United Nations Educational, Scientific and Cultural Organization

UNESCO Chair in Bioethics University of Haifa

MUHS

Bulletin of GSMC MUHS UNESCO Bioethics Unit

October 2019

World Bioethics Day
14th October 2019

Theme : 2019

Respect for Cultural Diversity

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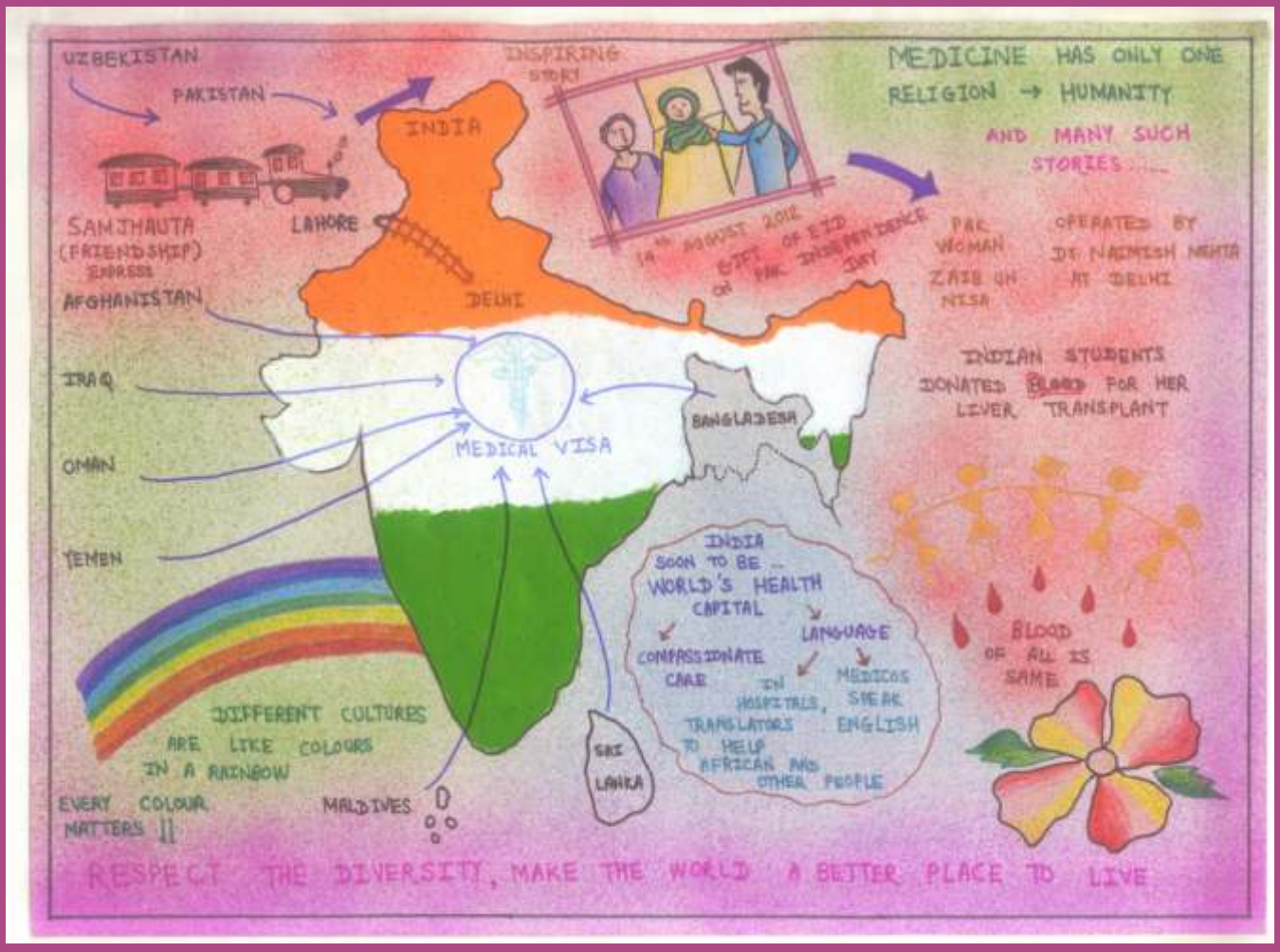
GSMC MUHS UNESCO Bioethics Unit

World Bioethics Day
14th October 2019

Poster Competition on
'Respect For Cultural Diversity '



First Prize

Prashant Saraf, First Year, MBBS

Introduction

Advances in biomedical sciences have made ethical lens imperative for medical practitioners, researchers and society at large so that adherence to moral values of beneficence, justice, autonomy in medical practice and research are up held.

Warren Reich's encyclopedia of Bioethics defines Bioethics as *'an area of interdisciplinary studies'* concerned with systematic study of human conduct in the area of life sciences and health care. Dr. James Drane calls the discipline paradigmatic because the dilemmas force the scholars to examine the essential life and death questions in the context of medical conditions. Scholars from diverse disciplines like philosophy, theology, sociology, law, biomedical sciences alongside medicine have contributed to development of the field. With their contributions to the development of bioethics core principles since 1960s, these streams have been instrumental in guiding medical practitioners towards rights based approach to health. So in way it is a union of the two trees of knowledge- humanities and philosophy on one side and medicine and biosciences on the other; that leads to growth of an integrated approach towards not only human but also environmental well-being and growth.

The Oxford dictionary defines the word *'Inarch'* as a plant graft created by connecting a growing branch without separating it from its parent stock. The term conveys the spirit of synergy between the two streams. Hence we chose this name for our bulletin which will bring to you articles on bioethical issues by medical faculty, students, ethicists, philosophers.

Our bulletin is intended for undergraduate, postgraduate students in medical, paramedical subjects and nursing as well as practitioners and teachers. It aims to open up discussion on ethics of practice, research, curriculum content and advances in biomedical sciences.

GGG

Editorial

The Current theme 'Respect for Cultural Diversities' is the foundation of medical ethics. Culture is hard to define and harder to have unanimity on about the scope of what it may cover. Ethnicity, gender practices, religion, language, art and more can be included in what makes culture. Each of these shape, modify, enrich and sometimes even hurt the cultural make up and integrity of society. Cultural intolerance acted out by some individuals to racial diversities marred India's image globally. Rejection of our own linguistically diverse countrymen for political gains has harmed our own economy and stability.

Need for diversity training was felt more than decade ago by Western medical universities. Curricula were rolled out, but synthesis of homogenous curriculum was not possible. Understandably so, as communities are different, cultures are varied, so one shoe cannot fit all. So customized curricula are required. Those too may undergo rapid change as the needs of the stakeholders keep changing.

Culture is a dynamic phenomenon. Canvas of culture is very vast and Indian cultural diversity is practically ever perplexing. Hardcore medical education has limited capacity to infuse cultural competence in a scholar. Probably, diversity education must start in premedical years. When a student studies health practices, disease responses, celebration of birth and acceptance of death on the backdrop of this knowledge of diversity, he/ she may be able to better relate to how and why his/ her patients, families of patients and communities around them, live, think, act and respond to their ecosystems.

Reflections on cultural encounters is a great concept to begin appreciation of culture. Ensuring cultural safety of the patient is to be demonstrated by a responsible teacher to his/ her students. Its relevance in successful management has to be discussed. A conscious teacher must take into account the informal learning that happens in the wards and OPDs. Role model in cultural competence is very important for a student to unlearn harmful culturally blind or destructive ways and to acquire cultural sensibilities. Mentoring of the students is an important responsibility of the medical teachers. In the global village of today, heterogenous populations come together in universities. A cautious and conscious mentor will continually introspect and confront biases within.

Psychiatric illnesses, fertility and infertility, terminal illnesses and death are all grounded in cultural make up of people. To give due regard to their beliefs, to understand taboos, to negotiate in a respectful manner is to ensure success.

Nurses are an integral part of medical team. They are, at most times, more nurturing, more tolerant and more close to the patients than doctors. They are advocates for patient needs. Cultural diversity training is relevant and important as India becomes a medical destination for patients from various countries.

It is a welcome move on part of Medical Council of India to add cultural competency in the core competencies in the foundation course recently rolled out for the medical school entrants. Sky is the limit for imaginative teaching of cultural diversity and competency. Integration of the impact of culture on various conditions should be done as an ongoing training in undergraduate and postgraduate teaching. At the same time a compendium should be prepared for teachers' training.

Appreciation of diversity is not a new phenomenon in Indian ethos. Our national anthem describes the cultural diversity and beauty of this great nation and we all must be proud of the rainbow of cultures Mother India has gifted us.

Happy reading!

- Dr. Padmaja Samant

United Nations Educational, Scientific and Cultural Organization

UNESCO Chair in Bioethics University of Haifa

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Message

It gives me great pleasure to know that the GSMC MUHS UNESCO Bioethics Unit is bringing out its Annual Bulletin INARCH 2019 as part of the World Bioethics Day celebrations 2019.

The World Bioethics Day celebrations are held on 19th October every year in conjunction with all the Bioethics units of the International network of the UNESCO Chair in Bioethics (Haifa). This year the theme chosen is Article 12 of the Universal Declaration on Bioethics and Human Rights, which is related to Respect for Cultural Diversity and Pluralism.

I hope that this year's theme will give us all a chance to reflect on the importance of cultural diversity and pluralism and also reaffirm a commitment to human dignity, human rightsand fundamental freedoms.

I am sure that all the Units of UNESCO's Chair of Bioethics throughout the world will developa series of initiatives to reflect, encourage awareness, debate and involve an ever-increasing number of people, towards these important and fundamental concepts.

I wish the GSMC unit all the very best in their future endeavours and may they continue to carry the message of the UNESCO Chair forward in the days ahead.

Best wishes

Professor Russell D'Souza MD
Melbourne, Australia

Municipal Corporation of Greater Mumbai

Seth G S Medical College and K E M Hospital, Parel, Mumbai

Dr. Hemant Deshmukh

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Dr. Hemant Deshmukh

Dean, Seth G.S.M.C. & K.E.MH.

Municipal Corporation of Greater Mumbai

Seth G S Medical College and K E M Hospital, Parel, Mumbai

Dr. Milind Nadkar

Message by Dean (Academic)

The whole purpose of bioethics discourse is to understand disparities, inequalities and existing health problems of the communities by joining the dots. The theme for this year's 'World Bioethics Day' is "Respect for Cultural Diversity" which is most fitting in that context. It is heartening to witness that enthusiastic teachers and students of our institute are holding events and competitions based on the theme and also releasing the annual bulletin – INARCH as per the tradition.

In today's fast paced world, it is vital that medical fraternity is aware of all the ethical dimensions related to healthcare and bioethics unit of our institutions is working towards creating the awareness among professionals and students

My best wishes to the Unit in all its endeavors.

Dr. Milind Nadkar

Respect for cultural Diversity: Minding the gap

Mariya Jiandani, Jyotsna Thosar
Physiotherapy School & centre,
Seth GSMC & KEMH

India is known for its rich cultural heritage as one of the most religiously and ethnically diverse nations in the world. Elements of India's diverse cultures, such as religions, philosophy, cuisine, languages, martial arts, dance, music and movies have a profound impact within and across the Globe. The culture of modern India is a complex blend of its historical traditions, influences from the effects of colonialism over centuries and current Western culture – both collaterally and dialectically.

Culture refers to an integration of learned behaviors ,norms, and symbols characteristic of a society that are passed from generation to generation. It includes fundamental values, beliefs, attitudes, and customs, including those related to health care and illness. Indus civilization which is the first civilization based on agriculture practice, shows evidence of plantation of medicinal plants and trees. "Ayurveda", a branch of ancient medical practice was multicultural in origin. "Yog" part of Indian culture promotes the purification of soul and body to head towards the healthy life. With migration and westernization cultural health beliefs and practices are speedily changing and evolving. However there still exists a struggle with being 'between cultures'– balancing the 'old' and the 'new'.

Diversity is a broad term with multiple meaning. For some it may simply mean differences or variation across individuals or social groups, for others it may mean differences that make a difference may be with unequal access to power, resources etc. In health care it generally implies difference from the norms (majority). It can be both visible or invisible. Visible refers to race, ethnicity, age, physical appearance, language? and gender. Invisible refers to differences that are not readily evident such as sexual orientation, class, religion, illness and occupation. Visible differences cannot be concealed and are open to stereotyping and discrimination. Invisible differences have the option whether they should be disclosed or concealed depending on one's own comfort and the reaction of health care provider.

Changing demographics underscore the importance of cultural competence in a profession where the patient-centric approach is the key to determining the quality of care. Both healthcare professionals and patients, are influenced by their own values and respective cultures. Areas where different perspectives can affect health care include beliefs related to conception, birth, sexuality, causing of illness or disease, its expression and experience, choice of health care, roles within the family, death and after life. At times as providers we may be culturally blind. Ethnocentrism refers to the belief that one's own cultural values, beliefs and behaviors are the best and superior. The bias thus created may result in very different perception and preferences related to health. Problems arise when ethnocentrism and bias are so strong that we are unable to consider other view- points. In order to reduce disparities in health care related to ethnic and racial differences , it is important for policy makers from management , government and academe to identify their perspectives on the field focusing on health care policy, practice, and education. Example -Religious observance and practices as certain dates of importance may choosen for surgery, specific prayer times, prayer methods, astrological beliefs need to be considered. Being aware of and negotiating such differences are skills known as 'cultural competence'. It has evolved from older terms such as "Cultural Sensitivity", "Cultural Awareness" and "Cultural Skills".

