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Original Article

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Factors Affecting Outpatient Satisfaction at a Tertiary Care Hospital in Sikkim

Bidita Khandelwal[1], Vijay Pratap Singh[2], Sumit Kar[3]

Abstract

Patient satisfaction has become a frequently researched outcome measure of the quality of health care delivery . The health care industry is undergoing a rapid transformation to meet the ever increasing needs and demands of its patient population. Today's patient is an educated consumer having many service demands and better care choices available. A valid and reliable questionnaire is a relevant tool for assessing patient satisfaction. A descriptive cross sectional questionnaire based survey using Patient Survey Questionnaire (PSQ) III short form was used to assess the outpatient satisfaction at a tertiary care hospital in Sikkim. A total of 6000 outpatients were interviewed and the response was assessed individually for each item as well as for the subscales and was expressed as mean. There was overall satisfaction with the medical care received by the patient.

Keyword: Outpatient; Patient Satisfaction; PSQ III; Sikkim.

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Introduction

The quality of health care delivery is measured using several parameters and outcome measures; patient satisfaction is a frequently researched outcome measure. In order to meet the ever increasing needs and demands of the patient population, the health care industry also needs to undergo rapid transformation. Today's patient is an educated consumer who chooses the best available services depending on his expectations and demand [1]. There is a transformation of healthcare market from a seller's market into buyer's market and so health care providers are turning more and more towards marketing of their services. Patients are consumers and have ample opportunity to compare between the hospital qualities and choose the one, which in their opinion would provide the best care at an affordable cost. Hence, it is pertinent to assess the factors affecting patient satisfaction as there is definite association between patient satisfaction levels and patient's compliance thus resulting in better treatment outcome [2]. Literature pertaining to patient satisfaction in the inpatient setting is extensive but there is a paucity of data on patient satisfaction pertaining to outpatient clinical services. Identifying the factors affecting the satisfaction level of patients attending outpatient department will help to identify and rectify the voids and hence improve the quality of healthcare provided and outpatient statistics.

Materials and Methods

A descriptive cross sectional questionnaire based survey using Patient Survey Questionnaire (PSQ) III short form (PSQ III SF) was carried out to assess the satisfaction level of patients attending the outpatient department at a tertiary care hospital in Sikkim after

approval from the Institutional Ethics Committee. All consenting patients attending the outpatient department were included. After obtaining an informed verbal consent from the eligible participants, they were requested to fill the PSQ III SF.

Patient satisfaction questionnaire developed by Ware, Snyder and Wright (1976) for the National Center for Health Services Research (NCHSR) provided the foundation for PSQ III. The initial questionnaire was 80 item battery (PSQI) and was revised to 68 item questionnaire (PSQII) in 1983. It was further modified to 50 item questionnaire (PSQIII) and was well validated for use. Despite the noteworthy characteristics of the PSQ III, its 50 item length places significant burden on respondents requiring approximately 10-15minutes to complete. This led to development of an abbreviated, yet reliable and valid version of the PSQ which increased the percentage with which patient satisfaction could be measured and encouraged its wider application for assessment of health care. PSQ III short form which has 18 items (PSQ18) tests for General Satisfaction (Items 3 and 17); Technical Quality (Items 2, 4, 6, and 14); Interpersonal Manner(Items 10 and 11); Communication (Items 1 and 13); Financial Aspects (Items 5 and 7); Time Spent with Doctor (Items 12 and 15); Accessibility and Convenience (Items 8, 9, 16, and 18). The instrument contains both positively worded and negatively worded items in order to control acquiescent responding. The items of different subscales are placed randomly in the questionnaire.

Participants were asked to indicate how they feel about the medical care they receive in general, with no reference to a specific time frame or visit. Each item is accompanied by five response categories (Strongly agree, agree, uncertain, disagree, strongly disagree) and scores from 1 to 5 are allotted to them. The respondent was asked to circle the number for each statement that represents the opinion that is closest to his or her view.

Some PSQ-18 items (1,2,3,5,6,8,11,15,18) are worded so that agreement reflects satisfaction with medical care, whereas other items (4,7,9,10,12, 13,14,16,17) are worded so that agreement reflects dissatisfaction with medical care. All items should be scored so that high scores for negative worded questions reflect satisfaction with medical care and low scores for positive worded questions reflect satisfaction as 1 stands for strongly agree, 2 for agree, 3for uncertain, 4 for disagree and 5 for strongly disagree.

Statistical Analysis

After item scoring, items within the same subscale were analysed to create the seven subscale scores. Items left blank by respondents (missing data) were ignored when calculating scale scores. In other words, scale scores represent the average for all items in the scale that were answered. Internal consistency reliability estimates for the PSQ SF 18 scales have been calculated using Cronbach's coefficient alpha. The mean and standard deviation for each item were calculated individually as well as in subscales.

Results

Item analysis and subscale analysis of response of consenting participants (n=6000) is depicted in Table 1 and 2 respectively.

The subscales were calculated according to the following groups: General Satisfaction (Items 3 and 17); Technical Quality (Items 2, 4, 6, and 14); Interpersonal Manner (Items 10 and 11); Communication (Items 1 and 13); Financial Aspects

Table 1: Showing item analysis of the response (n=6000)

Statement	mean	SD
Doctors are good about explaining the reason for medical tests	1.32	1.03
I think my doctor's office has everything needed to provide complete care	1.35	1.06
The medical care I have been receiving is just about perfect	1.32	1.04
Sometimes doctors make me wonder if their diagnosis is correct	3.58	1.36
I feel confident that I can get the medical care I need without being set back financially	1.33	1.04
When I go for medical care, they are careful to check everything when treating and examining me	1.35	1.05
I have to pay for more of my medical care than I can afford	2.97	1.35
I have easy access to the medical specialists I need	1.34	1.05
Where I get medical care, people have to wait too long for emergency treatment	3.57	1.36
Doctors act too business like and impersonal toward me	3.56	1.37
My doctors treat me in a very friendly and courteous manner	1.33	1.05
Those who provide my medical care sometimes hurry too much when they treat me	3.57	1.36
Doctors sometimes ignore what I tell them	3.57	1.36
I have some doubts about the ability of the doctors who treat me	3.52	1.39
Doctors usually spend plenty of time with me	1.34	1.08
I find it hard to get an appointment for medical care right away	2.33	1.07
I am dissatisfied with some things about the medical care I receive	3.51	1.39
I am able to get medical care whenever I need it	1.36	1.09

Table 2: showing subscale analysis of the response (n=6000)

Subscales	mean	SD
General Satisfaction (Items 3 and 17)	2.91	1.21
Technical Quality (Items 2, 4, 6, and 14)	2.89	1.2
Interpersonal Manner (Items 10 and 11)	2.93	1.2
Communication (Items 1 and 13)	2.94	1.19
Financial Aspects (Items 5 and 7)	2.65	1.19
Time Spent with Doctor (Items 12 and 15)	2.95	1.22
Accessibility and Convenience (Items 8, 9, 16, and 18)	2.64	1.14

(Items 5 and 7); Time Spent with Doctor (Items 12 and 15); Accessibility and Convenience (Items 8, 9, 16, and 18) and the results were as depicted in Table 2.

