

## Vulnerability & Suffering of Healthcare Professionals

*The conference, organised by the Groupe Pasteur Mutualité (1) on 4 December 2008 in the Maison de la Chimie, Paris, on 'Vulnerability and Suffering of Healthcare Professionals' facilitated deeper probing than conventional burn out analysis.*

*This exhaustion syndrome demonstrates both the need for communication and, for each of us, reconsideration of our relationships to others.*



Conference chaired by **Dr Alain Marie** (centre) medical director of Quotidien du Médecin (magazine).

Today no one can deny the existence of burnouts. Neither healthcare professionals: doctors, nurses, auxiliary nurses, pharmacists, dental surgeons etc., all affected by or susceptible to them at some time, nor the governing authorities who have set up watchdogs, financed studies, proposed solutions, which are still in the embryonic stages, but which have the positive effect of bringing burnout into the open.

Patients themselves, and indeed the whole of society, can no longer remain oblivious to this phenomenon. As medical practices have developed, so has the patient-doctor relationship, but the consequences have not been considered: the patient's respect for the omniscient doctor has made way for the demands of the user from the care provider. And the result is not positive for either side. It is however not too late for both sides to respect each other for what they are: human.



**Dr Bruno Gaudeau**, head of the Groupe Pasteur Mutualité.

### The fall of Icarus

Hippocrates wrote, as **Dr Bruno Gaudeau** reminds us, *"the doctor will have a healthy colour and stature, because the public imagines that those whose bodies are not healthy will not be able to care for others properly"*. This precept, still current, lead to generations of super heroes flying to the aid of poor suffering humanity. Furthermore the professor, who does the rounds in the hospital, surrounded by his learned assembly of students and nurses, is still almost divine for the patients and the medical personnel. And the motto of all doctors is: *"achieve quality, without error and at the same time reduce costs, be irreproachable, polite, available, sympathetic..."* **Prof Marc Berthel** concludes. Carried by fundamental morality based on the desire to care for people, doctors strive to attain the level of their ideals. To the detriment of their private lives, holidays,

- (1) With the participation of:
- National Council of the Order of Doctors (CNOM);
  - the Directorate of Hospitalisation and Care Management (DHOS);
  - the French Independent Doctors' Pension Fund (CARMF);
  - the French Medical Association.

## Every caring relationship includes suffering

the 35 hour week, sport, time spent doing other things.....How is it possible to maintain a healthy body (and mind) in order to care for others?

GP, single, large number of patients, performing home visits, working at least 57 hours a week, not including being on call, rarely closing the surgery....Is this the ideal doctor? No, this is the profile of someone threatened with alcohol dependence, physical exhaustion, depression, in short, burnout, even suicide. **Dr Yves Léopold** describes this doctor as “a fallen god because he is burnt by his ideals – as suggested by the word burnout – when he is confronted by constant failure: none of his patients will survive...this is a reality which doctors find it difficult to come to terms with.”

### What does the concept of life mean?

The patient also holds an idealised vision of health; or rather health is a right which he asserts imperatively. **Corinne Pieters** sees here the explanation for the malaise of healthcare professionals: “*Illness, and in particular chronic illness, is failure. Not having a cure, when admitted by a healthcare professional, is always an admission of powerlessness. Not having to suffer is seen as a due right by the patient, or even as a duty imposed on the healthcare professionals.*” She considers that if the conflicting relationship exists in all aspects, it is primarily linked to what we expect in terms of both quantity and quality of services. When compared with another sensitive profession, such as teaching, there is something specific to medicine: the relationship of care or treatment itself which



**Prof Marc Berthel**, geriatrics professor Louis Pasteur University, Strasbourg, assistant head doctor of the geriatrics centre of the Strasbourg university hospitals and **Michèle Sauder**, health manager of a nursing home.



**Dr Yves Léopold**, GP, deputy chairman of the CARMF.

### Suicide: ultimate expression of burnout?

14 % of deaths of active private practice doctors result from suicide, compared to 6% at a national level. This is the highest level of all professional categories. These figures originate from a national study from 2003. Only the data from 26 départements (regions) can be used as the larger départements still do not know hide behind professional confidentiality. In 2008 the CARMF and the CNOM decided to undertake research into the deaths of private practice doctors based on a survey sent to each family. They only asked for the cause of death and the age of the practitioner. But, Dr Yves Léopold explains, “despite being anonymous, this survey recognises the existence of suicide and it’s distressing.”