Cultural competence refers to an ability to interact effectively with people of different cultures. Hudecek (2001) cites five essential elements of cultural competence that health care providers need.1) valuing cultural diversity. 2) Capacity for cultural self- assessment.3) Awareness of inherent dynamics when cultures interact 4) institutionalized cultural knowledge. 5) Developing adaptation in service delivery that reflects understanding of cultural diversity. In order to understand and effectively interact with people across cultures, one needs to be culturally competent. It simply means accepting the different ways in which the world is viewed.

To increase acceptance of diagnosis and improved treatment adherence, one needs to develop awareness of a patient's culture to promote trust. Cultural

competency in health care can be defined as having the appropriate knowledge and skills to deliver care consistent with a patient's cultural beliefs and practices. In doctor-patient relationship, as a provider one has to understand the values and beliefs of the individual with whom they are working. Whether they are primarily 'collectivist' or 'individualist' can help health professionals with diagnosis and with tailoring a treatment plan that includes a larger or smaller group. Indians view the needs of the individual in the greater context of family, culture and environment. As a result, family members, especially elders, can have a strong influence on decision-making related to health matters, including informed consent. Developing rapport, collecting and synthesizing patient data, recognizing personal functional concerns, and developing the plan of care for a particular patient requires cultural competence. For example, knowing that coin rubbing is a traditional Asian healing remedy, Patient refusal of medical treatment believing that God will heal them, Muslims refusing to plan for death as it would challenge the will of Allah, unwillingness for stoma would change approach to patient care. Linguistic competence involves communicating effectively with population which is diverse with low literacy skills and disabilities. It also conveys respect for the community. It requires a mental shift that frames diversity competency as a means to address quality health outcomes for all, rather than an end goal in itself.

The following suggestions for interaction with a culturally diverse population have been adapted from Burton and Ludwig:

Acknowledge your own cultural beliefs and biases

Address the patient with appropriate title. First names should be used only with the patient's invitation to do so. In Maharashtra it is customary to address elderly as Aji /or Baba.

Respect the individual's beliefs and attitudes regarding health care, traditions, and religion.

Use common proper terms with avoidance of slang language.

Use an interpreter in case of a linguistic barrier.

Eye contact should be used cautiously as it may be perceived as disrespectful or a challenge to authority.

Learn to identify cues of communication on patient's facial expressions and nonverbal communication.

Seek clarification if you do not understand something that the patient has said.

Cultural competence has been described on continuum that ranges from cultural destructiveness to cultural proficiency (Cross 2001). The extreme negative end highlights attitudes, practices, organizational policies that focus on superiority of one culture. It can occur in an individual patient health care provider encounter where insensitivity and prejudice impedes health care and moves from incompetence to destructiveness. Creating new knowledge and innovative practices to ensure high quality health care with an understanding the positive role that culture plays leads to cultural proficiency.

In order to provide optimal care, it is essential to develop cultural competence at individual, organizational and systemic level. It is important to be culturally sensitive in identifying identities and understanding that not all share the same beliefs regarding health and illness, nor do they agree on what is an appropriate treatment for a disease. Everyone has preferences, and accepting cultural diversity does not minimize our own values. We need to ask ourselves "Why do I believe, think or act what I do in this situation? Would someone else do the same or do it differently?"

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The Pains and Gains of Democratisation of Medical Education

Neha Madhiwala

Introduction

Equalising opportunity in higher education through preferential admission to students from socially disadvantaged groups is now an integral part of education policy in most liberal democratic societies. Worldwide, social and political struggles have pointed out to the fact that higher education has been accessible primarily to the dominant groups in society, perpetuating disadvantage and inequality. Therefore, a demand to enhance the participation of traditionally disadvantaged groups in higher education is made, not merely to benefit those individuals alone, but as a pathway to greater social change.

There has been a general expansion of higher education among the lower castes, minority groups and women, particularly in regions with higher concentrations of urban and urbanising regions.(1) There has been a gradual linking of aspirations for social mobility and status to professional education among groups hitherto not participating in higher education. Thus, for castes which primarily engaged in agriculture, trade or craft, producing professionals such as doctors has assumed a significance much beyond the material returns that can be derived from it. For traditionally marginalised groups, medicine continues to have value as a means of gaining status and a secure, middle class life. Apart from the prestige of being engaged in an intellectual, technology invested occupation, medicine retains its association with service and public life, imparting prominence and influence to successful entrants and their community.(2)

However, is the education, training, socialisation and professionalisation of diverse students a straight forward process? In this commentary, I drawn upon my doctoral research to probe this question.

At present, government policy does not go beyond equalisation of opportunity at admission. After that, it is left to the institution to deal with the material that is handed to it. Once admitted, a new hierarchy is established based on a single rank obtained in the entrance test. Although there is enough literature to show that multiple-choice questions-based tests do not evaluate higher level learning skills required for professional education, but simply test memorisation skills and 'exam-cracking' skills, rank has become imbued with a lot of moral meaning. Rank, as a context-free, abstract unit of measurement, does not account for the vastly different worlds from which the aspirants were drawn. If anything, it is simply co-related with the ability to pay for coaching classes and having enough family support and a peaceful environment for exam preparation. Despite this, it is assumed that high rank holders among the general category (implicitly being upper caste) are intrinsically more 'meritorious' than those who hold lower ranks, but are admitted through quotas.

The metropolitan government medical colleges (MGMC), where these trends converge, is, therefore, an interesting place to study the pains and gains of democratising medical education. There has not been sufficient research into the social composition of students, but all evidence suggests that present day students are highly diverse, in terms of their caste, regional and religious backgrounds. More than ever before, they are first generation professionals, with no prior exposure to medicine as a profession. The government medical colleges, apart from its diversity also have an exclusive status as an enclave where scientific medicine is practised. Free from the compulsions of profit-making and somewhat protected from state neglect by their political importance, these are spaces where teachers and students can be committed to science and act only motivated by the interest of the patients.

Diverse students in the MGMC

The metropolitan government medical colleges (MGMC) are products of a complex history. Beginning out as colonial or nationalist projects of modernising healthcare, they represent more than simply training centres for future medical practitioners. These institutions are invested with the ideological goals of philanthropy, science and nation-building. In the present day, they have been decentred by the onslaught of private medical colleges, who drain their faculty and, lately, also usurp their prestige

and cause the politicisation of education administration. This has led to more inclusion, but also more corruption and political interference. Even so, they remain the hallowed halls for a new middle class, non-metropolitan, non-elite and, often, non-modern, who seek to fulfil their individual and collective aspirations by acquiring their training and certification here. They bring with them a host of challenges, a lack of history in higher education, poor basic education, poor grasp of English. At the postgraduate level, they also have additional problems to contend with, poor basic medical training and lack of a professional ethic.

Contrary to common belief, reserved category students did not 'grab' seats in the most prestigious colleges even when these were available. The most marginalised students in this study voluntarily chose non-Mumbai colleges for their under-graduate study as they felt daunted by the city. Many chose district towns closest to home.

For small town students with middle class backgrounds, they will prefer a college in Pune, even if they are getting admission in a Mumbai college. Pune feels a little more like your own home-town. Its less scary. Again, getting hostel accommodation in Mumbai is difficult. Parents feel scared about their child staying in Mumbai outside (in private accommodation) if they can't get a hostel room.

For the students who do choose a Mumbai college for their UG, the cultural clash is quite significant.

I had never used jeans or shoes up till 12th, because I used to stay in a small city. There was lot of cultural difference, then again the language; we used to speak Marathi with friends and all. Even our teachers would teach us in Marathi more than English.

The training experience at MGMC

Many of the students had a negative experience during their under-graduation training, which increased their determination to seek admission to a MGMC. As first-generation students from small towns, it is only after they enter medicine that they become aware of its intricacies. They are able to evaluate the quality of training that they are receiving. Moreover, they gain the confidence to move to a large city. Apart from better facilities, they had been given to understand that there was more professionalism and active teaching in Mumbai.

However, at the MCMC, they describe a very regimented working environment and very functional interactions with the faculty. These contribute to making the training experience rather impersonal. The main attraction for students is being exposed to a vast range of cases and being taught protocols for management. This is sharp contrast to what older students describe. They described their unit/department as a family unit. They talked of 'loving the teachers' and, in turn, receiving love from them. They could name individual teachers who they felt had shaped their identity as doctors. While the work routines that they describe are quite similar to what residents experience today, they remember acts of kindness, or efforts to individuate and support students, or risks taken by faculty to protect them.

We used to be very fond of our teachers. And let me tell you, my teachers used to come in the evening and take classes, they were all honoraries. See, how much love they had for the students! So they would come in the evening at 7 O' clock, (and) they will take (lectures) till 9 O' clock. And then we all will (sic) go and attend. In gynaecology there was a doctor who was taking (evening lectures), in medicine there was a doctor taking (evening lectures). (There were) more than one (such) doctors. So they all used to teach with lots of love and affection. So we learnt how to love your students and then how to teach your students. That extra mile, you go to teach them, "see, this is how I have seen… when you give this, this happens, even though it is not written in the books".

This does not imply that erstwhile teachers were more benevolent and better human beings than today's teachers. Several changes have taken place in the MGMCs. Firstly, the locus of power has shifted to the university, outside the college. It has less control over admission, assessment, curriculum or teaching. What this has led to is a certain bureaucratisation, with specific norms to be met, reports to be filed and procedures to be followed. These are the inevitable consequences of standardisation. Secondly, teachers and students alike have not been formally oriented to deal with diversity, unlike in the developed countries, where institutional mechanisms are in place to teach cultural competency and buddies to support junior students, support systems for ethnic minority students or socially disadvantaged students which help them to adjust to the college environment.

So, everyone must cope as best they can with the situation. Given the highly competitive environment

of the medical college, its not surprising that there are strong biases on all sides. Social prejudice merges with rigid hierarchies to create a hostile environment. As faculty has little direct contacts with junior residents and interns, a considerable amount of power gets vested in relatively inexperienced supervisors, like the registrars.

Many ways are there, they can harassyou. Like they will not leave you for food, they will not let you sleep, they will tear off your papers, "ye galat likha hai, wapas likh". Yhey will make you sit 24 hours in the ward, they are given all powers, and you cannot complain about them. Registrar can harass the residents.

Critical perspectives on medicine

To add to the administrative and institutional problems listed above, there has not been much change in the way medicine is taught in our colleges from the earlier understanding that medicine is an exact science and the ideal doctor is one whose life is dedicated to the pursuit of knowledge. The invisible side of the image of medicine is that it was dominated by the elite, whether it was white men in the West, or upper caste urban men in India. They did not have to worry about making ends meet, their families were looked after by their wives and their social standing allowed them to mingle as equals with the elite in society. Today's doctors are a very different breed. Many are women, who are rushing home to take care of children and households, many are paying back loans and pulling their families out of poverty, many come from families and communities that still face a lot of social discrimination.

Also, diverse professionals bring a lot of new knowledge to medicine. For example, Men and women have different understanding of the body, disease and health. There was a time when it was believed that women's mental health problems were linked to their reproductive organs. It took a century of radical research and protest to prove otherwise. Likewise, in every aspect of medical knowledge, culture has a role to play. For instance, how we understand pain, or how we cope with disease, what we know of plants and herbs. Also, not everyone can or needs to fit into the stereotype of the ideal doctor.

Globally, it is now understood that difference is not necessarily an impediment to the formation of a professional identity and can, in fact, contribute to making medicine more relevant and humane .(3) While women doctors were the first to assert their right to be both women AND doctors, medical students today organise to assert several different identities, based on race, ethnicity and sexual orientation.(4) The literature emerging from these movements has greatly enriched the theory of professional socialisation, contesting long held views and values. However, much of this knowledge has passed by medical education in India.

The challenge, therefore, facing our medical colleges today is complex. However, instead of seeing it simply as a problem, if medical colleges were to look at increasing diversity as a success of democracy, it would pave the way for a more fruitful engagement with students. Their experience can enrich the discipline of medicine. They bring new vocabularies, life experiences, sensibilities and approaches. While it is common for colleges to be nostalgic about their past, a critical look at the present may reveal that the future need not/can not look like the past. However, in the future, the college may actually be a better, more equal and more just place than it has ever been

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Cultural Competence: Healthcare beyond Medicine.

Dr. Trupti Ramteke, Assistant Professor, Dept. of Biochemistry.
Dr Karuna Nadkarni, Associate Professor, Dept. of Occupational Therapy
Dr Padmaja Marathe, Professor (Additional), Dept. of Pharmacology and Therapeutics.

William Osler rightly said, "The good physician treats the disease: the great physician treats the patient who has the disease".

In order to alleviate suffering and offer relief to a patient, a physician must understand his patient well. The process of understanding the patient should go beyond diagnosis and treatment. Communication, building trust and rapport are crucial steps. Cultural competence is an attribute which can help a physician break barriers in the way of understanding the patient.

Culture isa heterogeneous mixture of ethnicity, language, traditions, beliefs and practices. Many cultural factors including different beliefs about causes of disease and death; beliefs and approaches to healing practices and health promotion impact health. In a country like India with 22 major languages and 720 dialects, communication difficulties resulting from language barriers and cultural differences can affect accomplishment of healthcare goals. Hence it is essential for health practitioners to bridge this gap in practice to get the true essence of cultural competence.