Discussion

It was observed in the survey that scoring of PSQ-18 items (1,2,3,5,6,8,11,15,18) which reflects satisfaction with medical care, there was general agreement, whereas other items (4,7,9,10,12,13, 14,16,17) which reflects dissatisfaction with medical care, there was general disagreement except for Item 16 ie. The patients find hard to get an appointment for medical care right away. There was overall satisfaction with the medical care which they had received.

Patient satisfaction is a multifactorial attribute with various aspects of care. Apart from patient centred, timely and efficient health care, there are several other associated functional services such as pharmacy, laboratory, hospital policies, attitude and mannerism of the supportive staff, work culture etc. which may be an obstacle to patient satisfaction even if the initial three factors are in place. The communication style of doctor, both verbal and non verbal is also an important factor that determines the effectiveness and quality of health care. How we convey the diagnosis is as important as what is the diagnosis. A clinician may often equate a successful outcome as a success of health care system but it may not necessarily be so from patient's perspective.

There are limitations of patient satisfaction survey being used as a tool for assessing patient satisfaction. Researchers have often criticised the use of survey method as assessment due to the gap between the clinical knowledge of patients and health care providers. A high satisfaction rating may not actually be representative of quality of health services. Most items in such survey actually assesses evaluative data related to health services rather than descriptive data related to patient satisfaction [3-4]. Respondent's characteristics such as age, educational level, socio economic status, expectation level, psycho socio condition etc. often influence the ratings. Several methodological factors such as sampling technique, data collection procedure, questionnaire format and the response rate also influence the accuracy of the ratings [5].

Conclusion

The satisfaction trends in any health care setup should strive for improvement. Priority should be in improving the satisfaction levels of the patients attending the hospital and not only improving the statistics and revenue. Conducting regular surveys, adopting an effective feedback mechanism, accepting the deficiencies with dignity and employing corrective measures can improve patient satisfaction.

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Kayakalp: Rejuvenating Public Health Facilities through Incentives and Awards

J.N. Srivastava[1], Sushant Kumar Agrawal[1]

Abstract

Background: Ministry of Health And Family Welfare has launched a new initiative "KAYAKALP" on 15th May 2015, to promote cleanliness and enhance the quality of care at public health facilities. The main aim of this initiative is to promote and recognise efforts of public health facilitiesin creating a healthy environment in the Society. Recognitions and Financial incentives are provided to public healthcare facilities for showing exemplary performance in adhering to standard protocols of cleanliness and infection control. For district hospital level facilities,Winner award money is Rs 50 Lakhs for the states with 10 or more districts. The program was embraced by public health facilities with zest, zeal and enthusiasm and created a positive and health amongst them. After two years of its successful implementation it has shown remarkable impact on public health facilities. *Conclusion:* Through this article we can conclude that Kayakalp award scheme has promoted cleanliness, hygiene and Infection Control practices in Public Health Facilities and inculcate a culture of healthy competition among them.

Keywords: Kayakalp; Hygiene; Swachhata; Award; Competition; MoHFW.

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Introduction

The Swachh Bharat Abhiyan launched by the Prime minister on 2nd October 2014, focus on promoting cleanliness in Public spaces. To complement this effort and to leverage political commitment, MoHFW, Government of India had launched Kayakalp Award Scheme on 15 May 2015 with aim of promoting 'Swachhata' and Hygiene in Public Health facilities.

Kayakalp Award scheme has following objectives -

a. To promote cleanliness, hygiene and Infection Control Practices in public Health Care Facilities.
b. To incentivize and recognize such public healthcare facilities that show exemplary performance in adhering to standard protocols of cleanliness and infection control.
c. To inculcate a culture of ongoing assessment and peer review of performance related to hygiene, cleanliness and sanitation. .
d. To create and share sustainable practices related to improved cleanliness in public health facilities linked to positive health outcomes.

Based on the set criterion prize winners receive a cash award with a citation. Additionally Certificate of Commendation plus cash award is given to such facilities that score over 70%.

In the last FY 2015 -16, Kayakalp Initiative was for 10 selected Central Government Tertiary Care Institutions and all District Hospital level facilities of the nation. In the current FY (2016-17), the initiative has been extended to Sub-division Hospitals, Community Health Centres and Primary Health Centres.

Assessment Tool

The Kayakalp assessment of facilities is done using checklists. These checklists are compliance of

Table. 1:

Level of Facility	Ranked Awards	Certificate of Commendation
Awards for Central Government Tertiary Care Institutions	1st Prize- 5 Crore 2nd Prize:- 3 Crore 3rd Prize:- 1 Crore 4th Prize:- 50 Lakhs	Not Applicable
District Hospital	1st- Rs.50 lakhs 2nd- Rs.20 lakhs	Rs. 3 lakh
CHC & SDH	1st- Rs.15 lakhs 2nd- Rs10 lakhs	Rs. 1 lakh
Primary Health centres	Winner - Rs. 2 lakhs	Rs.50,000

themes, Criteria and checkpoints in a very systematic manner. Apart from these, a checklist provides assessment method and means of verifications against each checkpoint.

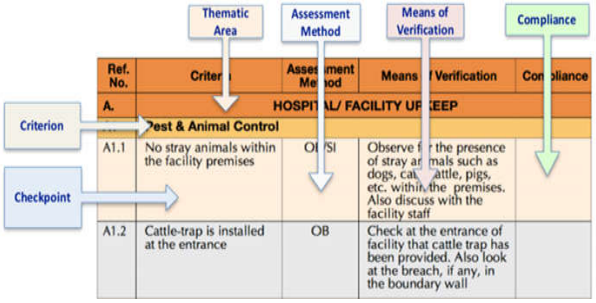


Fig. 1: Kayakalp Check-list for Secondary Care Health Facilities

In Figure1 Kayakalp Checklist for DH, SDH & CHC Award to Public health facilities, Kayakalp 2016.

There are four types of checklists for four different levels of public health facilities:-

1. Tertiary care Level Checklist:- Applicable for Central Government Tertiary care Institutions
2. Secondary care Level Checklist:- Applicable to District Hospitals, Sub District Hospitals, Area Hospital, Taluk Hospital and CHCs.
3. Checklist for 24X7 PHC:- Applicable to PHC with indoor facilities and labour Room
4. Checklist for PHC (without beds):- Applicable to ambulatory setting such as Additional PHC & Urban PHCs.

The award is distributed based on the performance of the facility on the following themes of the checklist

(i) Hospital/ Facility Upkeeo
(ii) Sanitation and Hygiene
(iii) Waste management
(iv) Infection Control
(v) Hospital Support Services
(vi) Hygiene Promotion

Assessors can provide following scores on checklists against each checkpoint:-

a. Full Compliance: - If all requirements met, scores of 2.
b. Partial compliance:- If at least 50% or more requirements met, scores of 1.
c. Non Compliance:- If less than 50% of requirements met, scores of 0.

