**Saved by a syncretic faith? A case study from 1995**

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I was on emergency call early in 1995 at the Pramukhswami Medical College in Karamsad near Anand in Gujarat. It was my first job as an Assistant Professor in what was then a medical college in a rural area, not yet recognized by the Medical Council of India. It was my first experience of working in rural India after spending six years at AIIMS in New Delhi. The experience of the medical college was quite the opposite of AIIMS with its endless waiting lists, and patients desperate to get our ear. At Karamsad on the other hand I would have to spend a lot of time to convince a woman with severe hypertension and complications and her family, of the need for admission. The major stumbling block in such a case would be the buffalo at home that would create a fuss if milked by any other person than the woman of the family. The patients initially did not care a damn for me, who in their eyes was a doctor from Delhi who couldn’t speak Gujarati. They however accepted me wholeheartedly when a few months later; I could do so in a passable manner.

The unique feature then of this college and the major reason for my interest in joining it were its links with the Tribhovandas Foundation, a large NGO supported by AMUL, which wanted to replicate in terms of human health what was achieved in terms of animal health by AMUL. I ran outreach clinics for this organization at two of their centers. The foundation provided free of charge daily therapy including rifampicin and this would draw a lot of patients with suspected TB in the backward district of Balasinor (now famous for India’s only Dinosaur fossil park). However we were dependent on the government for sputum microscopy services and to a hospital for X-rays. I shared the frustration of the patients as they waited often weeks for a microbiological confirmation of diagnosis. Ten years before the publication of a trial in the Lancet in 2004 which finally laid the regime which limited the use of rifampicin only to the initial 2 months to its well-deserved place in the graveyard; my patients in Balasinor were telling me that they wanted to continue rifampicin throughout the six months of therapy. I was powerless to change the regime, but since then I have strived to listen more closely to the real experts on any disease- the patients.

Emergency duties were a different cup of tea in this college then, since there were no post-graduates and junior faculty like me doubled up as residents in our roles. I was in the small emergency room seeing another patient when Aslam (not his real name) was wheeled in the stretcher. He looked desperately ill, unconscious and gasping for breath. I called out for the emergency equipment, and decided to intubate him as a life-saving measure after taking the concerned but strangely composed relatives quickly into confidence.At that time the college had a cardiac care unit but had no ventilators, so my decision to intubate him committed us to a situation where he would have to be manually ventilated using an Ambu bag. Initially the nurses would do it and then the relatives would take over. In any case, recoveries from such situations, till then, had been rare.

When I later enquired about the details of his illness and looked at the investigation reports, I realized the situation I had got into. A few weeks ago he had traveled for some work to Bombay. He developed fever for a few days which was followed by appearance of jaundice and soon thereafter alteration of consciousness. He was also noted to have acute renal failure and bilateral pneumonia, possibly related to the unconsciousness and aspiration. Treatment at the Bombay had been to no avail, and his condition steadily worsened. The relatives gave up hope after a week and thought of bringing him back home, reconciled to the fact that would not survive. The journey from Bombay to Anand was by an ambulance. However when they reached their village about 20 km away, Aslam was still breathing. It was then that they came to the college. At that time, there were some private hospitals in Anand which had a better-equipped ICU, but they chose to come to the medical college.

His was unresponsive to pain with severe anemia, renal failure, jaundice, pneumonia in both lungs, adding up to a critical situation. The hospital at Bombay had diagnosed him as having liver failure following acute hepatitis but I noted that they had not ordered a malaria test, possibly due to lack of suspicion. Kheda district was endemic for plasmodium falciparum malaria, I had a lot of experience with severe falciparum malaria which could be associated with all these complications.His blood films did show severe falciparum malaria, and that was fortunate because it offered a small ray of hope in a desperate situation. He was ventilated using the Ambu bag by his relatives who took turns in a 3 hour duty shift. I hoped that he should not require dialysis, as there was no dialysis unit in the hospital either. By the third day, things started turning around, with his consciousness, renal function and pneumonia improving. By the fourth day we could remove the endotracheal tube much to the relief of his relatives. He stayed in the hospital for 2 more weeks, because he had developed a bad bed sore while in Bombay. When he was discharged the family organized a small celebration, and as they were involved in running a small business of selling imported items, gifted a nice watch to nurses and doctors alike. I acknowledged the gesture but felt it appropriate to hand it over to the authorities, with whom it still lies.

