncomplaining, but the call of her vocation over-rode all, and she strove, even lying there in pain to do her work. In nurse she sensed one to whom the religious life appealed, and so she was comforted for being laid aside in that she could even here speak for the Master and plead with this nurse to give herself entirely to the Master's service and take the veil. The nurse passed on to her next patient, a Roman Catholic Sister-such a young slip of a thing she was and oh such a naughty patient! But what of it? The pain of it must be something terrible. Nurse remembered yelling the street down when she had had earache as a child, and this young thing had had three ear operations. She must feel pretty bad now . . . and underneath the child was so in earnest over her vocation and comforted that even here she could speak a word for the Master. It was curious she also felt that the veil was nurse's vocation ... Nurse passed on to her next patient, an enthusiastic evangelistic Puritan. It was only two days since she had been dangerously ill, and nurse knew that there still remained the possibility of a sudden fatal relapse, but she also was gripped by the call of her vocation to preach and to speak for the Master, and she also pleaded with nurse to give herself entirely to His service.

Nurse passed on to her next patient--one who had been ill for months, who had terrible burns on her back and the front of her throat .... 'Now, Nurse, don't you be doing anything more for me .... I'm fine and comfortable. You are tired-but you know it makes a lot of difference when you take Prayers. You are fond of serving Him, aren't you?' And nurse passed on feeling that the invisible cloud of witnesses is a very real thing, and how woefully blind we often are.

FROM OUR ARCHIVES

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1966

'PEOPLE-THE HEART OF THE HOSPITAL' (Special Article)

D.S. GORDE, LL.B., Secretary, Wanless Chest Hospital, Walnesswadi

Hospitals are organized for people and they exist for the benefit of the people, therefore, the people should know the benefits they can expect from them so that there is mutual understanding and appreciation and good-will towards each other. The good-will of the people towards the hospitals will depend on understanding and understanding will come through getting to know more about the hospitals.

Hospitals are public institutions of service and the people they serve have a right to know about them. Hospital authorities have been critical of the public and the public in its turn have considered hospitals as horrible places where they are not treated as human beings. Of the many fields in which the hospitals can influence the public and present an 'image' to the public, the following may be cited as important.

(a) Development of Public Understanding, appreciation, and good-will on the part of the public towards the hospital. A carefully planned programme of public Education is necessary in which hospitals in the area should co-operate. This programme should take advantage of the two; Radio, and Newspaper. A Public Relations Officer should co-ordinate their programme to present to the public the hospital 'Image'. This programme should be directed against securing wider sympathetic interest; and explain to the public the place of the hospital in the community. Care must be taken to see that the programme differs from the business publicity. In presenting the hospitals to the public, ethical standards must be maintained.

(b) The personnel in the hospital must be made aware of their place in the programme so that they understand the work of the hospital and maintain closer contact with the public. The Nursing and Medical Staff can influence the patient- and make him feel secure and satisfied by their services.

The other employees also can do their share of work by their work and attitude to the patient, his friends and relatives. It is therefore necessary that all workers know the policies of the hospital so that they may participate in the education of the public.

(c) The most important person in the hospital is the patient. A satisfied patient is hospital's best public relations man. All patients are interested in the merits of the service of the hospital and it is here that the hospital to personnel have to present a good hospital picture.

(d) Explain to the Government and other Public bodies the character of the voluntary hospital so that they will understand the financial difficulties of the hospitals and come to help them with grants and donations. The general public should also be made aware of the financial difficulties of the hospitals so that when they pay the fees they do so with understanding. The feeling at present in the mind of the public is that the hospital fees are exorbitant. The purpose of this phase of the programme should be to solicit grants and donations to the hospital

(e) Educate the public in such a way as to make them aware that hospitals are the chief source of skilled medical and nursing services to the public and that the public should take advantage of these services, offered by the hospitals. In carrying on this programme offer the public means of improvement of health, and welfare conditions, through use of hospital facilities.

SAFE BLOOD TRANSFUSION

Blood transfusion is an essential part of modern health care. Used correctly, it can save life and improve health. However, the transmission of infectious agents by blood and blood products has focused particular attention on the potential risks of transfusion.

The World Health Organization (WHO) has developed the following integrated strategies to promote global blood safety and minimize the risks associated with transfusion

Dr Rohini Suryavanshi

1. The establishment of nationally coordinated blood transfusion services with quality systems in all areas.
2. The collection of blood only from voluntary and non-remunerated blood donors from low risk populations.
3. The screening of all donated blood for transfusion transmissible infections, including the human immunodeficiency virus (HIV), hepatitis viruses, syphilis and other infectious agents. Good laboratory practice performed according to quality system requirements, in all aspects of blood grouping, compatibility testing, component preparation, storage and transportation of blood and blood products.
4. Reduction in unnecessary transfusion through appropriate clinical use of blood and blood products, and the use of simple alternatives for transfusion, wherever possible.

The safety and effectiveness of transfusion depend on two key factors:

- A supply of blood and blood products that is safe, accessible at reasonable cost and adequate to meet national needs.
- The appropriate clinical use of blood and blood products.

The appropriate use of blood and blood products means that the transfusion of safe blood products that is only to treat a condition leading to significant morbidity or mortality cannot be prevented or managed effectively by other means. Transfusion carries the risk of adverse reactions and transfusion-transmissible infections. Plasma can transmit most of the infections present in the whole blood and there are very few indications for its transfusion. If transfused without testing in an emergency, the blood donated by family/ replacement donors carries a higher risk of transfusion transmissible infections than blood donated by voluntary non-remunerated donors. Paid blood donors generally have the highest incidence and prevalence of transfusion transmissible infections. Blood should not be transfused unless it has been obtained from appropriately selected donors, has screened for transfusion transmissible infections and tested for compatibility between the donor's red cells and the antibodies in the patient's plasma, in accordance with national requirements.

Blood should not be transfused unless it has been obtained from appropriately selected donors, has screened for transfusion transmissible infections and tested for compatibility between the donor's red cells and the antibodies in the patient's plasma, in accordance with national requirements.

The need for transfusion can often be avoided by:

- Prevention or early diagnosis and treatment of anaemia and conditions that cause anaemia.
- The correction of anaemia and replacement of depleted iron stores before planned surgery

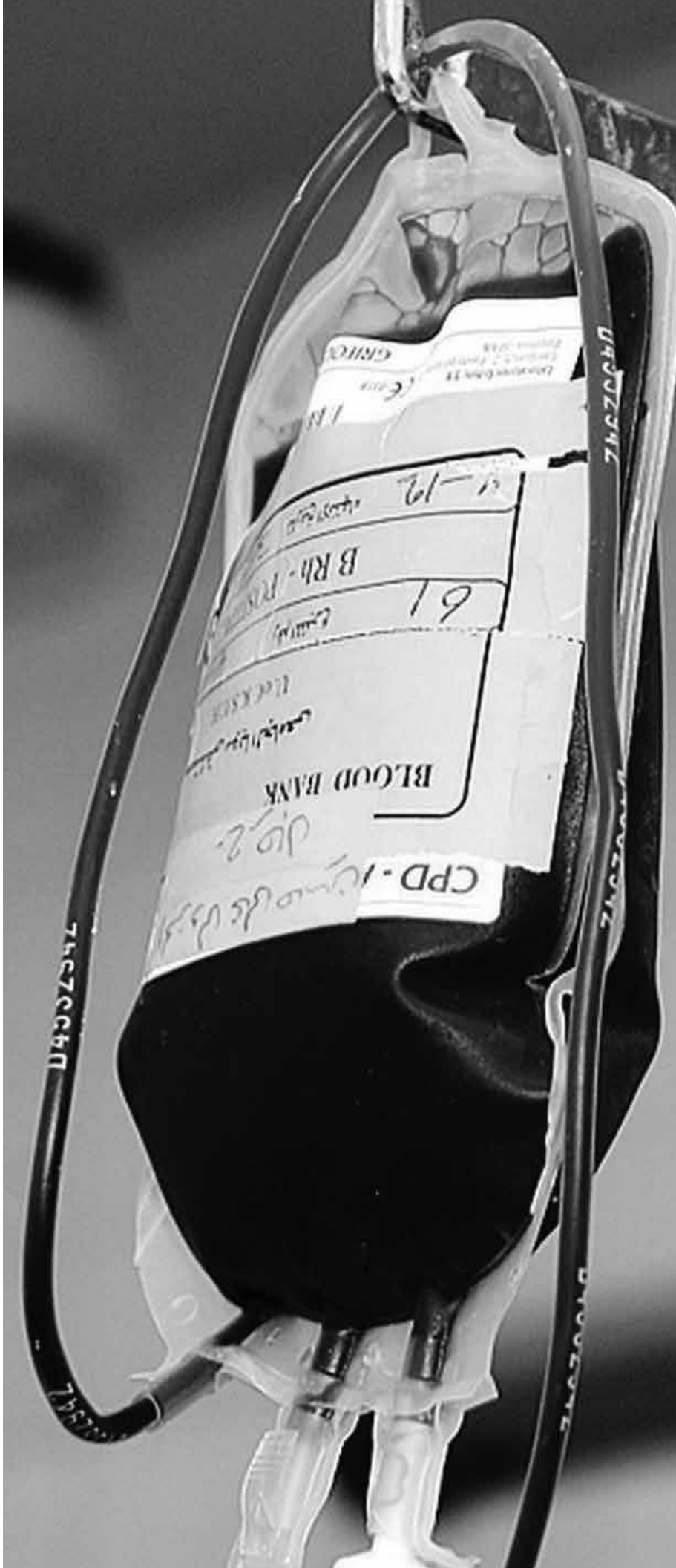
- The use of simple alternatives to transfusion, such as intravenous replacement fluids.
- Good anesthetic and surgical management.