Icarus embodies man’s desire to go ever further, which leads to the risk of finding oneself faced with the fact that one is only human.

Other countries the situation is overexposure of female doctors”.

Based on the information collected, Dr Yves Léopold details the pointers to suicide risk (which are more associated facts than risk factors):

- addictive behaviour (in 1 out of 2 suicides alcohol is involved) ;
- an emotional breakup (1 out of 2) ;
- financial difficulties (1 out of 3, late payments to the Pension Fund or to the Council of the Order are warning signs) ;
- legal proceedings, ordinary or administrative (1 out of 3) ;
- illness, physical or mental (1 out of 4 or 5).

The healthcare professionals who present the largest risk are psychiatrists, anaesthetists and GPs, regardless of their form of practice (in a surgery or a hospital, alone or in a group surgery) and the place (urban or rural). This indicates that the aspect of individual weaknesses should be examined initially...

## Care in itself is therapeutic

“requires further reflection on what the concept of life can mean”. A notion which Corinne Pieters analyses as “a power which of course carries and supports the subject but also as something which simultaneously orchestrates its own destruction. Because it is indeed the power to destroy life which destabilises reassuring beliefs in terms of treatment and in particular in terms of all powerful treatment”. Corinne Pieters suggests that in order to understand the forms and the issues relating to the vulnerability of medical professionals faced with a situation of suffering, the illness must be seen as “a complete experience which shatters all links, all the identity markers of a sufferer, which therefore contaminates all aspects of his or her existence...and not just during opening hours!”

And no one withstands this ‘modifying power’ of the illness, the medical professional no more than the patient, even if, of course, the methods of resistance cannot be directly compared.

How can you escape from this double paradox: the patient accepts being ill ever less and the medical professional feels increasingly guilty for not having a cure?

### Treatment is not the same as a cure, but still...

The philosophical approach to inherent suffering in medical practice leads to a redefinition of the term care. Corinne Pieters reminds us that the goal of a healthcare professional is not the cure (even if that is a personal aim and requirement), but taking charge is, or, in other words, the care. While for the patient a cure is what he or she is owed by medicine, for the majority of medical professionals it is the most appropriate and the most tried and tested treatment that he or she owes the patient. There are obligations in terms of treatment and means, but not in terms of results. So here we have the fundamental difference between a healthcare professional and a healer!

Being a doctor means looking after the patient and not just the illness, this means taking care of them. But, says Corinne Pieters, in the idealised vision of a cure, the link to care, nevertheless decisive, disappears: “As curing the patient seems to go without saying, the true difficulty in all circumstances of care is pushed into the background and the universality which transcends cultural differences is forgotten. Care is the effort to save man from his suffering and it is self conceived, regardless of the practical results, as an active response to this emotion, to the concern of the other party, which immediately materialises in an action which is therapeutic in itself. Care: to take care is already a cure, in a certain way”.

### The medical professional, a cog in the machine of society

This philosophical approach is definitely necessary to understand the social role of a medical professional, says **Dr Eric Galam**, who does not separate fragility from humanness: “One must remember that we are human beings and that is what is important in our work, not just suffering and vulnerability.” Quoting the singer Jean-Jacques Goldman (“In her eyes she had that slight pain which makes people bearable”), he is pleased about the fragility of medical professionals: “that makes us human, which is rather good news!”



Corinne Pieters philosophy lecture at University of Paris V, Marie-Rose Moreau's department.

### Burnout syndrome

The burnout concept, formed in the 70s, concentrating on paramedics, has recently ceased to be a taboo. Dr Eric Galam explains that three elements characterise burnouts:

- emotional exhaustion (stress, loss of motivation...);
  - depersonalisation: no longer seeing patients as humans, rather as illnesses, objects, even problems);
  - no longer enjoying the job and thinking one never will again.
- These three criteria can be analysed by means of a tool approved by the scientific community, the *Maslach Burnout Inventory*, which comprises 22 questions to test oneself.



Dr Eric Galam, GP coordinator of the Association of Professional Support for Private Practice Doctors (AAPML).

## *As a healthcare professional, I am a public service*

Fragile, sensitive, yes, but healthy, both physically and mentally. It is about preserving the health capital of healthcare professionals, not just as people: *“The healthcare professional has a responsibility to the people he is treating, so if he catches a cold, the whole system sneezes”*. Burnout is a matter of public health because the healthcare professional is a considerable social and human investment, *“someone who has been trained, who knows what looking after sufferers means. It is a real form of care-capital which must be preserved and optimised”*.



