FRIENDS OF
VELLORE NEWSLETTER

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CHRISTIAN MEDICAL COLLEGE AND HOSPITAL, VELLORE, S.INDIA

LAUNCHING OUR NEW WEBSITE

Friends of Vellore UK have created a new website which is now available at the same web address as our old site: www.friendsofvellore.org. All the content has been updated and presented in an accessible format; there are articles on CMC, its history and founder, Dr Ida Scudder, you can read information about each of our projects that we are currently supporting and find out about our Trustees. You can also make a donation or download our newsletters.

We hope the new site is easier to navigate and enables our supporters to keep abreast of the work we are doing. Please do visit the site to see for yourself. We would also welcome any feedback you may have.

We encourage our supporters to **get involved** in a number of ways:

- Please be **praying for the work of CMC**. You can download the Maitri prayer booklet produced annually by CMC. Alternatively why not pick a project each week to pray for?
- Please consider making a financial donation to the projects we are supporting. You can read details of each of the projects we are involved with under the **'Projects'** menu. You can **donate** directly via the website under the **'Get Involved'** menu, or you can download a donation form and post a cheque, or set up a bank transfer.
- You might be in a position to **volunteer** at CMC or **visit** the hospital or go on a **student elective** there. More details are available under the appropriate headings in the **'Get Involved'** menu.
- Some of our supporters have the opportunity to promote CMC and Friends of Vellore by arranging a local talk or fundraiser. Please do **contact us** if you would like any help or materials for this.

(Items in bold correspond to page/menu headings on the website.)

We recognise that not all our supporters access the internet but we will continue to send out our newsletters twice a year to keep you informed of the work of the charity. Please do not hesitate to contact the office if you would like any further material or have any questions regarding our work.

ABILITY OR AVAILABILITY: CURING OR CARING - See page 12

Welcome to the Autumn 2016 issue of the Friends of Vellore Newsletter

Thank you to all those who responded to our questionnaire in the last issue regarding the newsletter. We welcome your comments and feedback and hope to use them to improve our newsletters in the future.

In this issue we want to update you with various news items from the Christian Medical College and Hospital (CMC), Vellore. We also have updates on several of our projects and some patient stories to tell, demonstrating just how much a difference your funds are making to the lives of people in Tamil Nadu and beyond. We also have an article on Palliative Care written by a CMC alumus, Dr Kumar, a research article written by one of our Trustees, Professor Mike Keighley, and a write up of a visit to CMC by one of our supporters, Dr Ruth Ashbee. This issue we are trialling printing the donation form on the inside back cover rather than as an insert. We hope you enjoy reading the newsletter and are inspired by the wonderful work going on at CMC.

In September we held an Annual Meeting following the CMC Alumni reunion weekend to update supporters on news from CMC and in particular the work in the Jawadhi Hills that we have an opportunity to be a part of. This meeting was publicised via email and also by letter to those supporters we were already writing to over the summer. We are sorry for those supporters for whom we weren't able to contact with the details. If you didn't hear about the meeting by email and have an email address, please can you let me have it? We hope to hold similar meetings in the future and would love to be able to tell you about them.

Ruth Tuckwell, Administrator *friendsofvellore@gmail.com*

CHAIRMAN'S REPORT

For the first time in many years, we had our General Meeting in Coventry on 11th September, 2016. It was lovely to meet so many Friends and the alumni who joined in following their reunion the previous day.

Hugh Skeil from the Development Office at CMC was our guest speaker. He gave us an update on the main projects and activities in Vellore. Anu Rose, in charge of the Jawadhi Hills project, spoke over a teleconferencing link. Her presentation was both clear and in sufficient detail to inform us about the need in this mountainous area for health and other development. The meeting was so successful, I would like to continue holding the General Meeting of Friends alongside the CMC Alumni Reunion each year.

In July, I attended the Council meeting in Vellore and visited our projects. Meeting the people who are involved with RUHSA, LCECU, Rehabilitation and Palliative care was enlightening. We are so proud to be associated with these projects. Our interest in CMC's role with Mission Hospitals, via the appointment of a Missions Coordinator has been so successful that CMC has decided to continue by enlarging the department with supporting staff.

I look forward to seeing more of you at our next General Meeting in September 2017. We hope to give you further details in our Spring newsletter next year and on our new website.

Yours in Christ, Ajit Butt

General Meeting.

Lunch following the meeting.

NEWS FROM CMC

After several months of anticipation the long-awaited approval for the Kannigapuram hospital has been given.

CMC are now able to progress with the next phases of this much needed project. Currently services at the main hospital are very over-stretched with 8000 outpatients a day. They are thankful to God for the progress so far and would appreciate prayers for the planning phase and the building work ahead.

The CMC Chittoor Campus is located in an area which was historically served by Dr Ida Scudder at the roadside clinics. On 31st of August 2016, surgical services at CMC Chittoor Campus were

opened to the people of Andhra Pradesh with the launch of the theatre complex. There are 4 spacious state-of-the-art theatres with a sizeable recovery room and day care ward with several other amenities that a modern theatre complex can offer. The facilities promise to be a great blessing to the people of Southern Andhra Pradesh in particular. With the launch of the surgical services, CMC Chittoor Campus now offers basic medical, surgical, orthopaedic, paediatric, gynaecological and community services, along with outpatient facilities at affordable rates, keeping in mind the wellbeing of the local community and the motto of the institution: Not to be ministered unto but to minister.

Chittoor Inpatient Facility.

Apart from building new capacity, the hospital has been kept very busy attending to issues surrounding the National Eligibility and Entrance Test (NEET) for undergraduate admissions into medical colleges. The Medical Council of India recently ruled that all Indian hospitals now have to use NEET as their sole selection criteria whereas previously non-Government funded medical colleges were exempt. This represents a big challenge to CMC whose selection procedures have been based on interviews and aptitude tests in addition to academic results. CMC want to preserve their Christian heritage and mission and would value prayers as they seek legal advice and meet with Indian authorities.

Person to Person Scheme

We have raised almost £25,000 to date this year to support the Person to Person (PTP) scheme. This is a fantastic amount and we would like to express our gratitude to all our supporters who have contributed.