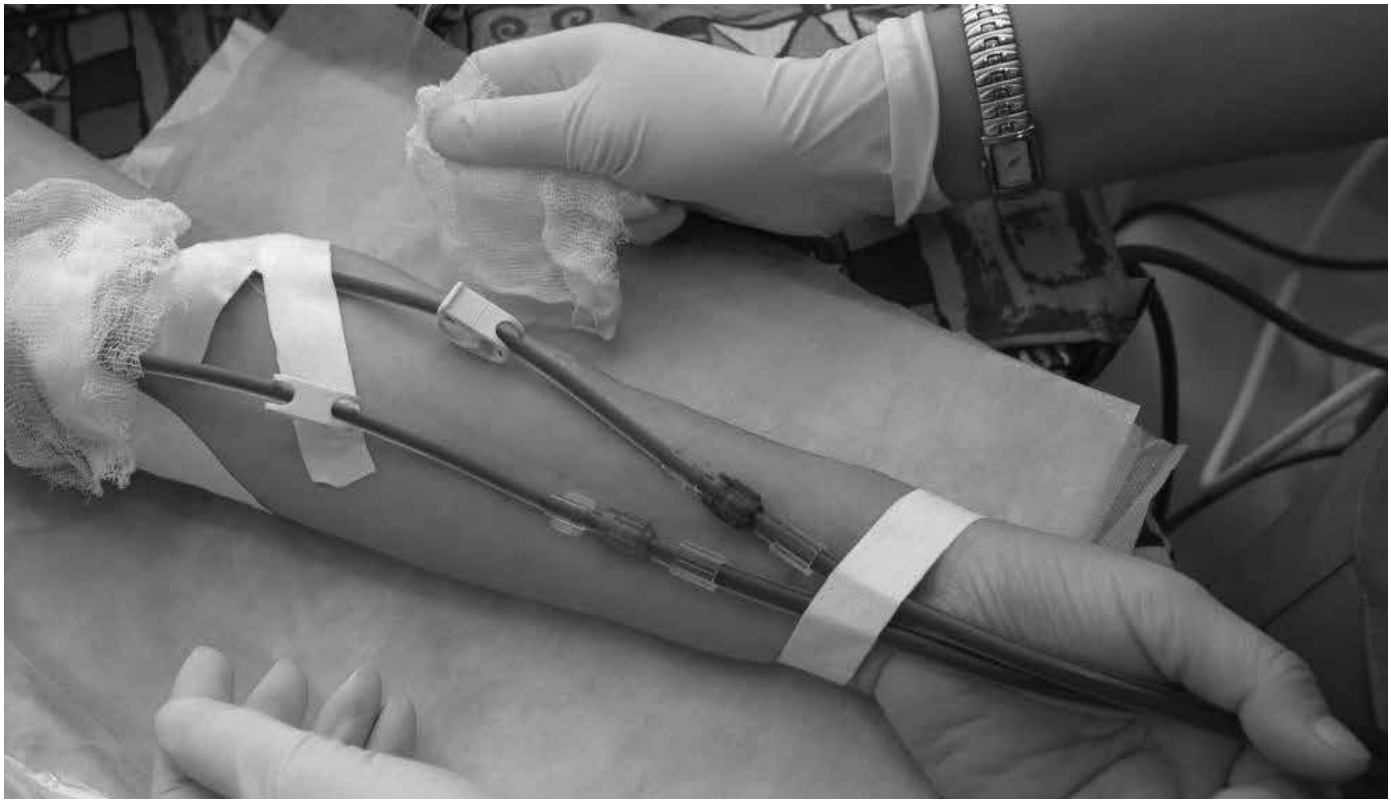
Blood transfusion can be a life saving intervention. However, like all treatments, it may result in acute or delayed complications and carries the risk of transfusion transmissible infections including HIV infection, Hepatitis, Syphilis, Malaria and Chagas disease etc.

Transfusion is often unnecessary for the following reasons:

- Blood is often unnecessarily given to raise a patient's haemoglobin level before surgery or to allow earlier discharge from hospital. These are rarely valid reasons for transfusion.
- The need of transfusion can often be avoided or minimized by the prevention or early diagnosis and treatment of anaemia and conditions that cause anaemia.
- Transfusions of whole blood, red cells or plasma are often given when other treatments, such as the infusion of normal saline or other intravenous replacement fluids would be safer, less expensive and equally effective for the treatment of acute blood loss.
- If blood is given when it is not needed, the patient receives no benefit and is exposed to unnecessary risk.
- Blood is an expensive, scarce resource. Unnecessary transfusion may cause a shortage of blood products for patients in real need.

In clinical practice, transfusion is only one part of the patient's management. Red cell transfusion is needed only if the effects of chronic anaemia are severe enough to require rapid increase in the haemoglobin level. Sometimes the correction of anaemia and replacement of depleted iron stores are required before planned surgery; similarly, the use of intravenous fluid replacement with crystalloids or colloids, in cases of acute blood loss. Stopping anticoagulants and anti-platelet drugs before planned surgery or using alternatives approaches such as





desmopressin, aprotinin or erythropoietin where it is safe to do so is necessary.

The quality and safety of all blood and blood products must be assured throughout the process, from the selection of blood donors, to the administration of blood and then to the patient. This requires the establishment of well organized blood transfusion services with quality systems in all areas, the collection of blood only from voluntary non-remunerated donors from low risk populations, and rigorous procedures for donor selection like the screening of all donated blood for transfusion transmissible infections such as HIV, Hepatitis viruses, Syphilis, Chagas disease and Malaria. Good laboratory practices in all aspects of blood grouping, compatibility testing, component preparation, and the storage and transportation of blood and blood products. Unnecessary transfusion through the appropriate clinical use of blood and blood products, and the simple alternatives to transfusion should be reduced wherever possible. Whatever the local systems for the collection, screening and processing of blood, clinicians must be familiar with it and understand any limitations that it may impose on the safety or availability of blood.

A final identity check of the patient and the blood unit to ensure the administration of the right blood to the right patient is mandatory.

For safe blood transfusion, every hospital should have standard operating procedures for each stage of the clinical transfusion process. All staff should be trained to follow them. Clear communication and cooperation between clinical and blood bank staff are essential in ensuring the safety of blood issued for transfusion. The blood bank should not issue blood for transfusion unless a blood sample label and blood request form has been correctly completed. The blood request form should include the reason for transfusion so that the most suitable product can be selected for compatibility testing. Blood products should be kept within the correct storage conditions during transportation and in the clinical area before transfusion in order to prevent loss of function or bacterial contamination.

The transfusion of an incompatible blood component is the most common cause of acute transfusion reactions, which may be fatal. Hence, for the safe administration of blood we need to follow certain protocol such as accurate and unique identification of the patient as well as the correct labeling of the blood sample for pre-transfusion testing.