It was in some ways a miraculous recovery, with the long road journey, with the severe involvement of the brain, lungs and kidneys, and the delay in starting appropriate therapy. This particular patient and his recovery was a sort of milestone in my own journey as an itinerant physician and I learnt some valuable lessons. Here was a patient whose diagnosis had been completely missed at a well-equipped hospital in Mumbai but was confirmed by my house-officer who was like his peers an expert at examining thick smears for detecting the malarial parasite. I recalled my struggle at getting thick smears for malaria read at AIIMS (the laboratory staff insisted that the less sensitive thin smears were good enough) and also recalled the difficulty we had in procuring quinine for a patient with falciparum malaria in Delhi. Here all those things were perfectly in place. I realized then and the belief got stronger as time passed by, that the skills of the health care providers determine the level of care rather than the brick and mortar and the equipments. One can provide prompt high quality care under a thatched roof and fail to provide it even with the state of art equipment around. Also that providers working at primary and secondary care levels are often more aware of locally prevalent diseases than those working in tertiary care who may not see these patients on a frequent basis.

The other lesson for me was the successful management of a patient who required ventilation with the cooperation of the patient’s family with the aid of a simple Ambu bag and oxygen. The family trusted in us and was reluctant to go anywhere else and we persisted with our attempts to do our best. This situation is often the lot of many physicians and surgeons in rural areas where referral to a so-called higher center is often a myth and doing one’s best with a prayer on your lips is often the only real option. At AIIMS I had never managed a person ventilating only with an Ambu bag but it was during a stint as a visitor to Christian Fellowship Hospital Oddanchatram in 1994 that I saw residents saving lives thus . That gave me some hope and the labors of the family members bore fruit. It was quite a unique situation to see the family intimately involved in the delivery of intensive care, rather than being spectators. There would be other occasions, including in patients with snake bites that we would be successful in saving lives this way.

The most memorable feature of this incident was the exemplary calm and trust with which the family had conducted itself. I wondered why they chose to come to the college, as they were not really that poor, and what accounted for their composure during his treatment which was unusual in relatives of a young patient in a life-threatening situation? The brother finally put my doubts to rest. The family members were followers of Swami Krishnanand, who lived at the old Shanti ashram in Bhadran a nearby village. He was by all accounts a loved, respected figure for them and many others. The Swami had died a few years earlier in 1989, and his body was donated to the medical college as per his wish. The family believed that the spirit of Swami Krishnanand and was present in the medical college and this accounted for a large part for their faith in our treatment and the composure.

I never visited the ashram or met any of his other followers. But I did read now, some of the accounts of his travels across India. The accounts are mostly about people he met, ordinary people in extraordinary situations, and also of seekers. He himself seems to have had an interesting journey in his life from his birth in Burma, to his fleeing to India during the Second World War, to a peripatetic existence with a final settlement in Gujarat. It is refreshing to find someone in robes stating that the purpose of life is not to attain moksha (salvation) or encounter God, but to become fully human; to state that he was just a seeker with no special powers, to go to great pains to explain away the so-called miracles attributed to him; to acknowledge the hospitality of Christian priests in Shillong who helped him when he was in a tight spot.

This incident came back to me in the present times tinged with a sense of loss of a bygone era. Now Karamsad has a large ICU and Oddanchatram too has ventilators. In ICUs across India, patients and their families might spend a good part of their annual income for a day’s stay. I wonder whether I would do the same that I did then faced with a situation today in another setting. I left Gujarat in 1999, though the portents of the events which unfolded later were discernible even then. I wonder if there will ever be more of the likes of Swami Krishnanand preaching a simple humanity of peace and brotherhood ; and leaving their bodies to a medical college (and in the eyes of their followers their spirits too). I wonder if there are still the likes of Aslam in Gujarat who can access such men representing India’s syncretic faith if and where they do exist.