Cultural competence is not only the understanding and awareness of cultural diversity bt also combination of knowledge, attitude, skills and behaviour required for a healthcare provider to provide optimum health care to patients. In multiculturalism, diversity is a reality and many cultures with varied ethnicity, sexual orientation, gender, religion, class and socioeconomic status coexist with the influential culture. Respecting cultural diversity and considering this aspectshould be integral aspect of medical practice. A health care provider should be able to recognise, protect and preserve the cultural ethos and dignity of patients.

The Cultural Competence Continuum [1]: It is a 6 stage continuum that explains the unhealthy and healthy values and behaviours of persons, policies and practices of organizations. The first 3 stages show cultural incompetence while the last 3 move towards cultural competence.

Cultural Destructiveness: Attitudes, policies and practices destructive to other cultures, dehumanising of other people, assumptions of superiority. Example: undervaluing the role of traditional medicine (Ayurveda ,Unani)

Cultural incapacity: Unintentionalsuppression of other cultures, creating fear and a paternalistic approach.

Cultural blindness: Cultural differences are ignored. 'Treat everyone the same way' approach is detrimental as it may ignore needs of non dominant cultures.

Cultural Pre-competence: Cultural issues are explored. Needs of individuals and communities are considered.

Cultural Competence: Individual and cultural differences are recognised. Advice is sought from diverse groups. Unbiased staff is hired.

Cultural Proficiency: Itis ability to build strong cross cultural relationships through effective communication skills. Staff trainings are conducted.

Culture is dynamic and evolving constantly. Narrow focus on our own cultural norms which may be completely different from another's may lead to misunderstandings, misinterpretations, loss of productivity and exclusion and ultimately health disparities.

Cultural Competency and Applications: [3]

Knowledge base: Cultural Competence requires knowledge of cultural diversity, self awareness, compassion, authenticity, humility, openness,

availability and flexibility. One needs to examine one's own biases and prejudices toward other cultures and develop skills to conduct cultural assessment in sensitive manner during cultural encounters.

Language: Using simple, understandable dialect or effectively using an interpreter is helpful. Clear doctor-patient communication during exchange of vital information is necessary for an effective treatment.

Physical Interaction: Non-verbal communication in form of physical interaction comprises of eye contact, space, touch frequency and gestures. For rapport building and positive treatment outcomes, the practitioner should respect and follow cultural norms.

Introducers of Cultural Proficiency in Healthcare in Rural India:

There are some philanthropic institutions and doctors working for the welfare of the rural populations in India. They could successfully overcome cultural barriers and revolutionise healthcare for the poorest people of India.

Life Saving Dot [4]: Neelvasant Medical Foundation and Research centre, Nasik along with Grey Group Singapore, initiated the Life Saving Dot program for the women in rural areas of western Maharashtra. The women in these areas fighting Iodine deficiency were provided with scarlet bind is having adhesive covered with 150-200 micrograms of iodine. It works on transdermal dispersion technology, where in, a woman wearing the iodine bindi absorbs on average 12% of their daily requirement of iodine.

Dr. Abhay and Dr. Rani Bang [5]have been working in Gadchiroli, Maharashtra through their non-profit organisation SEARCH since 1985. They regularly organised summits called "People's Health Assembly" where they brainstormed with the tribals on what they wanted and what their major concerns were. The Bangs focussed on demand-driven health care. Tribal people had fear of big buildings. They likened the doctors and nurses in white coats to ghosts and refused to seek help from them. Keeping in mind these cultural taboos, the Bangs built their hospital in the form of small huts acceptable to the tribals.

Dr. Bang noted infant mortality due to pneumonia as a major concern in the community. Babies and mothers, after delivery, were confined to small, dark, damp rooms and were not allowed to leave the room for a one and half month to avoid the evil eye. This deprived the new born babies of necessary medical care. Attention to this cultural taboo led the Bangs to create **'a home-based package of neonatal care'** provided by meticulously trained and equipped village women called community health workers. The infant mortality rate dropped from a staggering 121 in 1988 to 30 per 1000 live births in 2003. WHO and UNICEF endorsed their approach of home based care for the neonates. This revolutionary healthcare model is being replicated in other parts of India as well as in Bangladesh, Nepal, and many African countries.

Dr Prakash and Dr Mandakini Amte[6]started **'Lok Biradari Prakalp'** in 1973 for integrated development of Madia Gonds, the primitive tribals of Bhamragad in Gadchiroli, Maharashtra. The Amtes overcame the language barriers by learning local Madia language. Dr. Prakash Amte also started wearing half pants and vest to be one of them. They went from village to village in search of the sick. Madias had more faith in the local quacks, and believed in witchcraft and mantras and refused to take help from the doctor couple. It took a lot of time and effort before the tribals trusted them and started to seek medical help. The Amtes also built residential school for children of tribal people. They received the 2008 Ramon Magsaysay award for Community Leadership, in recognition of their compassionate interventions.

Dr. Ravindra and Dr. Smita Kolhe[7] improved health outcomes in Melghat Maharashtra and helped the tribals there to gain access to electricity, roads and primary health care. They identifiedmalnutrition and poverty as the root cause of death. So along with successfully treating diseases, Dr. Kolhe studied

veterinary science and agriculture. He developed fungus resistant seeds and organised camps to raise awareness about new farming techniques. They themselves started farming to create a role model. The revolutionary farming techniques helped villagers to fight poverty.

Dr. Ashish and Dr. Kavita Satav[8]have been working in tribal region of Melghat for 20 years through their trust MAHAN to reduce the mortality rate in reproductive age group. Their focus is on malnutrition, anaemia, tuberculosis, pneumonia, hypertension and heart diseases. They adopted around 100 villages where their interventions brought down the mortality by 50%.

The Roadway to Cultural Competence:

Asking right questions respectfully can be useful to reveal the cultural attributes of health and open communication channels.

The 4 Cs of Culture [9] are developed by Slavin, Kuo and Galanti to help clinicians to remember the questions to ask their patients to understand the their perspective.

What do you **call** a problem? (What do you think is wrong?)- patient's perception of the problem.

What do you think **caused** the problem?-patient's beliefs regarding the source of problem.

What have you done to **cope** with the problem? (Home remedies, traditional healers etc.) Action the patient has taken.

What **concerns** do you have about the problem and the recommended treatment?-how the problem interferes with patient's ability to function and acceptability ofthe recommended treatment.

Berlin and Fowkes' LEARN model [10] describes similar steps of culturally competent engagement with patients-

Listen with sympathy and understanding to patient's perception of the problem.

Explain your perception of the problem.

Acknowledge and discuss differences/similarities

Recommend treatment.

Negotiate treatment.

We learn from the exemplary work by the doctors mentioned above that acquisition of cultural competence requires hard work but it is not impossible. As said by Audre Lorde, “It is not our differences that divide us. It is our inability to recognise, accept and celebrate those differences.”

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Legal Medicine in Relation with Respect for Cultural Diversity

Dr. Shashank Tyagi

Introduction:

"Bioethics is still largely entangled in an asocial, acultural, and decontextualized philosophical, moral, and legal discourses. It has yet to investigate comprehensively the social and cultural realities that matter to diverse patient populaces "[1].

The United Nations Educational, Scientific and Cultural Organization (UNESCO) defined culture as follows: "... culture should be regarded as the set of distinctive spiritual, material, intellectual and emotional features of society or a social group, and in addition to art and literature, it encompasses lifestyles, ways of living together, value systems, traditions and beliefs"[2]. There are legal and ethical considerations to take into account when working with diversities. Here some such issues are deliberated upon.

Human Organ Transplantation :

One of the challenging issues for medical teams in organ transplantation is the religious and cultural viewpoints about organ donation among different populations [3]. It is well-known that these beliefs in religious countries, particularly in Asian regions, play a pivotal role in behaviour and decision making regarding organ donation [4]. However, few efforts have been made to promote a positive view of organ donation.

There are numerous examples of positive attitudes towards tissue and organ transplantation in religions. As an example, in The holy *Qur'an* (The holy book of Muslims), it is well-illustrated that removing organs, as the only way of treating the ailment, can be acceptable and the donor and their family members must give the necessary consents to do so [5]. Islamic jurists permit living and cadaveric organ donation.

In Jainism, compassion and charity are the mostimportant tenets. Organ donation has been widely supported by the Jain community leaders [6]. It has been reported that in Mumbai, Jains and Gujaratis have a lion's share (85-90%) in all organ donations including eye donations[7]. Gujarat has madehugestridesin eye donation program especially since Jain communityconsiders eye donation as a supreme form of charity.

In Hinduism, the physical integrity of the body after death is not considered important [8]. Hindus value reincarnation and prolonging life which allows for many individuals to agree with organ donation .

There is a strong belief in Hinduism that Atman- soul is immortal and death is like a change of old clothes for the soul. Hence after death, the body is insignificant. Numerous other faiths hold similar views.

Altogether, cultural and religious views have important roles in the formation of beliefs about organ donation. By considering diversities in this regards, health professionals are able to react properly. Also, providing an opportunity to consult with a religious leader about organ donation can help families passing through hard circumstances in order to make the best decision.

Cultural beliefsstrongly influence transplantation decisions due to its complexity and the ethical issues at every step of transplantation process.

Clearinsights into cultural influences and respectful counselling are means to success of organ donation programs. Cadaveric donation is culturally difficult to accept in the Far East. In the Middle East, live donor organ transplantation is primary form of transplantation despite religious acceptance of

cadaveric donation. Due to shortage of organs, Kuwait and Iran have introduced the concept of "rewarded gifting" for the living donor and for the family of the deceased donor [10].

Initial public misgivings about brain stem death, cadaveric donation and subsequently living donation, have been set aside as no major religion around the world forbids living or cadaveric donation. Still,culture majorly influences the way in which organ donation developed in different regions across the globe. On a positive note, organ transplantation has overcome cultural barriers and is giving more and more patients a new lease for life.

Medical Termination of Pregnancy:

Religions have ideas about the subject of personhood. The fetus is a human person just after ensoulment takes place. Ensoulment is breathing the soul by God into the fetus. According the Roman Catholic Church, the ensoulment takes place just after conception. According to most Islamic schools, however, the ensoulment takes place 4 months after conception. According to these beliefs, Muslims and Christians have their own ethical opinions and judgments about the abortion, assisted reproduction and contraception. These opinions should be respected and their believers should be free to practice based of them [11].

Distinct cultural differences between the states in northern India and the states in southern Indian have important implications for abortion seeking behavior. There is some evidence that the incidence of legal abortions is higher in the south than in the north [12]. For women in northern statesinduced abortion is more often viewed as one of the forms of birth control, whereas induced abortion for those in southern states, it is more often viewed as a remedy for contraceptive failure []. Generally, sociocultural differences between northern and southern India translate into overall women's equal status and lower levels of son preference in the south. These underlying cultural and contextual influences on southern and northern women's behaviour should result in important regional differences in the predictors of induced abortion [13]. The underlying cultural and contextual factors result in important differences in the predictors of induced abortions in the states. The other reason could be that the southern states have higher women's literacy rates and development indices, which means they may have better and more effective contraceptive use. It was also anticipated that there would be less variation in abortion-seeking behavior across different groups of women in the southern group of states than in the northern group. The perception of small family norm is comparatively a new occurrence in the northern states of India, which gradually emerged with increasing women's education and employment. The diffusion of the small family norm, however, is greater and already existed for southern women in contrast to northern women [14,15].

Euthanasia:

Despite the heavy emphasis on intensive care and medical interventions, most people around the world die at home without any medical intervention. Not surprisingly, the economic wealth and cultural heritage of the country are most important determinants of where people die.

Culture creates the context within which individuals experience life and comprehend moral meaning of illness, suffering, and death. It influences the process of patient and family's communication with physician and decisions in the end-of-life care[16]. For instance, in India, where illness is more a shared family affair than an individual one, a physician is likely to respect the family's wishes and withhold the truth about the diagnosis of a fatal disease to the patient while in Germany a physician is legally required to inform the patient about the disease. Similarly, while advance directives are virtually non-existent in India, in Germany they are regarded as mandatory and health care is covered by insurance.

In relation to the acceptance of euthanasia, because

of secularisation, religious people in the Netherlands tend to be more liberal and progressive as compared to countries where there is still a more conservative religious climate like Italy, although Christian people in the Netherlands are still more likely to be against assisted suicide when compared to their non-believing fellow countrymen [17].

POCSO:

The Protection of Children from Sexual Offences: The POCSO Act 2012 defines a child as any person below the age of 18 years and provides protection to all children under the age of 18 years from sexual abuse. The minimum age of consent for sexual intercourse was raised from 16 to 18 years only in November 2012, when this Act came into force.

Exception 2 to Section 375 (rape) of the Indian Penal Code, which permits "intrusive sexual intercourse with a girl aged between 15 and 18 only on the ground that she is married.

