Foster research activities in the department:

1. Publication of books, monographs or atlases;
2. Sending a promising young staff member or resident abroad to a reputed training centre to introduce advanced techniques into the department;
3. Purchasing expensive books, teaching aids for use in the department; and
4. Expensive tests or drug therapy for very poor patients.

At times, the dean or director of the institution is able to help through available funds. At other times, the social service department finds donors for poor patients. Societies such as the Neurological Society of India help promising youngsters by providing travel grants. Even so, fiscal crunches do crop up from time to time and can prove extremely frustrating.

Here are some suggestions to overcome these difficult times:

1. Foster research activities in the department: These need not be esoteric or projects necessitating use of expensive equipment. They must be relevant to our needs and must advance knowledge on the topic even if in a limited manner. Through such activities, younger members of the team are introduced to the rigour and discipline of research. They are made to use ‘the little grey cells’ oft-championed by Hercule Poirot. They are forced to ask meaningful questions, the answers to which are hitherto unknown. The advantages to the researcher in particular and the department in general include access to funds offered by such agencies as the Indian Council of Medical Research, Department of Science and Technology and the Department of Biotechnology. These funds can be used to augment the facilities available in the department and provide additional means for its activities.

2. Develop activities that will generate funds: The development of greatly needed tests or techniques (such as endovascular therapy) not hitherto available in the city is one such endeavour. Once the test or therapy is standardized, it can be offered on payment to any clinician, department or institute. The publication of an expensive, well-illustrated and printed atlas (of anatomical or pathological interest, on imaging or illustrating operative techniques) is another example. The atlas can be priced such that the author(s) and department are financially rewarded. The funds accruing to the department can be used to further its activities.

Existing administrative practices can, however, prove a hindrance to the use of funds so generated. Most institutes stipulate that all income must be deposited into the institute’s coffers and the department is denied access to them. This dampens enthusiasm and inhibits initiative.

Suggested solutions include creation of separate departmental accounts for accruals from research, services or publications. These accounts are subject to audit and open to scrutiny by the dean, director or other authorized officials. The departments are permitted the use of funds generated by them for further productive work and other developmental activities subject to authorization by the dean or director after scrutiny of the proposals. Red tape must be kept to a minimum while ensuring probity and accountability.

TWO UNUSUAL MEDICAL HISTORIANS

Over the past few years, it has been our privilege to gain the friendship of two unusual medical historians. Their activities are especially stimulating as interest in the history of medicine is at a pathetically low level in India. There is little or no teaching of the contributions made by our medical pioneers, analysis of the difficulties they faced and the audacity and tenacity with which they overcome obstacles—at times at the cost of their lives. Lessons taught by the pioneers can motivate and encourage us to make our own contributions to medicine, however humble they be.

The endeavours made by the National Institute of Mental Health and Neurosciences (NIMHANS) and St John’s Research Institute towards inculcating a sense of medical history in students have been referred to in my previous Letter.

In this dispiriting atmosphere the endeavours by Kalpish Ratna provide a shining and stimulating example to the rest of us. The spines and title pages of their books would suggest a single author. The nom de plume is, in fact, a combination of the names of two persons dwelling on widely separated continents. Dr Kalpana Swaminathan lives and works in Mumbai while Dr Ishrat Syed spends a considerable part of the year in America. The pseudonym translates as ‘the pleasures of imagination’ and is thus doubly apt.

In response to my queries for information, Dr Swaminathan sought time as she conferred with Dr Syed, perhaps through the magical medium of email. Here is what I learnt from their joint answers.

They met at their medical alma mater, the Grant Medical College in Mumbai. Dr Swaminathan joined the college in 1973 (six years after I left it), and Dr Syed enrolled as a medical student in 1975. Eventually, both trained in paediatric surgery, Dr Syed signing up as house surgeon while Dr Swaminathan was registrar. Dr Swaminathan set up practice in Bandra. Dr Syed worked for a year in Dahanu, for 7 years in Mecca and then in the UK. They continue their surgical practices.

‘One day we decided to write down a conversation we were having about an animal we didn’t know much about. That turned out to be the first of our columns—The song of the Tuatara.’