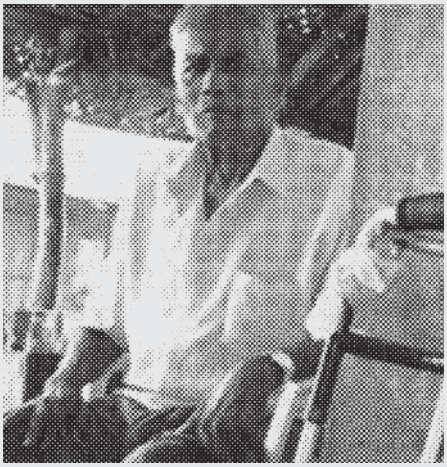
This fund is used to provide small targeted grants (up to Rs 5,000 or approximately £50) to help pay the hospital bill for specific patients who are unable to pay for their treatment. Donors to the scheme receive reports directly from CMC detailing how their money was used. Below is the story of Vadivelu, one patient who this year benefitted from the PTP scheme.

Vadivelu

Diabetes is a major problem worldwide. In India, it has almost reached epidemic proportions. Some of its symptoms are very similar to leprosy, though it is not contagious. 78-year-old Vadivelu, father of six, lives with his oldest son's family in a village about 12 km from the hospital. The house is built with brick walls and a concrete roof and has electricity and sanitation facilities. The family collect water, which is available, twice a week from the public tap and have three meals a day. Vadivelu has studied up to high school level.

His whole family is very much affected by diabetes. His third son had diabetes mellitus and had to have his leg amputated in a local hospital, but died two years later. His remaining five children: three sons and two daughters are married and live separately with their own families. Vadivelu's wife also had diabetes and high blood pressure and died recently.

He was not content just sitting at home so he took out a loan from the local



government and runs a shop in which he sells biscuits, cool drinks and ropes. He manages to open the shop four days a week and earns £35 per month.

Vadivelu had pulmonary tuberculosis for which he had been treated previously at CMC. He was also taking regular medication for diabetes and hypertension. He had a small blister on the bottom of his left foot which burst. He was initially treated in a local hospital. Since there was no improvement, he came to see the doctors at the Community Health and Development (CHAD) Hospital. By then the ulcer had developed into an abscess, with a cavity extending to the heel. He was referred to CMC hospital for further treatment and was admitted. In the ward he was diagnosed as having a diabetic foot which required part of his foot to be amputated under spinal anaesthesia. He recovered post operatively on the ward with daily dressings and was discharged in a stable condition after four days in hospital. He was advised to continue the dressings at CHAD Hospital.

The cost of hospitalisation for his treatment came to £282. His sons contributed some money towards the hospital bill but they couldn't afford the whole amount. As a result of the generous donation of one of our UK donors, Vadivelu was helped through the Person to Person scheme.

JAWADHI HILLS

80,000 people live in this rugged terrain in Tamil Nadu, 37 miles from Vellore and their health, literacy and development indicators are tragically low.

CMC's Community Health & Development Program (CHAD) are working in this area together with Don Bosco, a Roman Catholic institute, to improve health and provide development opportunities. Dr Sunil Chandy, the hospital director has invited all the International FOVs to fund different aspects of the work going on here.

The Vellore Foundation (USA) are sponsoring a model village. The first phase, construction of toilets for each household, has been completed. Next is the provision of a clean water supply and proper waste disposal. If successful, other villages in these hills could be adopted for similar projects.

FOV Australia have funded a 4 wheel drive vehicle and some student scholarships. FOV Germany sponsored the Summer Camp for school age children this year and are also funding student scholarships. FOV Sweden are looking at alcohol issues.

In April 2016 our Trustees committed to raise £20,000 and to choose an area of support that is in line with our charitable objectives and that helps the community to improve their assets. The Trustees want to explore funding development opportunities for young people. They would like to support work to regenerate the community workshop and provide vocational courses (eg carpentry) for young people that would provide them work in the hills rather than needing to go elsewhere.

CMC's Community Clinic.

CMC are unable to use their clinic in the Jawadhi Hills effectively because overnight facilities for staff are not available and the journey time from CMC is three hours each way. Having somewhere for people to live at the health centre would seem to be the key to further development, however, the land needs to be purchased first. Please pray that it would be possible to buy the land and also that funds would be raised for the purchase of the land and for building staff accommodation.

Houses and the community grain store.

OCCUPATIONAL THERAPY FOR PAEDIATRIC SURGERY

This year Friends of Vellore UK have started to fund the post of an Occupational Therapist to work in Paediatric Surgery.

Interviews have just taken place and a job offer has been made. We have agreed to fund this post for three years to enable CMC to assess how effective it is. If it is proved beneficial, the post will be incorporated within core departmental funding after three years. The therapist will work alongside burns victims and children suffering from Myelomeningocele.

CMC have approximately 80 patients with major paediatric burns admitted to their five bedded burns facility annually. Often these are caused by cooking accidents in the home. A typical burn patient is a two year old with about 24% of his or her body surface affected. He or she spends on an average 15 days in hospital receiving medical care. These days are drawn out and etched in the memory of these youngsters and their families for all the wrong reasons.

Myelomeningocele (MMC) is a birth defect in which the backbone and spinal canal do not close before birth. The condition is a type of spina bifida. The Paediatric Surgery department sees around 70 children less than 15 years of age annually with MMC, 20 of whom are neonates. A newborn with this disorder will undergo surgery to repair the defect and most children will require lifelong treatment for problems that result from damage to the spinal cord and spinal nerves. These include bladder and bowel continence issues and muscle and joint problems.

The occupational therapist will work with the children during their time in hospital to brighten their stay through a process of engagement and also do home visits where possible. They are uniquely suited to keep the medical goals in focus while ensuring that the road ahead for these patients is manageable. The therapist will enable a smooth transition from hospital to home and society. They will help patients and their families to develop coping strategies, manage the scarring, advise on exercises, monitor continence and provide timely intervention.

Below and on page 6 are the stories of Mohammed and Kugan. They were both patients in Paediatric Surgery earlier this year.

Mohammed

15 year old Mohammed should have been born with a pair of boxing gloves! From the time he was born he needed to put up a fight.

He was born two months early, and to top being premature, he decided to come out bottom first! It must have been quite a pull, or the birth attendant may not have been very comfortable with a breach delivery, because the entire process resulted in both some trauma to his spine and him refusing to breathe for a long time.

The lack of oxygen to his brain and some trauma to his spine resulted in this lovely young boy having a lot of disability to struggle with as a child. He struggled to walk normally and his legs were too weak to hold his body up properly. The nerves to the bladder and his intestine were damaged and this caused him to continually leak urine and stool.

His mother managed his incontinence with nappies for years, but after three bad urinary tract infections in Bangladesh, a friend suggested they come to CMC hospital in India. It was a struggle to arrange the visa and passport to come – but once they did, they were glad they had made the effort.

