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HARNESSING THE HUMAN RESOURCES IN AMC

Dear Editor,

A mandatory aptitude test given to newly recruited AMC Clerks resulted in 50% failure. The same test when given to Clerks with 2 to 12 years of service did not produce any different result. Medical units receiving newly qualified personnel of all the trades often complain of their inadequacies and inaptitude. Units are scared of new drivers as much as they are scared of themselves to drive in hilly terrain. It is said that fresh technical hands lack knowledge, skill, compassion and human touch. They are ill-disciplined, ill-tempered and unwary of policies and procedures.

It is a common belief that people join Army (AMC) as the last resort when all their attempts to pick up other jobs fail. Majority joins for sheer employment. Others join as part of family tradition or with the pressure from family. Army Medical Corps does not attract people who like to serve patients, who have patriotism, who love uniform, character building and sports. Personnel cling on to service for pay, perks, promotion, good living conditions, sports and adventure activities. All these are wrong.

A recent survey conducted among AMC recruits and serving soldiers revealed a different story. One-sixth of all recruits have aptitude to serve the patients. The aptitude is found to be increasing with service. Patriotism is not a myth. It has worked as a motivating factor for the new entrants and a hygiene factor for the serving soldiers. A surprising observation is that 'discipline' has acted as a catalyst for the intake of recruits and a binding factor for the middle level soldiers.

'Uniform' has impressed many to join AMC and it is found to be important even to the seasoned soldiers. The intake in AMC is not influenced by its 'image', but luckily many of the practicing soldiers are impressed by the 'present face'. The recruits who joined AMC as sport lovers have been disappointed. The survey shows that practically nobody joins AMC to imbibe the family tradition or to uphold the pressure from family.

One important factor is the changing priorities of the recruits and the soldiers. While only 6.4% of the recruits considers AMC as an avenue for employment, about 14% soldiers has accepted it as an employment. So is the case with job security. About 13% of the soldiers believes that AMC gives job security unlike 6% of the new entrants.

The survey was directed to find out from the serving soldiers what they liked and disliked the most in Army Medical corps. The first six attributes liked by 68% of the personnel are service to the sick, image, esprit de corps, discipline, service to the nation and uniform in that order. The survey showed that they were vehement and discreet in their dislike. Their dislike in just three factors like slow promotion, poor pay and allowances and poor living conditions was amounting to 68%. This is an interesting finding. While they are satisfied with the higher order needs like service to the sick, image, esprit de corps, discipline and service to the nation, they are dissatisfied with the lower order needs like promotion, pay and allowances and living conditions. This is an evidence of 'Frustration Tolerance' where there is a shift to higher needs without satisfying the lower needs. It is a curious finding. It should be utilised in harnessing the human resource in AMC.

A scanning through the intake pattern of AMC personnel indicates that about 50% of the recruits are above matrics although the entry rate requirement is only matric. A close scrutiny of the mark sheets reveals that the above highly qualified are just 'scrapers'. It may not be an asset. But the real asset is the survey findings-their aptitude, preparedness to serve the sick and the nation and their yearning for discipline, uniform and character building. The success of AMC will depend upon strengthening the assets of the new entrants and harnessing them to a desired generation. The onus is on organisation and not on the new entrants.

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HALITOSIS AND MOUTHWASHES

Dear Editor,

Halitosis (foul odour from mouth) is psychologically depressing and social embarrassment for the individual. To get rid of halitosis, patients often brush their teeth forcefully and frequently and rinse their mouth with different mouthwashes currently available in the market but the underlying cause remains untackled. This letter attempts to explain the cause of halitosis and highlight the adverse effects of mouthwashes.

Gastrointestinal problems like amoebiasis and giardiasis lead to coating of the tongue. The intake of tea, coffee, milk or food on a coated tongue often leads to a foul taste in the mouth. In acute maxillary sinusitis, patient complains of a foul odour along with the presence of postnasal drip and mucopurulent sputum. Diseases of the respiratory tract like lung abscess and bronchiectasis must be ruled out. Persons suffering from uncontrolled diabetes mellitus may have a typical acetone breath. In chronic renal failure, nitrogenous waste products like urea and non protein nitrogen (NPN) are retained in blood. One of the ways by which the body eliminates these is through the buccal and intestinal mucous membrane. The mouth has

a foul ammoniacal odour and white coating accumulates over the tongue. Uraemia results in swollen and haemorrhagic gums [1]. In acute fever, salivary secretion is inhibited and the mouth becomes dry. Food debris are not washed away and hence bacteria multiply leading to halitosis.