I was puzzled about the mechanics that went into the seamless and apparently effortless series of books that have flowed from their pens (or computers). ‘More energy than effort,’ they replied. ‘Each book is set off by an adventure that continues into the book. With Room 000 (their latest work) it was that awful misspelt plaque.’ Here, they refer to the plaque commemorating the work of Dr Waldemar Haffkine at the Petit Laboratory of the Grant Medical College. It was installed at the behest and personal expense of Mrs Edythe Lutzker, an American historian and devotee of the life and work of Dr Haffkine. It is a tribute to the selflessness of Mrs Lutzker that there is no trace of her efforts or contributions on the plaque. The deficiency noted by Kalpish Ratna is in the spelling of the word ‘mankind’ which now reads...
where they strut about posing for photographs and talk of how servants', shakes them from their apathy and forces them to make with consequent loss of life and limb activates our 'public existence of teachers and students in our public medical colleges public hospitals. Politicians and bureaucrats are cognizant of the is a startling disconnect of the powers that be and workers in our address, on a continuing basis, their needs and aspirations. There strikes—was provoked by the failure of the authorities (the impending strike in July––as, indeed, earlier that would shame fisherfolk results in crumbs being thrown at the action and a series of meetings are held with the strikers. Bargaining suffering of poor patients, the wheels of bureaucracy creak into the consequences of the strike in terms of deaths and worsening when no doctor turns up for work.

Gone, long ago, are the days when ministers, senior bureaucrats and officials met deans and other senior officials of medical colleges and hospitals, discussed projects and made plans for continued upgradation of equipment and services. In those halcyon days, there was mutual respect between those wielding administrative power in government ministries and municipal corporations and deans and professors in medical college hospitals. During those discussions, administrators in medical colleges and hospitals were able to make constructive suggestions for the welfare of patients and all those working for them. Quick decisions and their rapid implementation ensured smooth functioning of medical colleges and hospitals. Of course, then, ministers and bureaucrats also had a personal interest in ensuring that public hospitals offered services of the highest standards as they themselves always availed of those services. With the advent of five-star private hospitals, ministers and bureaucrats have turned to them for their own personal needs—blissfully unaware of the implication on how they run institutions under their own control. Worse, they travel abroad to seek ‘better’ treatment.

There is also an attitude of unwarranted superiority among ministers and bureaucrats. Here is just one example: I have seen an Additional Municipal Commissioner expecting deans and professors to rise when he entered the meeting room, frowning on those slow to do so and offering no apology for making them wait for over 45 minutes. Proposals made by deans and professors are dealt with peremptorily and sanctions given as though great favours are being done.

Under such conditions, it is not surprising that resident doctors and nurses, forming the ‘lower rungs’ of those working for patients, are scarcely considered by ministers and bureaucrats. Despite pleas over the past 60 years, there is no mechanism in place for automatic increases in stipends and pay scales based on the cost of living; monitoring of the conditions under which they live and work and of the care they deserve when they, the caregivers, are in need of medical care themselves.

Small wonder that we see periodic strikes by doctors and nurses. A set formula has now evolved. A strike is announced and a charter of demands distributed. Administrative bigwigs glance at the charter and put it on the list of items to be dealt with when time permits. At best, there are meetings at which there is a lot of talk but little by way of decisions. Lack of action stokes the growing irritation in those proposing the strike and the day dawns when no doctor turns up for work.

Eventually, with newspapers displaying on their front pages the consequences of the strike in terms of deaths and worsening suffering of poor patients, the wheels of bureaucrat creak into action and a series of meetings are held with the strikers. Bargaining that would shame fisherfolk results in crumbs being thrown at the strikers with promises of more to follow. Along with the crumbs come threats of terminating their jobs, making it impossible for resident doctors to continue their postgraduate education and of eviction from their rooms in the hostels.

As the quantity of crumbs is increased and as the strikers reach the end of their tether, they accept defeat and resume work. Bureaucrats are well aware of the fact that resident doctors are short-stay professionals in transit in public teaching hospitals, that they have shallow pockets and that they have no powerful, potentially troublesome labour union.