A final identity check of the patient and the blood unit to ensure the administration of the right blood to the right patient is mandatory.

It is also very important that for each unit of blood transfused, the patient should be monitored by a trained member of staff before, during and on completion of the transfusion.

For safe blood transfusion each hospital should ensure that the following are in place:

1. A blood request form
2. A blood ordering schedule for common surgical procedures.
3. Guidelines on clinical and laboratory indications for the use of blood, blood products and simple alternatives for transfusion, that include intravenous replacement fluids, and pharmaceuticals and medical devices to minimize the need transfusion.
4. Standard operating procedures for each stage in the clinical transfusion process, including:
    - Ordering blood and blood products for elective/ planned surgery
    - Ordering blood and blood products in an emergency
    - Completing the blood request form
    - Taking and labeling the pre-transfusion blood sample
    - Collecting blood and blood products from the blood bank
    - Storing and transporting blood and blood products, including storage in the clinical area
    - Administering blood and blood products, including the final patient identity check
    - Recording transfusion in patient records
    - Monitoring the patient before, during and after transfusion
    - Managing, investigating and recording transfusion reactions.
5. The training of all staff involved in the transfusion process to follow standard operating procedures.

The safety of the patient requiring transfusion depends on cooperation and effective communication between clinical and blood bank staff.

How to get the right blood to the right patient at right time?

Once the decision to transfuse has been made, everyone involved in the clinical transfusion process, has the responsibility to ensure the right blood gets to the right patient at the right time.

National guidelines on the clinical use of blood should always be followed in all hospitals where transfusions take place. If no national guidelines exist, each hospital should develop local guidelines and ideally establish a hospital transfusion committee to monitor clinical blood use and investigate any acute and delayed transfusion reactions.

Before any blood or blood product transfusion, it is absolutely necessary to follow the instructions like assessment of the patient's clinical need for blood and when it is required. Appropriate information has to be given to the patient and/or relatives about the proposed transfusion treatment and recording of the same in the patient's notes. It is also necessary to record the indications for transfusion in the patient's notes.

Selecting the blood product and quantity required can be done by using a blood ordering schedule as a guide to transfusion requirements for common surgical procedures. Completing the blood request form accurately and legibly can help the Blood Transfusion Officer (BTO) to select the most suitable product for compatibility testing. If blood is needed urgently, the blood bank can be contacted by telephone immediately. Always send the correctly labeled blood sample and the blood request form for compatibility testing.

Once the blood sample is received by the blood bank the laboratory performs pre-transfusion antibody screening and compatibility tests and selects compatible units. Then there is delivery of blood/blood products by the blood bank or collection by clinical staff.

Storage of blood products in correct storage conditions if not immediately required for transfusion is the essential part of blood transfusion process.

In the clinical area it is necessary to check the identity of the patient, blood product and patient's documentation. When the blood product is administered it has to be recorded in the patient's notes. The record includes patient's identity, a type and volume of each product transfused, unique donation number of each unit transfused, blood group of each unit transfused, time at which the transfusion of each unit commenced and the signature of the person administering the blood.

Never forget to monitor the patient before, during and on completion of the transfusion. Record the completion of the transfusion as well as transfusion reaction if any and respond immediately to it.

Safe transfusion of the right blood to the right patient at right time can save the life of a patient.

Dr Rohini Suryavanshi, MD (Microbiology) is a Consultant in Richardson Leprosy Hospital (TLM), Miraj and Regional Secretary (CMAI) for Maharashtra & Goa.

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'MODERN ORTHOPEDICS IN RURAL CHHATTISGARH': 5 YEAR'S JOURNEY IN DEVELOPING ORTHOPEDIC SPECIALITY AT CHRISTIAN HOSPITAL MUNGELI

The initial exposure in Mungeli


Dr Deeptiman James

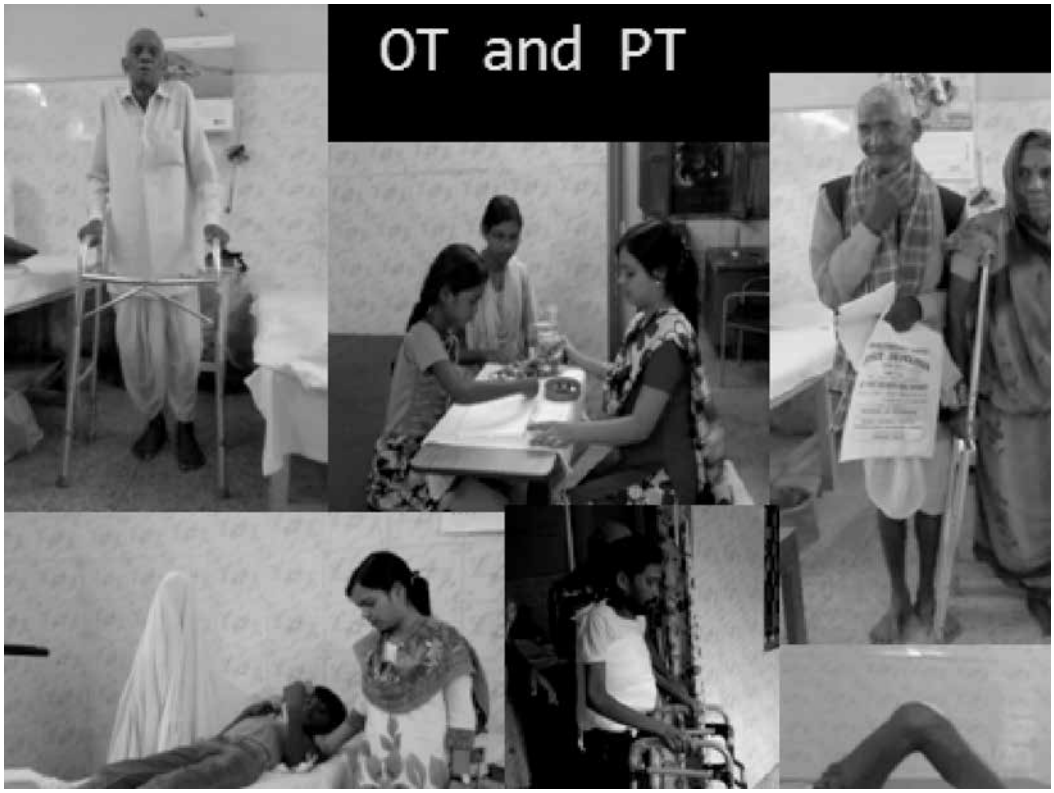
I began my posting as a rural Orthopedic Surgeon amidst the clamor over relevance of mission hospitals in current healthcare scenario. Burdened with the mandate to mimic orthopedic excellence of my alma mater in rural Chhattisgarh, I repeatedly encountered God Almighty's grace through the rough and tumble of mission hospital experience. He stood fast to His promise of watching over me when I went out to this remote part of Central India and never left my side in the five years that I have been here (Gen 28:15).

My first exposure to Orthopedics in Mungeli was as an Orthopedic Registrar accompanying Dr Issac Jebraj on an orthopedic camp. Then we revised a failed Sherman plate that was used to fix an adult tibial shaft fracture to an open reamed tibial nailing using antiquated tourniquet and manual reamers. It was much later that I would actually come to know this implant as an obsolete equipment of the yesteryears, which stubbornly found its way repeatedly into my implant trays despite all attempts to condemn them. However, this experience jolted me out of the comfort zone from the orthopedic operation rooms at CMC Vellore and I earnestly started preparing for what was inevitable.

Bilaspur has always been the nearest railway station and the gateway to Mungeli. Anxious to get help to carry my luggage at Bilaspur station, where I arrived in the middle of the night, I was surprised to have the director of the hospital fill in as my porter as well as my driver. I was in for another surprise when at morning I got a first glimpse of the hospital that was going to be my bedrock for the next five years. The remoteness of the area did not hit me until I realized the missing broadband connectivity that I was so used to at MIQ quarters in Vellore. High acceptability of the disabled as one's destiny and lack of awareness of available treatment was appalling. When I approached a patient's relative stricken by Polio, crawling on all four to offer surgical correction, he gave me a look as if I had blasphemed against divine powers. The deformities that I had witnessed in and around Mungeli were not solely due to divine intervention. I soon realized that my toughest competitors were not the orthopedists at faraway Bilaspur, but rather the native bonesetters of Bicharpur, some 20 kms away from the base hospital. Having visited Bicharpur during the aforementioned camp under the ruse of sightseeing, I was aware of the quackery and cheap fees of the bonesetters and villager's unwavering faith in their treatment. I had my task cut out, to allure people away from such devious mischief with no excuse or space for error.