The score card for the kayakalp generated either through manual calculation or through formula fitted excels sheets.

Implementation of this Scheme

The implementation requires broadly following four sets of activities.

1. Awareness workshop for all state officials including Principal secretaries, Mission directors and Chief medical officers of all districts at State level. Similar kind of training at all districts for District magistrates, Medical superintendents and Medical officer in charges of all public health facilities of the districts.
2. Training & capacity building of Health professionals and front-line workers for assessment as well as improving the 'Swachhata'.
3. Assessment of the health facilities through a 3-tier system of internal, peer & external assessment.
4. Declaration of award & felicitation.

Major Activities Undertaken in FY 2015-16

- The States & UTs were supported in 'Kayakalp' roll-out as a part of National Health Mission (NHM)–Funds for awards, trainings, assessment, hospital improvement, etc. and technical assistance through NHSRC was provided.
- Hon'ble HFM had personally communicated to Health Ministers of States for scaling-up of KAYAKALP initiative.
- The Ministry of Health and Family Welfare had organized an Awareness workshop on the Kayakalp in New Delhi on 25th June 2015. Trainings on Kayakalp ''Awareness'' and ''External Assessor training'' were conducted in all states.
- KAYAKALP Website with the domain name of ''kayakalpindia.com'' has been launched.
- Activities under the KAYAKALP initiative had also being shared on social media -https://www.facebook.com/pages/Kayakalp/586316831510706
- The Ministry had consultative meeting with leading NGOs of the country on 09th July 2015 for involving them in improving 'Swachhta' at Public Health Facilities.
- All States had rolled out this program and declared ''Kayakalp award'' for district hospitals in FY 2015-16.
- External assessment of 10 selected Central Government Institutions was conducted by expert from centre and three best facilities were selected for kayakalp awards.
- Ministry of Health & Family Welfare had organised 'National Felicitation of Kayakalp Awardees' on 16th March 2016. Besides Central Govt. Institutions, District Hospital In-charges, State Health Secretaries & Mission Directors and other state functionaries had attended that function.

Major Activities Undertaken in FY 2016-17

- The ''Kayakalp'' award has been extended to all Public Health Facilities – DHs, SDHs/CHCs and PHC's during the current FY.
- Kayakalp tools have been expanded to include a separate check-list for the PHCs with beds, and another check-list for the PHCs without beds.
- Biomedical Waste Rule 1998 has been revised and new rules have been promulgated on 28th March 2016. Hence Theme 'C' – Waste Management in the Kayakalp's existing tools has also been revised.
- A master training on 'Swachh Bharat Abhiyaan' at state level and similar kind of ''Swachh bharat Abhiyan training'' at all districts and facilities has been initiated this year for implementing kayakalp programme and improving Swachhata and infection control practices in public health facilities.
- Launch of ''Swachh Swasth and Sarvatra'': - The ''Swachh Swasth Sarvatra'' is a part of the Union Government's flagship Swachh Bharat Mission.
  - It is joint initiative of Ministry of Health and Ministry of Drinking Water and Sanitation to achieve better health outcomes through improved sanitation and increase awareness on healthy lifestyles.
  - Its objective is to build on and leverage achievements of two complementary programmes – Swachh Bharat Mission (SBM) and Kayakalp.
  - Three broad objectives of this scheme are:-

I. Enabling Gram Panchayat where kayakalp awarded PHCs are located to become ODF.

II. Strengthening Community Health Centre (CHC) in ODF blocks to achieve a high level of

Table 2: Activities completed under kayakalp for FY 2016-17

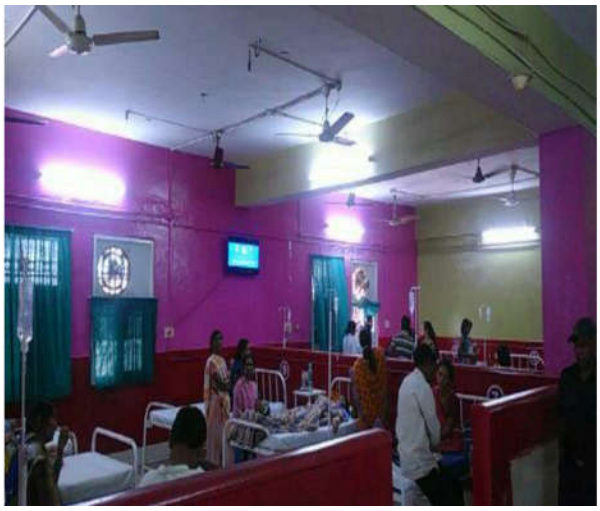
Activities completed under Kayakalp, till 26th February 2017* *As per information provided by States to NHSRC.*				
Level of facilities	**Facilities under Kayakalp**	**Internal Assessment Completed**	**Peer Assessment Completed**	**External Assessment Completed**
District Hospital Level Facilities	812	782	528	248
SDHs/CHCs	5691	4551	1904	555
PHCs	15250	9273	2782	1290
UPHCs/APHCs	1264	273	36	22
Total	**23017**	**14879**	**5250**	**2115**

cleanliness to meet kayakalp standards through a support of Rs 10 Lakhs under NHM.

III. Build capacity through training in water, sanitation and Hygiene (WASH) to nominees from such CHCs and PHCs.

Table 2 Depicts Activities done under Kayakalp Programme for FY 2016-17 till 26th February 2017

- Out of 26 eligible states of the country 25 States has completed all assessments and have identified ''Kayakalp'' awards for district hospital level facilities. Only State of Jammu and Kashmir is not able to complete external assessment of Kashmir region due to heavy snowfall during January to Mid-February 2017.
- In SDHs/CHCs categoriesout of 36 States and UTs 27 States and 2 UTs has completed all assessments and declared ''Kayakalp'' awards.
- Out of all 36 States and UTs of the country 28 States/UTs has completed all assessments and



Picture 1: Improved aesthetic in a general ward, Indra Gandhi Distric Hospital, Korba (Chhattisgarh)

Picture 2: Children's play area in paediatrics ward at Civil Hospital, Amritsar

Picture 3: Renovation for better dietary services at Indra Gandhi Distric Hospital, Korba (Chhattisgarh)

Picture 4: Cleaning of Hospital Kitchen

Picture 5: Hand Washing training for school children, District Hospital Panchkula, Haryana

Picture 6: Improving the Cleaning Process at DH in Madhya Pradesh

Picture 7: Scientific Management of Biomedical Waste at DHH Koraput (Odisha)

Picture 8: Patients Queue Management at a DH in Tamilnadu

Picture 9: ICU at District Hospital Khera, Gujrat

Picture 10: Patient information system

declared kayakalp awards for PHCs level facilities. Till date 242 districts of the country have identified winner and commendation award winner PHCs.

- Assessment of Central level Government Institutions has completed and awards distributed to 1 winner, 2 Runner-up and 3 commendation award winner facilities.