Child marriage is considered illegal under POCSO act though in India, it has sanction under certain personal laws, thereby creating a deadlock between secular laws and personal laws. Age below 18 years is the only criterion under POCSO for consideration of a minor . Under sections 4 and 6, having sexual intercourse with a minor is punishable. However, unlike in case of rape under IPC, the consent clause is not included here. Thus, even consensual sexual intercourse is punishable. According to some personal laws, marriage is valid with a person below the age of 18. Hence, physical relations between a man and wife who have not attained majority according to the Indian legal standards is perfectly valid as per the personal laws. But, POCSO doesn't make any such exception. The conflict between the two laws is likely to arise, wherein one allows 'child' marriage, but the other criminalises it. Moreover, the problem worsens by the presence of another conflicting law. The Prohibition of Child Marriage Act, 2006 defines a 'child' as one who has not completed the age of 21 in case of males and the age of 18 in case of females. POCSO does not distinguish between a male and a female child, but the 2006 Act makes this distinction, leading to a conflict. The three laws viz., the 2006 Act, POCSO and the personal laws, together lead to confusion due to the conflicting legal prepositions.

In many countries age of consent is 16 or even less.Many American states, Europe, Japan, Canada, Australia, China and Russia belong to this category. As per National Crime Records Bureau data, about half of the POCSO Act cases fall in the age group of 16-18 years. Removing cases of consensual sex under this category can help a better focus on sexual assault cases.

In some countries, one has to be married before you have any sexual relations (Iran, Pakistan and Saudi Arabia). In other countries, one can have sex from the age of 11 (Nigeria) and quite a few countries allow the age of consent to be 13, including Japan and Niger. For many, such low age of consent is unthinkable. But this variationis a reflection of traditions and culture of a community.

Perhaps the laws of consent need to be more flexible and realistic to ensure that young people are protected and seek ever needed advice on safe sex without fear.

Conclusion:

Transparency, education and communication will bridge the gap between cultures and will ensure the success of medical endeavours but it requires a global effort and cooperation which must stretch beyond geo-political, economical and cultural barriers.

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Importance of cultural competency/ diversity in nursing practices

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Introduction- Cultural competence in nursing practice is the cornerstone of providing complete care for people of all cultures. It is relevant in our everyday lives, but even more so for nurses who regularly care for patients in their most vulnerable state. As a nurse, main focus is on provision of skilled patient care to the best of one's ability. As the cultural landscape of our world continues to diversify, cultural competence in nursing practice has become more relevant than ever before. When patients enter medical care, they may be highly stressed because of pain, nerves, fear, and worry. If they are accompanied by family members, sometimes, the stress may be intensified as these emotions are compounded. This is the critical time when empathetic nursing intervention gives a moral boost to the patient.

Cultural competence is defined as the ability of providers and organisations to effectively deliver health care services that meet the social, cultural, and linguistic needs of patients.

Cultural diversity is the existence of a variety of cultural or ethnic groups within a community. Cultural diversity of a community indicates need for effective care for patients who come from different cultures. In nursing, it requires sensitivity and effective verbal and non-verbal communication. In nursing, cultural competence as allows one to comfort those with different beliefs and gives the nurse an opportunity to provide care at the highest level. Distinct cultural practices may influence the care plan and even how a patient perceives his or her illness. This is another reason why effective nursing and cultural competence go hand in hand.

Inculcation of Cultural Competence in Nursing Practice

Through years of research and education, many medical scholars have shared knowledge and techniques that nurses can employ to practise cultural competence.

1. Knowledge

Nursing and culture cannot be separated. Culture is incredibly important while dealing with stoma patients. while marking a stoma, cultural upbringing around self concept, religious practice etc. are to be considered. Culture has influence on people's help seeking behaviour, coping styles, social supports they have, and how much stigma they attach to an illness.

2. Attitude

Attitude plays a large role in the ability to become and serve as a culturally competent caregiver. In case of a nurse, attitude refers to a level of self awareness and awareness with respect to stereotypes, rules of interaction and communication customs in a community. Being sensitive to

other cultures allows a nurse to plan the best care for patients. for example, during pre-op counselling maintaining eye to eye contact with patient increases trust. But in some Asian cultures, eye contact may indicate rudeness, and patients, out of deference may avoid eye contact.

3. Skills

Developing a cultural competence skill set can be accomplished by focusing on skills like communication and conflict-resolution. Clear communication between different cultures during medical treatment is critical. An example of culturally competent communication is making an effort to use layman's terms with patients and their families who do not speak dominant native language. Medical terminology can be difficult to understand in one's own language, let alone a foreign language. Medical encounter also involves learning to adapt to new and different situations. Hospital environment may not be a familiar ground for patients; especially when it's outside the realm of their cultural identity. In such a case, if there is a language barrier during counselling, one can use non-verbal communication or if required take help of a translator. Even some disabled patient learn pouching by tactile exploration.

Toady's nursing practice is faced with increasing challenges in delivery of culturally competent services to patients from diverse cultural backgrounds. Whatever the setting, a nurse must have the ability to identify cultural differences among the clients. It is expected that a nurse be aware of demographic differences, diverse beliefs and norms, diverse practices in different communities and take community perspectives into account in health care delivery. Cultural competence is an inalienable part of health care and goes a long way in eliminating of racial and ethnic health disparities.

A nurse should be able to utilise cultural assessment skills in the work setting.

Cultural awareness and competence has become imperative in Healthcare delivery because of population diversity, competitive health care market, regulations on discrimination and litigious society.

It is essential for nurses, as part of the health care delivery system to be aware & knowledgeable about the unique cultural issues related to providing care and treatment to people from different cultures.

Nurses need to know how to adapt their skills and duties to the diverse cultural needs of each client. Use of these skills could involve attitudinal and behavioural changes that will enable nurses to engage patients and families more successfully.

Component of a cultural assessment include :

1. Where the patient was born & how long he/she has resided in the country.
2. Ethnic and religious affiliation.
3. Patient's major support system.
4. Primary and secondary language and non-verbal communication style.
5. Food preferences and taboos.
6. Economic situation and adequacy.
7. beliefs and practices related to health, illness, birth & death.

Nurses are patient advocates and they can effectively bridge the gap between doctors, health systems and patients.

Ways to provide culturally competent nursing care and enhance their presence in the global nursing discipline.

- Obtain a certificate in cultural competence - Knowledge and skills can be enhanced through cultural competence training, workshops, or seminars. Journals, textbooks, and the internet offer information that can help improve cultural competence.
- **Improve communication and language barriers.-** Increasing proficiency in the local languages helps in accessing and assessing a culture. One can also use pictures, gestures, or written summaries to improve communication with patients and reduce language barriers.
- **Directly engage in cross-cultural interactions with patients-** Understanding that each patient is unique can help nurses effectively interact with patients.
- **Online networking-** Online networking can have a great influence on improving nurses' perceived cultural competency and cultural awareness and keeping them up-to-date on cultural competency issues.

Conclusion

As nurses become more aware of the diversity and needs of various cultures, it becomes necessary to create within ourselves the tools needed to ensure that every patient receives the highest quality care available. Knowledge of each patient's cultural needs for the healing process enhances the potential to create an environment of safety and satisfaction for patients, families, and within ourselves, while providing an essential aspect of holistic healing for the patient. To become culturally proficient is truly a dynamic learning experience. Consistently working towards being culturally competent is an exercise in compassion and respect.

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Cultural Diversities Discourse in Medical Education

Dr. Padmaja Samant

"Human diversity makes tolerance more than a virtue; it makes it a requirement for survival."
-Rene Dubos

Abstract: Ethnic, religious, linguistic, gender and sexual diversities make up cultural diversities. Orienting medical students to 'Cultural Diversities' and inculcating Cultural competence in them is a felt need acknowledged by medical institutions across the world. Though the underlying ethical principles of respect, dignity, autonomy, non maleficence, justice remain the same; diversity issues in different geographical and cultural areas differ. So, the curricular content may vary a little. Here we discuss the need of inclusion of diversity acknowledgement in the formal curricula and curricular delivery methods. The informal transfer of attitudes in managing diversities and the required caution is also discussed.

Background: Though bioethics as an academic enquiry started in the sixties, the diversity competencies discourse started in medical education in last 30 years. The gender inequities and discrimination in medical service provision was rejected by the civil society and social science researchers; and demand for reforms started. Gender in medical education culminated in reorienting teaching. In Indian context, the Pre conceptional and prenatal Sex Detection act had to be brought in to regulate gender discriminatory sex selective abortions. Civil movement for acceptance of sexual diversities culminated into the law recognising gender diversity. Hence, diversity-inclusive medical teaching is the need of the day.

The need:

A major short coming in the conventional curriculum is that Medicine is taught as hard science; a science of human body and organ systems, diseases and treatment. Human mind, emotions etc. have been taught mainly subject of inquiry with respect to mental illness. Responses, and behaviour pertaining to illness, birth, death, fertility, infertility, sexuality are considered to be universally similar while teaching. Hence culture as a societal traditional process and its impact on health is ignored.

Secondly doctors are actively taught to be neutral. Gender neutral, culture-neutral stance of conventional formal medical curriculum has been responsible for culturally incompetent medical practitioners and culturally insensitive practices.

Hence, inclusion of competencies addressing respect for cultural diversities is a timely and welcome step by the Medical Council of India. 'Demonstration of understanding and respect of cultural diversities and development of skill to interact with those with different cultural values' is a competency added in the foundation course designed for the preclinical undergraduate medical students.(1)

The global village phenomenon: Industrial and scientific advances and rapidly developing commerce have made the world 'a global village'- homogenous in some but heterogenous in many other ways. Migration of people from across the globe created racially, linguistically, religiously and culturally diverse communities. It may not always be visible but culturally embedded value systems of societies cause either acceptance or rejection of the 'other' populations making them vulnerable to

discrimination and injustice. Cultural practices of these vulnerable populations affect their health seeking as they find the health systems culturally unsafe.

Health care delivery to these communities is inadequate if the health care providers are not culturally aware and competent. It is not only unethical but also creates an economic burden as the health problems are incompletely addressed.

The scope of cultural diversities in the western medical field is much wider and distinct from Indian medical field. For example, United States of America have Caucasian, Chinese, Hispanic, Asian communities. It has been estimated that By 2050, the proportion of racial and ethnic minorities will be about 35 percent of the elder population in the United States of America.(2) It is imperative for the health systems to take into account linguistic and cultural barriers to care of the ethnically diverse ageing population with chronic health issues.

In 1993 General Medical Council recommended that Cultural diversities be included in the medical curricula.(3) The Liaison Committee on Medical Education(LCME) made cultural competency a mandatory competency in all medical schools in the United States and Canada.

Teaching models:

Both, formal and informal curricula must accommodate 'cultural diversity and competency training' at undergraduate as well as postgraduate levels. The scope and depth at the two levels may vary.

The teaching tools can include anthropology, sociology, philosophy texts as well as other literature and art in various forms. Humanities have abundant material from which universities on the broader scale, and individual teachers on a personal scale may select material.

Dogra and colleagues (3) described various 'cultural diversity teaching models' in medicine and nursing that have been tried and critiqued over years. They observed that there was lack of uniformity of policy, theoretical basis and modality in teaching cultural diversity.

These issues persisted in a review five years later.(4) Conceptual clarity is hard to develop and the programs are bound to vary. It is obvious that each country may have some unique features to their programs.

University Kebangsaan Malaysia has included a module on Diversity Managing in the personal and professional development training for the medical students.(5) They have adopted a combination of multiple teaching learning methods including lectures, movies, video clips, small group discussions to sensitise the students. The training is spread from preclinical to clinical years.

Considering the Indian scenario, people are racially homogenous except in a few states; but traditional, linguistic and religious diversities may be extreme depending on the state and multiple models may be required to address the diversity issues. Hence, the most viable method seems to be teaching the students the skills of reflection on their own values systems and biases.

Narratives and reflections are very potent in increasing understanding and sensitivity to cultures. Diab and colleagues emphasised that the relevance and authenticity of the clinical encounters used in collaborative reflection helps in bringing out the nuances in cultural diversities.(6) Curiosity adds to cultural knowledge and awareness. Nonjudgemental and respectful approach break barriers in communication and make the cultural encounter a positive and mutually fulfilling one.

Indian medical schools, for last some years, have started getting a socially, linguistically diverse pool of medical students. After the recent MCI mandate (1), many medical schools must have just started

skimming the surface of the very complex 'Diversity' phenomenon with newly enrolled medical students. These students have not closely seen the inequities in health but they are exposed to various social inequities. Appropriate examples and innovative use of popular media including movies has proven a good way of introducing the concept of cultural diversities. Indian culture defines Indian movies and Bollywood movies influence cultural adaptation and shifts too. These are a popular and easily relatable resource on cultural diversities. An important element is the language in which one emotes and expresses personal beliefs and experiences. Spaces to express cultural encounters in one's own language may have dual benefit. It may make the content unedited and richer; secondly, peer learning about diverse languages and their nuances may bring the students closer and help them appreciate diversities better.

Informal curricular delivery:

Informally occurring skill transferin clinical settings has a very strong influence on students. An important fact to remember is that 'physicians' are also a cult. They develop a particular philosophy towards life, health, pain, death, infertility, sexuality …. anything that comes under their control. With the philosophy comes elitist attitude that then reflects in elitist behaviour. So, even if a physician and a patient belong to the same culture and/ or the same linguistic group; the physician still thinks, accepts and rejects emotions, beliefs and values differently from the patient. It may be due to 'medicalisation of a person' or plainly, desensitisation. It may not necessarily reflect in rudeness or bluntness; just that the thinking processes are different. In some cases, it gives the physician a different and more objective view of the ailment, but in many others, this difference may be counterproductive and results in a breakdown of dialogue with the patient and the family. The skill to know when one should let go of the objectivity and allegiance to the science of medicine; is actually the art of practice too. This particularly applies to situations like terminal illness, fertility regulation and death where the responses are influenced by upbringing. An insensitive and blunt communication is likely to be considered fashionable and a norm. Glamour attached to the profession makes medical students learn the impersonal objectivity demonstrated by teachers and sometimes, the cult practice much faster. So, teachers must be extremely conscious of their power to influence the students and what impact informal commentaries on culturally diverse populations may have.

