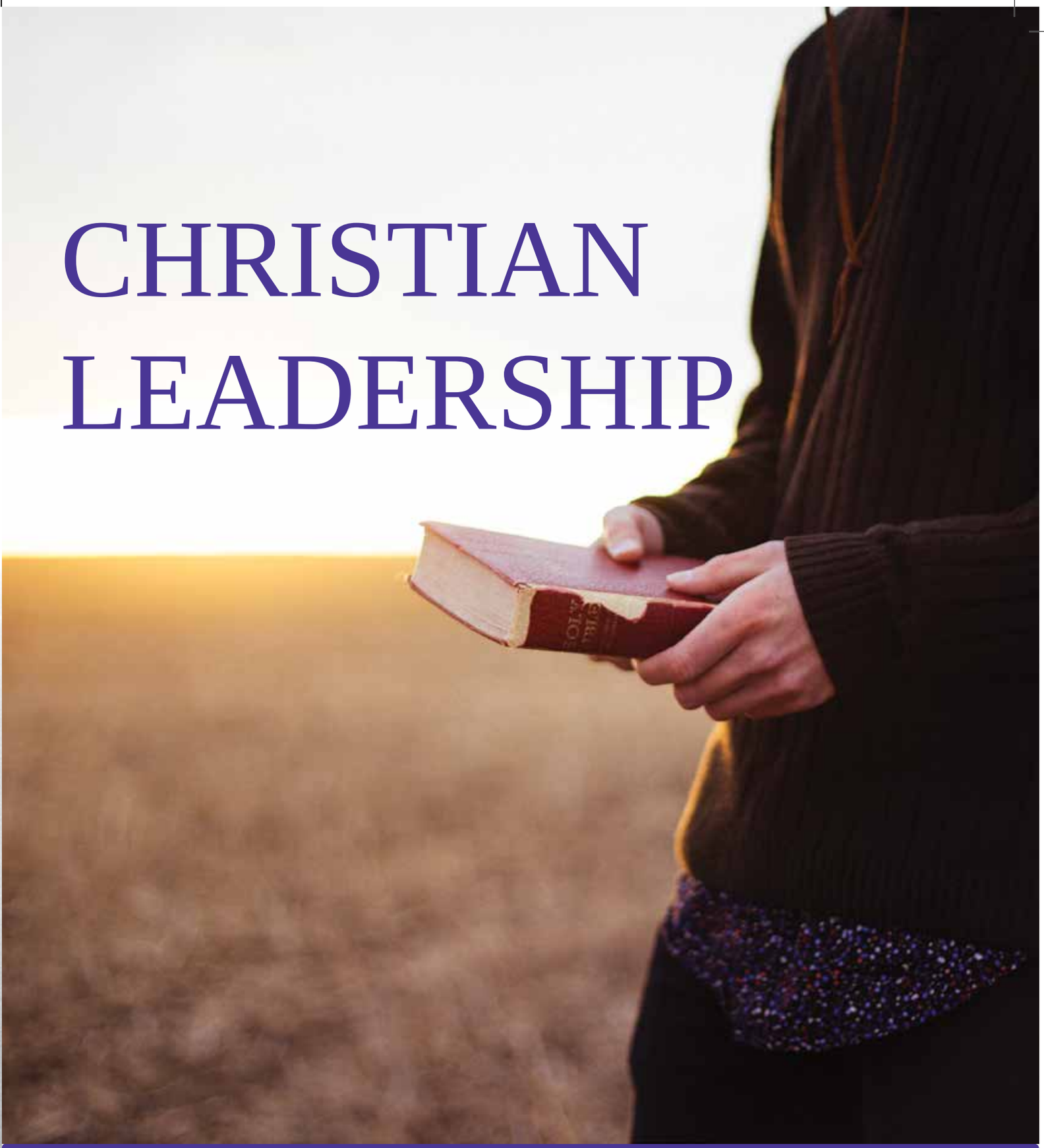
CHRISTIAN LEADERSHIP



CHRISTIAN MEDICAL JOURNAL OF INDIA

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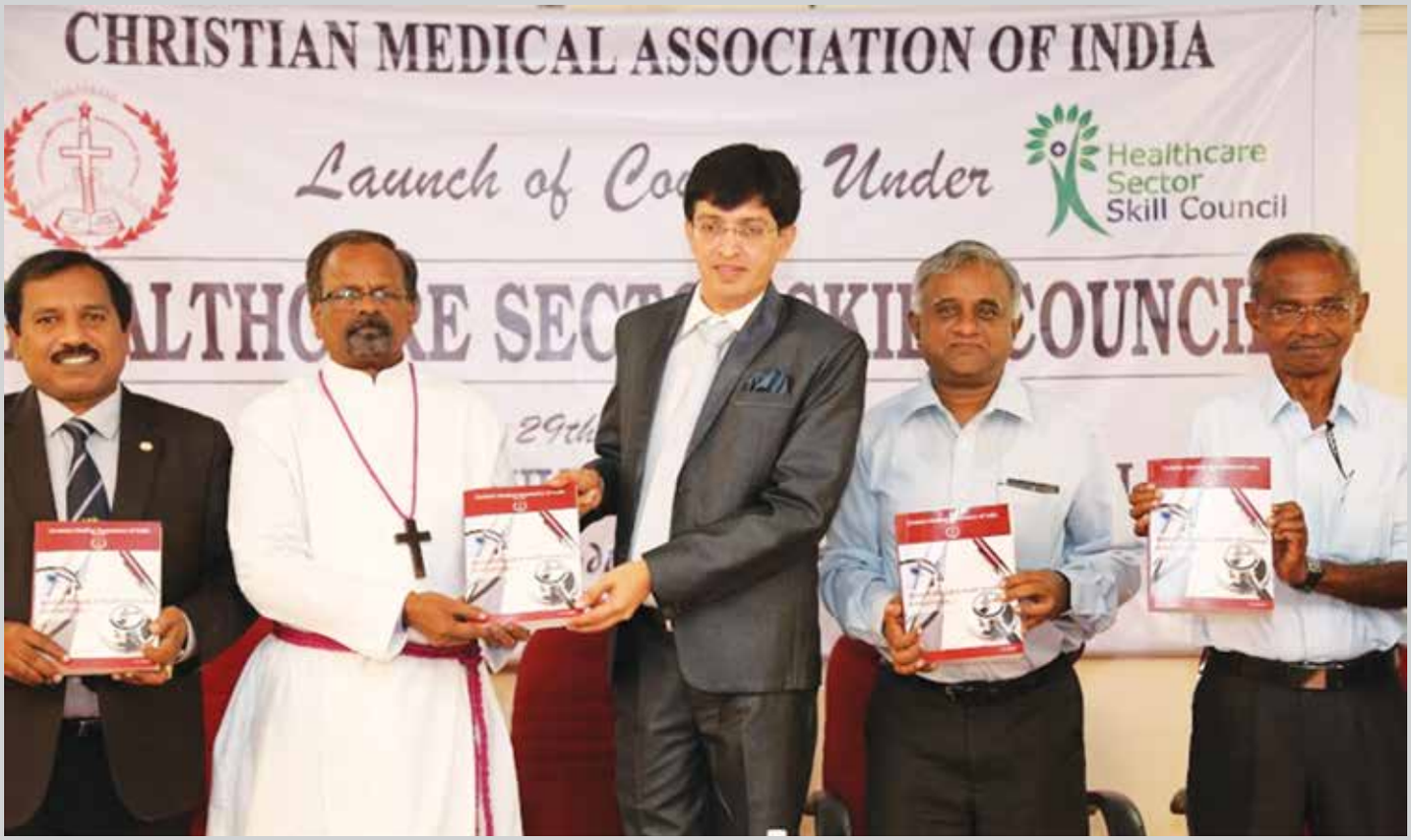
VOLUME 31 NUMBER 4 : OCTOBER - DECEMBER 2016

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.

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

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

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LETTERS TO THE EDITOR

Greetings in Christ's precious name!

I would like to share my sincere thanks and praises for what God is doing through CMJI & CMAI. I am the first batch of FCAMS, three-year Clinical Multi Specialty course and I am also a life member of CMAI. At present I am working in a corporate hospital in Bhimavaram AP, apart from private practice.

It is my joy and pleasure to go through all the articles of CMJI. I really praise God when I observe how He is using His children as medical professionals at different hospitals in our country. Our mighty God has strengthened His people in developing the hospitals like Mure Memorial Hospital, Nagpur, Evangelical Hospital, Khariar, Odisha and other hospitals from small beginnings to big institutions in serving several needy poor patients and giving training to many professionals. May our God continue the same progress amidst several difficult situations in the coming days too.

With love and prayers

Yours sincerely

Dr. Z.Prabhudoss Babu.

LETTERS / ARTICLES FOR CMJI

We invite your views and opinions to make the CMJI interactive and vibrant. As you go through this and each issue of CMJI, we would like to know what comes to your mind. Is it provoking your thoughts? Please share your thoughts with us. This may help someone else in the network and would definitely guide us in the Editorial team. E-mail your responses to: **ronald.l@cmai.org.**

Guidelines for Contributors

SPECIAL ARTICLES

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

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

LETTERS

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

GENERAL GUIDELINES

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

ADDRESS FOR COMMUNICATION

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

EDITORIAL

LEADERSHIP @ THE JESUS STYLE

Dr Nitin Theodore Joseph

We in India always seem to be in the election mode and observing the canvassing, allegations and mudslinging that goes on we naturally get a negative idea of leadership. There are numerous cases where people seek to become leaders by fraudulent means and so many of our *netas* are convicted and punished. Christian Leadership in contrast has its roots in the Bible and Jesus is our model of the ideal leader. Of all the many definitions of Leadership I remember one, perhaps for its brevity! **"Leadership is influence"**, said J.Oswald Sanders, and this to me encompasses everything that leadership is about. And so we can have good leaders who exert a positive impact on their followers and bad leaders who cause misery and discouragement.

In His brief but high impact earthly ministry some 2000 years back Jesus clearly demonstrated 3 models of Christian Leadership:

The Christian Leader as Shepherd: The idea of a shepherd leading his flock through possible danger and inadequacy to "green pastures" is easily understood by us due to the familiar 23rd Psalm. In His beautiful parable of the Lost Sheep, Jesus taught of the shepherd who left the ninety-nine sheep safe in the fold and went in search of one who was lost. The heart of a shepherd is at the very core of Christian leadership.

The Christian Leader as a Steward: At many places in the gospels Jesus taught about the importance of good stewardship in a leader. In the Parable of the Talents, Jesus taught of how we must not only be trustworthy in what has been entrusted to us but we must also invest wisely to increase it for the God's work and be accountable at all times. Sadly when we look around we do not see very many leaders who are good stewards in the Christian network.

The Christian Leader as a Servant: On the face of it "Servant Leader" may seem to be an oxymoron. But Jesus exemplified and was the progenitor of this model of Leadership. He said that He had come not to be ministered unto but to minister. And when all the disciples were arguing as to who among them was the greatest, Jesus quietly took a pail of water and a towel and began washing the feet of His disciples.

We have all heard that a number of Mission Hospitals, Christian Schools, Hostels, etc. have shut down since our country became independent. The reason for most of these instances is a paucity of good Christian Leadership. Many *mission hospitals* today have an identity crisis with fat salaries but poor patient care. The need of the hour is to follow the example of Biblical Leadership. Moses could lead 6 million men (add to it women and kids) through the 40 years wilderness experience because he was the humblest man that ever lived (Num.12:3), and he trusted God at all times rather than his own wisdom. He did not seek his own fame but the glory of God. As you go through this issue may you be blessed and develop new ideas and paradigms to do His will.