**Dr Jean-Claude Monfort**  
head of a psychogeriatric  
support body, Saint-Anne  
Hospital Centre, Paris

Furthermore, Dr Galam claims simply that: “as a *healthcare professional, I am a public service*”.

## What do healthcare professionals suffer from?

In healthcare professionals **Dr Jean-Claude Monfort** sees people pulled in 5 different directions: the material itself in treating people, which is sickness and death; physical or verbal abuse, to which all practitioners are exposed but particularly at the heart of sensitive sectors such as accident and emergency and psychiatric services; the institutional constraints which widen the gap between regulations and what is put into practice (doubtless due to a plethora of impending threats); and finally, in the background of the professional environment, the family of the healthcare professional, which can also be a potential stress factor, blaming him for not being at home enough or by maintaining, even subconsciously, the image of a super hero. To avoid the burnouts of a few healthcare professionals infecting the entire medical profession, all measures are welcome, because, Dr Monfort concludes “*the situation is so bad that we have reached rock bottom, so things can only improve...crazy logic, but I believe in it.*” (Continued on page 6)

### A clinic dedicated to ill healthcare professionals

A care programme for active healthcare professionals was jointly created by the Catalan Order of Physicians (Spain) and the regional government in 1998. It is run by Dr Antoni Arteman (Galatea Foundation of the Catalan Council of the Order of Physicians). Progressively, outpatient treatment, then day patient treatment and finally, last year, a specific building was made available to doctors and nurses (\*): the Galatea clinic (22 beds, 15 day patient places) is characterised by:

- confidentiality (name changing at the entrance, direct phone line, anonymous localisation of services)
- a ‘therapy contract’ signed by the therapist and the patient together with psychiatrists from other structures, public and private, who become involved where necessary;
- free treatment for healthcare professionals from Catalonia.

Up to the present the clinic has treated some 1800 patients: individual psychotherapy, group sessions, psychiatric tests and evaluations and hospitalisation.

84 % by choice and 11 % following pressure from those close to them, these patients require more intense care. The Galatea Foundation also offers preventative programmes: preparing for retirement, burnout prevention, healthcare of resident physicians etc., and publishes various studies on the health problems of healthcare professionals:

[www.fgalatea.org](http://www.fgalatea.org)

(\*) Integral Care Programme for Sick Physicians (PAIMM) and Return Programme for nurses.

### Bad patient

According to **Dr Antoni Arteman**, a doctor is the worst patient of all due to his status as an all powerful healthcare professional, denying burnout, the fear of stigmatisation and violation of confidentiality. Indeed, what delays treatment above all is the fear of losing the right to practice. Consult an associate? For Dr Eric Galam: “*it is no mean feat to treat a healthcare professional. It is a bit like a family member, to be taken with caution..... and then you are reluctant to get paid, which is fine at least for a few consultations, but not if I take a lot of time. Finding doctors who agree to treat their associates is not easy. It requires hard work in recruiting, training and accompanying the healthcare professionals of healthcare professionals*”.



**Dr Antoni Arteman**, specialist in public healthcare and preventative medicine, director of the Galatea Foundation's PAIMM programme.

## Hospitals must once again be sanctuaries

### Violence towards healthcare professionals

Since 2005, acts of violence which occur in hospitals in France must be reported to the National Hospital Violence Watchdog (ONVH). A police commissioner is responsible for the coordination and evaluation of prevention and security policy. When it comes to the figures **Fabienne Guerrieri** is cautious: on the one hand not all establishments report incidents or not in the same way, on the other hand *"we must not forget the gap between what is felt and what occurs: there is a tolerance threshold which is different for each person and also each establishment."*

Although an exhaustive study is impossible, she believes that the data is relatively close to the truth. This can be seen in an increase of 21% in reported incidents from 251 public or private establishments between 2006 and 2007. 67 % were property (theft with in). Among the more than half verbal abuse and increasing. The violence are cases or people them (15%).

*"We have found common trigger to response from the not correlate to the In half of all cases doctor who specific request for a sick signed off sick", Dr explains.*

statistics confirm people there are accompanying one time around higher the of the attack. phenomenon: in a surgery there is people who are waiting for or leaving their consultation."