Students may not have the maturity or the lens to focus on the discerning approach of the guide or mentor. Active discussion and reflection is a helpful tool for the teacher/guide/ mentor teaching the medical students. Sheriff laid stress on cultural humility as a valuable ability to self critique in a cultural encounter and institutional philosophy of nurturing individuality and autonomy.(7)

Lastly, like the healthcare beneficiaries, majority of medical students are from diverse backgrounds; especially in large universities. Mentoring faculty may have to nurture and engage with mentees from diverse cultural backgrounds and should be aware of their own cultural biases.(8)

Conclusion:

Diversity training is the need of the hour. Multimethod training that the students can relate to at ethical and spiritual level should be used to enhance their pre existing sensitivities and sensibilities.(9) Collaborative reflection promises to be a good way of introducing cultural diversities and competencies.

Each society may have different diversity issues. The local diversity issues should be included alongside global ones in medical education to make it more relevant and productive.

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Diversity and Inclusion which are the real grounds for creativity,must remain at the center of what we do

Marco Bizzarri

C C C

Philosophy in Healthcare

Dr. Venkatesh Rathod
Dr. Nayana Ingole

"A man without ethics is a wild beast loosed upon this world." – Albert Camus

We live in an extremely diverse world today and these diverse microcosms adopt diverse views about existence, right wrong, good bad etc. In essence, they have different philosophical views of life. The Universal Declaration on Cultural Diversity describes cultural diversity as 'the common heritage of humanity'. It states that cultural diversity is necessary for civilisation as biodiversity is for nature. and that its defense is an 'ethical imperative inseparable from respect for human dignity.'

Bioethics and medicine continues to struggle with the problem of cultural diversity. Cultural diversity is something that decision makers in bioethical context- doctors, nurses, policy makers should try to understand , respect and protect in every possible way.

There are numerous sociocultural and religious, political and philosophical differences among societies such as India, China, Japan, United States and others. Unlike in the west, all individual health decisions are also made in consultation with family. To many Eastern cultures, Western bioethical principles like individual autonomy are not very acceptable.

Philosophy is study of fundamental nature of knowledge, reality, and existence, especially when considered as an academic discipline. In many civilisations like Hinduism, spirituality, religion and philosophy cannot be segregated unlike in the west.

Hence there is a debate about applicability of western bioethics to non western societies.

Philosophy as a discipline:

Greek philosophy is the earliest documented western philosophy dealing with Metaphysics and Ethics. Socrates, Plato and Aristotle were the famous philosophers who had distinctive ideas about politics, science and ethics. Socrateswas one of the founders of Western philosophy, and as being the first moral philosopherwho deliberated on ethics. According to him, "virtue is knowledge and it can be taught".

Philosophy of Medieval Europe: It deals with question concerning religion, God and belief. Although it saw some great development in logic, it is closely linked with Christianity.

Modern philosophy: Scientific philosophy developed in England, Germany and France. German idealism is most famous . This matured into **Contemporary philosophy** with the increasing professionalism of the discipline focus on analytic philosophy.

Indian philosophy: It focuses on many concepts such as dharma, karma, reincarnation, dukkha, meditation with almost all of them focusing on the ultimate goal of liberation of the individual- nirvana- through spiritually sound lifestyle. Hindu philosophy is different from western as it is intuitional.

The philosophical basis of healthcare: The ethical or moral premises of health care are complex. For any geographical area, the philosophy of health care is rooted in human societal structure. The philosophy of healthcare is primarily concerned with questions such as: who requires or deserves healthcare? What should be the basis for healthcare budgeting? How can healthcare reach the greatest number of people? How is quality assurance in research maintained? At some point in every person's life, a decision has to be made regarding one's healthcare. Can they afford it? Do they need it? Where should they go to get it? Do they even want it? And it is this last question which possesses the biggest dilemma facing a person.

Epistemology: A branch of philosophy of medicine concerned with knowledge. Knowledge is of three types: knowledge of acquaintance, competence knowledge, and propositional knowledge. These correspond to namely, knowledge, skill and application.

Metaphysics; In medicine, Metaphysics deals with causality of health and disease.

Ontology of medicine:A branch of metaphysics dealing with the nature of being. Ontologies related to medicine are:

(1) Ontological revolution – that helped development of modern science.

(2) Cartesian dualism – differentiates mind and matter (human body) into two independent principles and states that Medicine simply investigates the body as machine. To some extent this philosophy restricted holistic view of disease and approach to practice.

(3) the monogenic concept of disease informs about the underlying mechanism of the genesis of disease.

(4) 'Placebos' and 'placebo effects' are contextual and may have meaning to patients depending on their belief systems.

Medical ethics: Ethics is the study of human conduct.UNESCO has been promoting universal bioethical norms and principles, and assisting countries in the translation of those principles into concrete policy outcomes.

Medical ethics is specifically focused on applying ethical principles to the field of medicine. Medical ethics has its roots in the writings of Hippocrates and the practice of medicine was often used as an example in ethical discussions by Plato and Aristotle. Writings of Charaka Samhita, Sushruta Samhita are the Indian counterparts of Western ethics writings.

Political Philosophy of Medicine: There has long been a debate regarding the private versus public nature of health care system. Both have their own advantages and limitations. The national healthcare service in the United Kingdom has been appreciated for fewer variations in health outcomes and being affordable but it has also been criticized extensively for the long waiting lists. In the United Sattes, majority of people are covered by insurance, but often the poor people have to depend on charity to pay for their healthcare. India has a combination of both public as well as private healthcare system. Mahatma Jyotiba Phule Jan Arogya Yojana is an example of government funded health insurance scheme for the poor.

Business Ethics; Numerous factors like consumer protection act, frivolous lawsuits, introduction of Clinical establishments act and ISO certifications; costs of healthcare have gone up. There is a raging debate on what good-quality healthcare means. Does more expensive healthcare mean higher-quality healthcare? It is an undeniable fact that certain minimum standards of quality must be met for all patients regardless of health insurance status. In India, to reduce the cost of health care, generic medicines have been introduced. Netherland has done away with all accreditations. Also, the concept of Stewardship of resources is finding favour wherein it is recommended that the least costly treatment should be provided unless there is substantial evidence that a more costly intervention is likely to yield a superior outcome.

Culture and Medicine; Culture can be subjective and objective. Subjective culture is the intangible part of culture, which could include ideas, attitudes, assumptions, and beliefs. Objective culture refers to products made by man, such as dress and tools. Both play a major role in healthcare system. The demand to be treated by a lady doctor, the refusal to disrobe, the refusal to accept blood transfusion or the refusal feed the colostrum to a new born; are all part of the cultural beliefs and taboos of a particular community or geographical area and often hinder optimum patient

management. Some detrimental practices like female genital cutting threaten lives of girls and women. If we say culture is dynamic, progressive changes must be hailed and propagated by the gatekeepers of cultures.

Aesthetics: Aesthetics is concerned with beauty or the appreciation of beauty. It is said that "beauty lies in the eyes of the beholder". The definition of beauty varies in different parts of the world – from the current trend of 'Size zero' in the Modern world to voluptuous woman in the Eastern culture. The long-necked women of Myanmar, stretched earlobes and a shaved head in Kenya and other parts of Africa, lip stretching in parts of Africa and South America, tattoos in New Zealand, and small feet in Japan – some of these may be detrimental to health too. A medical commentary on these practices has to be unbiased and nonjudgemental and give hard facts to the society about health hazards.

Philosophy and medicine have had a long history of overlapping ideas. The philosophy of healthcare is strongly interlinked with the social structure and geography. This has often led to contrasting ideas and views. Culturally acceptable health intervention should be the new mantra of practice in the midst of these contrasts.

In the meantime, one should remember Kant's famous statement: **"Act only according to that maxim by which you can at the same time will that it should become a universal law."**The morality of an action, therefore, must be assessed in terms of the motivation behind it.

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Reflection of Cultural Diversity in Issues of Dying and Death

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Introduction:

Death! Is there anyone who does not fear it? Maybe a yogi or a fool. Does anyone understand it? Again, truly nobody understands it. Talk of cultural perspectives of the death and there are a plethora of ideas and aspects including those about afterlife.

The medical definition of death is 'the irreversible cessation of all vital functions especially as indicated by permanent stoppage of heart, respiration and brain activity'. Even though by this definition, death means end of life, certain individuals and group of people perceive it differently. The reason for such differences lies in religious, spiritual and cultural background of these individuals or groups. The cultural background and cultural beliefs are a significant factor in the understanding of the way people perceive and react to death or even explain the issues of death and dying.

Terminal moments:

Some communities desire to get their priests to bless the soul at departure. Facilitating suitable arrangements is the least medical facilities can do for the families. Many large institutes and even corporate hospitals have prayer places for the families to attain composure in hard times.

Varied concepts of death and life after death:

The concepts of death, after lifeand rebirthare different in different cultures. There is belief in passage to heaven and hell as against the concept of rebirth. Hindu culture believes that we take rebirth to settle our karmic accounts and once we are free of all debt, we attain Moksha.

There is also this contrast of considering death as the final end as against being a step of transition to another forms of life or rebirth. There are also cultures that vouch for a constant interaction between the living and the dead.(1)

Cultural competence is important and expected from healthcare professionals while dealing with the end of life care and issues related to death. All health care interventions and especially those towards end of life aim at reducing suffering due to illness or deferring death.

The interventions include medications and technological innovations such as cardiac pacemakers, respiratory support, antibiotics to treat infections and cardiopulmonary resuscitation. (2)

Rituals:

Rituals around death are as varied as the cultures. Burial, burning, leaving the bodies in the towers of silence are some of them practiced in India. Knowing what the wishes and needs of the bereaved families are is very crucial and appropriate questions may be asked in a sensitive manner to handle the bodies.

Interventions:

Performing surgeries and blood transfusions are amongst the life-saving interventions in emergency situations. Different cultures have their own belief systems that usually determines acceptance or non-acceptance of a particular medical intervention. There is inadequate awareness among medical professionals about the culture related issues involved in end of life care. The western culture individualism values autonomy and views death as a failure. They prefer to use modern technologies to save lives. Here the patient is told about his/her critical health condition directly. Here, autonomy and self-determination are taken into consideration. Whereas eastern culture collectivism values beneficence over other ethical principles. Mainly in Chinese and Indian culture, the critical health condition is not directly communicated with the patient. Here in this case, the family plays an

important role in decision making about end of life care. Western culture demands use of modern technologies to prolong life whereas certain eastern cultures view death as natural and inevitable and have accepting attitude towards death.(3,4)

The Chinese culture has great respect for 'the learned' which includes doctors also. This culture expects the health care provider to act as patient's family member, protect the patients from harm and bear patient's burden of illness.(5)

There is a sectamong catholics known as Jehovah's witnesses. These patients do not accept blood transfusion. This practice could be fatal in emergency situations demanding blood transfusion to save the life of these patients. On the other hand, they accept organ transplantation and red blood cell depleted stem cell transplants.(6)

Organ donation:

This is an important aspect associated with the process of death. Certain religions do not allow organ donation after death due to strong cultural beliefs pertaining to death and life after death. Organ donation is not preferred in Jewish, Buddhist and Native Americans.(7)

There are many advances being made in the field of health care. Many of these advances are technology based, all of which are trying to improve diagnostics and treatment. With such advances is coming unpleasant fact of commercialisation of health care. There have been thus a steady rise in the number of litigations against hospitals by disgruntled utilisers of health care who feel cheated, not only financially but also in terms of wise selection of treatment choices. In such a scenario, will the doctor who is required to modulate decisions in near death situations be well motivated to do so? One can only hope for that degree of motivation.

As culture plays an important role in the medical decisions of patients, the knowledge of cultural beliefs can improve communication between doctor and patient or their family members. It helps in providing culturally sensitive care towards end of life. We have been able to overcome the beliefs about organ donation by pointing out that one saves lives through it and can continue to help other individuals by doing it. Similar ideas can be used to get by cultural variations and improve healthcare acceptance.

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C C C

Cultural Diversity and Mental Health

Dr. Ajita Nayak
Dr. Avanti Rave

Strength Lies In Differences Not In Similarities
- Stephen Covey

Introduction:

Cultural norms have always served as a guide for what is acceptable behaviour and emotions of an individual. Cultural diversity, which exists across the world has a significant impact on mental health practice and it needs to be considered in various aspects of prevention and cure of mental illnesses. Even the latest form of classification system Diagnostic and Statistical Manual of mental disorder - 5 has acknowledged and included Cultural Formulation Interview (CFI) as a diagnostic tool. This interview stresses the importance of considering the cultural belief while diagnosing and treating psychological illness.