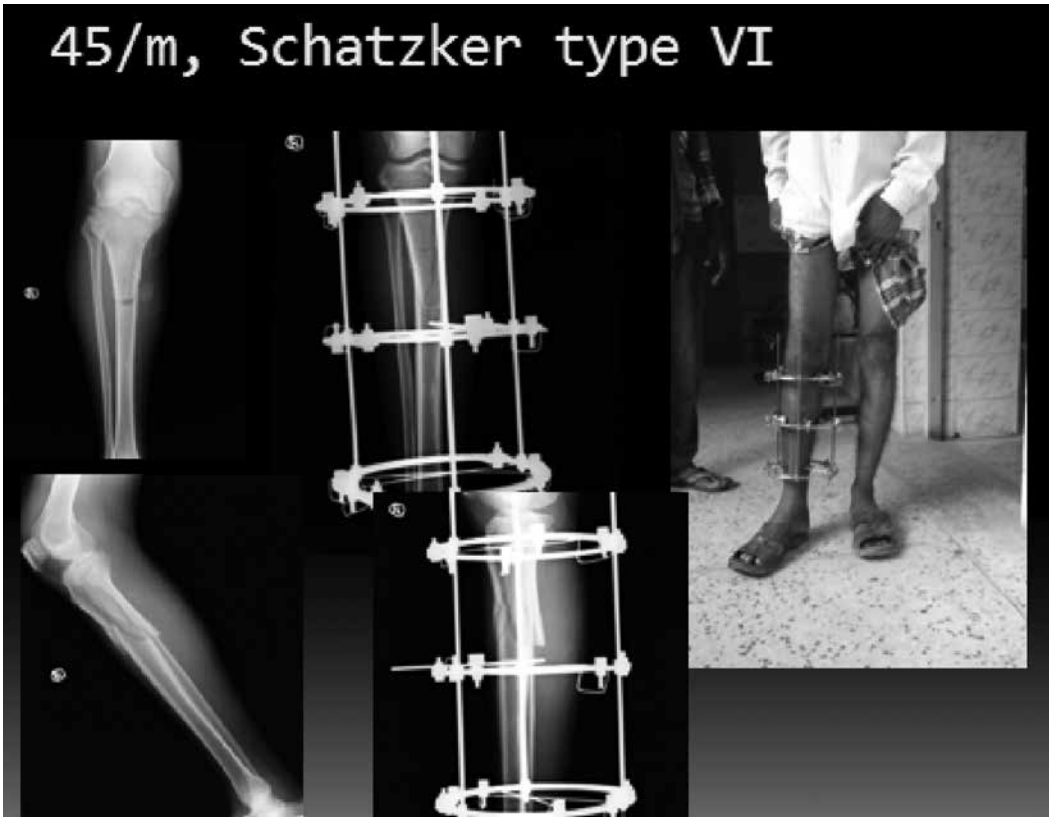
Challenges

However, my priority was to get hold of an efficient orthopedic team. Problems of staff attrition plagued us constantly due to the revolving door policy owing to service obligation of bond candidates. I drew inspiration from my stint at Christian Hospital Diptipur, where I had worked with the legendary Dr VK Henry. I started training with the available staff and students as orthopedic surgical assistants. Several staff including the dentist, physiotherapist, AYUSH doctors, GNM students and visiting medical students from Denmark and USA were promptly enrolled in the program. While they learnt on the job, I ensured a steady supply of manpower to run the


OT and PT


Radiology at CHM


Post op and 3 years follow up


45/m, Schatzker type VI

HIV Awareness Camp at Mungeli

department. Along with the hospital's management we started functioning as the first independent department at Christian Hospital Mungeli as well as the first orthopedic trauma care center catering to a population within a 100 km radius.

Perseverance in the midst of dismay

Challenges were galore, whether it concerned human resources, equipment or materials. I was once asked to summarize the principle pillars of CMC Vellore to which I had promptly replied 'sincerity, honesty and one's willingness to do justice in serving the poor'. I soon realized the mist of my beautiful quote fast fading in the harsh light of reality. The severe distrust among the general population towards practitioners of modern medicine was something I will eventually grow into, but in those heydays when I began serving at Mungeli, I found myself repeatedly frustrated by patient's and relative's denial in accepting their diagnosis and thus, refusal to accept treatment.

I acutely recall the desperation when parents, who were labourers of a two year old child with large femoral diaphyseal osteomyelitis refused surgery even when offered completely free of cost. I have never agreed with the concept of disillusioning the patient and rushing him or her into surgery without discussing the plan of treatment with them. Even though it gave them an opportunity to over-think the treatment plan and sometimes, even opt out of the plan, it gave me crucial time to plan and strategize the treatment. Through my success and folly, I have realized the "essence of successful orthopedic surgical practice lies in the meticulous planning of the procedure". Rampant quackery that has replaced the vacuum in the healthcare sector in rural areas surrounding Mungeli made my task of establishing evidence based orthopedic practice even more difficult as people expected magical injections for miraculous healing of fractures and deformities. One of my friends, whom I never considered very religious, shared a sermon with me where Jesus Christ offered salvation to all through the Father's grace, but not all accepted that gift. Similarly, he infused in me to continue offering the correct treatment without clouding my judgment with the frustration of the inability to convince each one.

The biggest thing we humans are afraid of is change. Change scares us all. Orthopods are generally

Besides being the orthopedic surgeon, I filled in as the occasional driver to pick and drop people at the railway station or Raipur airport; an emergency physician for critical patients in the ICU; an anaesthetist; in some cases, general anaesthesia for orthopedic procedures.

compulsive obsessive creatures when it concerns sterility of the operation theatre. Having to share the operating room with general surgical, obstetrics and gynaecological procedure, my team quickly adapted to my stringent perioperative protocols. Changing OT (Operation Theatre) dress and mandatory fumigation prior to all orthopedic procedures, double autoclaving of orthopedic instruments and implants, sterile draping and C- arm covers, and strict sterile principles were some of the changes CHM witnessed. Given the dynamic nature of current orthopedic practice, we changed to adopt newer, cost effective and efficient equipment, implants and procedures. The most welcome moment was when we changed from foot pedal operated bone drill to hand held bone drill. Biological fixation and minimally invasive surgical approaches were adopted along the learning curve. Basic trauma care evolved into poly trauma management, upper limb and lower limb deformity correction, hand surgery and flap reconstructive surgery and diagnostic arthroscopy.

Mission doctors are often called to play multiple roles. Besides being the orthopedic surgeon, I filled in as the occasional driver to pick and drop people at the railway station or Raipur airport; an emergency physician for critical patients in the ICU; an anesthetist; in some cases, general anaesthesia for orthopedic procedures. I even performed several emergency cesarean sections until my wife later joined CHM as a gynecologist and choreographer for the annual staff kids Christmas dance. My teachers and peers at CMC Vellore, classmates serving in other needy areas of the country, orthopedic surgeons in and around Bilaspur, my beloved wife and my family and above all God's gracious presence helped me tide through all the up and down so commonly associated with mission hospital service. I must acknowledge the hardworking and diligent staff and students of Christian hospital Mungeli whose constant sacrifice and devotion continues to help the flame burn through the darkness of the sick.