‘ma nkind’. Obviously, the engraver of the marble plaque had spelt it ‘mainkind’ and the lead filling in the first i was laboriously removed when the plaque was installed. The plaque refers to ‘Room 000’ in which Haffkine worked. This forms the title of Kalpish Rata’s account of the plague epidemic that ravaged Bombay (present Mumbai) at the end of the 19th century. To the best of my knowledge no one has commented on either the error in spelling or the most unusual room number till these authors commenced their work.

Dr Swaminathan also finds divergence of opinions between her and Dr Syed invaluable in the writing of their books. ‘Our strongest suit is dissent. The more we disagree, the more we agree. It is dangerous on days when we agree, we know something disastrous is going to happen soon! Any process that works we don’t question it too closely. We are just grateful it works.’

Dr Syed is a renowned photographer and his images illustrate some of their books. He developed this art unaided by any teacher. When queried about his photographs, he merely points to the prints and says, ‘The pictures are there to explain.’ Perhaps to Dr Syed’s annoyance, Dr Swaminathan also educated me on his abilities with the artist’s brush and in calligraphy. She also credits him with the design of all their recent books.

Their interest in history is attributed to worry about events that led to developments in medicine. ‘What happened here? What am I standing on?’ Modestly—and perhaps erroneously—they attribute similar curiosity to most people and then state: ‘We had the luck of being able to look for answers.’ And find them in the most unusual locations and in difficult to locate works on science, medicine and history.

Social misbehaviour exasperated them. In an interview, Dr Syed echoed a sentiment also expressed by others. Dr Syed exclaimed: ‘The next World War is not going to be about Islam or religion. But water. We have a mindset of extractivism, take it out, use it, what you leave behind you don’t give a damn about.’ The hidden message in some of their books is that humankind must hold itself responsible for much of the disease and devastation that plague us now and will do so in the future. The overt message, of course, is the account of the lives and work of doctors denied their place in history.

What perhaps drives them most strongly is the thrill of the chase. ‘When we started digging, we found thrillers waiting for their place in history.

DOCTORS’ STRIKE

Mumbai faces yet another strike by resident doctors in public hospitals. The impending strike in July—as, indeed, earlier strikes—was provoked by the failure of the authorities (the Government of Maharashtra and the Municipal Corporation of Greater Mumbai) to maintain a dialogue with resident doctors and address, on a continuing basis, their needs and aspirations. There is a startling disconnect of the powers that be and workers in our public hospitals. Politicians and bureaucrats are cognizant of the existence of teachers and students in our public medical colleges only when there is a crisis that imperils their own equanimity.

A flood, a bomb blast or the collapse of one or more homes with consequent loss of life and limb activates our ‘public servants’, shakes them from their apathy and forces them to make a beeline for the casualty departments and emergency wards where they strut about posing for photographs and talk of how well the patients are being looked after. When the crisis is over, they return to their games of one-upmanship and manoeuvrings for power and pelf.

And then, of course, there are strikes by the residents.

Eventually, with newspapers displaying on their front pages the consequences of the strike in terms of deaths and worsening suffering of poor patients, the wheels of bureaucrat creak into action and a series of meetings are held with the strikers. Bargaining that would shame fisherfolk results in crumbs being thrown at the strikers with promises of more to follow. Along with the crumbs come threats of terminating their jobs, making it impossible for resident doctors to continue their postgraduate education and of eviction from their rooms in the hostels.

As the quantity of crumbs is increased and as the strikers reach the end of their tether, they accept defeat and resume work. Bureaucrats are well aware of the fact that resident doctors are short-stay professionals in transit in public teaching hospitals, that they have shallow pockets and that they have no powerful, potentially troublesome labour union.
Doctors return to their work, disgruntled but somewhat mollified. The administrators in government and municipal offices and the ministers in their palatial cabins heave a collective sigh of relief and return to their perennial machinations.

The cost of strikes is not paid either by doctors and nurses or by secretaries in ministries or by the ministers themselves. It is paid by the poor, who commit the crime of falling sick or getting injured in accidents. During the strike, the unlucky are turned away at the gates of the hospital. Those a little less unfortunate lie in corridors, outpatient departments, emergency rooms or on the beds in their wards. Their pain worsens: they die.