Each culture has a unique approach towards mental health, what gets defined as mental illness and treatment seeking. For example in certain cultures or religions it is embedded since childhood that it is a sin to commit suicide; as a result we statistically see less number of patients committing suicide in that particular culture. Many theories of psychiatric practice have emerged from Western cultural traditions and understanding. It takes a reductionist approach, and mind and body are considered clearly distinct. Whereas in Chinese medicine a disease is a product of lack of balance between 'Yin' and 'Yang' pathogenic factors. In Indian Ayurveda, mental health is considered a product of Karma and balance between 'wataa' that is air and 'Swabhav'. Both Indian and Chinese medicine don't make demarcation between mind and body; patient is treated as a whole. Recent studies in psychosomatic medicine and psychoneuroimmunology substantiate positive results if a composite of body, mind and environment is considered.

The impact of diverse cultural origins are observed in multiple aspects concerning mental health (fig 1).

Pathogenesis:

The perception of etiology of psychiatric disease can be very different across cultures. In some cultures the onset of mental illness and initial symptoms are attributed to possession by spirits, evil eye or black magic or even breaking of taboos. Possession by deity which would be diagnosed as dissociative disorder however is a normal belief in India. The fate of these patients is placed in the hands of faith healers or elders of the community who in turn will operate at their level of understanding. Thus healing temples of Indian pilgrimage sites are visited every day by thousands of people experiencing mental health issues. These beliefs though not encouraged should be accepted as part of tradition.

Cultural diversity not only affects expression of illness but also contributes to the vulnerability. For example Jewish or Christian culture encourages social and controlled drinking of alcohol. Hindu and Muslim cultures have been averse to same. Thus its consumption is not socially controlled. So although the total number of users is less, heavy drinking is much common. Cannabis use is considered a part of religious or cultural experience in most parts of North India and is available in vicinity of temples. Also consumption of Bhang or cannabis is common on Holi festival. So careful history taking is important without labelling or passing judgement.

Stressors:

Stressful events are major precipitatory factors of mental illness. Different stressors have to be identified and dealt with in a non-judgemental way to alleviate patients suffering and symptoms. For example migration is a stressful event and has a great impact on mental health. In India the migrant population from native place to metropolitan cities work at the lower end of labour market with lower pay and mostly on contract basis. India being so diverse, they may not identify with or relate to new culture.

These inequalities affect their mental health. They have greater exposure to racism, discrimination, violence and poverty. Some cultures place stressful events as normative. For example menarche or coming of age rituals. Careful evaluation of the stressors may help optimising treatment.

Help seeking patterns:

In many cultures mental Illness is not considered as a disease. Instead they are often considered as weakness of willpower, personality problem or evil forces. These people will first visit temples. Keeping this in mind and respecting their cultural values many institutions have opened "Dava and Dua" centres i.e. medicine and prayer. So patients can have their rituals but at the same time can also receive pharmacological treatment.

Stigma:

Stigma is perhaps the greatest challenge faced by both patients and mental health professionals. Most communities devalue and discriminate against a mental patient. Mental illness seems to reflect poorly on entire family, marriage and economic prospects. Shame may lead to patients hiding symptoms and seeking help after illness becomes unbearable. People with conservative background may not be open to talk about sexual problems. So it is important to spread awareness about availability of treatment for such problems in a way that is acceptable to this population.

Manifestations Of Emotional Difficulties:

In western countries mental health patients present with more cognitive-based symptoms whereas in India moreover in North and North Eastern region patients seek help for psycho somatic complaints. It is imperative to remember this because patients with depression may complain more about headache, body aches, dizziness, generalised weakness more than mood symptoms.

The institution of marriage and gender roles also differ in different cultures. Prevalence of emotional disturbances arising out marital conflicts and divorce differ.Asexpressing these conflicts may be considered a taboo in Indian culture, these traumatic effects may go untreated.
Sexual disorders too need to be explored with sensitivity as Indian culture does not encourage sexual expression. Individual privacy and confidentiality become paramount in such patients especially those suffering from STDs and HIV. Sexual orientation issues should be dealt with in a culturally appropriate manner.

Culture bound syndromes: Clinicians need to be aware of various culture bound syndrome . As a result of globalisation, urbanisation these syndromes are no more culturally bound but are culturally influenced. Most common in India is the Dhat syndrome, where patient presents with vague psycho somatic complaints attributed to semen loss in urine or masturbation or nocturnal emission. Detailed psycho education, reassurance along with pharmacological treatment is of importance without disrespecting or outright rejecting the ideas patient grew up with. There are other culture-bound syndromes like genital retraction seen in China and Malaysia; Sleep paralysis and BOUFE DELIRANTE (sudden outburst of aggression, confusion and psychomotor excitement) in South Africa and Amok dissociative disorder seen in South East Asia. With rapid migration, it is imperative for clinicians to equip themselves with knowledge of all syndromes and how they change presentation over time. Rigid One Direction approach will not help but it should not lead to over diagnosing certain disorders.

Therapeutic interventions:

Psychological mindedness andcultural background should also be considered while making choice of treatment modality. Psychotropic drugs have been considered toxic, unnecessary and with a lot of side-effects for the longest time. Clinicians are trying their best to spread awareness about newer safer options. Although, there is a silver lining when it comes to rich Indian culture in the form of yoga and meditation. People are more accepting towards these techniques and these techniques are practically very effective along with medication In patients with mild anxiety and depressive symptoms these relaxation technique are sufficient therapy. . Psychotherapy which forms a significant part of treatment in neurotic disorders is

more acceptable in the western cultures. Being able to recognise and talk about their emotions and psychological conflicts is more acceptable in western culture.

Family support and extended family system common in India where people are more accepting can have positive effects on mental health. Grandparents looking after the grandkids apart from primary caregivers act as safety net for child's mental health. As compared to western population very few geriatric patients in India live alone.

PREVENTION:

Various cultures provide a positive protective aspect to members of its society. A strong social network form the framework of each cultural group. They share the same experiences and beliefs which provides a sense of belonging. It improves the resilience and coping in the individual. This leads to building an emotionally strong personality during the development stages of a child. It canact as a prevention mechanism against mental disorders.

To conclude, Holistic medicine does advocate a bio-psychosocial spiritual model to understand etiology and develop a multipronged treatment approach for all illnesses. With use of positive protective aspects of culture and with a strong backbone of science, mental health professionals can promote mental health by empowering and educating people to take control of their lives and more adaptive ways to become more resilient.

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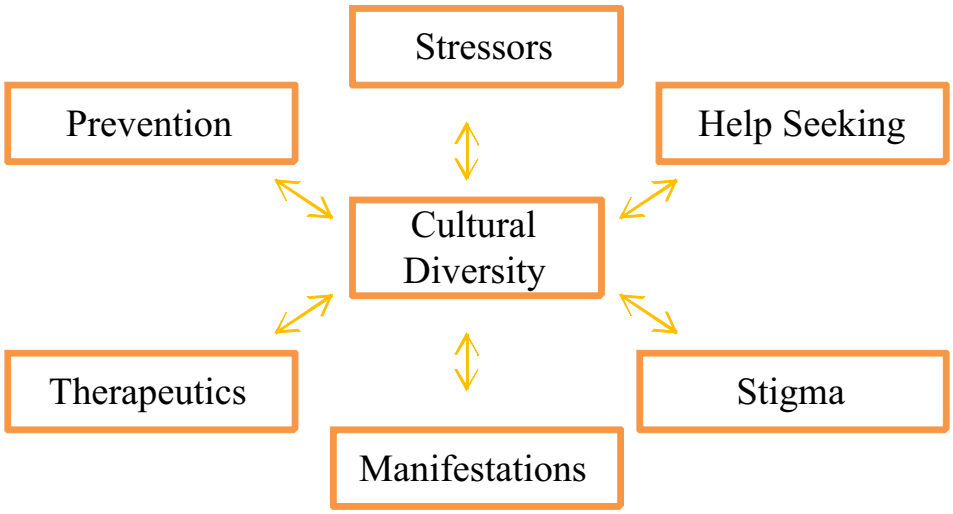
FIGURE-1



SNEHA

Dr. Armida Fernandez

As the city of Mumbai prospers, half its population (6 million) has no choice but to live in heavily congested and neglected informal settlements, where poor hygiene, lack of resources and limited knowledge threaten people's health every day. Health enables people to build better lives, and is the foundation of children's ability to learn. If this cycle of poor health is not broken now, future generations will continue to remain excluded from the economic development. **SNEHA (Society for Nutrition, Education and Health Action)**was thus found in 1998 by a group of leading Neonatologists, headed by Dr.Armida Fernandez, with the aim to break this cycle of poor health givingvulnerable mothers and children an opportunity to lead a healthy life. She believed that to bring about a substantial change in the health status of the most vulnerable communities, it is necessary to adopt preventive strategies that encompass health and nutrition education.

SNEHA's vision is "Healthy Women and Children for a Healthy Urban World" and our mission is to work in partnership with communities and health systems building effective and replicable solutions, empowering women and their families in urban slums to improve their health.

SNEHA thus works across the following four large public health areas, seeking to improve the health and nutrition of women and children, living in the most vulnerable urban informal settlements:

(a) Maternal and Newborn Health
(b) Child Health and Nutrition
(c) Sexual and Reproductive Health in Adolescents and Gender Equity
(d) Gender-based Violence against Women and Children

SNEHA's integrated life-cycle approach seeks to break the inter-generational cycle of poor health, a major by-product of poverty and deprivation. Its life-cycle approach intervenes at critical junctures: adolescence, pregnancy, child-birth, post-partum and early child-hood, to bring about improvements in health and nutrition of communities, living in the margins of a mega polis, for which health might not be a priority.

SNEHA uses a two-pronged strategy across its programs: We work with vulnerable communities, to improve health-seeking behaviour and awareness of health services; we also work extensively with public health systems and health-care providers to improve service delivery through training, capacity building and advocacy.

SNEHA uses the concept of 'Appreciative Inquiry', to engage with public systems, such as government health and nutrition workers and the Police, to effectively identify a common vision and work towards concrete goals, to bring about significant shifts in public health service delivery. Our tested approach of delivering interventions through partnerships with existing public infrastructure enables us to leave behind sustained impact within the infrastructure, as well as reach a scale that would be unimaginable working on our own.

A combination of electronic documentation, in-house research and partnerships with leading academics has enabled SNEHA to develop a strong evidence-based approach to design and implementation of its programs. Our electronic data collection and data-driven approach also facilitates feedback into program implementation that helps regular monitoring and evaluation of our interventions. University College London is a full-time research partner and has partnered with us to deliver

pioneering interdisciplinary initiatives, including two randomized control trials and a public-engagement art project. Our Research from field interventions is featured in renowned international journals such as British Medical Journal, Lancet, and Global Public Health etc.

In the financial year 2018-19, SNEHA directly reached out to a beneficiary-base of over 250,000, across the Mumbai Metropolitan region, through a combination of interventions including referral networks, home-visits, crisis intervention, counselling and group education classes. SNEHA also conducts extensive mass education through campaigns on infant and young child feeding, healthy pregnancy, healthy cooking, safety, sexuality, gender-equity etc. and reached out to a population of almost 750,000.

SNEHA believes in creating models of excellence in public health by working directly in and around Mumbaiand scale these models through partnerships with Government agencies and other Non-Profits in other geographies. SNEHA had partnered with the Central Government's 'National Health Mission' to form over 9000 Women's Health Committees across 95 urban areas in Maharashtra, to empower women to address the health needs of their communities. SNEHA has also formed partnerships with other Non-Profits as “Technical Partners” to scale our evidence based models and impact women and children in Bihar, Jharkhand, Pune and Gujarat.

Our governing board includes experts from diversified fields like doctors, finance and Management professionals who bring in their skills and experience to support SNEHA's interventions. Our team comprises professionals from a wide range of backgrounds committed to bring in large impact in public health.

SNEHA's work has also been awarded and recognized in various forums. In 2019, SNEHA received the Outlook Poshan award for its immense work in Child Health and Nutrition in urban slums. SNEHA was one of the Finalists andhad a special mention for Sandvik India Diversity Awards in 2017. SNEHA received the Woodpecker International Film Festival Award for Best Film in the category of Health and Sanitation in 2016. Hindustan Times awarded SNEHA the Changemaker award for Mumbai and it also received the Ahtesab Humanity Award in 2015. Vodafone Foundation Mobile for Good Awarded SNEHA for building the first app for crowdsourcing violence in 2014. SNEHA received ICICI CNBC TV India Inclusive Awards in 2012.

SNEHA being one of the leading players in urban health will continue to focus on:

a) Creation of evidence based models of urban health intervention in Mumbai Metropolitan region
b) Scaling these models across India through partnerships with Governments and other NGO's
c) Advocacy and informing policy at state and national level

Cultural Encounter In Residency : Art of Practicing Science

Dr Divya D'silva,
Dr Manan Trivedi.
(Residents, Department of General Surgery, KEM)

The language of patient management is that of warmth and care , the culture which combines all involved together is that of compassion.

Usually we consider relation between a doctor and patient, doctor and fellow doctors as an individual sample , however the core of practicing medicines lies roughly around accepting / respecting the difference we harbour and yet not let it come in the way of a harmonious decision making and the most important of all Patient Care .

Our experience at KEM , as General Surgeons has been exhilarating , on a daily basis we come in contact with patients who belong to various parts of the country , who speak different languages, different dialects of the same language, having a very different cultural and intellectual background, YET the same medical problems !

However , the bigger challenge is to be with our fellow colleagues, who we practically live with each moment in the hospital, back at the hostel, and they become such integral part of our lives , they have this entire new set of cultural variation, contrasting habits , which is so new to us, yet we slowly learn to accept it , and they start accepting ours, making this beautiful blend of cultural secularism personally and professionally .