Milestones:

2011: First Ponsetti clubfoot correction
Cemented Thompsons' hemiarthroplasty
Automatic pneumatic tourniquet
Training of first batch of orthopedic surgical assistants
Integrated trauma management with physiotherapy

2012: First Gastrocnemius flap reconstruction surgery (open IIIB fracture)
Stryker system VI automatic hand drill was acquired
First Ilizarov fixator application (severe pediatric knee deformity correction)
One thousand outpatients and 200 orthopedic procedures

2013: First Cemented Bipolar Hemiarthroplasty in the region
HIV awareness program for staff and students
Locked compression plates was introduced
First minimally invasive surgery at CHM
First Ilizarov procedure (schatzker type V fracture)

2014: New fracture table was purchased
Outpatient clinic crossed 5000 patients
Introduction of Orthofix fixator and proximal humerus fracture management
Management of orthopedic infection with antibiotic cement beads and cement spacers
First Uncemented hemiarthroplasty at CHM

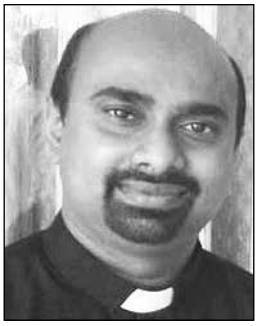
2015: Diagnostic knee arthroscopy
Minimally invasive flexible nailing for severely displaced pediatric fractures
VAC (Vacuum Assisted Closure) wound management
CHM represented at Chhattisgarh Orthopedic Association for the first time
First scientific publication from orthopedic department, CHM
First Spine camp with visiting Spine surgeon from CMC Vellore

2016: New C arm acquired
Outpatient's clinic attendance crosses 12000 patients

Dr Deeptiman James is Orthopedic Surgeon MS (Ortho) at Christian Hospital Mungeli, Chhattisgarh

FAITH - BASED ORGANISATION AND THE ETHICS OF PUBLIC HEALTH CARE

Health Care System and India's Poor



Rev Dr Allan Samuel Palanna

It is an obvious stated fact that there is a lot to be desired in terms of the public health system in India. In many instances, one needs to recourse to private health care. The private finance of health care in India is almost entirely comprised of out-of-pocket expenses borne by the consumer, and supplemented by donations from charitable organizations, insurance schemes and non-governmental organizations. There is no specific financial provision for health in the budget—any spending is covered by the general health budget. Private contributions remain high at all levels of care (primary, secondary and tertiary) and unreachable for the poorest and the vulnerable.

The World Bank report, a good while ago in 1997, made a pointed remark about the then-Indian private health care services: "private health services have been *inaccessible* to the *poorest and most vulnerable sections* of the population and do not address public health issues of national significance."[1] Of course, we need not have the World Bank telling us what it had done to the 'most vulnerable sections of the population!' It is obvious that the country allocates very scarce financial resources and has grossly inadequate human resource and infrastructure for health care. It also lacks proper health policy and legislation to direct its health programmes and services. There are various instances of gross neglect in this area. These examples need careful scrutiny to derive useful lessons and carve directions for the future.

The fact that legislations have proved ineffective in relation to the conditions mentioned suggests that it has to be overcome by sufficient political will to improve availability of and access to humane health care.

While health policies and services are increasingly progressive and apparently humane, the National health policy is minimal at best. The successes remain spotty and scattered, emblematic of what could have been done with more consistency and commitment throughout the country. Despite these plans, the ground situation has not changed and the implementation of the programme has failed to deliver.

Also, the health planning and management in India is completely dominated by infectious and communicable diseases. It does not deal with other disease matrix like mental health. However, a favourite argument against overall health funding is that the country is too busy fighting 'scourges' such as Tuberculosis, Malaria, Leprosy and Cholera to fund what is an unimportant area of concern. Although the magnitude and severity of infectious diseases has 'stabilized' over the years, these still constitute a major public health priority and draw away most public health resources. This is, however, not to undermine efforts to fight such diseases, but to highlight the gap in perception of health. Often, such health perspectives are uni-dimensional. Many states of the country also have not implemented the basic health legislation even now.

The many reasons that may be suggested for the lack of will to broaden the scope of health include the complete lack of cost estimates and the absence of provision of budgetary support; unrealistic minimum standards for hospitals; restrictive licensing requirements; complete exclusion

of faith-based organizations and the traditional health sector from the ambit; and divergent perspectives among psychiatrists, government, and the legal point of view are reasons for the failure to implement the new legislation. The fact that legislations have proved ineffective in relation to the conditions mentioned suggests that it has to be overcome by sufficient political will to improve availability of and access to humane health care. Political will, in this context, refers to the inclination, shaped by convictions for policymakers to take action and to make change. The reaction to any disasters, unsurprisingly, is to commission a judicial inquiry which set predictable recommendations. These ritual recommendations always include improved infrastructure, safe-guards, and penal action for any violations of the legislations.

Faith Communities and Health Justice

Tyndale, commenting from the perspective of developmental change, suggests that faith groups "are more firmly rooted or have better networks in poor communities than the non-religious ones and that religious leaders are trusted more than any others."[2] Faith-based organizations are thus seen as essential agents both for influencing the opinions and attitudes of their followers and for carrying out development work at the grassroots. Harcourt, along with Tyndale, believes that the spirituality of members of faith organizations acts as a vital source of commitment and motivation.[3] These authors are convinced that faith ensures a person to person relationship with the poor. However, it is to be accepted that whilst faith may sustain an enduring link between people and places it does not automatically result in meaningful dialogue or change.

Anecdotal evidences indicate that religious institutions provide services in the areas of assistance with basic needs of living (for example, clothing and food programmes), family services, and select health programmes.

Despite the apparent importance of such faith representatives, there is little systematic information concerning the interface among religious organizations and the health services delivery system.[4] Accurate knowledge about available services is critical for both self-referrals and referring others for needed services. Health agencies should use a partnership model in the development of programmes with religious institutions. With the assistance and sponsorship of community health care agencies, a variety of health programmes have been conducted in churches in India. Along similar lines, social service agencies and religious institutions might collaborate to develop grass root referral systems for health care.

This potentially could be an ideal partnership, given their unique and complementary resources. Religious institutions have access to large groups of individuals, whereas social service agencies have expertise in delivering services. Working alliances of this sort may be particularly important in the current atmosphere of overall neglect.

The available literature certainly is limited in addressing these questions in a systematic manner. Anecdotal evidences indicate that religious institutions provide services in the areas of assistance with basic needs of living (for example, clothing and food programmes), family services, and select health programmes. Renewed interest in the role of faith communities in the delivery of health and social welfare services and programmes could stimulate discussion and research in these areas and reflect an attempt to identify various cultural resources and strengths existing in such communities in order to provide immediate care for the most vulnerable persons. Faith communities and other community spiritual resources may offer a great deal to persons on the edge of health care. They may also foster a sense of belonging; sustain shared meaning; alleviate the effects of change; provide both tangible and emotional support; and offer practices and rituals that structure and give purpose to life.

Theology and the ethics of Health Care

Theology is faced with the task of addressing key ethical issues and challenges, with special emphasis on the dilemmas that arise in the context of healthcare in India. In doing so, it seeks to address prime questions with regard to the nature of Christian ethics in general and applied ethics in particular in the areas mentioned above.

They may also foster a sense of belonging; sustain shared meaning; alleviate the effects of change; provide both tangible and emotional support; and offer practices and rituals that structure and give purpose to life.

To begin with, the ethical and theological explorations from the viewpoint of 'being human' are to be addressed. It calls for a theological model in referring to the questions of self and self-worth.

The particular healthcare areas that needs discussion and analysis from an Indian health care perspective include: the Indian health care context, philosophical and theological approaches to health care, subaltern communities and health care, biomedical challenges such as euthanasia, human cognitive enhancements, physician assisted suicide, various reproductive issues such as cloning, surrogacy and abortion, medical research ethics including genetics, law and medical ethics, end of life studies etc. Areas of public health care in India and emerging issues in public health care policies also need examination.

In the theological exercise, one may either incline towards 'theological purity' or 'theological realism', where the former category seeks moral and ethical derivatives entirely from scripture and has little or no correspondence to the secular world, and the latter seeking a close alignment between theological and secular thought to the point of accepting every stride in health care.[5] Inclining towards any of the above theologizing categories has its inherent difficulties of either being irrelevant in terms of the former category or treading an uncritical ground in terms of the latter. To begin with, the ethical and theological explorations from the viewpoint of 'being human' are to be addressed. It calls for a theological model in referring to the questions of self and self-worth. How does one perceive personhood? This question is somewhat difficult to answer with certainty. The Scriptures express that personhood occurs very early (Jer. 1:5; Isa. 49:1; Ps. 139:13; Luke 1:41-44).