His doctors at CMC told him that he would need help since he was unable to empty his bladder in the normal way - his kidneys had swollen up threatening to cause lifelong irreversible kidney damage. They reassured him that he could easily manage emptying his bladder and not soiling himself if he learnt to give himself enemas and to keep himself clean. He was taught how to empty his bladder with a tube and given medicines to relax his bladder which made a remarkable improvement to his quality of life.

Mohammed proudly shows off his surgery.

He came back to Vellore a year later – better, but still leaking urine far too often for his mum to manage emptying his bladder. After a few more tests, it was decided that his bladder needed to be enlarged. The operation was a major one that required Mohammed to stay in the hospital for about a month. A part of his intestine was stitched to his bladder to enlarge it and make him dryer for longer periods of time. A small channel from the new bladder was made to and hidden in his tummy button so he could easily empty his bladder himself if he went to school or at work later in life.

His mum is delighted - she was most worried about how her son would manage once she grew older. Now he will be able to manage himself without being dependent on others. The family are thankful that they came to CMC, because there are no doctors in Bangladesh who were trained to look after Mohammed with these procedures. He still has a long way to go, but he is on the right track!

Mohammed still has difficulty walking normally. His mobility and quality of life would greatly improve with the attention of an occupational therapist.

Kugan

Two and a half year old Kugan was playing with his older brother Sujith just a few days before Christmas. His parents had promised them some hot vadai and so between their play they kept running in and out of the hut to check if their favourite snack was ready. Their mum, a housewife in a village about 20 miles from Vellore, was heating the oil in a deep pan on the wood fire on the floor of their backyard. The vadais needed very hot oil to cook just right.

A young patient on the road to recovery.

Little Kugan was unaware of the dangers of running around that pot of oil. No one expected the pot to tumble and the boiling oil to spill over and cover him from the neck downward in an instant. It took his horror-struck mother minutes to recover from her shock and take up enough courage to wash off the hot oil from the screaming boy. Being illiterate she was told by a neighbour to pour some ink over the wounds. Kugan's father was sent for. He works in whichever field he can get work in as a manual labourer and earns around £25 a month. After the incessant rain in Chennai and Vellore over the last month, work had been scarce as most fields were flooded.

Kugan was brought to the CMC hospital paediatric casualty. There a nasal tube was fitted to ensure he was kept fed, and his burnt skin washed and dressed. He developed a high fever soon after he was brought to the burns unit and required expensive antibiotics very early in the course of the treatment. Kugan hardly felt like eating and all the nutrition he got was from the nasal tube that was placed into his stomach.

He had days when his skin looked like it was healing but then it would often worsen as he frequently became septic from the extensive dead and burnt skin. The dead skin was removed as often as it looked ready to come off. A dedicated burns nurse was assigned just to Kugan to ensure he got his feeds, dressings and was kept clean. The skin over his thigh, buttock and leg as well as the front of his tummy was burnt. With so much burning, his arms and legs became contracted and bent. The burning also caused extensive damage to his urinary passage.

His parents have spent all their savings on his treatment. His father has spent the past two months in the hospital sleeping outside the ward and so unable to earn an income. Kugan's mother has been in the ward trying to console the constantly crying boy. Kugan's only solace is when his older brother visits. Their hospital bill has exceeded £2000 with the Government health insurance paying only about £270. They have hardly been able to eat a normal meal themselves and are evidently struggling. They have been warned that this battle may be futile but all they can do is hope for the best and help in any way they can. They do so by collecting willing village friends to come and donate blood for Kugan, and they have learnt how to make his porridge and raw egg that is used to feed him.

Burns sadly affects the poorest of our society and requires the most expensive of treatment. The expense is because of the need for long stays, antibiotics for long periods and time in Intensive Care every time the child becomes septic. Often parents give up, because there is a lot of demand on the care givers both emotionally and financially. This story was written up in February. However, very sadly, Kugan died that month from his injuries. If he had survived them, he would have benefited greatly from the attention of an occupational therapist.

Obituary

Mrs Eirene Mills (nee James) entered eternal rest on 18th August, 2016. She was sent to Vellore by the Methodist Missionary Society as Chief Pharmacist and lecturer to medical students. She worked as a pharmacist at CMC from 1946-1956, when Dr Cochrane was the Director and the Revd James McGilvray the General Superintendent. In 1956 she returned to England, where she remained Secretary of the Bournemouth Branch of the Friends of Vellore for many years. During this time, she and her husband John raised large sums for CMC arranging an annual garden party and a Bournemouth concert. Our thoughts and prayers are with her family at this time of grief and loss.

News from RUHSA

Brand new outpatient block.


RUHSA Inpatient and A&E facilities.

RUHSA is the Rural Unit of Health and Social Affairs and is located 30km from Vellore town. This unit delivers health and social development services to the local rural area with a population of 200,000. Friends of Vellore has a subcommittee, the Vellore Rural Community Trust, which funds various projects here including farming clubs, elderly welfare centres and a children's play centre.

NEW OUTPATIENT BUILDING

On 6th July 2016 the new Outpatient Building and 3-bed emergency room in the Rural Unit of Health and Social Affairs (RUHSA) campus was dedicated and inaugurated. This project was a response to many years of struggles managing an overflowing patient crowd in a congested building with inadequate space and privacy. The new building provides a spacious outpatient department with rooms to attend to about 100,000 outpatients annually.

The emergency room was a much needed facility for the people of K.V. Kuppam block and also of the Gudiyatham, Madanur and Peranambut blocks who otherwise access care from 30-40km away at Christian Medical College or 40-50km away at Government Medical College, Vellore.

RUHSA has come a long way from its humble beginning of a rural health centre way back in 1944 mainly providing services for the women in labour and leprosy patients. In the 1970s the centre was upgraded to a revolutionary health and social development model serving the people of K.V. Kuppam block, complementing and enhancing the health services provided by the Government through its Primary Health Centres. The new facilities will provide much needed space to enable RUHSA to continue to serve the rural community.

A plaque was unveiled to mark the 40 years of RUHSA's dedicated service to the community. Dr Rita Isaac, Head of RUHSA said "The Lord has done great things for us, and we rejoiced!" Psalm 126:3

DIABETES 'PATIENT NAVIGATOR SYSTEM' PROJECT

We are delighted to tell you about a new diabetes project that Friends of Vellore are involved in. This is a joint venture between FOV, Aberdeen Royal Infirmary (NHS Grampian Endowment fund) and RUHSA. As part of a matched funding scheme, Aberdeen Royal Infirmary have been approved a £12,000 grant from NHS Grampian to support complication prevention screening for diabetes at RUHSA. The matched funds of £12,000 are being provided by FOV via the Vellore Rural Community Trust and the Aberdeen branch.