Major impact of the Programme

1. Enhanced cleanliness and improved aesthetics of public health facilities
2. Reduction in Hospital Acquired Infections
3. Improved Bio Medical Waste Management system of facilities
4. Speedy recovery of patients
5. Enhanced Patients' Satisfaction
6. Helps in Quality Assurance programme
7. Inculcate culture of maintaining cleanliness at Public spaces
8. Regain trust and confidence of the community in Public healthcare facilities.

Conclusion

Kayakalp scheme has been encouraging public health facility in the nation to work towards standards of excellence to ensure facilities stay clean and hygienic. This scheme had shown that there is significant increase in cleanliness, hygiene and infection control practices in public healthcare facilities.

This scheme has been initiating a culture of ongoing assessment and peer review of performance to promote hygiene, cleanliness and sanitation. This scheme will also provide opportunities and incentives to bolstering inter sectoral coordination for the improvement of health systems.

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Review Article

Indian Journal of Hospital Administration
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Organ Donation and Transplantation: Role of Nurse

Amirtha Santhi S.[1], Malarvizhi S.[2]

Abstract

Organ donation is when a person allows his/ her organ to be removed, while the donor is alive or after death with the assent of the next of kin. The need for the organ is very high but the donation rates are very low. The nurses are having very important role in organ donation and transplantation. As the legal procedures keep on changing the nurse has to update themselves about organ donation procedures.

Keywords: Organ donation; Donor; Transplantation; Assent; Next of kin.

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Introduction

Organ donation is when a person allows his/ her organ to be removed, legally, either by consent while the donor is alive or after death with the assent of the next of kin. Donation may be for research, or, more commonly healthy transplantable organs and tissues may be donated to be transplanted into another person [1].

Nurses play several roles in the field of organ donation. Nurses may work with patients waiting for transplant or with individuals who have already had organ transplants. Hospital nurses who work on regular medical or surgical floors are also sometimes asked about organ donation by patients or their families [2]. So it is important for the nurses to know the details of organ donation, transplantation. As the legal procedures keep on changing the nurse has to update themselves about organ donation procedures.

Annual Organ donation rates in India [3,4]

Rate of organ donation in India is very less when we look at other countries. In India it is 0.26 per million, 26 per million in USA and 36 per million in Spain. So the health care personnel's have to very important role to play in the field of organ donation.

S. No.	Organs & tissues	Needed	Available
1	Corneas	2,00,000	50,000
2	kidneys	21,000	5,000
3	Hearts	5,000	70
4	liver	2,00,000	750

Role of Nurses in the Organ Donation and Transplantation [5,6]

The organ donation rates are very low in India so the nurses need to take extra effort to improve the rate of organ donation. All the individual patients coming to the hospital need to meet the nurses for one or the other purpose. So there are few vital roles can be played by the nurses.

Hospital Nurses

If a patient or the family of a patient asks a nurse about the possibility of an organ donation or transplant, the nurse has to notify this to the transplant team in the hospital.

ICU Nurses

ICU Nurses take care of the live donors and recipients after organ donation, the deceased person till the time of organ donation after the brain death. If the patients and their relatives if they have any doubts it is to be clarified by the ICU nurse or the transplant team.

Transplant Nurses

When a patient is awaiting an organ transplant, he's under intensive medical care. In many transplant centers, each patient has a nurse assigned to him who sees him regularly, follows up on lab work and acts as a liaison between the patient and the transplant physicians. She also need to educate her patients about the transplant process and provide emotional support.

Procurement Nurses

Procurement nurses initiate contact with the family of the patient whose organs might be suitable for transplant — then coordinate the timing of the organ harvest from the donor with the transplant into the recipient. The procurement nurse also might assist with the surgical removal of organs from the donor and ensure that the organs are properly transported to maintain viability when they reach the recipients.

Surgical Nurses

The transplant team consists of doctors and nurses specially trained in transplant, which involves two patients: the donor and the recipient. Separate surgical teams might handle the removal of the organs from the donor and the placement into the recipient, or the same team might perform both surgeries.

Nurse Educators

Arrange CNE on organ donation and make the nurses to know about the legal aspects involved in the organ donation process.

In a study done at NIMHANS on 2015 about 81% of the nurses were 'willing to sign the card' for organ donation; however, only 3.8% of them actually 'signed the organ donation card'.

Nurse Researchers

The researchers can do research in the field of organ donation such as the quality of life of the live donors, recipients and their families, recipients, case studies on organ recipients and organ donors

Nurse Administrators

Nurse administrators must take the initiative to develop guidelines clarifying the role of nurses in the organ donation and transplantation process to promote organ donation and improve rates.

How to Improve Organ Donation Rates [7]

Create Awareness to the Public

The public need to be aware of organ donation and brain death. So that when there is a brain death the family members may know that the organs can be donated after brain death. Because at the time of brain death the family members may not be willing to learn about brain death and organ donation. The main reasons of disagreement were lacking of consent among relatives and religious beliefs. In a study done by Vaishaly K. Bharambe, et al., at Pune 78% of respondents were aware of organ and body donation, very few were aware of the necessary health status of the donor and 39% had no awareness regarding concept of brain-death [8].

Mass Media

Mass media such as internet, television, newspapers can be used to create awareness about organ donation. Especially whatsapp and facebook create great impact among the public and the information reaches the public very fast.

Can be Added as an Option in the Identity Card

There can be an option in the driving license, or identity card for the willingness to donate organs as it is carried by most of the working community.

Make them know

In all the hospital deaths the relatives to be told to think about organ donation

Add in the Student Curriculum

All the school and college students need to be taught about organ donation. Only the medical professions are learning about organ donation. But as it is the need of the hour all the school and college syllabus should cover the organ donation topic.

Conclusion

Nurses can improve the awareness of the public regarding organ donation educating the public, in all the hospital deaths talk to the relatives about the option of donating the organs, engage in the public talks, make the young nurse researches to do more researches on organ donation.

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Review Article

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Impact of Occupational Stress on Employees: A Glimpse of Existing Literature

Vevita Priya Aranha[1], Vencita Priyanka Aranha[2], Valesh Prajwal Aranha[3], Asir John Samuel[2]

Abstract

The present literature review describes about the various types of stress and examined the stress management strategies of the employees in different sectors. It elaborates about the various difficulties faced by the employees in their work place and about organizational oriented Strategies for coping Stress. Here we present the collective views from various researchers in the area of stress management. Finally this review highlight the research gap in the above area and open the door for the present day researcher to pursue their research work.

Keywords: Occupational Stressors; Work Performance; Employees; Motivation; Mental Health; Stress.

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Introduction

Stress means a nonspecific response of body to a certain demand [1]. It creates tension in our Nervous system and is result from the internal conflicts from a varied range of external situations. It affects almost every type of individual at different point of life [1].

Stress may cause by both sweet and bitter type of experiences. When stress is felt, the body will react by releasing various hormones and other types of biochemicals into the blood [2].