Intra-orally, halitosis may occur due to gingivitis, periodontitis, periodontal pockets, pericoronitis, deeply carious teeth with resultant stagnation of food debris and unhygienic dentures. Following tooth extraction or oral surgical procedures, patient is on a soft diet. Lack of normal chewing, slight bleeding and bacterial decomposition of blood gives rise to malodorous breath. Acute necrotizing ulcerative gingivitis (ANUG) has a characteristic metallic odour [2].

Mouthwashes generally contain an antiseptic such as benzalkonium chloride, antibiotic agents, essential oils used as flavours, alcohol, sodium perborate, zinc chloride, menthol, thymol, eucalyptol, glycerine and boric acid [3]. These substances can cause allergic reaction. Prolonged use of a mouthwash in which the alcohol concentration is high can induce white lesions in oral mucous membrane.

Chemicals irritate the oral mucosa. Studies by Kowitz et al [4] have demonstrated the occurrence of epithelial peeling, mucosal ulceration and inflammation, gingivitis and petechiae in patients using 20 ml of a full strength mouthwash for 5 seconds, twice daily for 2 weeks. To prevent dental carries, 0.2% chlorhexidine mouthwashes are generally prescribed. Chlorhexidine can cause altered taste sensation and superficial desquamation of oral mucosa.

Chewing of carrot and coconut after food cleanses the pits and fissures present on the occlusal surface of posterior teeth. To get rid of smoker's breath, it is advisable to rinse one's mouth with water after a cigarette and chew a clove. Essential oils present in clove, mint, aniseed and ajwain masks halitosis for a while. Chewing a betel leaf is an ancient Indian tradition. The ingredients of a prepared 'paan' and the juice of the betel leaf help in camouflaging halitosis. But prolonged use of betel nut (supari) and 'paan masala' causes oral submucous fibrosis.

A healthy body with regular bowel movements and proper oral hygiene can prevent halitosis.

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USE OF STATISTICS FOR HOSPITAL CONTROL

Dear Editor,

This refers to the short communication "Use of Statistics for Hospital Control", MJAFI, 1997; 53: 326-7. The author has brought out interesting statistics which on cursory glance project the Service Hospitals in brighter light. The author has tried to point out some of the reasons for it. However, two major aspects need further emphasis:

1. A large number of admissions like review after sick leave, re-categorisation, RMB, RSMB, sick attendant, dependents on patient, etc in hospitals are for administrative reasons and not for medical attention.

2. A number of patients are admitted for trivial ailments. Such cases will not even be considered for admission in any civil hospital.

Since these admission numbers also are included in the total number of patients admitted, they dilute the percentage in all statistical analysis. Therefore, it will not be proper to compare our statistics with the statistics of international or national civil hospitals. No wonder, it is said that statistics are like bikini. It reveals a lot but what it hides is more interesting.

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REPLY FROM THE AUTHOR

I congratulate Lt Col Shishir Gokhale for his valuable observation and contribution.

It is a known fact that Service Hospitals are constrained to admit a number of trivial cases and discharge many others slowly. Though such may reflect true service statistics, may be unsuitable for strict comparison. However the distortion is luckily restricted to only three parameters namely bed occupancy rate, average length of stay and death rate, out of a dozen parameters considered in the study. It may be interesting to note that our hospitals are yet to be optimally utilised (bed occupancy 62%) inspite of admission of all categories mentioned by Lt Col S Gokhale. It may modify the average length of stay positively or negatively (only a separate study can verify that). One parameter that will definitely be diluted is percentage of death rate. The remaining nine parameters are linked to specific type of

admission and therefore are unaffected by inflated admissions and often dull paced discharges.

The startling inference is that only two hospitals out of the responded 37 has all the parameters recorded. It otherwise traces out our pathetic sense of statistics. A mention of international statistics is primarily to reveal its availability. It can be used as a pointer and also as a stimulant to evolve our own system.

The purpose of my letter was not to compare the statistics but to motivate the hospitals to improve their statistics and develop courage to reveal everything.

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BETA 2 M - A NEW AVATAR OF ESR?

Dear Editor,

This refers to the article "Beta-2-Microglobulin levels in HIV infected subjects" MJAFI, 1997; 53: 251-4. Beta-2-M has been projected as a surrogate marker of progression of HIV disease. The authors have reported high levels of Beta-2-M in cases of PGL and AIDS, stages where the disease had already advanced to Stage III/IV and was clinically diagnosable. On the contrary, the levels of Beta-2-M in asymptomatic HIV infections (the cases that require intelli-

gent and informed guess for the rate of progression of the disease), were only marginally elevated. It appears that Beta-2-M levels as surrogate markers of progression of disease are not of much help in these early cases. Beta-2-M levels don't have any predictive value towards course of early HIV disease.

The main sources of Beta-2-M in the body are immune system and liver. Beta-2-M levels are elevated in number of conditions other than HIV infection [1]. In our country, as in other developing