**REFERENCE**


**SUNIL PANDYA**

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**Letter from Ganiyari**

**MENTAL HEALTHCARE: THE TELEPSYCHIATRY WAY**

*Introduction: Setting the stage in Ganiyari*

It was 2008 when I, as a visiting psychiatrist, first interviewed patients with mental health issues in Ganiyari. I was amazed that in one morning I saw case after case of psychiatric illnesses that matched textbook description. I now realize that session was just a tip of the iceberg.

With a suicide rate of over 43 per 100,000 population (data collected by the community health programme at Jan Swasthya Sahyog [JSS]) in our programme area (versus Germany’s 12.4 per 100,000 population) or rural India’s 22 per 100,000 population (>15 years of age), we have a huge mental healthcare need. In Germany (where I also practise), there is a dedicated mental health workforce. For every 100,000 Germans, there are more than 13 psychiatrists and 40 psychotherapists, who are supported by numerous psychiatric nurses and psychiatric social workers. The situation in Chhattisgarh is soberly different. In 2014, several months after opening the new mental hospital in the Bilaspur district, all psychiatric posts (including chief of the hospital) were vacant.

Confronted with the burden of mental illness in the outpatient department (OPD) and in the programme villages, we decided in April 2012 to provide regular mental health service without a psychiatrist available on a daily basis. Over the past three-and-a-half years, we have developed a model of mental healthcare in Ganiyari. The time has come to share that model.

**Telepsychiatry: Can it work?**

Telepsychiatry has been shown to be feasible in a wide range of settings, for a number of psychiatric treatments, in different ethnic groups and populations, and in all age ranges. Psychiatry is ideally suited to videoconferencing: most psychiatric treatments can be adapted to telepsychiatry and the doctor–patient relationship can be developed. Telepsychiatry has no known absolute exclusion criteria or contraindications for any specific psychiatric diagnoses, treatments or populations. Schizophrenia Research Foundation (SCARF) in Chennai has developed a telepsychiatry component of its community outreach programme in rural Tamil Nadu. The service is provided on a custom-built bus that has a consultation room and pharmacy. This sustainable model has served over 1000 people with serious mental disorders over three years.

**Our experience**

At JSS we started our weekly telepsychiatry clinic in April 2012. This outpatient clinic is run under my supervision via Skype from Germany. Audiovisual consultations are provided using a high speed internet (2 Mbps) connection. The Team Viewer allows all parties to simultaneously see the same results from the electronic medical records (EMR). Besides the patient, a resident doctor or paramedic is present to facilitate the discussion and perform logistic work during the consultation. Diagnosis and treatment plans are made as a team, with occasional emergency consultations.

**Challenges**

Most of our patients have perhaps never used a computer or the internet. It takes time for both the medical team and the patient to get accustomed to Skype. Imagine a rural Indian patient coming to the telepsychiatry clinic for the first time. The patient enters the consultation room where a few individuals are sitting. They are silent and the computer monitor or iPad starts speaking to the patient. Experience has shown that it is critical to say the patient’s name slowly and deliberately. These changes often come at the expense of modulation of one’s voice, an important aspect of developing a clinical relationship during a psychiatric interview. Longer pauses between statements are necessary because of the small but perceptible delay in transmission. Sometimes it is difficult for me to focus on the patient. The iPad’s microphone amplifies noise and cannot filter it the way the human ear can. These seemingly trivial details—a closed door and a few people in a quiet room—are important to seek a diagnostic impression. For the past one year we have started using EMR during the Skype session. It has the disadvantage of making the picture of the patient small as the bigger part of the screen is used by the EMR window. On the other hand, it is a great help to look directly at the records, document history and findings of examination as well as prescribe medication and treatment.

Psychiatrists believe that there is a strong association between physicians’ communication skills and (i) patients’ satisfaction; (ii) patients’ adherence to treatment recommendations; and (iii) treatment outputs. A large part of this communication is non-verbal, and the situation is different in telepsychiatry. The audio and visual components of the conversation are often not synchronized. Each party views a two-dimensional picture of the other. The symmetry of the psychotherapeutic interview (an equal...