These biochemicals will give more energy and strength, which might be good thing if the stress was caused by physical danger. But also it could be a bad thing, if their stress was due to emotional disturbance and there is no outlet for this extra energy and strength. Basically the stress is the result of either physical or emotional disturbances. The human function depends on stress [3].

There are various types of stress, like survival stress, internal stress, *environmental stress, fatigue and overwork.*

Type of Stress

The *Survival Stress* consist "fight or flight" type of reaction. This was a natural response by all the animals to any kind of danger. This is common between animal and the dignified animal, human. Only the sense of humour differentiates between them. But in times of danger, the body will naturally react with a burst of energy to make survive in the dangerous situation (fight) or escape from it (flight). Internal stress is one of the most important kinds of stress to understand and manage. Internal stress is when people make themselves stressed. This often happens when they worry about things that they were not able to control the situations. Some people become addicted to the kind of hurried, tense, lifestyle that results from being under stress. They even look for stressful situations and feel stress about things that were not actually stressful. *Environmental Stress* was a response to the things around which cause stress, such as noise, crowding, and pressure from work or family. Identifying these environmental stresses and learning to avoid them or deal with them

would help lower your stress level. The lastly, the kind of stress which builds up over a long time and could take a hard toll on the body *is fatigue and overwork.* It could be caused by working too much or too hard at job(s), school, or home. It could also be caused by not knowing how to manage the time well or how to take time out for rest and relaxation. This could be one of the hardest kinds of stress to avoid because many people felt this was out of their control.

Stress can be classified into another three types based on the time of response. They are acute stress, episodic acute stress and chronic stress. Acute stress is the most common type of stress. It is the immediate reaction to a new challenge, event, or demand, and it triggers fight-or-flight response. Severe acute stress could lead mental health problems, such as post-traumatic stress disorder or acute stress disorder. When acute stress happens frequently, called episodic acute stress. People who are often short-tempered, irritable, and anxious suffer from this type of stress. Unresolved acute stress which began to increase gradually and lasts for long periods of time are called chronic stress. This stress is constant and leads to heart disease, cancer, lung disease, accidents, cirrhosis of the liver and even the major caused for suicide.

This review would discuss the various causes of stress, the mode of stress, and the impact of stress on people.

Collection of Researcher's Views

- *Stress among Employees in Business Process Outsourcing (BPO) Industry*

Stress is common among the business process outsourcing (BPO) industry employees as they have wide job target in shorter span. A management researcher drafted the study to examine the casual relationship between job stressors and job performance with its impact on employees [4]. The study revealed that the job stress was negatively related to their performance. Their stress affects the mental and physiological health. The reason for stress among the BPO employees was inability to meet out the demands of the job and also their relationship between peers. Their stress could be reduced by engaging the employees in terms of creating fun at work, sufficient break between working hours and keeping them motivated towards organizational objectives.

- *Stress among Women Employees in Business Process Outsourcing (BPO) Industry*

Business process outsourcing (BPO) industry is one of the fastest growing sectors. They provide wide employment base in India and women occupies the greater share. A researcher has collected the data from women employees who are working in BPO industries, IT companies, and women working in private sectors to know their stress levels [5]. The stress generates factors for women employees is accountability at home and accountability at office. They have to balance their both the side. There are many problems faced by the women workers in work environment. Some of them are security, gender discrimination by employees, social constraints, 24 x 7 work pressure, prolonged working shifts and work life balance. The stress from these situations could be minimized by the following HR practices such as, mentoring programmes, senior leadership engagement, career counselling, multiple communication channel, equal employment opportunity and cultural programs.

- *Stress among the Employees in Information Technology (IT) Company*

Stress becomes a major issue in Information Technology (IT) companies. They affect the personal and social life of an employee. A management researcher looked upon the level of stress among IT employees and to identify stress coping strategies at their organizational level [6]. The survey report on 10 IT companies in and around Hyderabad with the sample of 200 in that 150(65%) were men and rest are women. Some of the stress coping strategies identified by the study include positive attitudes, meditation, stress management programmes, physical activities, life style modification, supportive organization culture and stress counselling programmes.

Stress Levels among the Indian Soldiers

Another management researcher studied the demographic profile of the Indian Army soldiers and analysed the differences in opinion of soldiers according to the six demographic variables namely age, qualification, income, designation, length of service and marital status [7]. The study was aimed to examine the differences in perceptions among the soldiers regarding occupational stressors based on their demographic profile and then to make recommendations to alleviate occupational stress in Indian Army. A sample of 415 Indian soldiers who were working below the officer rank in the northern command of the Indian army was recruited. The

sample was exclusively male, selected through stratified random sampling technique. Data was collected using structured, validated questionnaire and analysed. The study concluded the result that single soldiers belonging to lower ranks and younger age group with a service experience of less than 10 years were more prone to occupational stress [7].

Stress Level among the Bank Employees

A study was performed on the employees of bank to know the level of stress, its causes and effects of stress on their health [8]. Both primary and secondary data collection methods were adopted to collect data from 50 various nationalized bank situated in and around Hissar. They studied the importance of interventional strategies to manage stress and effectiveness of various stress management programs organized. According to researcher the reason behind employees stress was associated with the fear of decrease in quality in their work, work overload, non-achieving the target, family related problems, and many more. The researcher suggested organizational oriented strategies for coping stress such as flexible work timing, job sharing, work from home, longer lunch hours, health care advocacy, frequent stress management programmes, meditation and positive attitude would help to cope with the stress from banking sectors [8].

The Research Gap

Job performance, emotional intelligence, work life balance, job insecurity and combination of all these in a one research paper will help to get good result. Employee engagement [9] should also be considered while drafting a model to analyse stress among the employees. Combining all the above in one model would minimize strain on time to effectively study the level of stress and its impact on employees well-being. The suggestion should have been incorporated in future studies.

Conclusion

The research aimed at the integrated approach to reduce stress on employees should be drafted to get better understanding about the impact of stress on employees.

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Review Article

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Cost Effectiveness: Economics in Health Care

Vasantha Kalyani

Abstract

Health care consume was first introduced in 1930's. The consumer movement in 1970's led to increase demand for accountability and for the provision of all medical services. An assessment or determination of the most efficient and least expensive approaches to providing health care and preventive medicine services. Accident prevention programs, immunization drives, and safe-sex campaigns are designed to reduce the number of patients who will suffer preventable illnesses

Keywords: Cost Effectiveness; Cost Containment; Health Care.

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One way is to measure health improvement in terms of the "quality-adjusted life year," or QALY. This number reflects how many years of life are gained as a result of an intervention, on average, per patient, per episode—and weights the extra years of life by how patients subjectively describe the quality of those years. Effectiveness and cost are always comparative, because one treatment or procedure is always compared to another.

Cost of Healthcare Services

- Increase in the price of new technology.
- Sophisticated diagnostic treatment.
- Increasing population need.
- New care facilities, regulation among hospital construction.
- Average length of hospital stay.
- Increase elderly norms.
- Less Salary.
- Lack of consumption in the healthcare field.
- Higher survival leading to greater need for costly intensive or long term care.
- High cost of diagnostic health related equipment.