A leader is best when people barely know that he exists, not so good when people obey and acclaim him, worst of all when they despise him. "Fail to honour people, they fail to honour you." But of a good leader, who talks little, when his work is done, his aim fulfilled, they will all say, "We did it ourselves" (Lao Tzu)

Dr. Nitin Theodore Joseph

LEADERSHIP IS ALL ABOUT PEOPLE

Among the many values of the world which Jesus turned upside down, one was on leadership. In Matthew 20:25-28 Jesus lays out the whole principle of the leader being a servant. While I have developed this concept in detail in my book "Leadership through Service" in this article I want to look at Peter's take on how this works out in practice.


Mr. P. K. D. Lee

Peter gives advice to the elders of the church in his first epistle (Chapter 5: vs 1 to 5. This passage can give us valuable teaching on leadership.

It is all about people

1 Peter 5:2 says that the responsibility of the leader is to 'shepherd the flock of God'. Leadership is not about leading organizations but leading people. I prefer to call leading organizations as management, where you practice techniques to help the organization reach its goals. That is not leadership. That is management.

The flock of God represents the people you have been made responsible for in different areas of your life. At the work place, this include both your clients and your staff. At the church, even if you have not been any given specific responsibilities, we have a responsibility to the congregation. At home, it is the family and neighbours, and so on.

The flock of God represents the people you have been made responsible for in different areas of your life. At the work place, this include both your clients and your staff.

We cannot choose the flock we want to serve and ignore those we do not want to serve. These are God given responsibilities. Many organizations focus on serving clients and ignore serving the staff. Others focus on serving the financiers and ignore serving others. Some choose to serve the responsibilities at work and not at home. We need to identify the various flocks in our charge and make a conscious decision on the leadership we should give each of them.

Since my responsibility is the flock, my vision needs to be about them. I need to know their need and the solution to their needs. Leadership is giving solutions for the needs of the people. This can be of different kinds. For clients, it is helping them through the product or service we provide. For staff it is often helping them to perform their job with comfort and ease.

This creates a contradiction with our normal understanding of leadership where there is only one vision that can guide a person and not multiple visions. Depending on the stage on is in his life, he may or may not have an over-arching vision for what God has called him to do. But, within that over-arching vision he will have responsibilities that are what I call subordinate visions, that help him fulfil his over-arching vision. It is good to define these subordinate visions effectively, so that one can achieve them in his life.

So, understanding the support and strength a good church gives, while I am pursuing my vision in my workplace, I need to have a vision for my relationship to my church. This kind of integration is important to get a wholesomeness in our lives. Otherwise many of the flocks will be ignored and only the flock served by the over-arching vision will be served.

To give an example, in the hospitality industry, providing the clients clean and healthy environments with as much conveniences as possible is the vision of the organization. That needs to be broken down into a subordinate vision

David worked his way up from a soldier to an army commander before he could be king. John's family has hired servants with them (Mark 1:20), showing that they were well-to-do. John was well known to the high priest (John 18:15) and his gospel is written in excellent Greek.

for the HR department, of making the work place happy and enjoyable for the staff, as unhappy staff will not give clients happy service.

Hence, identifying the people I give leadership to, knowing their needs and the solution to their needs is the primary objective of the leader.

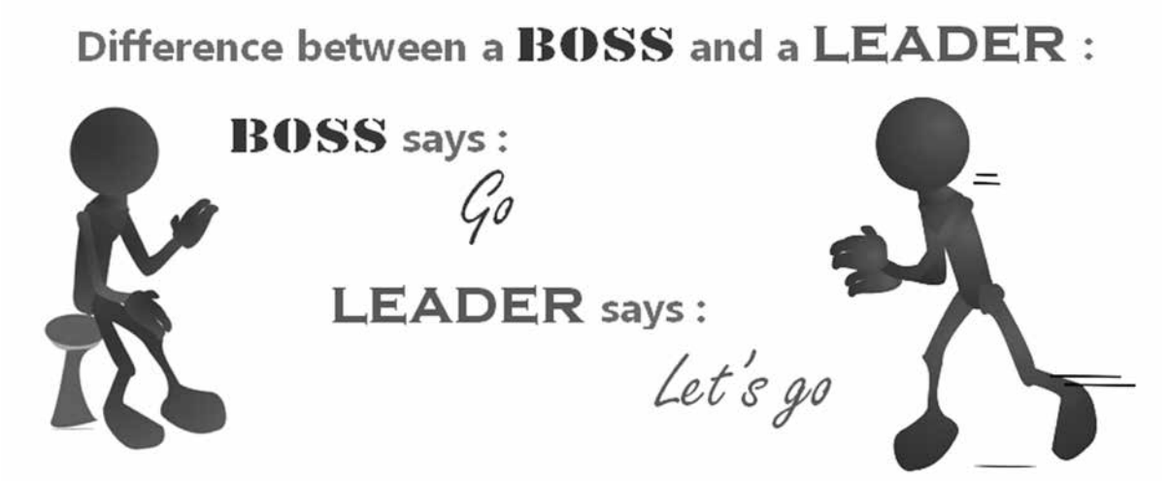
The motivation of the leader

Peter, further adds in verse 2 of the passage, that the motivation for providing leadership care to the people should not come from outside the leader, but from within. Maslow termed this as Self-Actualization in his hierarchy of needs. These motivations per Peter is a willing heart and a ready mind (KJV).

The willingness of heart comes from a genuine love for the flock entrusted to him, which makes him willing to serve their needs. Of course, apart from love we need to have an outlook in life to serve rather than be served. To check what our own outlook in life is, just look back at the things you grumbled about in the last week. You will find that all grumbling comes from expecting others to serve you. If you find that your life is full of grumbling, then your attitude to life is be served. But, if you find that you generally do not grumble, then you have the right attitude to be a leader. You are one who finds solutions to problems rather than grumbling about problems.

A ready mind comes from a belief in the activity we are engaged in. This belief comes from an understanding of what God is doing in the situation and committing oneself to this vision. For this we need to have a strong Biblical foundation and godly perspective. This is what Paul writes in Romans 12:2 '*And be not conformed to this world: but be ye transformed by the renewing of your mind, that ye may prove what is that good, and acceptable, and perfect, will of God*.'

Apart from a sound foundation in the word of God, the solution to the needs of the people comes from my knowledge, especially in my area of expertise, and my understanding of the context I find myself in. Hence, acquiring information about his area of expertise and about his context is essential for an effective leader. Somehow in the Indian church there has been a glorification of ignorance, and once a person accepts Jesus as his Lord and Saviour, he ceases to read anything but the Bible. In the Bible God always used people with knowledge in positions of leadership. Moses was raised in the best of the knowledge of the Egyptians (Acts 7:22). He was trained to be king. David worked his way up from a soldier to an army commander before he could be king. John's family has hired servants with them (Mark 1:20), showing that they were well-to-do. John was well known to the high priest (John 18:15) and his gospel is written in excellent Greek.



People stop respecting their leaders when they do not give the example, by walking the talk. But when we walk the talk we earn the respect of the people and they imitate our walk and fulfil what is expected from them. Often, we are not aware of the gap between our talk and our walk till open rebellion takes place.

This combination of knowledge and the wisdom of God from the Bible gives me a vision on how to be a blessing to the people and what God is doing in the place where I work.

The leadership style of the leader

In verse 3 Peter says that our leadership style is not to be dominating over the people but rather to be an example to the people. Arnold Toynbee, the British historian, uses a Greek term mimesis to describe the way in which people imitate leaders whom they admire. This is something the Christian leader uses, his exemplary life.

People stop respecting their leaders when they do not give the example, by walking the talk. But when we walk the talk we earn the respect of the people and they imitate our walk and fulfil what is expected from them. Often, we are not aware of the gap between our talk and our walk till open rebellion takes place. So we need to scrutinize our walk and ensure that we are walking with the values we claim.

For instance, if we expect our children to be studious, we need to be studious and seen as studious by them. But often, we ourselves do not study but expect our children to study! Some ask what should we study? In this knowledge era, one needs to read and be up-to-date about his profession and if nothing else, the Bible.

A leadership that does not dominate is what Jesus also says in Matthew 20:25-28 and Paul in Ephesians 5:25-27. In the latter passage, Paul says that husbands need to love their wives, like Jesus loved the church and gave Himself for it. So, husband need to give himself for the wife, and ask the wife how he can serve her, rather than trying to dominate her. This is the servant leadership style which Jesus emphasizes in His teaching and His example.

At the work place, this means that the head asks the staff, how he can help them in whatever they do, rather than pushing them to do what he wants. He sets the example by his own commitment to the vision and the people.

That is why Peter in verse 5 emphasizes the need for humility. Humility leads not only to a non-dominant style of leadership, but also enables the leader to see the good in others and helps him to build effective teams. Where there is pride, one cannot see good in others, and the team withers.

If we visit Mother Teresa's home in Kolkata, and see her room where she stayed, you will find none of the embellishments of power or status. Only the humble room of a servant. I think all Christian leaders need to make a pilgrimage to her home and see the room she operated from.

Mr. P. K. D. Lee
Worked as a Mechanical Engineer in the Indian Railways in various capacities for 20 years. Worked for 20 years with Haggai Institute in the Alumni Relations Department which later became the International Advancement department.
Has specialized in Christian Leadership and has taught that subject for 20 years with Haggai Institute. Has also been teaching on Christian Stewardship and on Generosity as an essential response to the gospel.

SERVANT LEADERSHIP - IS IT RELEVANT OR SUITABLE FOR HEALTHCARE PROFESSIONALS?


Dr. Madana Kumar

Leadership has always been a topic of interest. John Maxwell, noted Christian leader and renowned Leadership Guru put it succinctly. “Everything rises and falls on Leadership”. But why an article on Leadership in a Medical Journal? To answer that question, we have to first find the answer to the question, “What is Leadership”? Generally when this question is asked, people come out with various attributes of leaders, and they will focus on “what a leader would do”. But have you considered thinking about what is leadership per se?

Martin Chemers, a thought leader and author of ‘An Integrative Theory Of Leadership‘, defines Leadership as a “Process of social influence in which one person can enlist the aid and support of others in the accomplishment of a common task”. Ken Blanchard, Leadership Guru and Author, The One minute Manager, Lead Like Jesus etc, says “Leadership happens any time you are trying to influence the thoughts and actions of another individual to accomplish specific tasks or goals.” The best definition that I have come across is from John C Maxwell: Leadership Guru and author of books like, 21 irrefutable Laws of Leadership, 360 degree leadership, Leadership Gold etc., who also compiled the Leadership Bible. He states “Leadership is influence - nothing more, nothing less.” Come to think of it, you take any leader, Good Bad or Ugly, ranging from Mahatma Gandhi or Mother Theresa or Osama Bin Laden or Hitler, what do they actually do. They influence the thoughts and actions of others to fulfil their objectives and missions. Good, Bad or Ugly: does not matter; they influence.

Accepting this definition of Leadership gives us a whole new perspective about the topic. Suddenly we begin to see that we do not need a position or a title to be leaders. As long as we have an opportunity to influence someone, we are a leader. Healthcare professionals have significant opportunities to influence others and hence each Healthcare professional is a leader naturally. For Christians in this field, it becomes even more of a mandate. Jesus said ““You are the salt of the earth. But if the salt loses its saltiness, how can it be made salty again? It is no longer good for anything, except to be thrown out and trampled by men. “You are the light of the world. A city on a hill cannot be hidden. (Matthew 5:13-14). In John 15:16, he makes it even clearer: “You did not choose me, but I chose you and appointed you to go and bear fruit—fruit that will last. “ Multiple other verses point us to the need to influence others around us (John 15:8, 2 Cor 8:21, 1 Peter 2:12, Matt 5:16, John 17:18 etc.).