Intrestinglly , there was a patient we had to do a bilateral above elbow amputation , in view of wet gangrene of his upper limbs. As you can imagine, how devastating it got for the patient and his family , as he was the only working member of the house and everything he had was at stake. The patient hailed from west Bengal and could speak only in Bengali. It had become a really difficult task to convey to the patient and his family about the consequences of the surgery, its impact on his day to day life.

However with the help of a Bengali speaking intern we got through the consent part of it. But of special mention is the fact that post operatively the patient stayed with us for around 20 days. And in the mean time, we learnt the basic questions we needed to ask him on rounds in Bengali and the patient , with the help of his fellow patients learnt some part of hindi and Marathi. The patient was sent home with bilatral limb prosthesis and as functional a limb we could provide him with. He has just one thing to say, people here at our hospital, did and learnt beyond what is expected out of them just to help him, and he is going to be forever grateful about it, Its been two years since his surgery, but the patient still keeps in touch on every "DURGO PUJO" and we cannot help but be extremely grateful to all the gods up there, for letting us do what we do !

Medical proffesion is the one that is teaching us diversity is the art of thinking independently TOGETHER .

I would like to conclude by quoting , John F Kennedy " The wave of the future is not the conquest of the world by a single dogmatic creed, but the liberation of diverse energies of free nations and free men"

Doctor Patient Relationship Resolves All Differences

Dr. Dhaval Vasa
(Resident General Surgery, Seth GSMC & KEMH)

"Diversity underlies the difference in the way we hear patients' stories, approach problems, speak and interpret the same information"

The journey of residency for three years is an amalgamation of various cultures and etiquettesfrom the perspectives of managing patients, interactions with the patients and their relatives and interactions between colleagues, seniors and juniors.
Patients from all over the country come with a ray of hope to find a cure for their problems. They belong to different cultures, following different traditions, speaking various languages. The bond between a patient and a doctor is unique. As clinicians we are able to read the shine of hope in the patients' eyes when they confront us even without a compatible communication

I recollect a patient of mine; a young female who had consulted me in OPD with chest pain and was diagnosed to have a mediastinal mass. She spoke only Kannada and could not speak or understand other languages. Her husband a cable TV operator, who accompanied her, spoke Kannada and very little Hindi. She was in the ward for more than a month and was investigated and even operated for the mediastinal mass. The only reply she gave every time I asked her about her health was, "nanuchenagiddine" which means 'I am fine'. The bond which had formed between her family and me was such that even a simple eye contact and exchange of expressions it conveyed all the symptoms. Even today she comes with her husband for follow-up, she says, "nanuchenagiddine". Such is the bond between a physician and patient which overcomes all diversities if treated with compassion and care. We come across such culturally and diverse situations all the time in our profession. At times we do not understand the patients background, and snap at their behavior. But this patient taught me the importance of not only clinical signs but also emotional signs which helped me to manage her post-operatively. I remember my seniors lines; "a lot is picked up by the look of the patient".

Doctors are required to be competent not only in medicine but also in communication and caring for people with different disease burdens, socio-cultural realities, expectations, values, and beliefs. Culturally competent physicians enrich patients experience and thus prevents the mis-trust among doctor and patient. It helps physicians to treat effectively. The diversity of co-residents and the love of patientsgot me attached to my profession. This is the power of the doctor-patient bonding we enjoy while treating our patients.

Our Ability to reach unity in Diversity will be the beauty and test of Civilisation

Mahatma Gandhi

Reflections: Bioethics Learning and Application

Devi Bavishi

It is my immense pleasure to be a part of the World Bioethics Day for the third year in a row. It has helped me grow as an individual, a professional and more importantly as a human.

When I joined in 2017, I was new to the whole bioethics world and as we had no formal teaching, I only had a little idea about bioethics and was eager to learn. My teachers left no stone unturned to explain to us the principles. The meetings were intellectually enhancing. This entire process of learning and its application during my limited interaction with patients helped me absorb these principles and eventually it became my way of thinking. While taking history of patients during clinical postings, I decided to make a small change in my attitude towards the needs of my patient. I made sure that after taking the case, I give proper importance to closure and family message. This helped me gain the trust even more and then during internship, when I followed the samepractice, the patients were actually happy with my concern and approach in an environment full of sickness. An example discussed, opened me to the notion of cultural diversity. To give an idea, many pregnant women in the rural areas do not go to the hospital for delivery for various reasons. Respecting their cultural values, government of India, has appointed ANMs to assist these women in delivering their babies.

Every year, the team of GSMC MUHS UNESCO Bioethics Unit works hard to bring new things for development of students. Last year, every batch of undergraduate students benefitted with stimulating modules relating to different bioethical principles.

This year's theme for World Bioethics Day has been in adjunct with the struggles of ground level problems faced by every medical student, every resident and many professors, especially in our country, the one of cultural diversity. We I've in a racially, logistically, culturally and religiously diverse world. The Universal Declaration on Cultural Diversity describes *cultural diversity* as 'the common heritage of humanity' and says that its defense is an '*ethical imperative* that cannot be separated from respect for human dignity.'

Since ancient times, though there were many different cultures, Communities in India have coexisted in harmony with regards to principles followed in healthcare. Recently, due to westernisation, there are more stringent rules which have to be followed in making healthcare decisions, which may sometime hamper better doctor patient relationship in our setup. For example, in our hospital, if an adult patient has to undergo any surgery, the doctor informs the risks and benefits to the patient's next of kin in addition to the patient and the family participates in shared decision making. However, the bioethics principle says that only the patient's consent is required. Ever wondered why do we do so? In India, family bonds are very sacred and opinions of family members are valued. To quote another example, For a simple cold, cough, my grandmother gives me pinch of turmeric and steam inhalation. Is that practice incorrect or is it just not in line with western medicine? Similarly, there will be countless experiences and those many dilemmas. This is where the role of cultural diversity assumes significance.

Are we losing traditional obligations while trying to follow uniformity in delivery of healthcare? Are cultural beliefs that alien to us? Are universal principles guiding ethical decision making regardless of the culture in which those decisions take place? Are we making doctor patient relationship an algorithm instead of a mutual agreement?

Should every culture have its own bioethical principles or One for all system will be adequate? Which practicesare acceptable and which can actually cause harm? Where to find the balance is of crucial importance while dealing with delicate situations which many a times dictate life and death.

GSMC MUHS UNESCO Bioethics Unit.

Seth G. S. Medical College and K. E. M. Hospital, Mumbai, Maharashtra, India

NURTURING ETHICAL VALUES.....
ENRICHING MEDICAL EDUCATION.

Vision :

"Establishing highest level of ethical and professional standards in health professionals education, practice and research."

Mission:

"To inculcate the basic ethical, professional and humanitarian values in medical students right from the first day of training in order to make them not only expert clinicians but also compassionate human beings."

The 'GSMC-MUHS UNESCO Bioethics Unit' was formed in the month of August 2015. The solemnisation of the Unit under the MCGM Nodal Bioethics Unit and affiliation with UNESCO, Chair in Bioethics Haifa Australia was on 9th November 2015. The MCGM nodal unit was established at an event held in Topiwala National Medical College auditorium.

The objective of Bioethics Unit is to integrate the MUHS approved UNESCO Bioethics curriculum in the undergraduate and postgraduate students education and to train the faculty in effective implementation of the same.

1. To introduce and deliver bioethics and professionalism training in undergraduate and postgraduate curriculum.
2. To prepare an updated and modern curriculum, reflecting the need for integration of ethics during the training period and for its effective implementation in clinical practice.
3. To increase interest and respect to values involved in health care delivery and raising awareness for competing interests. To introduce various non-medical facets of medicine: sociology, economics, and public administration to students.
4. To add new chapters to present curriculum that will relate to new dilemmas, accommodating medical, technological and scientific progress.
5. To create training programs for teachers and instructors of ethics in medical institution.
6. To initiate, collaborate, facilitate and participate research related to bioethics.

GSMC MUHS UNESCO Bioethics Unit.
Seth G. S. Medical College and K. E. M. Hospital, Mumbai.
Steering Committee

1	**Dr. Hemant Deshmukh**	Chairperson	Dean (GSMC and KEMH)
2	**Dr Padmaja Marathe**	Head Bioethics Unit	Pharmacology &Therapeutics
3	**Dr Mariya Jiandani (PT)**	Head, Steering Committee	Physiotherapy
4	**Dr Yuvraj Chavan**	Secretary	Community Medicine
5	**Dr Karuna Nadkarni**	Treasurer	Occupational Therapy
6	**Dr Padmaja Mavani**	Editor	Obstetrics and Gynecology
7	**Dr Anjali Telang Lone**	Website coordinator	Anatomy
8	**Dr Santosh Salagre**	Member	Medicine
9	**Dr Nayana Ingole**	Member	Microbiology
10	**Dr Kanchan Kothari**	Member	Pathology
11	**Dr Venkatesh Rathod**	Member	Physiology
12	**Dr Monty Khajanchi**	Member	General Surgery
13	**Dr Usha Kasar**	Member	Occupational Therapy
14	**Dr Shashank Tyagi**	Member	Forensic Medicine
15	**Dr Trupti Ramteke**	Member	Biochemistry
16	**Sister Vaishali Chavan**	Member	Nursing
17	**Sister Aarya Deshmukh**	Member	Nursing
18	**Brother Ravindra Markad**	Member	Nursing
19	**Dr Jyotsna Thosar (PT)**	Member	Physiotherapy

GSMC MUHS UNESCO Bioethics Unit.
Seth G. S. Medical College and K. E. M. Hospital, Mumbai.

- Students' Wing -

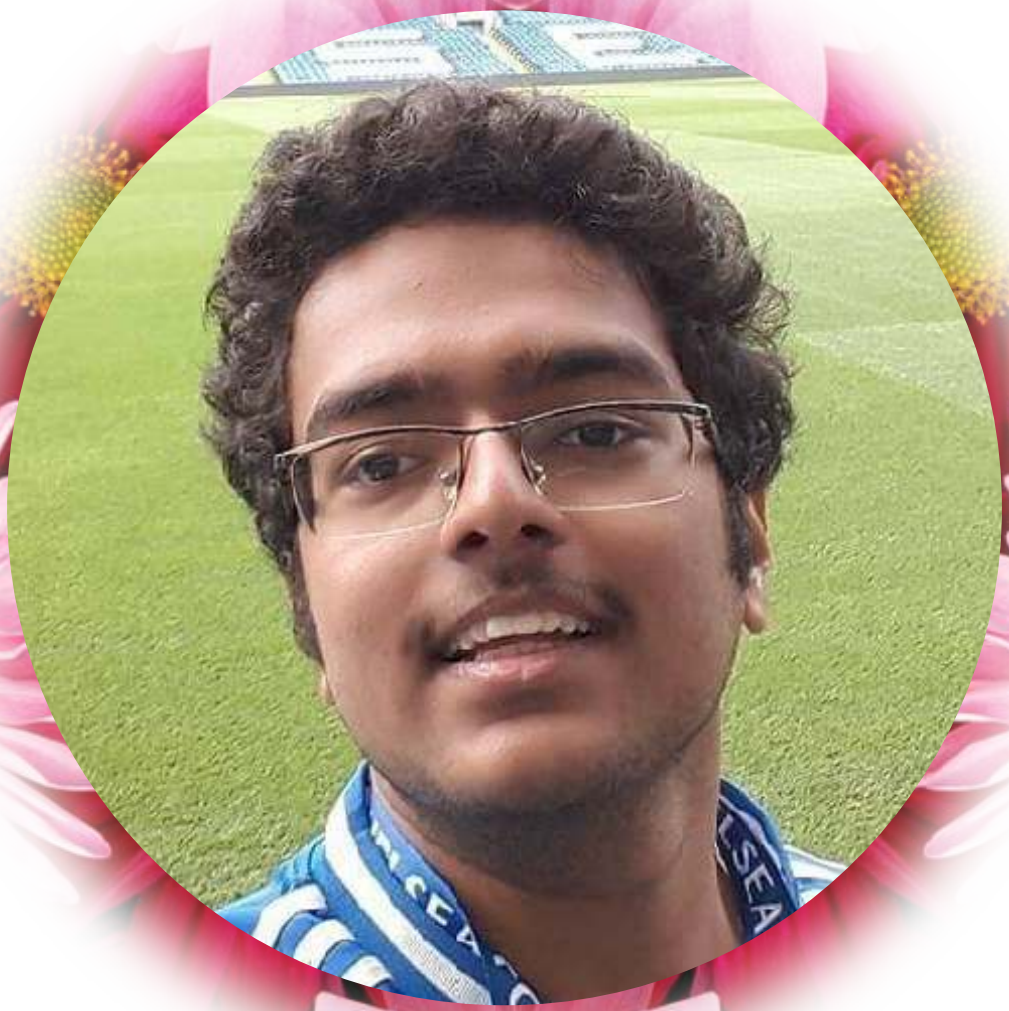
Sr. No	NAME	Discipline
1	Devi Bavishi	MBBS Intern
2	Gautami Chaudhari	MBBS Intern
3	Pratik Debaje	MBBS
4	Piyush Vinchurkar	MBBS
5	Jayesh Urkude	MBBS
6	Shruti Tilak	MBBS
7	Omkar Thakur	Physiotherapy
8	Sayoni Shah	Physiotherapy
9	Natasha Mehta	Physiotherapy
10	HimaniGirolkar	Physiotherapy
11	Sarah Sarosh	Occupational therapy
12	Himani Nahta	Occupational therapy
13	Mahima Bhuta	Occupational therapy
14	Sanjeevanee Charde	Occupational Therapy
15	Trupti Rane	Nursing
16	Manisha Pawar	Nursing
17	Varsha Kasar	Nursing
18	Monika bhoir	Nursing
19	Ankita Parihar	Nursing
20	Asmita More	Nursing

20

GSMC MUHS UNESCO Bioethics Unit

grieves the loss of a sincere and hardworking student of GSMC MUHS UNESCO Bioethics Unit

Omkar Thakur



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World Bioethics Day 2018 Celebrations

The World Bioethics Day 2018 Celebrations started with various competitions on 3rd, 4th and 5th October 2018 for undergraduate students on the theme of the International World Bioethics Day 2018- "Solidarity and Cooperation". The celebrations culminated into the mega event held on the 17th October 2018.