Economics in Health Care

- Compliance with budget.
- Compliance with staffing format.
- Healthcare hours per patient per day.
- Work load (Occupancy rates).

Cost effectiveness of professional health care activities to be carried out in each health delivery system as primary, secondary and tertiary levels.

For the Cost Effectiveness in Health Care the Following Activities to be Followed.

- Organization of health care services.
- Testing of specific health care interventions includes health personal roles, procedures and technological advance which used in various diagnostic tests.

Issues in Health Care Cost Containment

- cost of health care.
- The overcapacity of hospital.
- The unequal financing health care practices.
- cost of hospitalization.

According to WHO The Cost effective analysis: over view

- The growing use of cost-effectiveness analysis (CEA) to evaluate the costs and health effects of specific interventions is dominated by studies of prospective new interventions compared to current practice. This type of analysis does not explicitly take a sectoral perspective where the costs and effectiveness of all possible interventions are compared in order to select the mix that maximizes health for a given set of resource constraints. Much of the theoretical literature has taken a broader view of cost effectiveness, exploring its use in allocating a fixed health budget between interventions in such a way as to maximize health in a society.
- CEA of a wide range of interventions can be undertaken to inform a specific decision-maker. This person faces a known set of resource constraints (hereafter called a budget), a set of options for use in the budget, and a series of other (ethical or political) constraints. The set of constraints in this highly context-specific use of CEA for sectoral decision-making will vary tremendously from setting to setting.
- CEA of a wide range of interventions can be undertaken to provide general information on the relative costs and health benefits of different technologies or strategies which contribute through multiple channels to a more informed debate on resource allocation priorities. Such general information should be seen as only one input into the policy debate on priorities. Because it is not meant to provide a formulaic solution to resource allocation problems it need not be highly contextualized.
- For some decision-makers, the development of complex resource allocation models that explicitly incorporate a range of decision constraints and multiple objectives may be useful. But such efforts are information intensive, time consuming, costly and very often difficult to communicate to the full set of actors in any health policy dialogue. We believe that CEA can be most useful with more modest goals by focusing on the more general use of cost-effectiveness information to inform health policy debates without being completely contextualized. Moreover, sectoral CEA should identify current allocative inefficiencies as well as opportunities presented by new interventions.
- If one intervention is deemed more cost–effective than another in the context of a fixed budget, we can say that it will yield more health benefit per unit of expenditure than that other option. However, the results of a cost–effectiveness analysis cannot indicate if an intervention is a good use of the health budget because the comparator may itself be inefficient relative to other feasible options.

Recommendations on Interventions in Regard with Cost Effectiveness

- Groups of interventions where there are major interactions in either costs or health effects should be evaluated together.
- Analysts should evaluate all interventions initially against the "null", i.e. the situation that would exist if none of the set of interacting interventions were implemented.
- Interventions should be described in detail, which includes information on the setting, target population, time frame, regimen, and frequency of obtaining the intervention.
- All interventions should be evaluated under the assumption that they are implemented over a period of 10 years. However, costs and health effects related to the intervention should be followed for the duration of the lifetime of the beneficiaries. This could be varied by country analysts adapting the results or undertaking studies in their own settings.
- Resource use and health effects should be identified and valued from the societal perspective.

Several Possible Measures Due to the Inflation in Health Care Costs and Need to be Analysed

- The consumer price index (CPI) reflects the change in the cost to the average consumer of acquiring a fixed basket of goods and services. However, it is questionable if its determinants (i.e. choice of goods and services to include, and the weights used) are reflective of health costs as a whole. Moreover, the CPI is only appropriate if the price of the resource in question is changing at the rate of the general price inflation.
- The Gross Domestic Product (GDP) implicit price deflator is defined as the price index that measures the change in the price level of GDP relative to real output. It measures the average annual rate of price change in the economy as a whole. It also takes into account changes in

government consumption, capital formation, international trade and final household expenditure, and therefore covers virtually the whole economy. It is the broadest-based measure of inflation, and our recommended deflator for making health sector cost adjustments over time.

- The rate of wage inflation reflects the average annual increase in wages throughout the economy, or in specific sectors of the economy (e.g. public service). It is too narrow to used as a general index of inflation.
- The rate of inflation of specific product groups reflects the rate of inflation for individual or groups of products, such as agricultural products, raw commodities and food. Some countries have an index of inflation for health goods and services, but not enough to recommend its use broadly.

Recommendations

- Ideally, analysts should follow the ingredients approach and collect and report information on the quantities and prices of the resources used in addition to total expenditures.
- The cost of providing health interventions should be included in the analysis as should the resources used up in seeking or obtaining an intervention (e.g. transport costs). It is recommended that Cost of scaling up interventions an important question that is facing many governments is the cost of scaling up interventions to achieve target coverage levels. As coverage expands into remote areas, the marginal costs of providing an intervention to each additional person usually increase. The cost of scaling up interventions, including economies and diseconomies of scale, should be taken into account. For this reason, WHO-CHOICE presents cost-effectiveness estimates of different interventions e.g. at coverage levels of 50%, 80% and 95%. This involved the development of price multipliers to provide a conversion factor for prices at different levels of coverage, and unit costs of outpatient visits to health facilities at different coverage levels. More detail of the methods used and results of this analysis are available from the WHO-CHOICE web site www.who.int/evidence/cea. ?? WHO Guide to Cost-Effectiveness Analysis productivity gains and losses due to an intervention, including time costs of seeking or obtaining care, should be excluded from the CEA. Where they are believed to be particularly important, they should be measured (rigorously) in physical units (e.g. time gains or losses) and reported separately.
- Transfer payments should not be included in CEA. However, any related administrative costs should be included.
- Costs of central administration and the education of health professionals can be regarded as existing or ongoing costs and should not be included in the analysis. This does not include training costs for a specific intervention, which should be included.
- Shadow pricing should be used to determine the economic costs of goods that have no market price or if market prices are believed to have major distortions.
- Prices of traded and non-traded goods should, in theory, be expressed in terms of a common numeraire, and we recommend using the world (international) price level to allow for comparability of results.
- The annual costs of capital investments can be approximated by their rental price where a rental market exists and works relatively well. But because this is often not the case, the preferred approach is to annualized them taking into account purchase value, resale value, interest rate and working life.
- Costs should be discounted at an annual rate of 3% in the base analysis. The sensitivity of the results to using a 6% rate should also be explored.
- Analysts should report the capacity utilization that drives their cost effectiveness estimates. WHO-CHOICE consistently uses 80% capacity utilization to obtain estimates of the cost-effectiveness of interventions if they are undertaken relatively efficiently.
- Prices should be adjusted to a common year using the GDP deflator where possible. If this is not available, the Consumer Price Index can be used.

Conclusion

There is consequently a pragmatic need for policy-makers to borrow and adapt results obtained in other settings and to generalize these to their own settings. Global estimates, however, have limited credibility among policy-makers in individual countries because of the diversity of cost structures, epidemiological profiles and starting conditions.