Despite clear advise “If you will be a servant to these people today, and serve them, and answer them, and speak good words to them, then they will be your servants forever” (1 Kings 12:7), Rehoboam consciously chose to exercise his Power and Authority rather than choosing to “serve”

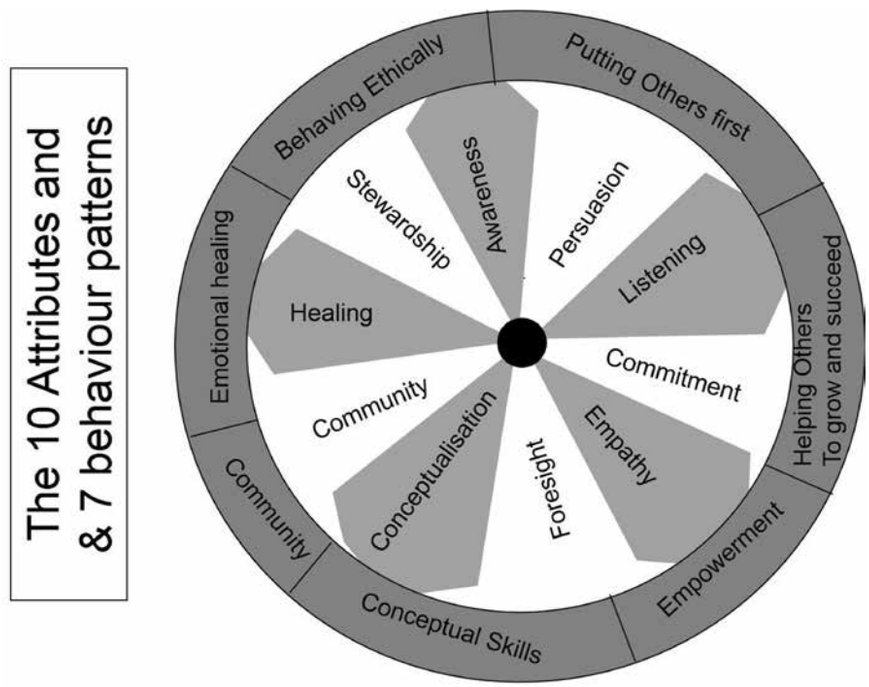
So as Christians and as Healthcare professionals, we have a duty, a duty to influence others, and hopefully lead them to Christ.

Once we have accepted this fact, the bigger question comes up. How do we influence the right way. History is replete with figures who misused their power and authority. We see this in examples of Hitler or Saddam Hussain. However, the Bible also has examples of Leaders who chose to exercise power and authority over others. We see this clearly when

This should not surprise us, because God has warned them through the Prophet Samuel about what a human "king" would do to them (1 Samuel 8:10-18). But this was not God's design for rulers. God had given the guidelines for the choice and duties of a king in Deuteronomy 17:14-20.

we look at the High Priests (Exodus Ch 28) or the Kings (1 Kings). They occupied positions that were powerful and they used their authority to rule over the people. We have a clear example of this in Rehoboam (1 Kings 12:1-16). Despite clear advise "If you will be a servant to these people today, and serve them, and answer them, and speak good words to them, then they will be your servants forever" (1 Kings 12:7), Rehoboam consciously chose to exercise his Power and Authority rather than choosing to "serve". This should not surprise us, because God has warned them through the Prophet Samuel about what a human "king" would do to them (1 Samuel 8:10-18). But this was not God's design for rulers. God had given the guidelines for the choice and duties of a king in Deuteronomy 17:14-20. But biblical history is replete with people who overlooked Gods guidelines and misused their power and authority. So it is not surprising at all that the world followed the same power and authority model of leadership.

But we see an transition happening in the history. As we saw above, the positions of High Priest and that of the King were positions of power, authority, wealth etc. So by worldly rules, when we put these two offices (that of a High Priest and a King) together, we must get a position that is even more powerful and even more authority, and even more wealth. We know of such a position, we know the one who was the High Priest and a King put together. True Jesus was more powerful than any High Priest or King put together (Hebrews Ch 5 to Ch 10). Jesus had more authority than all High Priests and Kings put together, but He consciously (knowing fully well about the power and authority He had; John 13:3) chose not to use that power and authority over his people , but chose the role of a servant (John 13:1-17). This is one of the occasions where Jesus thought it fit to explain His action clearly. After demonstrating servanthood, He clearly explains why He did it. He could not have been any clear than what He did in John 13:12-15 (NKJV) *So when He had washed their feet, taken His garments, and sat down again, He said to them, "Do you know what I have done to you? You call me Teacher and Lord, and you say well, for so I am. If I then, your Lord and Teacher, have washed your feet, you also ought to wash one another's*



feet. For I have given you an example, that you should do as I have done to you. And He ended this advice on a very direct note. John 13:17 (NKJV) *If you know these things, blessed are you if you do them.* I have searched many translations to find out if any of the versions use a different word than "do" here. Surprisingly (or not so surprisingly) all translations use the same word.. *you will be blessed if you **do***…. The focus here is on actions of Christians as leaders, as influencers, as people who impact others, as Christians who lead others to the truth. Focus is on Christian behaviour.

So that is the command for all of us. Follow His example that was set for us by Jesus Christ Himself. But does it mean we walk around with a basin a towel in our hands. Not necessarily. Application of Servant Leadership in today's world requires us to demonstrate certain attributes. The picture below shows 10 attributes that were propounded by Robert Greenleaf, who is known as the originator of the term Servant Leadership in secular, corporate circles. The outer circle of the picture shows the seven behavioural patterns of Servant Leaders.

The bigger question is of course, does it work? Is Servant Leadership practical in today's world. The research work done by me for my Doctoral thesis (and many other works referred by me during the study) prove that Servant Leadership behaviour by leaders does impact employee productivity and thus the organisational success. As given in the diagram below, Servant Leadership behaviour alone can make a difference of close to 18% directly and another 20% indirectly (through organisational commitment) in the performance of the employees.

And we can easily guess the impact such behaviour can have on general public, the patients whom we come in contact with, or our neighbours.

So here is our chance, an opportunity to obey our Lord and Master Jesus Christ, attract others to Him, and at the same time contribute to our own organisational success, through demonstration of Servant Leadership behaviour. May the Lord encourage all of us to adapt to this style of Leadership.

Dr. Madana Kumar is the Global Head-Learning & Development at UST Global, South Asia Institute of Advanced Christian Studies, Menorah Leadership Ministries. Worked with IBM, IBM Corporation, IBM India Pvt Ltd

CHRISTIAN LEADERSHIP IN NURSING - MEETING THE CHALLENGES

Dr. Punitha Ezhilarasu

In today's ever changing and demanding healthcare environment there is a huge leadership vacuum. Identifying and developing leaders is one of the greatest challenges faced by healthcare professions. Nurses, along with other leaders in healthcare institutions face tremendous and exciting challenges. Nurse leaders are confronted with the daunting challenges of care, economics, and good stewardship alongside the challenge of fulfilling their institution's mission in a cost-effective manner.

Leadership Challenges in nursing

In India, there are 20,306 hospitals, 3125 Colleges of nursing (UG & PG), and 3040 Schools of nursing (National Health Profile, 2015; Indian Nursing Council, 2016). In CMAI network, there are more than 350 hospitals with 12000 healthcare professionals in which, 6100 are nurses. We have a tremendous need for leaders in nursing profession both in hospitals and educational institutions. Leadership is critical in nursing and Christian leaders in nursing are called to make a difference in creating an impact on the healthcare today and in future.

How can Christian leaders be identified and developed? Do we have true inspirational and transformational Christian leaders who emulate the leadership qualities of Christ following biblical leadership principles? What is the best way of meeting this challenge? Nurses League of CMAI and the two Boards of Nursing Education have a great opportunity to participate in building the capacity of current Christian leaders and potential leaders for the future particularly in mission hospitals and schools of nursing.

Successful Christian leaders in nursing who leave a mark of legacy are few in number and are unable to make an impact at local, institutional, state and national levels. Do Christian institutions and their nurse leaders make a difference in the healthcare system by developing innovative nursing care delivery/educational models that are relevant and successful for our country? We lack Christian nurse leaders who possess deep faith, initiation, purpose/mission, courage, patience and self-control, who can practice partnership, inspirational and transformational leadership and achieve success.

Successful Christian leaders in nursing who leave a mark of legacy are few in number and are unable to make an impact at local, institutional, state and national levels.

Christian missionary nurses came to India and they served as nurse leaders in Christian hospitals and nursing schools/ colleges. Their leadership in nursing service and education was palpable and valuable in the healthcare system. During that time, nearly 90% of nurses were Christians but today only 30% are Christians. We cannot remain satisfied with the service, commitment, achievements and effective leadership demonstrated in Christian mission hospitals and nursing educational institutions in the past. The scenario is not the same today. We do have excellent Christian leaders in nursing today. The leadership is not sufficient to make significant impact on the healthcare of the whole country. How can we enlarge the number of Christian leaders with vision, identify nurses with excellent leadership potential and build their leadership capacity? Such leaders can make a difference and significant impact in today's healthcare? Christian institutions fail to identify and develop leaders who can contribute significantly to nursing profession and healthcare.

Learning leadership principles from the Bible

It is believed that leadership is learnt through rigorous training, and from successful CEOs and management consultants. We as Christians have a great opportunity to learn leadership from the Bible, the greatest book on leadership ever written. As a follower of Christ we are called to influence others. **The leadership ability determines a person's level of effectiveness.** Greater than the resources, talent, money or intelligence, leadership makes the difference when it comes to making an impact. Who is our model and where can we draw the leadership principles? Our model is the creator, the God Himself. God is our CEO. Who could teach more about leadership than God Himself? God is the ultimate leader and He has created us in His image (Genesis1:26) and has given us talents of leadership. He calls individuals to be leaders who can do mighty things with God's strength (See II Cor 12: 9). God called Moses to lead Israel out of slavery, Nehemiah to rebuild Jerusalem, Joseph to keep His people alive during famine in Egypt, and Esther to save His people through her influence. The bible teaches us leadership principles through the lives of several leadership mentors. Naomi, Ruth, Elizabeth, Mary, Esther, and Priscilla are some examples of women leaders found in the bible.

Biblical example of a successful leader

Nehemiah was a cupbearer for the king and was not in position when he began his leadership journey. He fasted and **prayed first.** He practiced self-discipline and intimacy with God. (Isaiah 40:31 " But those who wait on the Lord shall renew their strength; they shall mount up with wings as eagles; they shall run and not be weary; they shall walk and not faint''). He acted on his faith and **depended on God**. He got courage to speak to the king at the right opportune time. Nehemiah prayed for success and he **took initiative** in planning the rebuilding project. His initiative showed great insight. He acted when he heard the news that the walls of Jerusalem were broken. Complacency is what a leader should not have. Many Christians today are complacent when we see and hear news, which require action.

Nehemiah knew just enough to plan but not everything (Nehemiah1:6). **Knowledge** is what we need to make plans and nurses in most situations fail to gain knowledge that is required for planning and action. He got power and organizational skills and he **acknowledged God's gracious hand upon him (2:8).** Do you acknowledge God as your power source and the giver of gifts and talents? Nehemiah wisely uses his people as the main resources, set **priorities** and practiced **partnership**. Leaders should provide a supportive climate of trust and **teamwork,** stick on to priorities and give importance to important things and not to trivial things. They must practice partnership principle and integrate with all types of people respecting opposition, renewing people's strengths continually and reassuring people. Nehemiah practiced law of **victory, legacy and empowerment**. He finished the building project in record time. Problems and project go hand in hand. Success will leave legacy and successor. True success is measured by the legacy left for future generation. A successful project will **bring glory to God**.