Enabling earlier detection of complications will significantly improve the quality of life of diabetic patients in rural settings. This project brings together CMC's passion for patient care, research and education that can be generalisable to other Mission hospitals in the country and wider. It is exciting to see RUHSA at the forefront of this study. We hope to bring you more news of this project and stories of patients who have benefitted in 2017.

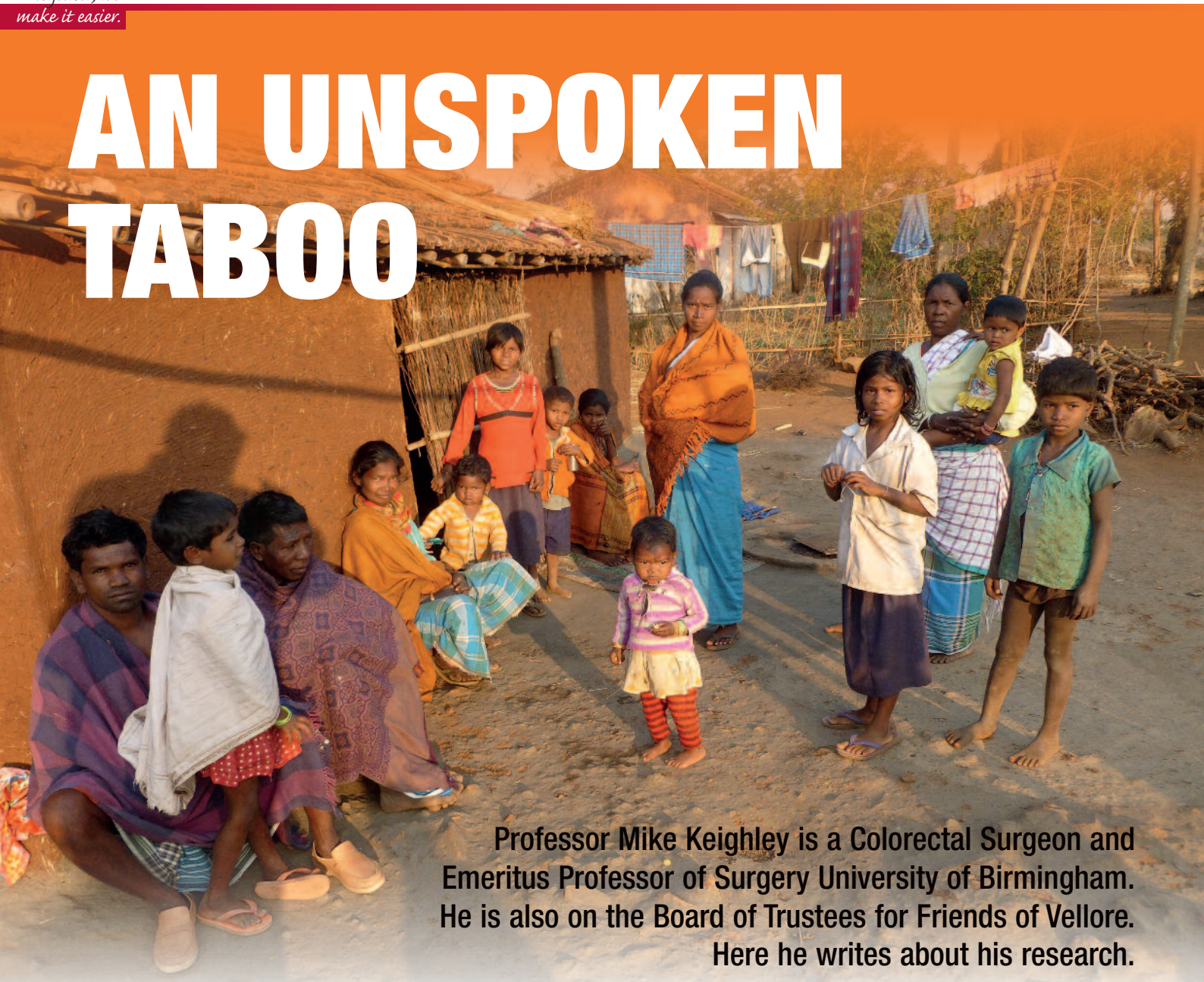
GIFT AID

Are you a UK tax payer and eligible for Gift Aid on your donations?

If so, have you completed a Gift Aid Declaration form and registered with us? Gift aid enables the charity to claim an additional 25% on every donation you make. It makes a huge difference to the projects we can support.

In order to be eligible, the donor must pay an amount of income tax or capital gains tax equal to the tax reclaimed on their donations (currently 25 pence is refunded per £1 donated). The Gift Aid Declaration form can be found on the inside back cover or is available to download from the website (under Get Involved, Donate). You only need to complete the form once, unless you change your name or address, in which case we will need you to complete a new form.

AN UNSPOKEN TABOO



Professor Mike Keighley is a Colorectal Surgeon and Emeritus Professor of Surgery University of Birmingham. He is also on the Board of Trustees for Friends of Vellore. Here he writes about his research.

A surgeon in retirement can either vegetate or become engaged in new things.

The new things for me were to help establish a new Colo-rectal Unit in the Department of General Surgery at CMC in 2004; attempt to take a surgical invention into the market place; train as a Reader in the Church of England; become a Trustee in a number of Charities (one being FOV), and exchange my role as a Professor of Surgery teaching and operating to being a student at Durham University reading Theology, Spirituality and Health.

Having spent many hours in the Operating Theatre repairing injuries to the anal sphincter and pelvic floor in mothers who had been damaged as a result of childbirth, I decided to research the ethnographic and cultural variables in India and Britain associated with coping with these injuries which had rendered these young, often first time mothers, no longer continent of waste. On learning of my interest in exploring this subject, the suggestion that I should read Theology at Durham came from the then Chairman of FOV.

During part of my course I was able to initiate a debate about the role of mission in retirement using my own model of intermittent service at CMC as the example of how this worked for me. I also did some fieldwork about religious factors which impacted on coping with a stoma in Britain and India.