From the point of Christian ethics, this surely and primarily entails looking beyond the physical to the spiritual reality of being, the same as 'the One who emptied himself'. Would Christ the bare essential Godself who emptied himself become a theologically viable model in theologizing on human worth? The Gospels does not shun away from portraying Jesus, in every sense a human person with a life-ethic that emerges from the reality of Godself expressed in Jesus Christ. Jesus engages in the life-ethic in ways of 'opening to compassion' whilst even 'trumping principled scruples.'[6]

Surely, affirmation of personhood goes much beyond than simple 'respect'. Uniqueness and affirmation of persons is clearly a non-negotiable value that may not be bartered even for the most profound goal.

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HELPLESS PATIENTS HAPLESS DOCTORS!

It was May 2011. In a tiny, remote village near Robertsganj in Uttar Pradesh State, a girl of seven years met with an accident. She was profusely bleeding, as the villagers did not know the basic first aid to prevent bleeding. She was brought in a tractor after a delay of two hours to a small 100-bedded hospital at Robertganj. The doctors present there examined the patient, they found transfusion of blood was an essential factor to save the girl; the girl will surely die within few hours! But, alas! As per the latest amendment in the *Drugs and Cosmetics Act* doctors are prohibited to transfuse blood from another person after cross-matching; they have to get blood only from the nearest blood banks. The blood bank, at that time was at Banaras – a distance of 90 Kms – a very jerky road which would take a minimum of three hours. Availability of blood was the next question. At midnight, one would wonder who would be there in a small Government Hospital, who would readily do the job with a smile on their face at given these odd hours! The girl was slowly dying before the eyes of the Doctors. They were qualified, experienced in their profession to cross-match and transfuse that blood, but it was illegal after 1999 and punishable with minimum one year of imprisonment or up to three years.

A hard decision had to be taken, either to save the girl and go to jail, or keep quiet and turn the other side till her life slowly ebbed from the body. This small medical team had chosen the first option, the girl was saved, now she is a grown up teenager but a criminal action was initiated and the two persons were imprisoned. The case is still ongoing in the Robertganj Chief Judicial Magistrate's Court! (1)

It would now be important to mention the two deaths that occurred despite a new blood bank being operational in Robertganj was due to the lack of timely supply of blood!

A patient arrived in Jiwan Jyoti Christian Hospital at 8.00 p.m. on 12th January 2012 with *post-partum* Hemorrhage, and a B.P that was not recordable on admission along with severe anaemia after a normal delivery at the Government Hospital. She was bleeding and in shock – the surgeon needed to do an emergency explorative laparotomy for which blood was essential. It took the relatives four long hours to obtain one unit of blood with difficulty, being night time, from the (new) Robertganj blood bank. The patient could not be saved.

Mr Samuel Abraham

A woman had a C-section on 16th March 2011 in a rural hospital. After surgery the patient developed Disseminated Intravascular Coagulation and went into shock needing urgent blood transfusion. Due to her unstable condition, she could not be shifted to another place where the blood bank was situated. Sadly, she expired at 1.35 a.m. on 18th March 2011.

These two are examples but thousands die because of the new amendment which virtually prevents Medical Professionals from transfusing blood from another person after cross-matching.

What is the new amendment?

Prior to 1999, the amendment says (i) blood transfusion can either be made available through services of blood banks (ii) OR can be taken from a donor and after doing proper tests, directly transfuse to the patient without "banking" or "storing". The second method is called **Unbanked Direct Blood Transfusion** (for brevity hereafter called UDBT). This procedure has saved thousands of dying patients in rural areas by quick,

It is an irony that on good faith a Medical professional is not able to save a life due to the non-availability of blood in the area when the relatives next to them are willing to donate. The patient may die but the law establishes the doctors as law-abiding citizens.

immediate and timely transfusion. The tests done before direct transfusion is called *"cross matching".*

But, the Union of India, brought an amendment in the Drugs and Cosmetics (2nd amendment) Rules, 1999 which changed the definition of blood. It mandated that even mere collection of blood required "*license for blood bank".* That means a doctor can collect blood from a third person only if his hospital has the license to have "a full-fledged blood bank". Generally, blood cannot be collected ordinarily just like any other product in a bag but in special "collection bags" that are chemically treated with a special liquid to keep the collected blood from being frozen or solid. This bag can be obtained only from manufacturers, after the amendment; the chemists were directed not to supply "collection bags" to donors doing UDBT.

What is the consequence?

The amendment should have been brought only after all the States have adequate number of blood banks both in the city and rural areas alike.

However at present, only cities and metros have adequate number of blood banks whereas in rural areas there are no blood banks. The decision to bring the amendment was made by decision makers from metropolitan cities like Delhi, Mumbai without taking into consideration the remote and rural areas. A gist of the following facts may explain the situation more clearly:

1. Minister of State Mr. Shripad Yesso Naik informed in the Indian Parliament that 81 districts in the country are **without** even one functioning blood bank.
2. The "blood storage centers" brought in alternatives for blood banks that can be adjudged by the volume of blood they are distributing. They are functioning very badly because the volume of blood is very negligible. In emergencies, they simply say "no blood"; they close their doors leaving the patient in the lurch.
3. In the District of Dhule in the State of Maharashtra, there were 5 blood banks. All of them were located in the District Town having a population of 3 lakhs leaving 26 lakhs population of the District with no Blood Bank.
4. Depending on the distance of the peripheral town, the time taken to procure blood from Authorized Blood Banks varies from 6 to 15 hours and even more at night, resulting in the loss of human life in the rural hospital and leaving the medical professionals helpless due to the amendment.
5. In the year 1988, according to a study, Blood Banks collected 5500 units of blood out of which only **300 units** were sent to the periphery area where a population of 26 lakhs were residing.
6. A study in the same district reveals:

- Out of 40 clinicians (doctors including Surgeons, Gynaecologists and Physicians) working in the periphery, 39 were still doing UDBT to save the patients (though illegally - risking penalization by law-enforcing authorities).
- A study across the country done in October 1999 reveals all doctors that practised UDBT still continue to save women at deliveries and victims of road traffic accidents.
- A study in rural Sivakasi town, Tamil Nadu gives the figure that out of 18 doctors, 9 were practicing UDBT even in 2003 and a few such doctors are under prosecuting process even now by the State Chief Drugs Controller U/S 18(1) of the **Drugs and Cosmetics Act, 1940**.
- **It is an irony that on good faith a Medical professional is not able to save a life due to the non-availability of blood in the area when the relatives next to them are willing to donate. The patient may die but the law establishes the doctors as law-abiding citizens.**
- 74% of the Indian population is living in rural areas whereas the blood bank availability is 10% to 15% only because rural hospitals are not able to spend

> **"However, the sad reality is that a service minded doctor who violates certain rules on good faith is put on an equal pedestal to a criminal offender- standing side by side in the Magistrate Court in the place earmarked for an accused person."**

money in maintaining a blood bank and obtain a licence.

- 25% deaths related to childbirth and pregnancy are due to bleeding (haemorrhage).
- The victims of road accidents occur mainly in the city outskirts and rural areas due to the slow vehicles. Such accidents have doubled in six years.
- Surgeons, Obstetricians and other qualified clinicians; especially in rural areas, are handicapped because they cannot give their highest level of professional service without the availability of blood.