Rises and falls in leadership

Every thing rise and fall in leadership. Eve and David are two examples. Every worthwhile accomplishment has a price tag in terms of hard work, patience, faith and endurance. Greater the achievement, higher is the price to be paid. The same is true of leadership. It comes only through persistent effort. Criticism is a great price paid by leaders. Emotional maturity is important to handle criticism. Fatigue is another price. A wise leader

should try to find a balance between work and relaxation. A Christian leader needs lot of time to creatively think and meditate. Most successful ventures are achieved only after many hours of thinking and careful scrutiny. A leader has to identify with people and also be isolated from people. Jesus is an example. He chose to be alone praying and He did this in the ministry.

Successful and Godly Leaders

God wants us to be valuable leaders and serve as models to others. God's wisdom provides purpose and direction. Like diamonds, Godly leaders reflect God's nature in all circumstances and shine brightly in the toughest of times. The differences between worldly leaders and Godly leaders are tabled below.

A True Christian Leader in Nursing

A true Christian leader is one who has Christ dwelling in himself/herself and emulates Christ as leadership model. A true Christian leader in nursing will continue to influence others in the profession and will produce more similar leaders. He/she must be a Godly leader and must aim to practice inspirational and transformational leadership where people's lives are changed from within and that kind of leadership is based on character, conviction and Christ likeness.

S.No	Worldly leaders	Godly leaders
1	Pressure weakens them	Pressure strengthens them
2	Prioritizing profits over principles reduces their value over time	Prioritizing profits over principles enhance their value over time
3	Their character weakens over time	Their character strengthens over time
4	They produce nothing other than bottom line results	They produce a legacy in addition to bottom line results

How to become a successful and Godly leader?

Regularly develop and integrate the following two areas.

- The outer development of your God given talents and skills
- The inner development of your spiritual core (through whole hearted pursuit and practice of God's principles)

Dr. Punitha Ezhilarasu is working currently as consultant in Indian Nursing council and was formerly the Dean of College of Nursing at Christian Medical College, Vellore. She is the Vice President of CMAI and was the chairperson of Nurses League.

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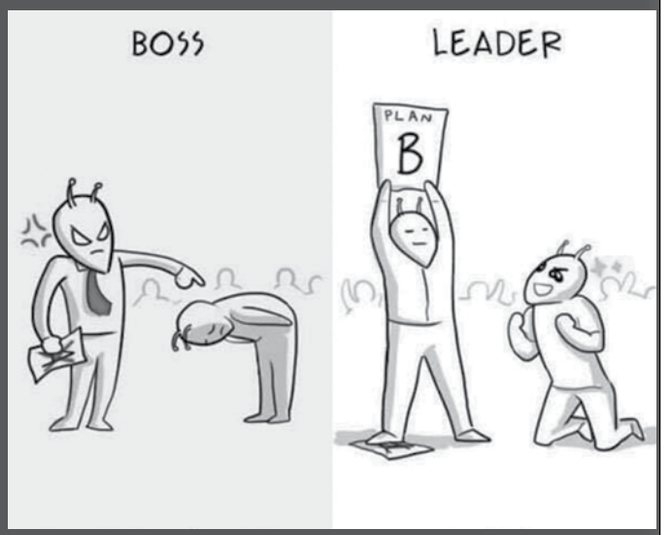
DEFENITION OF LEADERSHIP



Leadership is both a research area and a practical skill encompassing the ability of an individual or organization to "lead" or guide other individuals, teams, or entire organizations.

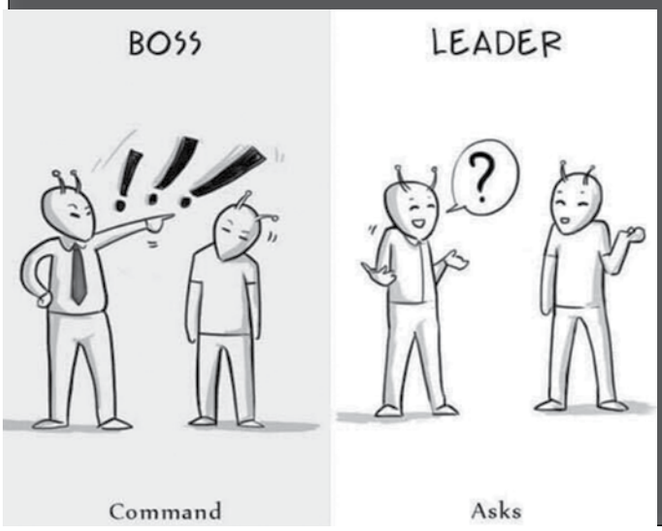
Source: https://en.wikipedia.org/wiki/Leadership

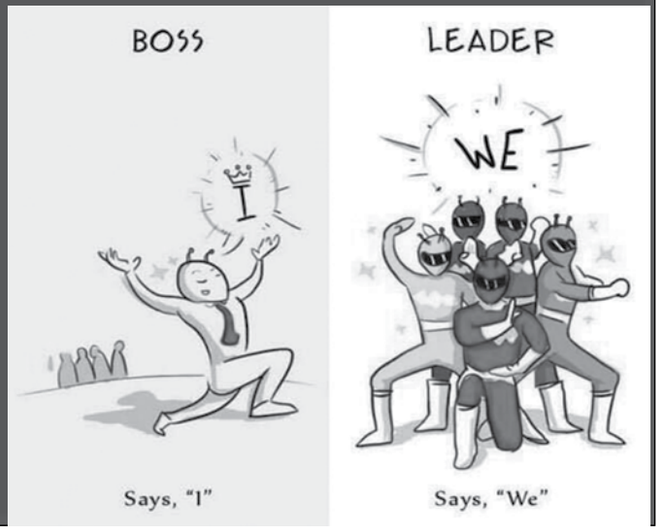
"If the blind lead the blind, both shall fall in the ditch."

- Jesus Christ

"Great leaders are almost always great simplifiers, who can cut through argument, debate, and doubt to offer a solution everybody can understand."

-General Colin Powell





FROM OUR ARCHIVES

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

Vol. XVI No. 3 1941

1941

MEDITATION

THE GROWING EDGE (Mathew 13:53-58)

When Jesus returned to his own home after launching his public ministry, amazing stories of his achievements had preceded him. His bearing and his words manifested a new power which puzzled his former neighbours and, outside the synagogue after he had preached, one could hear the conversations that Matthew reports, 'Is this not the carpenter's son? Whence then has this man all these things?' And they were offended in him and he did not many mighty works there because of their unbelief.

Many years before, the townsfolk of Nazareth had made up their minds about the family of Jesus. They were confident that they had measured accurately the potentialities of each member of that family. They had labelled them as people of minor importance and of little promise and had dismissed them as unworthy of further consideration.

But here came the eldest son of that family upsetting all their calculations. He was doing things and saying things that did not fit in with their preconceived notions. His neighbours had either to belittle these accomplishments they had heard about and convince themselves that they were fabrications of the truth, or they must revaluate their whole conception of this Man and admit that their first impressions had been wrong. That would involve pocketing their pride and this they were not willing to do. They refused to acknowledge that they had been mistaken.

The reaction of these people of Nazareth is typical of human reaction through all ages. Over and over again human beings cut themselves off from the immensely rich contributions of certain persons and certain experiences because they will not admit that their first impressions may have been wrong or at least inadequate. They will not submit to the difficult task of rethinking their judgements. William James claims that all of us should develop what he calls 'the growing edge'. This consists of two closely-linked characteristics of action. One is the willingness to examine the same experience, the same subject or the same person, again and again, convinced that there is more there than the eye first sees; the other is an attitude of constant expectancy, convinced that truth often comes cloaked in the most unconvincing garments and from the most unexpected directions. 'No man knoweth the day nor the hour' when truth comes.

This valuable possession of a growing edge is what has given science its greatest advances. Jenner watched the common folk of Gloucestershire inoculating themselves with cow-pox in order that they might not acquire small-pox and he brought this to the notice of the medical profession, a fact that had been known for centuries but ignored because folklore has no contribution to make to scientific medicine, or so it was thought. For centuries the peoples of Asia have been depositing the night soil on their fields and have known that it would soon disappear and not accumulate. For years scientific medicine has searched for antiseptics to destroy pathogenic bacteria but only now has it begun to realize something that has been known to the Indian peasant for centuries, namely, that in soil there are substances that destroy organic matter and that these substances destroy all but a few of the deleterious bacteria and always prevent their continued growth.

But this gift of the 'growing edge' is valuable in all walks of life and in our human relationships because this is the capacity to look again and again at what life' offers and to be ready, sensitive, expectant for the appearance of truth from the least expected direction and from the least prepossessing person. So often, as we grow older, we get into our own little habits of thought, our own little 'ruts' of doing things and we live to scorn all that is different or new. It is McGill University has a hard rule that no one of its own can be appointed to its own staff unless they have taught at years in other universities. In it ensures the inflow of new ideas and of new ways of doing things, maintains its 'growing edge'.

Not only in our attitude towards our profession and towards others must we have this 'growing edge', but also in our attitude towards ourselves.

Now that I am six, I am clever as clever And I'll go on being six for ever and ever. A. A. MILNE.

It is distressing to contemplate how many people there are whose biographies could be summed up in those two lines….

Then there is our own Christianity. Is Christ still to us what our first childhood impressions made Him out to be as He was to those men of Nazareth so that He could do no' great work there?' Or are we applying the growing edge to Him also, exploring constantly the great potentialities of power and grace that He

can bring into our lives? Man must learn not to be the victim of his first impressions, but the victor over them: If he will, he will find that Light of the World before his own evil intervening shadow blots it out. May it not be said of our lives that He did not many mighty works there because of our unbelief, because of our unchallenged first impressions.

FROM OUR ARCHIVES

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1966

CHRISTIAN MEDICAL STRATEGY IN THE DEVELOPING COUNTRIES: THE CHRISTIAN MEDICAL INSTITUTION

Kenneth M Scott, MD, FACS, Director, CMC, Ludhiana

Christian strategy is, I believe, something that belongs in the hands of our sovereign God. If we try to mastermind grand strategy, we soon find ourselves trying to bend God's will to ours and to pressure others to think as we do. Rather, our main responsibility as Christians is to trust and follow Him.

There is today nothing static about the developing countries and their peoples to whom Christian medicine ministers. Therefore, the shape of such a ministry, though not its motivation, will constantly change, often abruptly and sometimes drastically, if we are to keep abreast of the specific needs and opportunities with which God challenges us. We will encounter dangers and restrictions and harassments, for the whole Christian enterprise is full of risks. But if we risk nothing in Christ's service, we will achieve nothing for Him.

Some Christians have believed that missionary societies should 'blaze a trail' and that the government should 'pave the road'. We have seen many instances in which governments have indeed taken their cue from Christian pilot projects, such as in a number of tuberculosis and leprosy control programmes in Asia and in pioneer rehabilitation programmes for the handicapped. This kind of leadership is fruitful and must always be encouraged. It has always begun only when some concerned Christian has seen a large, unmet need and has done something about it.

In other instances of need, God has opened great doors of Christian witness and service before His people and a thriving Christian institution has come into being. That is how our medical institutions got started, including the mission hospital. Today we have these institutions on our hands, and we have become uneasy about them, because in recent years all mission institutions, whether medical or educational have had the spotlight of criticism focused upon them. We hear that institutions have consumed vast amounts of money. We hear that the prestige they have acquired has attracted non-Christian elements which have secularized them and emptied them of Christian impact. We hear that the local economy, and the struggling indigenous churches in particular, can never support them. We hear this and much more, and in sense it is entirely true.