' WALKATHON '

An ethical march" silently carried out inside the campus holding bioethics and the **World Bioethics Day** theme related banner and placards by unit members and Student wing. KEMH teaching and non-teaching staff and students also joined us.

Poster Exhibition

The Academic Dean, **Dr. Rajiv Satoskar** and **Dr. Lopa Mehta**, Former Professor and Head, Anatomy and our Senior teacher inaugurated the exhibition.

Release of "Inarch-2018" Bulletin

Key Note Address by Dr.Manisha Gupte, Founder and Co - Convenor, Mahila Sarvangeen Utkarsh Mandal (MASUM), Pune

Panel discussion on : **Use of Generic Medicines**

The panellists included Dr. Avinash Supe;
Dr. Jayashree Ghanekar, Dr. Aamir Shaikh, Dr. Omprakash. It was moderated by Dr. Nirmala Rege.

Prize distribution ceremony for felicitation of the winners of the bioethics competitions held as part of World Bioethics day celebrations.

Structured training in bioethics is conducted across all disciplines for undergraduate students. Modules as designed for MUHS UNESCO Bioethics curriculum are carried out using various interactive teaching learning methods such as Role play, movies etc followed by student interaction and discussions. All 3T trained bioethics faculty conduct these sessions.

Bioethics session for 1st year MBBS students was conducted on January 10, 2018 in MLT. The topics covered were Introduction to Bioethics and Unit activities, Historical perspectives of Medical Ethics, Human Dignity and Human Rights' and 'Cultural Diversities'.

A total of 127 students attended the programme. Dr. Mariya Jiandani , Dr. Pravin Iyer, Dr. Anjali Telang, Dr. Vyankatesh Rathod, Dr. Kinjalka Ghosh, Dr. Padmaja Samant and Dr. Yuvaraj Bhosale.

Education Activities of the GSMC MUHS BIOETHICS UNIT

Orientation Programme: 1st Yr Nursing Students

On 25th February 2019 bioethics orientation programme was held for first year GNM students.



Teaching Modules for MBBS, OT & PT students

Module 2 of the UNESCO bioethics curriculum for first MBBS, Physiotherapy, Occupational Therapy students were held on March 11th 2019


Foundation Course for First MBBS 2019-20 BATCH

As per MCI directives, the 'Foundation Course in Bioethics' was conducted during 3rd August 2019 to 23rd August 2019 for the new batch of First MBBS students. There were 7 sessions which covered the competencies addressed under the theme 'Professionalism and Ethics'

1.3rd August 2019 'Professionalism and Ethics
2. 8th August 2019 'Human Dignity and Human rights'
3. 13th August 2019 'Beneficence and Non maleficence'
4. 16th August 2019 'Equality, equity and Justice'
5. 20th August 2019 'Cultural Diversity'
6. 21st August 2019 'Honesty and Integrity'
7. 23rd August 2019 Formative assessment

Post Graduate Grand rounds

Post graduate grand rounds were held for residents of Radiology, Anaesthesia and Paediatric anaesthesia on 5th April 2019 in Community Medicine seminar hall. It was attended by 15 residents. The residents presented the cases of ethical dilemma and was followed by deliberations and discussion. Dr. Ravi Ramakantan was the invited faculty for discussion along with Head of departments Dr. Sneha Kale, Dr. Indrani Hemant kumar and Dr. Nandini Deshpande. Moderators for the session were Dr. Padmaja Samant & Dr. Mariya Jiandani.

Case 1 : The ethical dilemma presented by Dr. Dasari Ravi Kiran from Radiology department on whether the use of CT and MRI should be done for the purpose of conforming the diagnosis of appendicitis in a pregnant lady?

Case 2 : The ethical dilemma presented by Dr. Patankar Soniya Hemant from Radiology Department was revealing bad news as the diagnosis to the patient regarding anomalies in the fetus ?

Case 3 : The ethical dilemma presented by Dr. Isha Singhal from Anaesthesia Department was regards use of LMA in prone position which is not gold standard for spine surgery in a singer who developed hoarseness of voice post surgery.

Case 4 : Ethical issue was lack of ventilators leading to ambu bagging of the critical patient in need of surgery presented by Dr. Gauri Raman Gangakhedkar from Anaesthesia Department

Case 5 : ethical dilemma presented by Dr Praveen Benjamin from Paediatric Anaesthesia Department was related to training of residents for intubation in infants using simulation to avoid complications

Workshop : Psychological First Aid

On the 10th July 2019, the GSMC MUHS UNESCO BIOETHICS UNIT held a workshop on "Psychological First Aid " which an innovative, interactive session. Conducted by Dr. Shubhangi Parkar , Professor and Head of the Department of Psychiatry at KEMH along with Dr. Shilpa Adarkar Professor, Department of Psychiatry at KEMH. 38 undergraduate students attended from various discipline.

The workshop was well received with positive feedback and need for more such workshops.

Workshop on " Narrative writing and Reflections"

On the 19th of July 2019, the GSMC MUHS UNESCO BIOETHICS UNIT held an interactive workshop on "Narrative writing and Reflection". Narration and reflection are powerful tools for teaching medical ethics and professionalism. The students were introduced to the concepts of narrative writing in medicine and how to reflect . Conducted by Dr. Padmaja Samant, Professor, Department of Gynaecology and Obstetrics, Dr. Munira Hirkani, Professor Department of Physiology, KEMH and Dr. Henal Shah, Professor, Department of Psychiatry at Nair Hospital, the workshop helped students to develop skills on narrative writing and reflection.

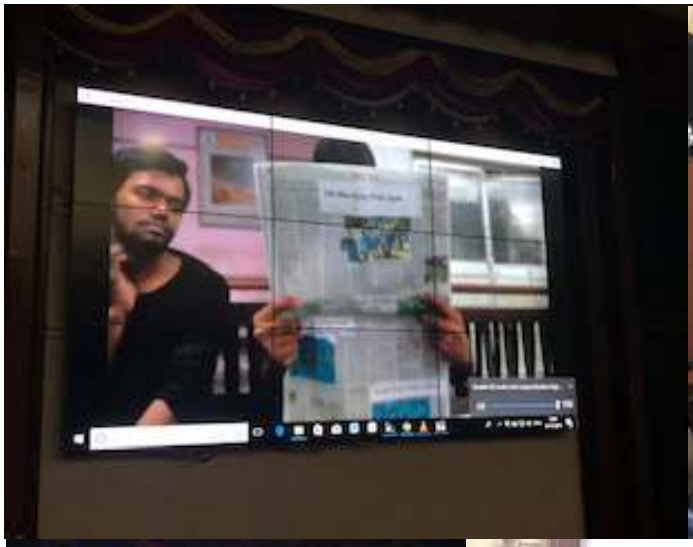
Competitions as apart of WBD celeberations The theme was "**Respect for Cultural Diversity in Health**".

The 'Poster Making Competition' was one of the events conducted as a part of 'World Bioethics Day Celebrations - 2019'. We got an overwhelming response in the form of 29 beautiful and thoughtful posters.
The winners of the Poster Competition are as under:

Prizes		
First Prize	Prashant Harish Saraf	I year MBBS
Second Prize	PranitaMisal	II year BPTh
	MeghaSuhasGavit	III year GNM
Special Prize for artistic excellence	MrunmaiGaikwad	III year BPTh

Street Play Competition 2019

Short Film 2019



Photography Competition 2019

ACKNOWLEDGEMENT

GSMC MUHS UNESCO BIOETHICS UNIT

Expresses its gratitude to judges of all competitions.

-: JUDGES NAME :-

Artistic Poster :

Dr. Nayana Ingole, Dr. Smriti Bajpayi, Dr. Urwashi Parmar Singh

Photographs :

Dr. Santosh Salagre and Dr. Ajay Rana

Ethoscope :

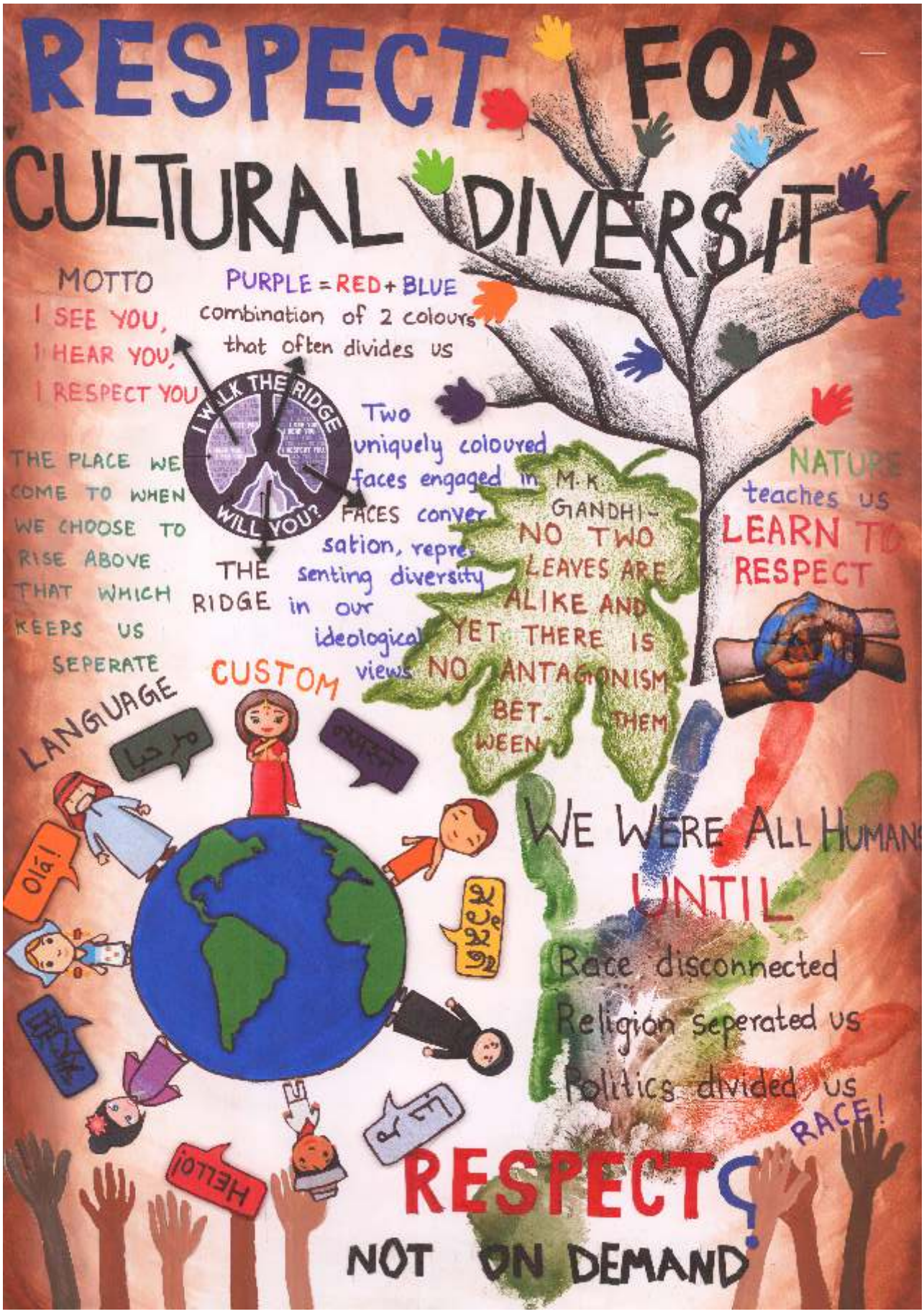
Dr. Vinita Puri and Dr. Padmaja Samant

Street Play :

Dr. Kishor Khushale

Rangoli :

Dr. Rashmi Yeradkar, Mrs. Deepali Vaidya, Mr. Prashant Jadhav and Mr. Sachin Mahadik



Third Prize

Samhitha Tammana, First Year, MBBS

GSMC MUHS UNESCO Bioethics Unit

World Bioethics Day
14th October 2019

Poster Competition on
'Respect For Cultural Diversity '

Special Prize for artistic excellence

Mrunmai Gaikwad, Third Year, Physical Therapy

GSMC MUHS UNESCO Bioethics Unit

Second Prize

Pranita Misal, Second Year, Physiotherapy

Second Prize

Megha Gavit, Third Year, Nursing