What about other advanced countries

The United States of America, one of the most advanced countries in the World, states in Title 21 – **Food and Drugs** – Chapter: 1 – Food and Drug Administration - Subchapter: F – Biologists PART 607 , Sub Part – D - Exemptions (b),

"Practitioners, who are licensed by law to prescribe or administer drugs and who manufacture blood products solely for use in the course of their professional practice"

- The Hon'ble Supreme Court of India in its landmark judgment in *Save Life Foundation & Anr. Vs. Union of India & Anr* in Writ Petition No. 235 of 2012 has recently observed the following facts in respect of good Samaritans who are willing to help road accident victims. In England and Wales, the Parliament has enacted the Social Action, Responsibility and Heroism Act, 2015, that provides certain factors to be considered by the Court while hearing an action for negligence or breach of duty. Section 2 of the Act provides that "*the court must consider whether the respondent was acting for the benefit of society or any of its members* (Para – 4) "*whether the respondent was acting heroically by intervening in an emergency to assist an individual in danger"* (Page 3, Para-4).
- In Iceland, Section 51-D of Civil Law (Miscellaneous Provisions) Act, 2011 provides *"that a good Samaritan will not be in negligence for any act done in emergency to help person in serious and imminent danger".*

"*Accident case requires fastest care and rescue which could be provided by those closest to the scene of the accident"* Para- 5

"The letter further states that research shows that a number of the accident victims can be saved if they receive immediate attention" - Para 6

"whereas injured gradually bleeds to death" – Para 7

What is happening in armed forces

UDBT is legal in Armed Forces:

The Armed Forces in a remote area of combative operations felt the need of UDBT or they may lose their most trained and loyal war veterans, and they cannot afford to wait for Blood Bank facilities – mostly remote – urgency and availability. The Union Cabinet has decided to exempt all the Provisions of Chapter IV of the Drugs and Cosmetics Act, 1940 and Rules framed under (Sub-section 30 in 4.1.2001)

Conclusion

The public at large, the voluntary organizations in the country, the Medical Association of India and similar organizations should join in one voice to pressurize the officials and authorities to take immediate remedial measures to save millions of the poor illiterate in the rural villages especially the under privileged women who are mostly affected by the enforcement of the amendment.

This would relieve thousands of medical professionals in getting involved in unwanted litigations while they serve in the rural areas tirelessly. However, the sad reality is that a service minded doctor who violates certain rules on good faith is put on an equal pedestal to a criminal offender- standing side by side in the Magistrate Court in the place earmarked for an accused person.

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ETHICAL HEALTHCARE IN CMAI MEMBER INSTITUTIONS

Background

Definition of Bioethics

Bioethics can be described in many different ways and through different definitions because it is a vast, diverse and complex field involving multiple streams and dimensions.

Dr Priya John

In relation to healthcare the definition by dictionary.com is: "a field of study concerned with the ethics and philosophical implications of certain biological and medical procedures, technologies, and treatments, as organ transplants, genetic engineering, and care of the terminally ill."

According to Dr. Darryl Macer, Director, IUBS Bioethics Program, Institute of Biological Sciences, University of Tsukuba, Bioethics is 'love towards life' and there are at least three ways to view it:

1. Descriptive Bioethics: describes the way people and society view their life.
2. Prescriptive Bioethics: tells us what is right and what is not and
3. Interactive Bioethics: discusses and debates between the two

In order to implement ethical practices in medicine there are four basic principles that have been defined:

1. ***Respect for autonomy*** - Every patient has equal right to be informed, answered to satisfaction and consented for the procedure - diagnostic, therapeutic as well as preventive.
2. ***Principle of Non maleficence*** - All our efforts should be focussed on reducing the risks and avoiding any intentional harm to the patient.
3. ***Principle of Beneficence*** - Every effort should be for the overall benefit and the welfare of the patient and not only towards reducing the harm and risks.
4. ***Principle of Justice*** - Justice here means fairness and equality. All patients should receive equal and fair treatment without any discrimination based on caste, creed, social and/or financial status.

The need for Bioethics

Patient care is not only about treatment of the disease but about the 'right way of treating the disease' keeping the general principles of bioethics in mind.

The commercial approach, thought processes, complexity of diseases, overload of patients, variations in cultures and communities, diversity, multiple treatment options and guidelines, lack of clarity in legal and guiding matters and variable other interests and factors make the issue/subject highly complex and thus we need bioethical guidelines for a streamlined process.

Bioethical aspects are broad enough to fit into any category or division of healthcare industry and there is an expanding need for study, research and practice of bioethics. CMAI proposes to introduce bioethical guidelines in consultation with the stakeholders for its member institutions to display ethical healthcare practice as part of their policy in order to reflect and position themselves as responsible healthcare service providers.

Background

India is a big and diverse country with the second largest population in the world. According to the draft National Healthcare policy, around 80% of healthcare in India is provided by the private sector and India has seen the mushrooming of commercial healthcare services at a very high healthcare cost leading to poverty to the people especially in the rural areas and the poor and the marginalised section of the community. With the advent

Ethics and decision making is based on values and the guiding principles. These values form the foundation of our knowledge about what is right and wrong and subsequently making the right decision.

of corporate hospitals and hospitals run on a business model rather than a service model, the relevance of the Christian Health Care network is being questioned.

Recognising best practices and validating the ethical and relevant health care provided by the Christian Health care network is needed. The professionals who have dedicated their lives to serving the poor in resource constrained settings need encouragement and upgrading of skills at regular intervals. This is required as the health care industry is in a state of constant change and it is important to keep abreast of this change in order to be relevant. Ethical and Relevant Healthcare ensures the providing of optimal and essential healthcare services to all who have come to the hospital, irrespective of the background. It also ensures that unnecessary treatment, investigations and procedures are not conducted

CMAI and Ethical Health care

Christian Health Services has been in existence for more than 105 years in the country. Although they are also part of the private healthcare network, the difference is that the Christian institutions make up the Not for Profit sector. Christian Medical Association of India (CMAI) as a national level member organisation of Christian healthcare institutions and professionals has to ensure that the ethos and principles of its members is recognised through a structured assessment mechanism.

Goal: ***CMAI members, Institutions and individuals, are recognised for good ethical healthcare practices***

- CMAI as an association network would generate evidence of the ethical and relevant health care practices in the Christian healthcare network through the following activities:
- Recognising member institutions for the practicing of ethical and relevant healthcare by use of a tool.
- Developing a foundational level Bioethics curriculum which will be rolled out through all the training programmes under Sections of CMAI.
- Conducting workshops on updating relevant information and training in specific skills to maintain a good quality of ethical services.
- Partnering with other organisations and institutions like The Centre of Bioethics, EMFI(Evangelical Medical Fellowship of India), CMC (Christian Medical College & Hospital)Vellore, EHA(Emmanuel Hospital Association), UBS(Union Biblical Seminary), Christian Legal Association, Management Institutions etc.

Ethics and decision making is based on values and the guiding principles. These values form the foundation of our knowledge about what is right and wrong and subsequently making the right decision. In a consultation with experts on ethics, organized by CMAI, five values were identified, namely:

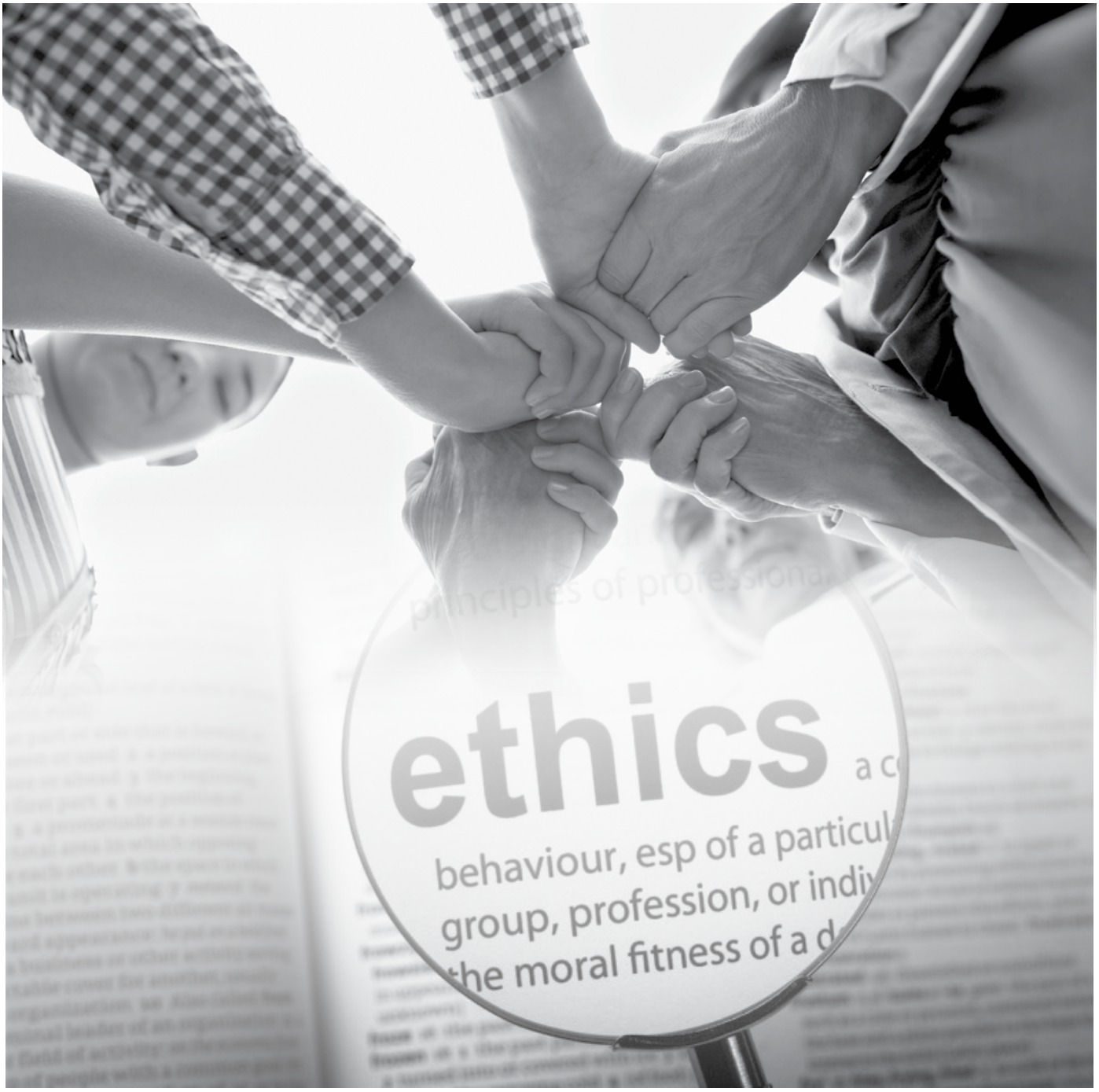
- Sanctity of life
- Professionalism
- Integrity
- Human Dignity (Equality, Holistic Care)
- Social Justice and Equity.