Christian mission hospitals, as we have known them over the past 50 years, are in deep trouble today. Expenses and minimum standards have shot upward, and financial resources to maintain the hospitals have not kept pace. Available personnel to staff them are getting increasingly difficult to find. In a number of developing countries many mission hospitals which flourished 40 years ago are having to close.

Some Christians are saying that because governments are now providing more and more medical facilities and care and have greater personnel and financial resources, Christian hospitals have now outlived their usefulness and should 'phase out' and let the government carry the load. But they forget that government institutions seldom are known for their spirit of kindness and outgoing concern...

At this point we need to be reminded that the avowedly Christian medical institution, which is under Christian management (not necessarily church- or mission-managed,) alone can provide the environment and the personnel to give a total *concerted* Christian impact far greater, I believe than is possible in a non-Christian setting. Therefore for this and other reasons, we dare not yet write off Christian medical institutions. God is still using and blessing them.

But Christian medical institutions are in a far different world today than they were yesterday, and they must adapt themselves to the facts of life today.

What are some of these facts?

I. Medical missionaries are guests in their adopted countries and serve as brothers and sisters alongside their national colleagues at the sufferance of their hosts and of their hosts' government...

II. All agree that every Christian medical institution today must *teach* if it is to justify its existence...

The Christian Medical Institution must teach not merely techniques but the worth of human life, and it must reveal the mind and spirit and love of Christ in *all* its interpersonal relationships; otherwise, it cannot be called Christian.

CANNABIS USE - INDIA'S DILEMMA

The aim of this article is to briefly discuss the influence of cannabis use on the individual in Indian society. Indian law forbids the possession of cannabis. It is however widely abused in India by smoking and some consume it with tea. Large tracts of the drug are grown in northern parts of India. Due to its popularity law enforcement is rare. As a consequence its use has damaging effects on the body and community.

Physiological influences

Addiction is defined as a state in which a person engages in compulsive, abnormal behaviour. The behaviour is reinforcing (rewarding or pleasurable). The Ventral tegmental area in the brain (VTA) is connected via reward pathway to nucleus accumbens (NA) and prefrontal cortex (PC). Neurones of VTA contain dopamine which is released in both areas (Fig. 1). Dopamine is the happy neurotransmitter. Its release influences other parts of the brain including judgement (Fig. 2). These pathways are activated by the reward stimulus. Drugs producing re-enforcing effects do so by increasing the rate of activity of this pathway. There is a loss of control of behaviour to limit intake of the drug.

Cannabis is prepared from *Cannabis sativa* (dried leaves, stems and flowers). It remains in the body after use for 2-7 days and up to one month for regular users.

It has psychoactive effects: THC (delta-9-tetra-hydrocannabinol). THC binds to cannabinoid receptors esp. in basal ganglia, hippocampus, cerebellum and neocortex. Anandamide is produced and it protects the brain from excitotoxicity. Resin forms are dried into hashish and further processed: potent hash oil. High doses impair psychological functioning, e.g. short-term memory. Symptoms of use include: slurred speech, unreality, emotional intensification, sensory distortion and motor

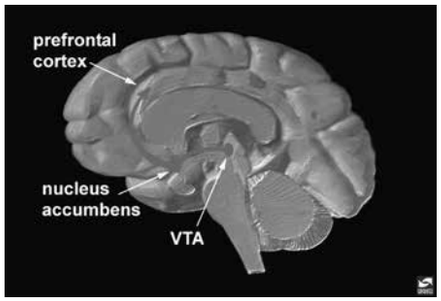

Fig: Neuron pathways emanating in the emotional centre of the brain (limbic system)

impairment. Its patho-Physiology includes: respiratory problems (cough, bronchitis and asthma), tachycardia and possible heart attack. Evidence for brain damage is debatable - it may be neurocognitive and memory effects. Some effects may be clinically beneficial: block nausea of chemotherapy, stimulate appetite, block seizures, dilate bronchioles, and reduce glaucoma & pain (Cooper, 2012 & Ettinger, 2012).

Cultural and legal aspects

Cannabis (bhang) use is culturally acceptable and has been associated with magic, religion, social functions and

The Indian Hemp Drug Commission (1893-4) listened to the therapeutic uses of hemp and recommended that cannabis be considered an important drug for the treatment of certain ailments. In 1896 the British Indian administration passed Act XII which dissuaded the use of cannabis as an intoxicant.

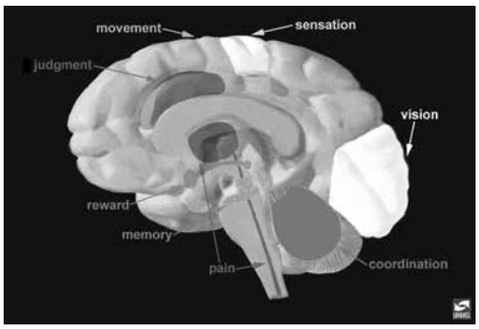

Fig 2: Functional areas of the brain influenced by the limbic system

medical use. Siva is described as drinking a cannabis concoction. In the Brahmin caste cannabis use is tolerated to assist spirituality. Cannabis was used to ward off evil spirits and as hospitality. Bhang has been used in religious yoga sexual acts. The Indian Hemp Drug Commission (1893-4) listened to the therapeutic uses of hemp and recommended that cannabis be considered an important drug for the treatment of certain ailments. In 1896 the British Indian administration passed Act XII which dissuaded the use of cannabis as an intoxicant. In 1930 the Dangerous Drug Act was passed which allowed state governments to detail rules

Cannabis can cause the heart to accelerate and plummet during different postures. This can lead to serious injuries. Eating cannabis cakes cause effects after 90 minutes, whereas smoking is within 3 minutes. Lung damage is common and it's important not to inhale deeply and limit smoking episodes.

of import/export from territories, transport, possession and sale of manufactured drugs including medicinal cannabis. Pressure to discourage the use of cannabis continued and in 1964 India had signed and ratified the Single Convention of Narcotic Drugs, 1961. The Narcotic Drugs and Psychotropic Substances Act, 1985 prohibited the possession, use and consumption of cannabis mixtures (Spicer, 2012).

Treatment

Behavioural intervention may include cognitive therapy and motivation in the absence of definite treatment therapies. Motivation may include giving a present if a definite cessation of cannabis use can be proven. Research is underway to try and develop a drug to ease withdrawal, block the intoxicating effects of cannabis and prevent relapse (NIDA, 2012). One should also be educated about the risks cannabis use imposes on oneself and their families. One should focus on quitting but also on attenuating the immediate health consequences (Jellinek, 2012).

Strength of cannabis and duration of use are important as it's difficult to determine if one had had too much or not. It can make one feel very sick and panicked. One should take breaks between inhalation episodes and rest in a quiet place. Cannabis can cause the heart to accelerate and plummet during different postures. This can lead to serious injuries. Eating cannabis cakes cause effects after 90 minutes, whereas smoking is within 3 minutes. Lung damage is common and it's important not to inhale deeply and limit smoking episodes. Indeed THC is rapidly absorbed so deep inhalation is not warranted. Depression can be accentuated by marijuana use. Combining cannabis leaves with tobacco may increase dependency. Appetite drive stimulated by cannabis needs to be controlled otherwise nausea will result. Cannabis use during pregnancy, treatment, at school/work and in traffic is a big no-no. Concurrent intake of cannabis and alcohol, magic mushrooms and other hard drugs is extremely dangerous and can cause bad trips. Smoking episodes should never be daily with break episodes (Jellinek, 2012).

Professor Ross G. Cooper

Formerly: Senior Lecturer in Physiology, BCU, Westbourne Road, Birmingham, UK; Department of Physiology, Bristol University, UK; Polish Academy of Science, Poland; and the Department of Physiology, University of Zimbabwe.

Prof. Cooper lectures Drug Misuse and the general aspects of Physiology. He grew up in Zimbabwe and has published extensively with a current citation index of 15. He supports orphans and organisations focused on combating drug misuse. He is a practicing Christian. He attends Potters House Christian Fellowship.

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THE DECLINE OF MISSION HOSPITALS IN INDIA

The failure of mission hospitals to adapt to the changed reality in post-independence India has resulted in a decline in Christian medical missions. There is a need to specifically address issues related to the different political climate, reduced financial support, capitalism, neoliberal philosophy, structural violence, increased cost of care, dominance of specialist care and training, corruption within the church and a reduced emphasis on social justice among Christians. It calls for a comprehensive and radical approach to revive the mission.

It is widely acknowledged that the number of Christian mission hospitals in India has seen a sharp and steady decline over the past six decades. While many hospitals are barely surviving, some are flourishing. Despite a few islands of success, Christian medical missions in India are in a state of decline. This article attempts to discuss the radically changed environment in today's world and the inadequacy of the response of Christian medical missions to this reality.

Many forces, national developments and international pressures have combined to alter the socio-economic and political reality of India and have contributed the decline in Christian medical missions in the country. These include (i) changed post-independence political reality, (ii) capitalism and a neoliberal agenda and their impact on medicine, (iii) inequity and cost of medical care, (iv) tertiary care as ideal and standard, and (vii) changes within the Indian church and among Christians. These are briefly highlighted.

Changed political climate

India's independence from colonial rule had a significant impact on the country. However, its impact on Christian missions was not obvious for many decades. While some hospitals flourished in the 1950s and 1960s, the absence of tacit governmental and administrative commitment coupled with the slow but steady reduction in financial support from abroad and the reduced number of foreign medical missionaries had a devastating impact on growth of mission hospitals. Many mission hospitals, which did not adapt to the reduction in political, financial, administrative and personnel support, closed down. Others limped along and many are now in a state of terminal decline.

Capitalism, neoliberalism and medicine

Despite its scientific base, medicine is a system sanctioned by the society in which it practices. Scientific knowledge is comprised of beliefs shared by experts. The social nature of science argues that scientific authority belongs to communities, both within and outside medicine.

The political economy of health (i.e. theoretical framework, which helps explain the political, economic, social and historical forces that shape contemporary health problems and healthcare) deeply rooted in capitalistic economic and social systems, supports many medical formulations. While medicine argues that its diagnoses are disease

conditions that require individual treatment, there is hard evidence to suggest that much physical and mental distress and illness are linked to social determinants of health (e.g. poverty, basic needs, education, livelihoods, social exclusion, political oppression, etc.,). Yet, medicine often supports treating individuals, instead of employing public health interventions and population approaches to prevent these conditions.

Disease labels and individual treatments offer distinctive niches to diverse stakeholders: reimbursement for physicians, profit for the health, hospital, insurance and pharmaceutical industries, and deflection of responsibility for governments. Medicine is politics writ large and the health sector is a powerful player in national economies.

Neoliberalism, with its emphasis on privatization, fiscal austerity, deregulation, free trade, reduction in government spending, and increased role of the private sector in the economy, is the new mantra for capitalism. The culture of medicine fits in well within the neoliberal agenda, allowing the free market to expand its business interests. It demonstrates the nested position of the discipline of medicine within the agendas of governing, which determines perspectives, formation of knowledge, institutional control and policy.

Michel Foucault argued that knowledge structures enhance and maintain the exercise of power. The technical approaches of evidence-based medicine are not necessarily value-neutral or above specific interests. It reiterates the historical relationship between medicine and governments, with governmental administration serviced by experts responsible for managing social security, stability and economic growth.

Inequity and cost of health care

India's economic development masks inequity in the country and the human cost of progress. The country ranks low on the Human Development Index, while its Gini Coefficient suggests marked inequality. Apologists of the capitalist economic system betray an ideological bias with assumptions that an unregulated market is fair and competent; that the exercise of private greed will be in the larger public interest. Even a cursory examination of assets and disparities across peoples suggests that those who succeed have inherited advantages and favorable playing fields, compared to those who do not.