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Review Article

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Trends and Disparity in Surgical Management of Coronary Diseases

Malarvizhi S.[1], Amirtha Santhi S.[2], Sheela J.[2]

Abstract

World health Organization projects that Cardio Vascular Diseases (CVD) is the first leading cause of death in the world. Mortality data from the Registrar General of India shows that cardiovascular diseases are a major cause of death in India now. CVD is caused by both modifiable and non modifiable risk factors. CVD can be treated by medicines or invasive procedures such as Percutaneous coronary Intervention, Atherectomy, Brachytherapy, Coronary Balloon Angioplasty or Coronary Artery Bypass Graft.

Keywords: Cardio Vascular Diseases; Risk Factors; Atherectomy; Brachytherapy; Angioplasty.

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Introduction

World health Organization projects that CVD is the first leading cause of death in the world. Coronary artery disease (CAD) is the leading cause of cardiovascular mortality worldwide, with more than 4.5 million deaths. As per world heart federation by the year 2030, cardiovascular disease will cause an estimated 23.6 million deaths worldwide.

Mortality data from the Registrar General of India shows that cardiovascular diseases are a major cause of death in India now. The disease occurs at a much younger age in Indians as compared to those in North America and Western Europe. India is at 39th rank in the world with death rate of 138 per 1,00,000 population with regard to coronary diseases [1,2,3].

Meaning

Trends: A general direction in which something is developing or changing.

Disparity: A great difference

Coronary: Relating to the arteries which surround and supply the heart

Coronary Diseases: Coronary diseases include ischemic heart disease, heart attack, myocardial infarction and angina pectoris.

Definition

Coronary Disease or Coronary artery disease (CAD) or Coronary heart disease occurs when the inside (the lumen) of one or more coronary arteries narrows, limiting the flow of oxygen-rich blood to surrounding heart muscle tissue [4].

Causes

I. Non- Modifiable

- Age
- Gender
- Family history
- Ethnic background

II. Modifiable

- Smoking

- High cholesterol in blood
- Stress
- Physical activity
- High amount of sugar in blood

Pathophysiology

As plaque builds up in the arteries of a person with heart disease, the inside of the arteries begins to narrow, which lessens or blocks the flow of blood [5].

Signs & Symptoms

- Chest pain
- Shortness of breath
- Palpitations
- A faster heartbeat
- Weakness / dizziness
- Nausea
- Sweating [6]

Diagnosis

- ECG
- Stress Test
- Chest X-Ray
- Holter Monitor
- Echo cardiogram
- Cardiac CT

Treatment

1. Medicines
2. PCI- Percutaneous coronary Intervention
3. Atherectomy- Plaque is removed with laser
4. Brachytherapy
5. Coronary Balloon Angioplasty- Balloon tipped catheter advanced
6. CABG- Coronary Artery Bypass Graft

1. *Medicines*
   a. Nitrates
   b. Betablockers
   c. Calcium blockers.
   d. A newer fourth agent, ranolazine (Ranexa)
   e. For people at risk
      - Aspirin
      - Statin

2. PCI- Percutaneous Coronary Intervention

(a) Percutaneous Transluminal Coronary Angioplasty (PTCA) is a minimally invasive procedure to open up blocked coronary arteries, allowing blood to circulate unobstructed to the heart muscle.

If a treatable blockage is noted, the first catheter is exchanged for a guiding catheter. Once the guiding catheter is in place, a guide wire is advanced across the blockage, then a balloon catheter is advanced to the blockage site. The balloon is inflated for a few seconds to compress the blockage against the artery wall. Then the balloon is deflated.

This treatment may be repeated at each blocked site in the coronary arteries. A device called a stent may be placed within the coronary artery to keep the vessel open. Once the compression has been performed, contrast media is injected and an x-ray is taken to check for any change in the arteries. Following this, the catheter is removed and the procedure is completed.

(b) PCI Procedures Includes

- PTCA- Percutaneous transluminal coronary balloon angioplasty and
- Coronary vascular stents (or scaffolds) such as bare metal stents (BMS), and drug eluting stents (DES).

i. Bare Metal Stents (BMS)

Coronary vascular stents are metallic 'scaffolds' that hold a blocked vessel open to restore coronary artery blood flow.The earliest type of stent developed was bare metal stent (BMS). Later, drug eluting stents (DES) were developed and widely used for PCI.

ii. Drug Eluting Stents (DES)

A drug-eluting stent (DES) is comprised of three components: a bare metal backbone (platform), the durable polymer, and anti-proliferative agents such

as everolimus, biolimus, or sirolimus.

The first-generation of DES, containing sirolimus or paclitaxel, was shown to reduce in-stent neointimal hyperplasia, reduce rates of clinical restenosis, and curtail the need for repeated PCI compared with BMS.Hypersensitivity reactions to the durable polymer component of the first generation DES can produce chronic inflammation which is thought to delay endothelial healing

The second-generation DES were thus developed using a thinner stent struts, permanent but biocompatible polymers to minimize inflammation or hypersensitivity reactions, and novel anti-proliferative agents

Third generation The most recent innovation (the third generation) in stent technology is the development of bioabsorbable stents.With bioabsorbable polymer stent, a bioabsorbable polymer impregnated with anti-proliferative drug is designed to elute the drug from the metallic stent with the polymers gradually degraded after implantation

3. Atherectomy

Atherectomy is a minimally invasive endovascular surgery technique for removing atherosclerosis from blood vessels within the body. It is an alternative to angioplasty for the treatment of peripheral artery disease, with no evidence of superiority to angioplasty.

4. Brachytherapy

Radiation is given to blocked coronary arteries to prevent reoccurrence after angioplasty.

5. Coronary Balloon Angioplasty

Interventional cardiologists perform angioplasty, which opens narrowed arteries. They use a long, thin tube called a catheter that has a small balloon on its tip. They inflate the balloon at the blockage site in the artery to flatten or compress the plaque against the artery wall. Angioplasty is also called percutaneous transluminal coronary angioplasty (PTCA).

6. CABG - Coronary Artery Bypass Graft

CABG surgery creates new routes around narrowed and blocked arteries, allowing sufficient blood flow to deliver oxygen and nutrients to the heart muscle [7].

Conclusion

The 20th century witnessed dynamic, worldwide changes in Coronary heart disease. (CHD) is the largest cause of mortality in the world and majority of deaths occur in low- and middle-income countries such as India and China.

Coronary heart disease mortality was expected to increase approximately 29 percent in women and 48 percent in men in developed countries between 1990 and 2020.