Based on these values, Guiding Principles were also documented. These are aligned with the Medical Council of India Guidelines for Ethical conduct. This is shown in the Table 1.

Based on these values and guiding principles, examples of an ethical code of conduct for our hospitals have been suggested, but this will be finalised after a consultation with the stakeholders. With this code of conduct, our member institutions will be able to have an understanding of implementation of ethical practices.

Table 1		
Values	**CMAI Guiding Principles**	**MCI Guidelines for Ethical Conduct**
1. SANCTITY OF LIFE	Every human being is made in the image of God (Gen 1:26-27)and therefore his/her life has intrinsic value ***(Every human being is made in the image of God and therefore his/her life has intrinsic value and deserves love, compassion, care, irrespective of sex, age, socioeconomic status caste/colour/creed/religion - 1 Sam 16:7)***	Chapter 2: Duties of Physicians To Their Patients
2. PROFESSIONALISM	Commitment to excellence and high ethical standards (2 Thess 3:8-9) ***(Quality of care, confidentiality - in our practice attitude and application, technically competent, develop good systems and practices, appropriate, financing, technologies, workforce, collaborations, partnerships)***	Chapter 3: Duties of Physician In Consultation Chapter 4: Responsibilities Of Physicians To Each Other Chapter 5: Duties of Physician To The Public And To The Paramedical Profession
3. INTEGRITY	An unwavering determination in the heart to do right irrespective of the outcome (1 Tim 6:18) ***(Honesty, transparency, truthfulness, punctuality, accountability, stewardship)***	Chapter 6: Unethical Acts Chapter 7: Misconduct Chapter 8: Punishment And Disciplinary Action
4. HUMAN DIGNITY **(EQUALITY, HOLISTIC CARE)**	Every human being is made in the image of God (Gen 1:26-27) and therefore he/she has dignity of life ***(Compassion, respect, best interest, human rights, promoting dignity, valuing each person, family and community -1 Peter 3:8)***	Chapter 1: Code of Medical Ethics 1.1,1.2,1.3 Chapter 2: Duties of Physician To Their Patients
5. SOCIAL JUSTICE AND EQUITY	Caring for the weakest/marginalized members of our society and promoting their welfare (Phil 2:3-5) **(*Rights and responsibilities of patient, care givers and health providers, access for all, inclusiveness, affordability, appropriate, fair opportunity based on need, documentation of ethical practices and violations, redressal, advocacy)***	Chapter 2 : Duties of Physician To Their Patients

Values	Suggested Guidelines for Ethical Conduct
1. SANCTITY OF LIFE	We will value every human life from conception to natural death We will do no intentional harm to individual life (abortion, euthanasia) We will celebrate every human life (focus on disability) We will make it a priority to promote health and prevent disease/disability
2. PROFESSIONALISM	We will share our professional knowledge, skills, values and mentor and build capacity of our teams We will develop good practices and systems ***(e.g. WHO Building Blocks for Health Systems- Health services, Health workforce, Health information, Health financing, Medical product and technologies, Leadership and governance)*** We will be professional in our conduct, practice and dealings (including financing) We will be appropriate to the environment and context We will provide high quality of care in safe environments We will adhere to high standards of care (e.g.CEA 2010)
3. INTEGRITY	We will be honest, transparent, truthful in our functioning We will be good stewards of time and resources We will be accountable for our actions and use of our resources including the environment We will be accountable to our patients, our communities, our teams and other stakeholders and above all to God We will be open for medical and systems audit We will be open to Social audit
4. HUMAN DIGNITY (EQUALITY,HOLISTIC CARE)	We will practice healthcare that is compassionate, inclusive and holistic We will uphold human rights (fundamental human rights) We will accord every individual respect and dignity We will maintain confidentiality of health related information of patients and communities We will strive for equal quality of care* irrespective of gender, socio-economic status, ethnicity, religious affiliation (*care to be defined, care pathways, protocol)
5. SOCIAL JUSTICE AND EQUITY	We will demonstrate good models of appropriate healthcare delivery in resource constrained settings to the poor and vulnerable We will speak up for inclusive healthcare in the Government Healthcare Centres for the marginalized sections of society We will document an evidence base of (i) ethical practices for learning and on-going improvement and (ii) violations of ethics for advocacy We will educate patients on their rights and responsibilities with regard to their own health We will promote health and prevent disease/disability among the poor and vulnerable.



The Foundation Level Bioethics Curriculum based on these 5 values has been written up by The Centre for Bioethics and will be rolled out through all the 5 sections of CMAI. The platforms for this dissemination will be regional workshops, institution level interventions as well as a training of trainers for the tutors and stakeholders involved in CMAI training programmes.

Making the right ethical decision is not easy. It requires our commitment to all the 5 values listed. This commitment has to be based on the Word of God and our willingness to be His witnesses as well as the light and salt of the earth.

Dr Priya John is the Sr Programme Coordinator, CMAI

Shanti Bhavan Medical Centre (SMC) Jharkhand

Shanti Bhavan Medical Centre (SMC), PO. Biru, District Simdega, Jharkhand, has added another milestone- first open heart surgery and very first in the district.

Prof Col. Dr. James Thomas, a renowned Cardio-thoracic surgeon says, "Open heart surgery was conducted for the first time in Simdega district of Jharkhand at the Shanti Bhavan Medical Centre. SMC is a two-year old, 100- bedded facility in this most backward district of Jharkhand. A brand new well equipped Cardiac Operation Theatre and Coronary Care Unit were commissioned with latest Heart Lung Machine (Sarns), new OT table, OT Lights, Anesthesia Machines, Ventilators (Maquet), Diathermy Machine, Defibrillators.


Mr N J Varughese Sharing the vision


The Civil Surgeon Inaugurates


Cardiac Operation Theater

The Hospital also has a CT Scan, Ultrasound scanner, Digital X-Ray, well equipped Lab, Blood Bank, Departments of Ortho, General Surgery, Medicine, Ob/Gyne, Pediatrics, and anesthesiology.

It was my great privilege and pleasure to help the hospital set the department. With our team from D Y Patil University, Navi Mumbai, conducted the first open heart surgery on a 16 year old girl from nearby Gumla District.

SMC hopes to add soon cardiac Cath Lab for the much needed service to the cardiac patients. Further plans are to expand the hospital to 350 beds. Mr N J Varughese, Founder and Chairman, has the vision to expand other super-specialties in the hospital.

Come and join hands and be part in the expansion of God's Kingdom

We require professionals in

Medical, Nursing and Allied Health service positions.

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