Disease and illness in a grossly unequal society are a huge cause of expenditure, poverty and indebtedness among the poor. Overburdened, impoverished and underfunded public health systems coupled with an increasingly widespread and unregulated private health sector with its unethical clinical practice results in significant out-of-pocket expenditure. In addition, technology- centered health care also increases costs, making the "right to health" a distant dream for common citizens.

Tertiary care as ideal and standard

Six decades of independence have also seen a meteoric rise of specialist perspectives and tertiary care practice in medicine, with a consequent decline in primary care and family medicine. The shift has also resulted in the rise in social status of specialists and a simultaneous reduced societal standing of generalists, general practitioners, primary care and family physicians. Situating medical training within tertiary care also translates to step-motherly treatment of primary and secondary hospital approaches. Consequently, training for medical students is weak, with most training programs unable to produce graduates who can practice independently. In fact, today's medical graduates are only fit to write entrance examinations for postgraduate courses, having been trained in theoretical knowledge without acquisition of skills and confidence necessary for clinical practice. Training in specialist settings with weak inputs from community health, primary care and family medicine departments, compounded by their lower social standing within the medical community, also steers graduates choose specialist careers rather than careers working as doctors in smaller, general and rural hospitals.

Walking the talk and serving the rural poor in "Bharat" presents huge challenges, with its lack of facilities, poor schooling, limited social life, and restricted remuneration and material rewards.

Changing trends within Christianity

The past few decades have also seen subtle and not-so-subtle changes within Christian communities in India. The impact of neoliberal policies, with their emphasis on profit and upward economic mobility for those with capital, has affected the medical profession. The pressures and pleasures of the materialistic world seem to have colored their view of Christ's message to serve the poor and the suffering and has highlighted the complexity of the human condition.

Many Christians have struggled to integrate their response of service to humanity with materialistic ways

Although many successful Christian hospitals have become training centers allowing for increasing the work force, the veneration of recent advances in medical care and technology inculcate aspirations to specialist practice among trainees, rather than a choice of serving in remote, rural locations and areas of need.

of contemporary middle-class India. Many find refuge from the contemporary confusion in their quest for personal salvation, while the message of Christ's mission of social justice has few takers. Social justice from a Biblical perspective is often incompatible with personal prosperity, while the message of personal salvation accommodates upward mobility much more easily. Walking the talk and serving the rural poor in "Bharat" presents huge challenges, with its lack of facilities, poor schooling, limited social life, and restricted remuneration and material rewards. Talking about mission service from the comfort of cities and tertiary care facilities is an easier option as is superficial tinkering with existing approaches.

The hurry to get rich in Indian society has also resulted in corruption within many churches. Sale of church property for kickbacks, bribes for admissions to church-run schools, payoffs for transfers of staff in church-run institutions, legal disputes, court battles, and convictions and jail terms for clergy and church administrators are not uncommon. Running down mission hospitals, often located in the center of small towns and cities, before selling the land for sizable fortunes have also been causal to the decline.

The two-tiered payment system, which uses the Robin Hood approach of over-charging the rich to subsidize the care for the poor, is a pragmatic solution.

Adaptations and their adverse effects

While many mission hospitals have closed, some have survived and a few are flourishing. Many innovations have helped the last category endure and swim against the tide, which has swamped many mission facilities. However, a closer study of hospitals, which have prospered in the radically altered contexts, suggests that they have changed course with the tide in order to survive.

While embracing super-specialization and advanced technology per se is not a bad tactic, the failure to manage its adverse effects of second-class status of non-specialists working in departments of community health, primary care and family medicine is a major fault line. Although many successful Christian hospitals have become training centers allowing for increasing the work force, the veneration of recent advances in medical care and technology inculcate aspirations to specialist practice among trainees, rather than a choice of serving in remote, rural locations and areas of need. Aspiring to work in less technologically advanced facilities like small mission hospitals is consequently considered indicative of inadequate ambition, and holding less rewards.

The medical curriculum, markedly skewed towards specialist perspectives and practice dependent on sophisticated technological input, does not provide basic skills, and confidence for graduates, forcing them to specialize rather than work as generalists. The archaic assessment systems continue to test trivia and exotic conditions, rather than evaluate competence in dealing with local and regional problems and ability to initiate appropriate solutions; this makes graduates less than competent when working in the community. Tinkering only with curricula, while retaining the examination and training systems within the tertiary care environments of medical schools, will not achieve its goals of producing competent basic doctors.

The "sponsorship" system of selecting and training students from diverse missions, while an excellent strategy to provide opportunities for geographically diverse people with varied backgrounds, has also proved a failure as most students selected leave their mission after their mandatory service obligation, instead of offering a lifetime of mission service. The mismatch between students from urban and middle-class backgrounds, with aspirations of economic security derived from specialist

We need radical and comprehensive reforms of medical missions in India in order to face the challenge of neoliberalism, structural violence and inequity, rampant in modern India. The changed context demands different strategies.

positions, trump the ideals of social justice and service that they often claim at entry into medical school.

The absence of foreign funding has resulted in hospitals having to generate their own resources. The two-tiered payment system, which uses the Robin Hood approach of over-charging the rich to subsidize the care for the poor, is a pragmatic solution. However, it still falls short of generating funds to treat very poor people, who often fail to turn up in hospitals because of their inability to pay and their fear of exorbitant charges. Community clinics and primary care often receive step-motherly treatment because of their inability to generate income. Public health approaches and population interventions are often on the back burner for similar reasons. In addition, physician compensation is also a major issue. The fear of losing qualified staff to market forces necessitates regular increases in pay and perks of medical personnel, thereby increasing costs of health care.

Conclusions

The decline in India's medical missions has been discussed and debated extensively within the Christian medical community; many solutions have also been suggested. Changes in selection policy, curriculum, examination systems, and skill-based training have been attempted. Structural and functional linkages and common platforms for missions have been discussed. However, most approaches have been piece-meal, patchy and inconsistently applied. They need to be radical and comprehensive, attempting to tackle all aspects of the changed reality.

Many meetings and conferences recall the lives and success of our founders, their conquest of adversity and their successes in harsh circumstances. While the Christian community needs such heroes, it is naïve to believe that their strategies of dedication, hard work and persistence would have automatically paid off in today's context of national pressures and significant international forces influencing the socio-economic and political environment. We need radical and comprehensive reforms of medical missions in India in order to face the challenge of neoliberalism, structural violence and inequity, rampant in modern India. The changed context demands different strategies.

While individual institutions may adapt and survive, their impact on the country as a whole will be limited. They stand out as beacons, while other hospitals close down. Yet, many would have compromised their original ideals of service to the poor and marginalized, in order to survive.

While there are no simple or single solutions, there needs to be a broader approach and a more radical and comprehensive framework and response, which is not yet within reach or even in sight. Otherwise, the decline is set to continue. The writing is on the wall.

Dr. K. S. Jacob teaches psychiatry at the Christian Medical College, Vellore. The views expressed are personal.

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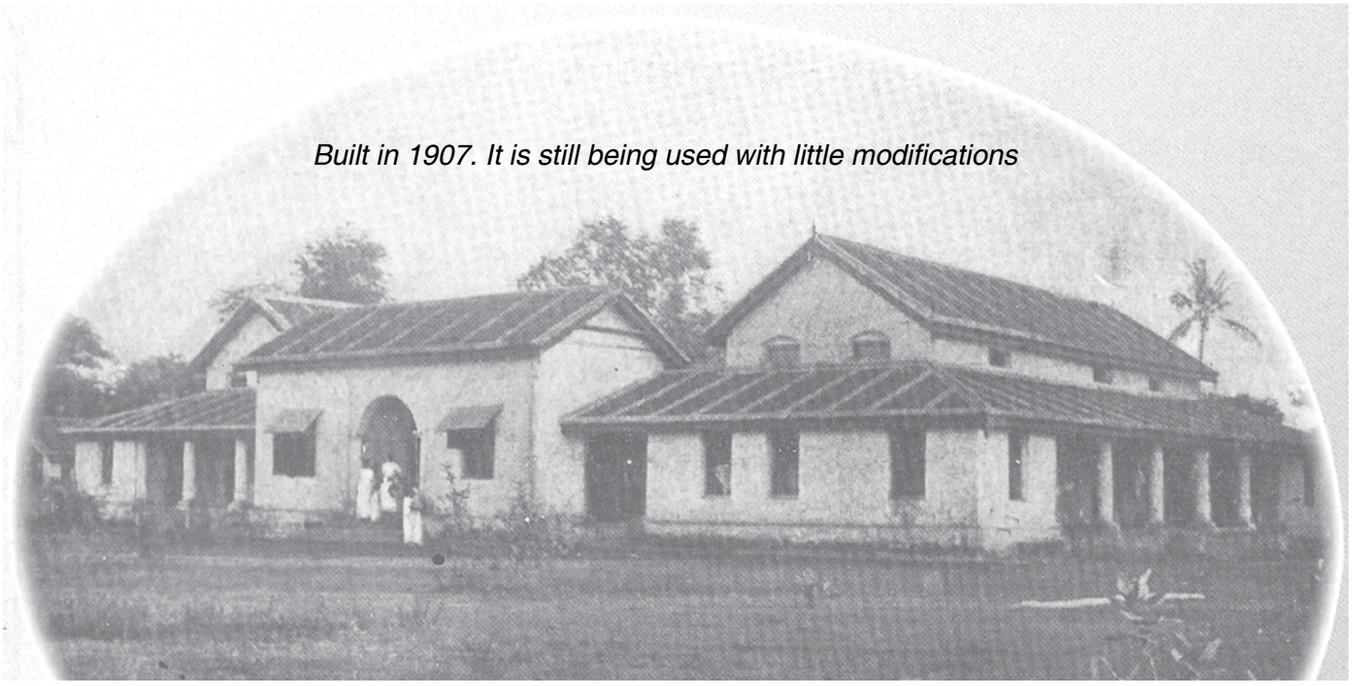
21-26 AUGUST 2018

"In the Footsteps of the Great Servant Healer"

REPENT | REPROVE | RESTORE

CHRISTIAN HOSPITAL BERHAMPUR



Built in 1907. It is still being used with little modifications

Introduction

Christian Hospital, Berhampur, Odisha, is a not for profit, charitable, secondary care hospital, serves the community in and around Berhampur in providing excellent health care, mainly to the women and children. Out Patient and In Patient Services in the hospital, Family Welfare Services in three wards of Berhampur and Rural Community Health Services are the areas of activities through which the hospital offers its services to the community.

Dr. Minal Kanta Nanda

History

The beginning of Christian Hospital, Berhampur was almost similar to most of the Mission Hospitals in India.

Moved by the primitive conditions in which the expectant mothers delivered their babies and their newborns were taken care of, Dr. Nina Ottamann, of Baptist Missionary Society (BMS), England started a clinic in the year 1900 AD in Berhampur. The clinic provided scientific care to the mother and their babies to reduce their high mortality and morbidity rate prevailing in those days. Demand for her services led extension of the work and thus a hospital: Christian Hospital for Women and Children was established in the year 1907(the Zanana Hospital as it was also known locally – Zanana means women). The hospital has been serving the women and children of the community in and around Berhampur since then. Alongside with the existence of the Hospital, the training of young Indian girls as nurses was also begun in 1907. Thus a School of Nursing was established. Many missionary doctors continued to provide their services through the hospital over the years. The last missionary doctor: Dr E J Marsh left the hospital in 1997 after serving for a good 38 years.

In the year 2000 the name of the hospital was changed to Christian Hospital, Berhampur and services to the male patients were also started.