The final dissertation however, was altogether more difficult because I soon discovered that mothers who cannot control waste are ashamed about their condition. They feel unclean, become isolated, suffer dignity loss, are hugely embarrassed about the psychosexual consequences and will not talk about their condition. This is an unspoken taboo whether you live in Britain or India. Consequently quite apart from the ethical committee hurdles that I had to jump through (the IRB clearance at CMC was far more rigorous that the University Ethics committee!), I found that interviewing mothers with this condition in a different culture where the English language is probably their third tongue proved very challenging. Even with a senior female member of the nursing profession with me as a chaperone and confidante, the impact of these injuries proved difficult to decipher in India. I therefore had to rely on secondary evidence from members of the profession to whom these ladies might be referred: psychiatrists, obstetricians, surgeons, counsellors, nurses as well as spiritual leaders. Very few had any knowledge of the condition in India thereby confirming this is indeed an unspoken taboo.

Many similarities emerged from

interviews in both countries. In the case of British subjects, a number of them were Asian and had lived here for from one to four generations.

For Muslims in both India and Britain, being unclean prevented them from attending the Mosque for prayers, participating in Ramadan festivals and Ede. Even private prayer at home had to be done in secret. In fact, the whole condition had to be kept a secret especially from their husbands and the family, because if not they would all consider themselves contaminated. I spoke to Imams and faith leaders in India and here at home. None had any knowledge of the condition or the impact that it has on the immediate family and community.

Hindus have a similar reaction to being unclean but the impact of being faecally incontinent on worship depended on the social circumstances and Caste. Brahmins would not be able to attend the Temple and even those of lower caste in rural communities would react similarly. The watchword was to remain silent for fear of making the rest of their local community unclean. Many Hindus considered that the injury was more the result of bad luck rather than evil or neglect.

Christians often felt uncomfortable about receiving communion especially in India, but amongst this group there was a stronger focus on hope and reconciliation if the injuries were the result of mistakes. They expressed a desire to move forwards believing that others in society might well have worse things to face. Consequently the believer was often able to share with others and come to an understanding with their husbands that loving might lose its spontaneity (many mothers felt the need to shower before and after close relationships) but that there were other aspects of a marriage relationship that were strengthened by adversity.

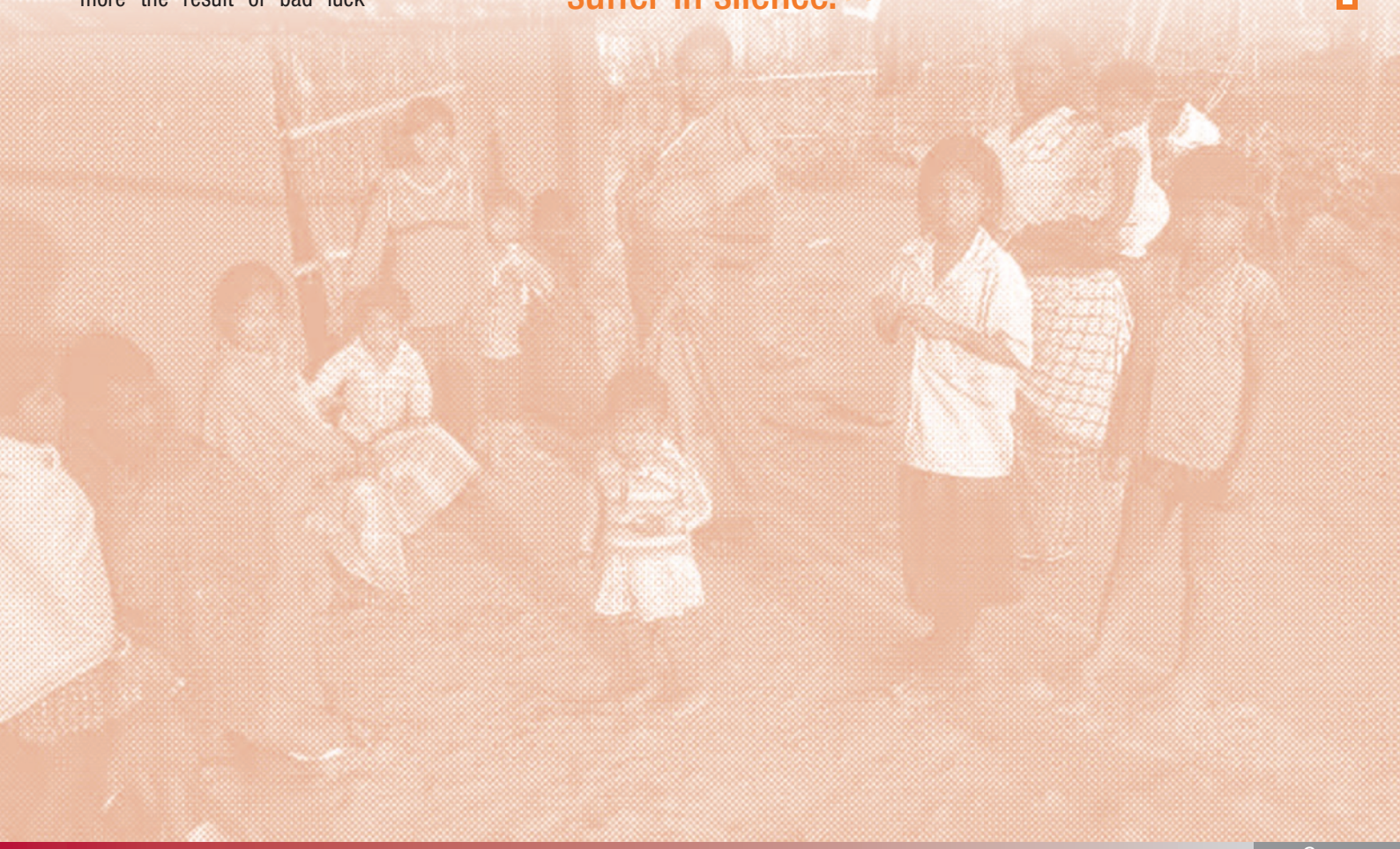
In Britain, there is no awareness of this condition amongst the public and very little knowledge within the profession despite the fact that this affects at least 10% of all mothers having a normal delivery. In India, there is absolutely no awareness but the incidence is likely to be two or threefold higher because obstetric services are more primitive, especially in rural communities where 70% of the population live.

Few women are identified with this condition unless their tears have been spotted and repaired at birth, in which case many of them do not suffer incontinence. It is the mothers with the missed tears who really suffer in silence. They are afraid to see the GP, who in turn may not realise the cause. Even if they are eventually identified, surgical operations are often unsuccessful. Coping strategies are best delivered by specialist nurses and physiotherapists. There are few counsellors trained to help with the particular emotional and psycho-sexual consequences of this injury and spiritual leaders struggle to help without some medical input.