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Deliberation on a Case of Partial Hanging Found at an Unusual Place: in the Rear of a Covered Tempo

Abhishek Yadav[1], Sumit Tellewar[2], Mantaran Singh Bakshi[3], Sudhir Kumar Gupta[4]

Abstract

Deaths due to hanging are routinely encountered by the Forensic Pathologists all over the world and are the leading method of suicide in India. In equivocal circumstances, the ligature deaths are distinguished into hanging and strangulation by a thin line and possibility of a certain foul play arises whenever any unusual circumstances or findings are encountered. We report a case where a person was found partially hanged in a rear of a covered tempo. The external and internal findings during postmortem examination were of a typical hanging case. The chemical analysis reported Ethyl Alcohol in concentration of 62.30 mg/dl of blood of the deceased. The findings were corroborated with the circumstantial evidences and the cause of death was concluded as antemortem hanging. The authors aim to add the findings of this case to the Medical literature for future reference, and recommend that the autopsy surgeon should interact with the relatives in such cases so as to address their doubts about the cause and manner of death.

Keywords: Suicide; Hanging; Partial Hanging; Ligature Mark.

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Introduction

Preferred methods of committing suicides are different in different countries [1] and Hanging is the most common method in India [2]. Hanging is generally considered as suicidal until proven otherwise [3-6]. The commonest place of hanging is inside the house [7-9]. So, doubts arise about the manner of death when a person is found hanged at an unusual location. More suspicion arises when the suspension of the body is not complete and the feet are touching the ground. We report a case where a person was found partially hanged in a rear of a covered tempo. The authors aim to add the findings of this case to the Medical literature for future reference.

Case History

A Tempo (Medium range Goods Carrier) **(**Image-1) was brought to Delhi from the state of Himachal Pradesh and after unloading of the goods the driver parked the vehicle in a ground meant for such vehicular parking. He came back to Tempo after three days for starting another trip and removed the cover on the rear of the tempo. He found an unknown person hanging in the rear of the vehicle (Image 2). The police was informed, identity of the deceased could not be established and after nine days the postmortem examination was conducted in the Department of Forensic Medicine, All India Institute of Medical Sciences (AIIMS), New Delhi.

Autopsy Findings

The body was of a young adult male with length 163 cm. The deceased was wearing a sweater, shirt

and pant. Clothes were dirty and intact. The rigor mortis was passed off, and postmortem lividity was present at the back. Bluish discoloration was present at the lips and the nails. Dribbling of saliva was present at the right angle of the mouth. Yellowish discoloration of sclera was present in the eyes. Signs of decomposition were present over the body.

A black and white nylon rope was encircling the neck having a single running knot present just below the left angle of the mandible. The neck circumference of the noose was 29cm; the ligature material was 3cm in diameter.

The Ligature mark was grooved reddish in colour, parchmentised and present in the middle one third of the neck. The width of ligature mark was 1cm. The ligature mark was present 7cm below the mentum and 11 cm above the supra-sternal notch in the centre of neck. The mark was 6cm below the right mastoid and 3cm below the left mastoid on the lateral aspect of neck respectively. The ligature mark was directed upwards, backwards and obliquely merging with the hairline at the back of the neck. On dissection the soft tissues underneath the ligature mark was dry, pale, glistening and devoid of any haemorrhage. The underlying musculature and blood vessels were intact and devoid of any extravasation or hemorrhage. The thyro-hyoid complex was intact and the trachea was congested.

There was no other external or internal injury present on the body. The visceral organs were congested and softened. The stomach was empty and mucosal walls were congested. The chemical analysis reported Ethyl Alcohol in concentration of 62.30 mg/dl of blood of the deceased.

Fig. 1: Tempo in which the body was recovered

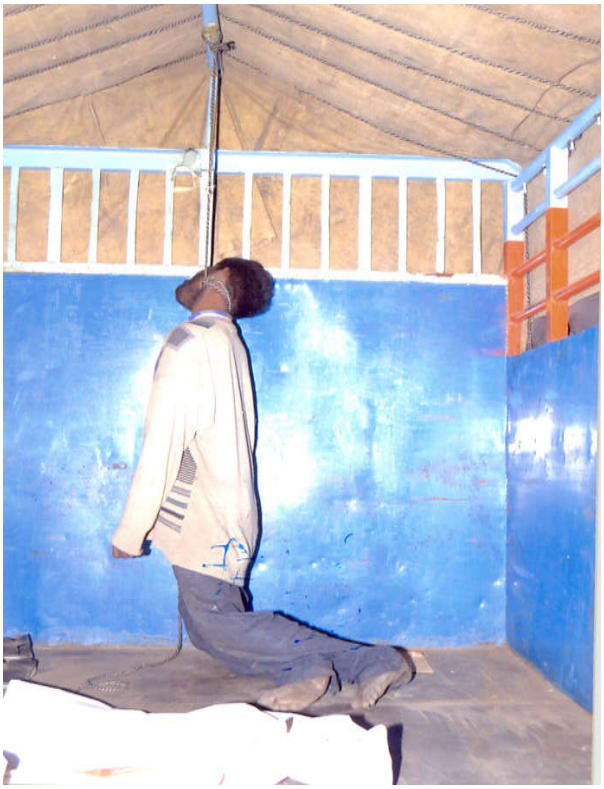

Fig. 2: Position of the Body in Tempo

Discussion

Hanging is caused by ligature compression of neck with the body weight acting as the constricting force due to suspension of the body [3-6]. In the present case we will first have a look at the autopsy findings. There was presence of dribbling of saliva, cyanosis over nail and lips and in-situ ligature material. The ligature mark was typical as seen in hanging cases [3-6, 10]. There was generalized congestion of viscera. No other external or internal antemortem injuries were present. All these clearly indicate the death was due to antemortem suicidal hanging.

The place where the body was recovered was unusual as it was a vehicle and an unknown place for the deceased. The suicide by hanging is done at a place known to the person, usually at home. But cases have been reported at very unusual places [8,11]. The suspension may complete with the feet above the surface/ground and when the feet are touching the surface it is termed as *Partial Hanging [10].* The body of the deceased is in partial hanging position (incomplete suspension) found with his feet

touching the surface with flexion on the knee joint. Nandy [10] mentions the partial hanging to be diagnostic of suicidal hanging. Bennewith et al found incomplete suspension to be present in up to 47.6% of suicidal hanging cases [7].

The detection of alcohol in the blood of the deceased proves that he was under the influence of alcohol while committing suicide. The relationship of alcohol as a confounding factor for committing Suicide is well established [12-15]. All the findings were discussed with the investigating officer to corroborate with the circumstantial evidences. The investigating report also could not found any foul play. So, the cause of death in the case was concluded as antemortem hanging which was suicidal in nature committed under the influence of alcohol.

The authors have seen in their experience while interacting with the relatives of the suicide cases and the investigators, that there is a misconception that the hanging is suicidal when the suspension is complete and suicide note is present. When the hanging is found in an unusual location, without suicide note and with the part of the body touching the ground/surface, the possibility of a certain foul play arises. In this case though there were no complainants as the body was unidentified, still the investigation has to be led to a logical course for legal conclusion. The authors also recommend that the autopsy surgeon should interact with the relatives in such cases so as to address their doubts about the cause and manner of death.

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Conflict of Interest

There is no conflict of interests of any of the author

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