Today, Christian Hospital, Berhampur is a thriving centre for obstetric and pediatric care, Laboratory services, Out Patient services and many more. It is the main source of quality Obstetric and Pediatric care in and around Berhampur. The demand for this service is increasing day by day. Majority of the patients attending the hospital are from the poor socioeconomic group. Either free or concessional treatment is given to these groups of patients. Highest standard of care to the women and children is being maintained with the committed staff with the available resources.

The founder: Dr Nina Ottamann

Facilities

120 bed hospital with out-patients and in-patients

- Post Partum Centre for family welfare activity
- Rural Community Health programme.
- Other training programme

The guiding force

Our aim is “to promote and to carry out on behalf of the Church of North India appropriate medical services and training, community health works, and the diffusion of useful medical knowledge, in the spirit of service and sacrifice which Christ practiced in his own life, being of service for the benefit of all persons irrespective of caste, creed, community and nationality”, which guides us all through out to carry on our work continually.

Services offered

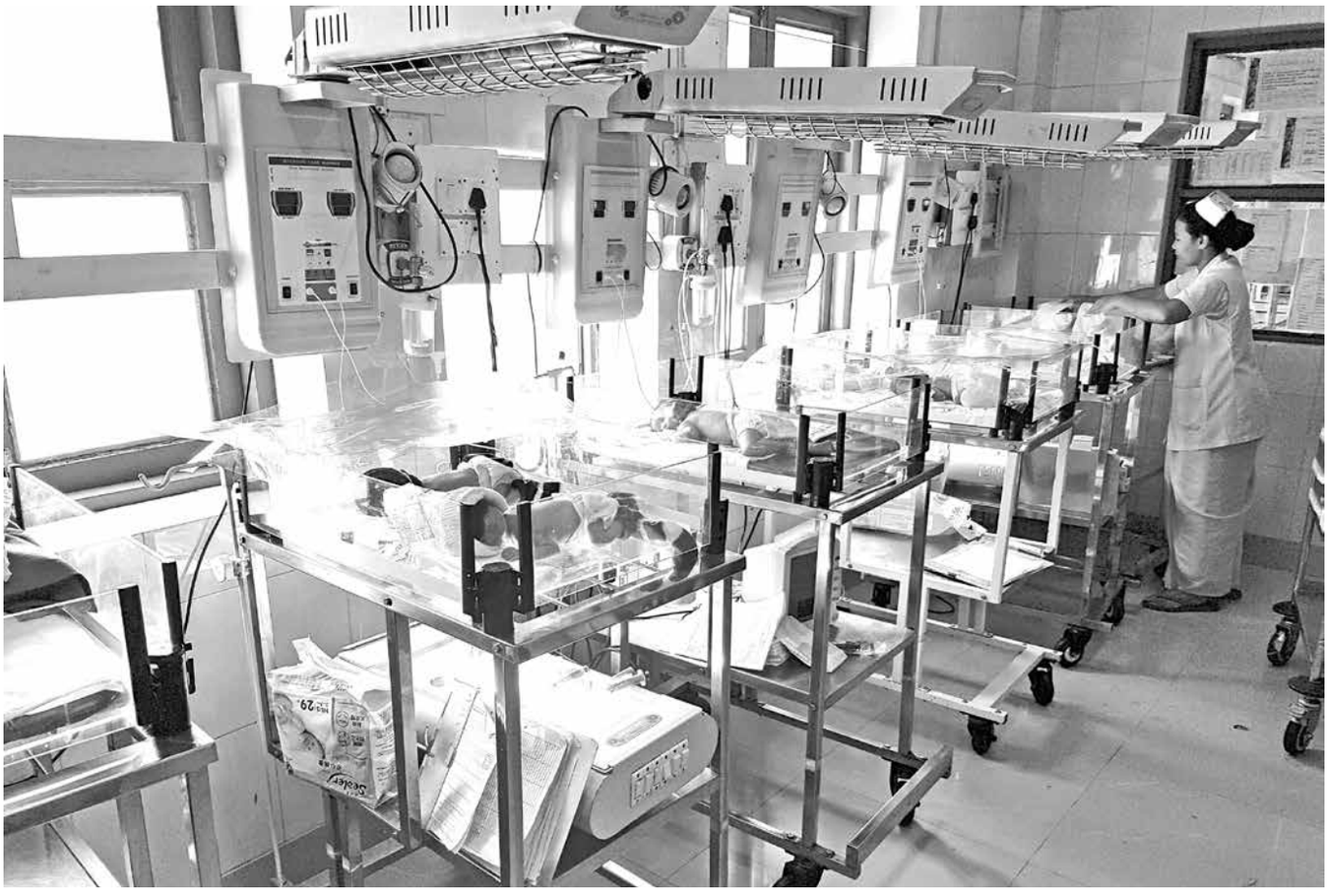
Majority of the patients treated are women and children. Over the years, the hospital has generated enough faith from the people for its efficient services with love and care, which we continue to offer.

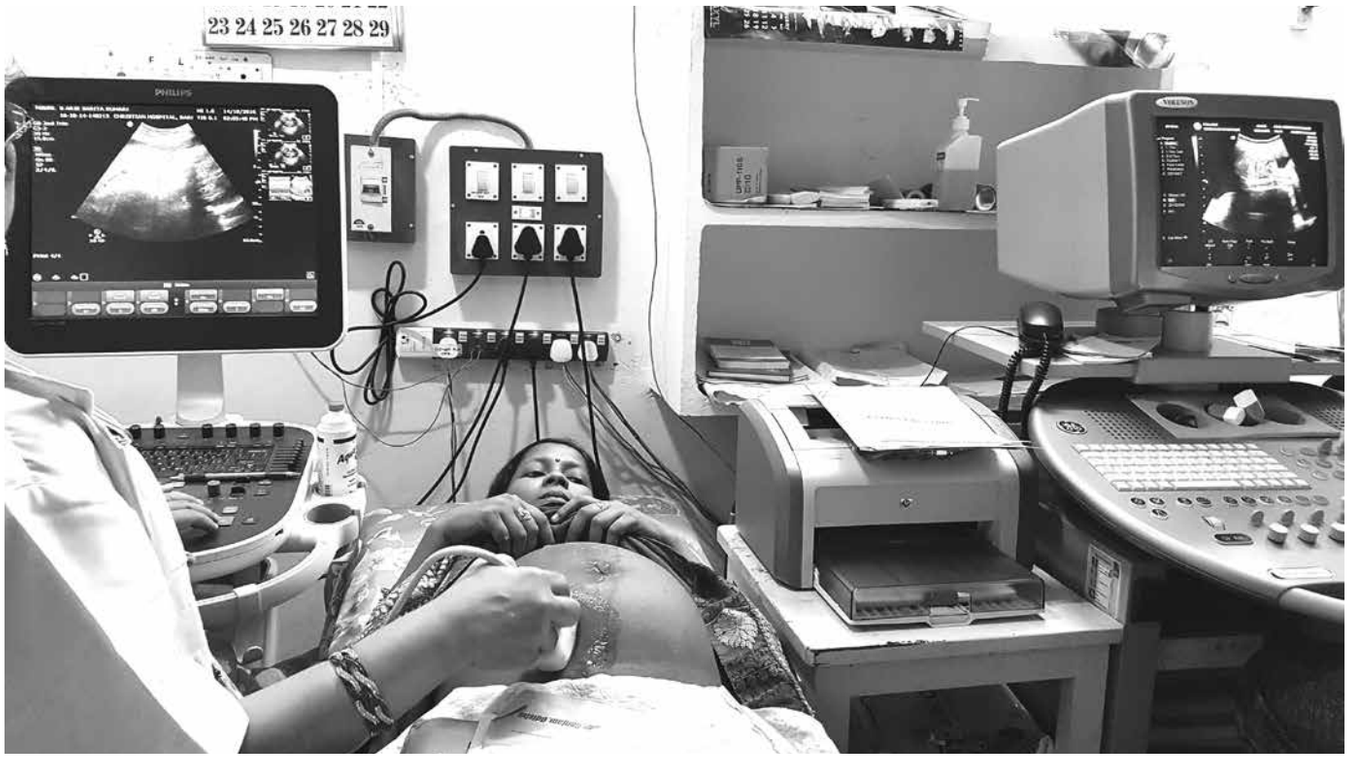
OPD: OPD Services is streamlined for treatment different group of patients in different days. Tuesday and Thurs day for ANC. Average ANC seen in a day is 290. Wednesday and Fri Day for WBC with immunizations, rest for general patients. Daily average patients seen are 178. All services are provided under one roof, like registration, general checkup, lab investigations, ultrasound scanning, X-Ray, Doctors consultation and Pharmacy services. The costs to the patients are very reasonable.

IP: The hospital has 120 beds. In Patient Services is provided through the various wards of the hospital. Doctors are available round the clock for routine and emergency services. The wards are: Dr E J Marsh Labour Ward, Surgical Ward, Jubilee Ward, NICU (level II), Pediatric Ward and the Men’s Ward. Beds are distributed according to the patient load. The bed occupancy was 106% in the year 2015-16 and it has remained consistently more than 100% for the past 5 years. Average stay was 3.7 days. One bed ICU is available for treatment of in patients who become sick in the hospital. There are three ORs, one specifically for the male patients.


IN PATIENT DEPARTMENT
WE DRESS THE WOUNDS
GOD HEALS IT.
IN PATIENT DEPARTMENT


PRAYER HALL
IN PATIENT DEPARTMENT

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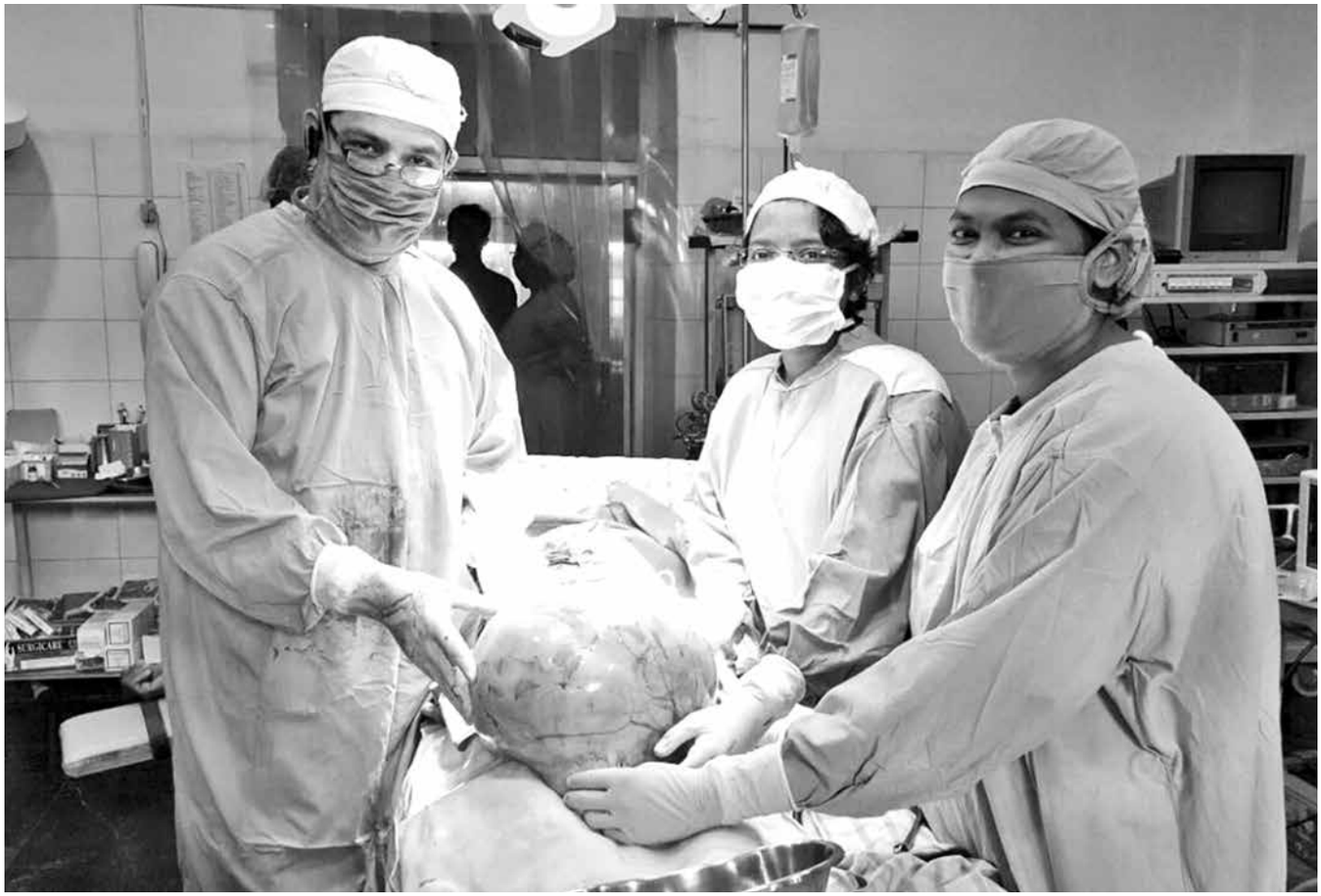


Support services like: (Central Sterile Services Department (CSSD), Laundry, Maintenance, security etc are efficiently provided by the team of dedicated staff of the hospital.