As a result of these studies we in Britain are trying to set up some sort of multidisciplinary support group. Maybe one day a similar programme of help, education and support will emerge in India.

Mike Keighley

“Few women are identified with this condition unless their tears have been spotted and repaired at birth, in which case many of them do not suffer incontinence. It is the mothers with the missed tears who really suffer in silence.”



THE GIFT OF HEARING

Dr Anjali Lepcha, head of the ENT IV unit and members of the Audiology Team receiving the equipment from Mr Richard Rajamanickam.

We are delighted to report that this August one of our Trustees, Mr Richard Rajamanickam, was able to take about 25 new high powered hearing aids to CMC as a gift from FOV UK. These hearing aids were donated by Mr Whiley and his staff at the audiology department of the Lister Hospital, Stevenage (where Richard used to work), with the commercial value of just over £20,000. They are for babies who are born with severe to profound hearing loss. For every 1000 deliveries at CMC, around 5 babies will suffer from profound deafness. The high cost of these hearing aids means most patients are unable to afford them.

Richard presented the hearing aids to Dr Anjali Lepcha, the head of the ENT IV unit. The audiology team were delighted with this gift and already have in mind some specific children who will benefit enormously from the hearing aids.

The Audiology Team conduct a neonatal hearing screening programme, trying to cover all the babies born in CMC's main hospital. At an average of over fifty deliveries a day, this is no mean feat. By doing this they have been able to diagnose cases of hearing loss at a very young age, and take steps to ensure that these children and their families are given the best start to life. This programme has recently won an "Order of Merit Award" from the Skoch Foundation in New Delhi. As far as CMC knows, it is unique in India in terms of both the number of babies screened and its comprehensive nature (at least 95% coverage).

Since many of the children born at CMC are from families that depend on agricultural labour and similar occupations with incomes of less than £50 per month, even basic hearing aids are beyond their means, and there is usually no government support available. As a charitable hospital CMC do their best to provide free or subsidised care for the marginalised, but can't easily afford high end hearing aids and other equipment like this. So this gift will make a huge difference to CMC, and more importantly, to the lives of the children who will benefit with a top quality hearing aid for free.

CONFESSION OF A PREACHER ON GIVING

Recently I was procrastinating over my sermon on Christian stewardship, a subject most preachers avoid and instead invite their friends to come and preach on the subject. The reason for avoidance is the issue of accountability which is at the heart of Christian stewardship. The simple truth is, while we feel immensely grateful for God's bountiful blessings, we are equally mindful that God has given all these good things to us, for us to enjoy. It does not come with a tag attached which says, 'give some of it to someone needier than yourself.' It is not required of us to share any of our hard earned money or inherited wealth. However, for those of us who are in any way related to the Christian Medical College Hospital in Vellore, the ethos of giving is at the very heart of who we are and what we do.

Our entry point at CMC is learning and I can confidently claim that education at CMC is nearly FREE. One of the greatest puzzles in medical education in India is how CMC can offer such highly subsidised education at best possible standards. And the answer is in the motto of CMC, 'Not to be ministered unto but to Minister.' And the one who made that bold statement in the first place, Jesus; and the one who believed it to be her motto, Aunt Ida lived it out in 'giving'. They gave unconditionally and unreservedly so that we may have life and life, abundantly.

Should you wonder where I am going with this 'confession' business, recently I was reviewing my giving to charities out with the church. Giving one tenth of my wages to God is part of my upbringing and it is to where we worship on Sundays. Out with that, we commit ourselves to supporting a few charities and FOV UK is one of them. I looked up my Direct Debit mandate which was set up some twenty or so years ago for a very modest annual sum which remained unchanged. Amu and I with a number of Friends raise several thousand pounds a year through fundraising events. A lot of our efforts go into it. But this should not hinder us from giving in proportion to what we receive. I must confess, on reconsidering my giving, I increased our standing order tenfold. It is better to give than to receive, says the Good Book.

God bless, Isaac

The Very Revd Dr Isaac M Poobalan

MEDICAL MYCOLOGY WORKSHOP

CMC, April 2016

Faculty and delegates at the Mycology Workshop.

Dr Ruth Ashbee is the Director of Ashbee Healthcare Consultancy Ltd and a lecturer at the School of Molecular and Cellular Biology in the University of Leeds. She is also a Friend of Vellore. She lived and worked at CMC for eight months in 2007-8 and now regularly visits CMC to help in the Microbiology department and the Wellcome Trust Research Laboratories. Here she reflects on her latest visit…

In April, I returned to CMC to help run a medical mycology workshop in the Department of Microbiology. I had previously worked in the department in 2007-2008 when we ran the first "Course in Basic Medical Mycology and Identification of Fungal Pathogens". Fungal infections are common in India and being able to diagnose them and identify the fungi causing the infections is important if patients are to receive the correct treatment. As well as mild infections, there are many fungal infections that can cause significant illness or even death in patients whose immune systems are weakened, usually through leukaemia, other cancers, solid organ transplantation and other diseases.

The Department of Microbiology has a long history of providing mycology diagnostic facilities, but arranging training in medical mycology has been a relatively recent initiative. In 2007 the department ran their first medical mycology training course. Since then, there has been a lot of interest in running another course. This was finally addressed when the "Postgraduate Continuing Medical Education on Laboratory Methods in Medical Mycology" was run from 25-27th April this year.

The course was attended by 23 postgraduates studying Microbiology in CMC and various colleges around Tamil Nadu and Andhra Pradesh. Clinical faculty from the Departments of Haematology, ENT, Dermatology and Infectious Diseases generously contributed their time to deliver lectures and present case studies, whilst staff from Clinical Microbiology demonstrated practical aspects of medical mycology in the laboratory. There was a pre-course and post-course evaluation to assess the quality of the learning, which showed a marked improvement in the level of understanding on completion of the course.

A rangoli is a colourful design, usually from coloured rice, sand or other powder, made on the floor near the entrance to a house to welcome guests. This is a rangoli drawn in the department welcoming delegates to the workshop.

One thing that always strikes me when teaching on these courses at CMC is the enthusiasm of both the delegates and the faculty. Delegates appreciate the reputation of CMC and the quality of training they receive and respond with a keen interest. The faculty realise the wealth of opportunities they have in seeing patients from so many diverse states of India. Despite temperatures of 45°C there was no shortage of questions, discussions and interactions between the delegates and the faculty over the three days!

I return to CMC on a regular basis at the moment to help with various aspects of work in the laboratories and I never fail to be moved by the dedication of staff there. They appreciate how fortunate they are to work in CMC and also how few of their fellow Indians enjoy such security or benefits. That understanding results in a dedication to their work which is humbling.

Please pray for the staff and work of the Department of Clinical Microbiology and other laboratory-based departments, who contribute so much, often "behind the scenes" to the clinical care offered by CMC.

Ruth Ashbee

Ability or Availability: Curing or Caring

Dr Kumar Narayanan trained in Vellore as a medical student, physician and cardiologist. He currently is a consultant cardiologist/electrophysiologist at MaxCure hospitals, Hyderabad. Here he writes about the essential qualities of a good healthcare practitioner.

I remember an elderly woman who was admitted to the ward when I was a junior resident in medicine. This woman had been admitted for evaluation of tiredness and aches and pains all over her body. She looked pale and fatigued. This would have been like any other routine case except that her son was a senior physician practicing in the U.S.A. which meant that all my actions were going to be closely monitored and probably questioned.

Initial investigations suggested multiple myeloma. The news was not good, though this was a disease which still had some treatment options. I used to hold "sessions" everyday with the patient's son and grandson, discussing the progress of the work up and newer treatment options for myeloma. I read feverishly from books and the internet to be able to display "latest knowledge" as I was keen to convey the impression that the best was being done for the patient.

Then something happened which made all of this irrelevant. An ultrasound of the abdomen revealed what looked like metastatic cancer deposits in the liver which would be odd for a myeloma. The cancer had started in the breast. Not that it made any difference now. Suddenly I seemed to run out of "effective treatment options." I was not sure anymore as to what I would say in my daily session with her son. I told him frankly and in as gentle a tone as possible. Of course we would confirm the diagnosis with a biopsy. I saw the sadness spread over his face, but he remained calm.

In due course, the biopsy revealed a poorly differentiated cancer of the breast. There was evidence of more extensive spread on further work up. The word "palliative" entered my vocabulary.

I still held my daily sessions with the son, but increasingly I found myself listening rather than talking as he would reminisce about his mother. He told me how she had brought him up, the sacrifices she had made for him, and how she was always hard working and cheerful. He wanted to know why this disease had afflicted his mother. I was surprised initially that he was asking questions like a layperson. Then I realised that as a human he was like anyone else. In his hour of sorrow, he needed support and someone to whom he could turn for comfort.

CMC's palliative care department demonstrate inspirational compassion and care. FOV provides ongoing financial support to the community team. Here they are with a patient on a home visit.

I lacked the experience to be able to say anything substantive. I told him that we would do whatever was possible to make his mother comfortable and pain free. I would talk to the patient in her in her native language asking her how she felt everyday and try to find symptomatic remedies for whatever she complained of. The son would stand quietly by the bedside, never interfering in my interaction with her.

Strangely, after a few days in the hospital, she said she felt much better than before and wanted to go home. To my surprise, her son wanted my opinion. He knew that I was a junior doctor, but still seemed genuinely interested to know what I thought. I had already discussed options of chemotherapy etc with him and had understood that he was not keen on them. So I suggested that she would probably be happier at home than in the hospital. She went home the next day with her son. The son came up to me before he left and thanked me for all that I had done. I thought that he was just being polite as in the last few days I had only been a messenger of bad news.

A month later her son called the office and insisted on speaking to me. I took the phone with trepidation. I learnt that his mother had died at home a few days back. He was planning to go back to the States. He thanked me again and there was genuineness in his voice which left me puzzled. What was he thanking me for when we had failed to do anything substantial for his mother? A few days later, a parcel arrived in the office addressed to me. It contained a book as a gift and a letter written by the son. In his letter he thanked me and said that I was "one of the best physicians he had ever met." I was stunned. This was a case which I had felt that I should forget as soon as possible but now it was etched forever in my memory.

This was the first instance where I had been sincerely thanked for "failing" medically. Over the years, I encountered a few more situations where we had not been able to offer much therapeutically; yet the relatives seemed genuinely thankful. Indeed it seemed to me that I often received the most appreciation in cases where the outcome had been bad. I also learnt from some of my colleagues that I was not alone in this experience as they had some similar tales to tell.

I have often reflected on this paradox. There are times when we feel that we have done a fantastic job and did not get the kudos we deserved. That is more easily explained as the layperson often cannot comprehend the intricacies of modern medical science and high costs would serve to further annoy them. But how do we explain the opposite? Why would someone be grateful when you actually did not succeed in treating his/her loved one? I can think

of only one explanation: because you were there when they needed you. Pain and grief often does not give any warning before it strikes. It does not allow one to prepare. When it afflicts someone suddenly, it turns their life upside down. In the seeming confusion and chaos, the person looks for more than just a cold clinical diagnosis and treatment. They reach out for hope and comfort. It is small wonder then that a person who provides solace in their most painful hour becomes worthy of their genuine gratitude.

Renowned surgeon Dr Paul Brand, in his book "The Gift of Pain", talks about one of his patients, a small girl named Anne whom he fails to save despite several surgeries. Yet years later, to his surprise the family remembers him with gratitude and affection. He concludes "...we in the health profession have more to offer than drugs and bandages. Standing side-by-side with patients and families in their suffering is a form of treatment in itself." [1]

A physician who ignores this aspect does not do full justice to their work. They are the central figure to the patient and their family in their time of pain. When they find themselves lost in the stormy sea of grief, he/she can serve as the anchor to which they can hold on. All it needs is their presence - for them to be available. A touch, an understanding word, a kind expression - all of these cost nothing and go a long way to heal a broken heart. Competence undoubtedly has to be the cornerstone of good medical practice, but is not enough by itself. Medical technology, in spite of great advances has its limitations, but there are no limits to human compassion. We, as doctors are in a privileged position to be able to heal not just diseases of the body but suffering of the mind as well. Curing may not always be in our hands but we can certainly ensure that we care. Aunt Ida demonstrated this powerfully a hundred years ago and we would all do well to always remember this lesson.

Aunt Ida's very first patient was a medical "failure". By logic, this should have spelt doom for her career as a doctor in Vellore. Yet more than hundred years later we find that she has been successful beyond imagination. How do we explain the fact that patients flocked in great numbers to a doctor who was unsuccessful in the very first instance? Therein lay a very simple truth. If we take a close look at her very first encounter we will find that she has actually not failed, but demonstrated a very fundamental principle, close to the heart of good medical practice: caring.

[1] The Gift of Pain. Dr Paul Brand & Philip Yancey. Zondervan Publishing House, USA, 1993.

Suresh

33 year old Suresh, his wife, their two small children, his parents, his younger brother, his wife and young child all stay together. They live near to the Medical College campus on the outskirts of Vellore City in their own house, constructed on unauthorised land.