The statistics for the year 2015-16:

- IP Admissions: 11259
- Total Deliveries: 4631
- Family planning operations: 749
- Total Operations: 3678
- Total Investigations: 97895
- Ultrasound: 12529

(These numbers are almost similar for the past 3 years)

The work force: The entire work is carried out by a group of committed and dedicated staff totaling 184, which includes: 10 doctors, 73 nursing and teaching staff, and 101 support staff.

School of Nursing:

It is the oldest nursing training school in the state of Odisha**.** Each year 30 students are admitted for GNM training. This course is recognized by the INC and is for 3 years. The School is affiliated to the MIBE. Required teaching faculties and infrastructures are available.

Post Partum Centre:

All the family welfare activities and immunization programme of the hospital and three wards of Berhampur are carried out through this unit. This is supported by the Govt. in form of grant-in-aid.

Community Health Programme:

We provide our community health service through two different centers. One at Boxipalli, about 15 km from Berhampur catering to the fisherman community of 6 villages. Weekly clinics are held here for women and children. The other one at Dengaambo, about 100 km from Berhampur catering to the tribal people of 22 villages. Health education, treatment of minor ailments, to facilitate implementation of govt. programmes etc and ambulance services to these remote villages are provided by two staff stationed at the centre.

Other training programme includes: SAB training for Govt staff nurses, obstetric training for staff of Tibetan settlement in India. Facilities are provided for (Integrated Management of Neonatal and Childhood Illnesses (IMNCI) training also for govt. staff. Nursing students from various sister institutions do visit the hospital for exposure in obstetric and pediatrics care.

Finances:

At present the hospital is able to generate income from its services which is sufficient to manage itself. Besides, some amount is available from the local income for capital expenditure and saving for future requirement.

Management and legal status:

The hospital has a local management committee which manages the regular activities of the hospital. It is under the ERBHS which makes policy decisions and appoint administrative staffs. ERBHS is a part of SBHS of CNI. It is a registered Society.

It is registered as a Clinical Establishment, Odisha. Has 12AA certificate and the FCRA certificate is renewed for 5 years from November 2016. Also have other required certificates. Fire safety certificate is to be obtained, for which the work is going on at present.

Way forward:

There is an ample of opportunity to expand the services of the hospital to cater to a much larger group of patients in different service areas. Even the Community health services have a demand for extension to larger areas, which we are working on to expand. Constant demand for our service is the indication that, the community needs a Mission hospital, which only can provide medical services with love and care to them at a reasonable cost. We wish to see Christian Hospital, Berhampur to become a 250 bed Multi Specialty Hospital in the days to come. We request all our friends and well wishers to pray for us and support us, for our dream come true.

Dr. Minal Kanta Nanda
Joined the hospital in 1989. Became Director and Medical Superintendent in 1997 and continuing till date.

STAFF VACANCY

The Christian Medical Association of India, New Delhi, a Christian NGO and a fellowship of Christian Hospitals and Christian Healthcare Professionals in India has an immediate opening for a staff at its Headquarter in New Delhi.

Name of the Post: Secretary, Chaplains Section

Post open: One

Nature of the job: Full time; coordinates the activities of the Section; requires extensive travel all over India

Age: 28-40 yrs

Educational Qualifications: A Diploma or Degree in Theology from a Theological University/College/Seminary in India

Professional Qualifications/Work experience: Ordination in any of the NCCI member Churches; Pastoral experience in parishes; Chaplaincy experience in hospitals/caring institutions and /or exposure to Healing Ministry/Pastoral Care and Counseling.

Period of appointment: Five years with first year as probation

Last date for application: March 31, 2017

Salary and perks: As per the CMAI rules

Send your curriculum vitae to:

The General Secretary
Christian Medical Association of India
Plot No 2, A-3, Local Shopping Centre
Janakpuri, New Delhi 110058
Telephone: 011-25599991, 2, 3
Email: cmai@cmai.org
Website: www.cmaiorg

AADHARSHILA SANSTHAN(CICM)

DAMOH (M.P.)

140 BEDDED CHRISTIAN HOSPITAL

WITH THE LATEST FACILITIES

URGENTLY REQUIRES

DOCTOR (M.D. - MEDICINE)

GYNECOLOGIST (M.S. / Dip.)

PATHOLOGIST (M.D. / Dip.)

ATTRACTIVE SALARY PACKAGE WITH
FURNISHED ACCOMMODATION

CONTACT IMMEDIATELY TO..

DR. AJAI LALL

DIRECTOR

AADHARSHILA SANSTHAN (CICM)

BOX NO. 12, DAMOH (M.P.) 470661

PHONE: 07812-222500, 223351

E-MAIL: cicmind@gmail.com

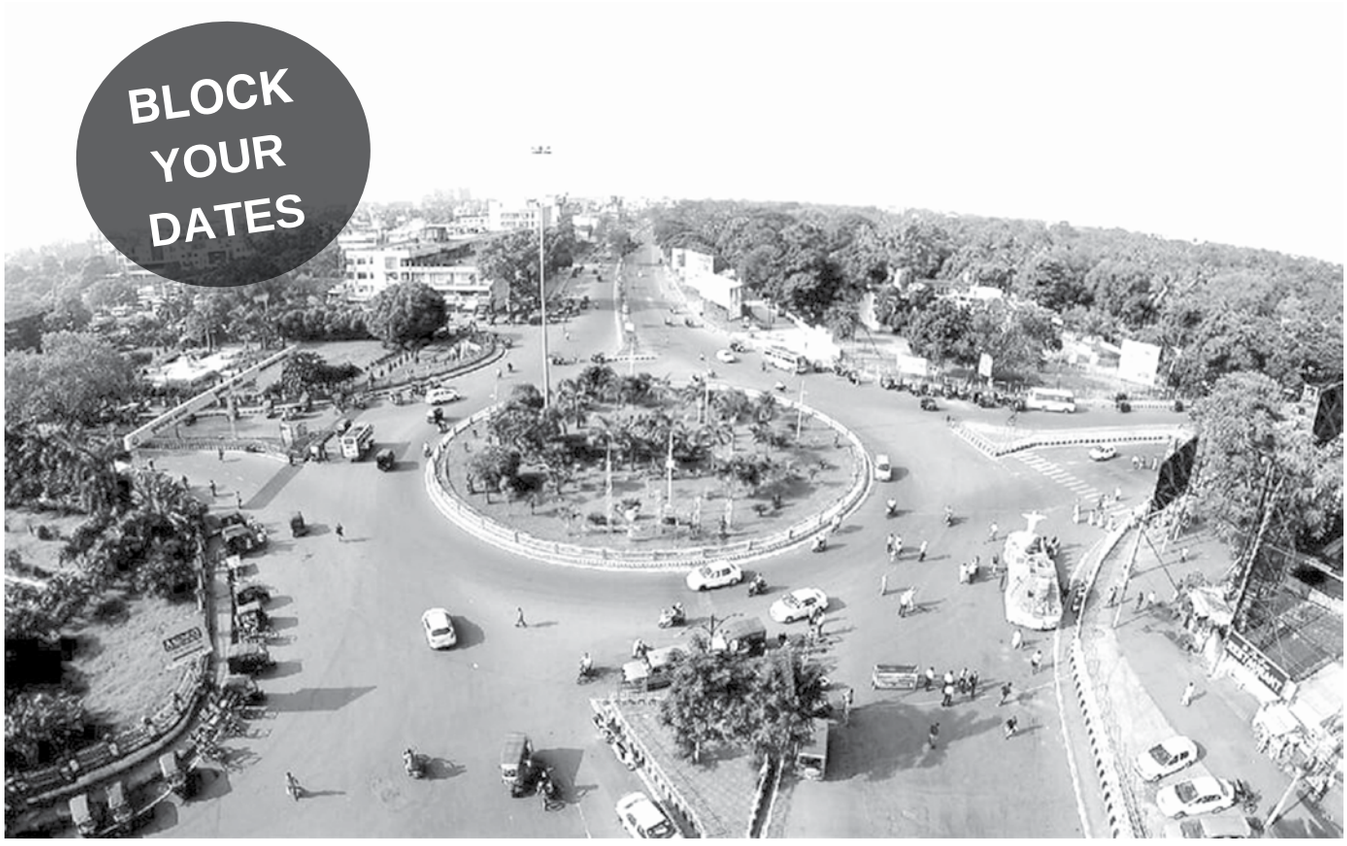
LETS COME TOGETHER ONCE AGAIN AT

BHUBANESWAR

FOR THE

CMAI BIENNIAL CONFERENCE

5 - 9 NOVEMBER 2017



Theme

“Partnering Together in the Healing Ministry of the Church”

Join Hands with us in Healing Ministry

COME JOIN US AS MEMBERS

CHRISTIAN MEDICAL ASSOCIATION OF INDIA

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

- CMAI has over 10,000 Christian health care professionals and over 340 institutions representing various denominations.
- CMAI builds individuals to be technically sound, spiritually alive, and socially relevant, in fellowship and with a Christian perspective on health and development.
- CMAI is the health arm of the National Council of Churches in India(NCCI).

WHAT DO WE DO ?

- Build capacity to respond to the current and future health care needs
- Advocate for innovations, create evidence and promote policy change
- Work closely with the churches, civil society and the government
- Build alliances for health action on a national scale

OUR PARTNERS

CMAI influences other networks and alliances on thinking change in health systems practices in India. We partner with national and international agencies to promote this objective.

OUR PUBLICATIONS

- Christian Medical Journal of India (Perspective)
- Life for All (Newsletter)
- Footsteps (Development) English & Hindi

COME JOIN US

The core of CMAI is its members- individuals, institutions and churches. Individual membership consists of five professional groups - Doctors, Nurses, Allied Health Professionals, Chaplains and Administrators. Each section comes together for retreats, workshops, conferences and campaigns to share resources.

For more information about our work and to download membership form visit our Website:

www.cmai.org or write to: cmai@cmai.org

General Secretary
CMAI, Plot No.2,A-3 Local Shopping Centre
Janakpuri, New Delhi -110058 India
Tel: + 91(0) 11 25599991/2/3 Fax: +91 (0) 1125598150

We invite Christian health care professionals, join us as members

COME JOIN US AS MEMBERS

Building a just and healthy society