Suresh with the tailoring teacher.

Water is delivered to their home by a water tanker, then pumped into a tank on the roof of the house. The family has never had much money. Suresh was sent out to work even before completing primary school. He found jobs on construction sites, gradually becoming skilled as a mason.

Drawn by the prospect of well-paid work, Suresh went to work in Chennai. Then disaster struck. While working on a building, he fell from the third storey. Health and safety rules were ignored, as so often is the case. He lost the use of his legs and became doubly incontinent. He was admitted to a private hospital in Chennai. His mother, brother and wife all came to be with him. After two weeks in that hospital, with no improvement, the builder who had employed him, sent him back to his home in Vellore by car. Suresh was left just lying at home.

Santa Suresh at the Christmas party.

One day, staff from the Community Health Department and the Rehabilitation Institute, affectionately known as Rehab, were making a home visit to another person living nearby. They visited Suresh, after neighbours told them about him. They saw his need and quickly admitted him to Rehab. There followed weeks of skilled treatment and care from the team at Rehab - doctors, nurses, physiotherapists, occupational therapists and social workers. Suresh had lost all confidence and was very depressed. The staff tried to motivate him. When the time came for his discharge, he should have gone to the Mary Verghese Trust (MVT), situated opposite Rehab. Here he could acquire new job skills, learn to be independent and gain confidence. But he did not want to be without his family, as all trainees at MVT need to be. So after two months in Rehab, he was discharged.

Suresh was followed up at home and finally he agreed to go to MVT for a six month course in tailoring, as he couldn't continue to work as a mason. He was still depressed, unsure of himself and even attempted suicide. Gradually with the care and perseverance of staff and support of other patients he became self-assured, a leader in the Centre. He was prominent in the Christmas programmes, playing Santa Claus, and in the Mela (the festival held in Rehab every February). When interviewed he was full of smiles.

The cost of Suresh's treatment and rehabilitation came to £850; a sum way beyond the means of his family. He had not worked since his accident. His wife was at home, looking after their little ones. His father, once a goatherd, due to his current poor health was no longer working. Only his mother was employed as a maid at a nearby canteen, earning £25 per month. Staff at Rehab were not deterred by this, but treated him freely, helped by a donation from the PTP Fund. Suresh will need a wheelchair and a sewing machine to set up as a tailor. Other benefactors have come forward to supply these needs.

CMC staff and well-wishers have been privileged to be able to bring help and hope to one more needy family.

UPDATE Mission Hospitals

We have just sent the final instalment of our third year of funding of the post of Mission Network Consultant. Dr Sam David who undertakes this role has been building links with mission hospitals who might benefit from a partnership with CMC. He is working with five hospitals in particular. He is also raising the profile of mission hospitals within CMC, encouraging more to serve in this way. He supports staff from CMC who have gone to work in mission hospitals on short or long term placements.

A Memorandum of Understanding (MOU) was signed in January between CMC and CSI Hospital Erode for CMC to be actively involved in reviving the hospital for the next 25 years. The hospital will retain its name but it will be fully managed by CMC, Vellore. The hospital is over 100 years old and is situated in the centre of Erode with the city having grown around it, much like Vellore around CMC. Structural renovations are being planned and CMC are inviting staff to consider working at the hospital on a short or long term basis. Please pray that CMC's input provides long term blessing and sustainability for CSI Erode. Pray too for all who are considering working there.

Last year, we funded a website for mission hospitals. This is now in the stages of its creation, and should go live this Autumn. It is hoped that the website will serve as a two way channel, facilitating interactions between CMC and smaller mission hospitals, sharing and collaboration.

COMPLETE TRANSFORMATION "Sorrow to Joy"

Your sorrow will turn into joy - John: 16-20

Thangamma is a 37 year old lady from one of the urban slums of Vellore city. She has two children, one in 12th Grade and the other in 9th Grade, both in Government schools. Her husband works as a flat rickshaw puller, earning about £2.00 – £2.50 per day but he is an alcoholic and spends all his earnings on alcohol. Her mother-in-law is a rag picker who earns about 20-30 pence per day. They live in a one-roomed thatched house with no toilet facilities or proper ventilation, paying a monthly rent of £3.00.

The Low Cost Effective Care Unit (LCECU) is situated slightly away from the main hospital, aims to give quality but low cost support to the poorest inhabitants of Vellore. Patients pay a nominal amount for registration, and then are only charged for drugs and investigations – even those charges are according to the individual's ability to pay.

Thangamma came to LCECU complaining that she had been suffering with headache, giddiness and vomiting for the past few months. She had been seen in the local government medical college and a CT scan taken there was reported to be normal. As she had clinical features suggestive of an intracranial tumor, she was advised to have an MRI of the brain at CMC which would cost her £66. She expressed her financial constraints to meet the charge for the test. The cost of the test was subsidised and Thangamma was required to pay only £2 towards the cost. The MRI revealed that she had a 'schwannoma' with raised intracranial pressure and she was advised to undergo urgent surgery.

During a visit to her home by the social workers it was found that the economic condition of the family was indeed bad. Her husband spent all his income on drinking. There was strained relationship between the husband, wife and family. He rarely came home and often used to drink and sleep on the roadside or in his friend's home. The children were not able to concentrate on their studies due to their mother's ill health, father's abuse of alcohol and the poor family economic condition. However she received good support from her mother-in-law, which was unusual and in fact it was her mother in-law who brought her to the hospital for treatment.

A typical street in "down-town" Vellore.

The estimated cost of surgery was £2,000 however Neurosurgery offered to do it free of charge and she only had to contribute a nominal, affordable amount towards the final bill.

LCECU's intervention was not limited to treating Thangamma's medical condition, but also in counseling her husband to stop his abuse of alcohol and to start him on de-addiction treatment. This included multiple visits to their home and counseling to bring him to LCECU for treatment. The psychiatrists from CMC's Mental Health Centre saw him at LCECU in their Friday Psychiatry Clinic. He is currently under treatment and is taking part in the alcohol group sessions as well. In a recent home visit it was found that he has resumed his work and has started contributing all he can to the family.

In a wonderful way, with the concern of her mother-in-law and the co-operation between LCECU and CMC's Neurosurgery department and the Mental Health Centre, Thangamma is able to enjoy life again. Her sorrow has been turned into joy.

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ACTION POINT:
> *GET INVOLVED*

Friends of Vellore UK have created a new website which is now available at the same web address as our old site: www.friendsofvellore.org - see page 1