In accident and emergency, **Dr Marc Bernard** reports, the situation in similar: blows and injuries: 43%, insults and threats: 55%. Nearly half of these unwanted incidents take place between 6pm and 1am. The identified reasons are initially waiting times, a lack of understanding of the functioning of the accident and emergency department, alcohol, refusal of treatment. When faced with a feeling of a threat of violence, felt by 95% of staff, one time in three the police are called. Physical restraint, only possible by injunction, is seen as a failure by the medical personnel, who are also reluctant to press charges, says **Anne Vanhoutte**.

The preferred solutions are institutional:

- the institutional plan (central or departmental);
- contractualisation between accident and emergency and in-patient services (planned in a bill from 2003, not applied);
- recognition of burnout as an occupational illness and taking of appropriate measures;
- increase in nursing staff funding for psychiatric counselling.



**Fabienne Guerrieri** main commissioner of the National Hospital Violence Watchdog



**Dr Marc Bernard** A&E doctor, court expert, Saint-Quentin Hospital, and **Anne Vanhoutte**, A&E/SMUR (Mobile Emergency and Resuscitation Service) nurse, Lons-le-Saulnier



**Dr Patrick Bouet**, GP, National Council of the Order of Doctors



**Gwénaél Godin**, deputy manager of Hautepierre hospital, deputy manager for the safety of people and property.

### Hospitals safe from violence

The Strasbourg university hospitals are displaying strong commitment in the fight against violence: 120 people with an annual budget (2008) of 840,000 euro are involved in security and incident prevention. The policies put into place entail organisational measures (entrance barriers, video surveillance, security guards, bracelets for newborns linked to an alarm system, etc.) and training for all employees. They involve reinforcing the feeling of security both of the medical staff and the patients as Gwénaél Godin explains, who engages the hospital in interaction with the evils of society: *"Incident risk management is achieved via the formation of partnerships with the police, development of a culture of reporting events, integration of the hospital in the politics of the city and development of internal and external communication"*. There is a clear will which can be seen by the range of specific responses at the CHU in Strasbourg (which cannot necessarily be implemented everywhere): *"Hospitals must once again be sanctuaries"*.

## We are not all equal when faced with the same events

### Building together

*“All the countries which have evaluated the effectiveness of measures taken to prevent burnout and its consequences (sick leave, changing profession...) reach the same conclusion: it is always team building, the construction of a collective unit which makes it possible to avoid undesirable events.”* **Dr Madeleine Estryn-Béhar** underlines the importance, at the heart of the hospital, of multidisciplinary work, time and places dedicated to discussion and an exchange of information. It is the quality of care which is at risk, as well as the satisfaction of the healthcare professionals. This is why she questions the legitimacy of *“the pooling of medical staff by centre that change department every day”*. She advocates in contrast the expansion of “care projects adapted to each patient, underlining that the existence of a *“united work unit is linked to less sick leave, less resignations and therefore less unplanned cover of absent colleagues”*. As for work in a surgery, in essence it involves solitude and it could be the private practice doctors to whom particular attention should be paid by the community and the institutions. *“The regulation of the continuity of care, the security guards for personal safety, all of this already exists but needs to be improved”*, states **Dr Jean-Marc Boivin**. He is equally sceptical about the role of listening bodies and ‘maisons médicales’ (out of hours GP surgeries): *“on the one hand doctors are already in the advanced stages of burnout when they ask for help, on the other hand it is also possible to feel alone in a group practice, you see colleagues but this is not really interaction...”*

To react effectively he believes it to be indispensable to evaluate the prevalence of the first stages of burnout (which affect around 40% of health professionals!) in more detail and to undertake epistemological studies on a large scale. A question of financing...

### Discovering fragility

Should we therefore select students by making them undergo a psychological interview before commencing their degree to identify who is likely to drop out of the course? On the one hand this would be a huge task due to the number of enrolled students. On the other hand the length of the course in itself in fact imposes a selection process on those who are less motivated or fragile. Yet it would be possible to spare them from suffering and disillusionment later on. Thus, Dr Galam reports, students in Quebec have motivation interviews when they enrol in the ‘Collège des Médecins’. Recognised by the Order and supported within the framework of the Aid Plan for Quebec Physicians (they are also the ones who make use of it most often), the students thus seem better protected against burnouts.

Mentoring – values and not just technical competences – is equally noted for helping to avoid the anxiety of the youngest, while at the same time developing the competences of the former students. Madeleine Estryn-Béhar envisages short training programmes for these voluntary mentors to supervise the least experienced and liven up services in the hospital. She believes that an improved exchange of experiences is better for everyone.



**Dr Madeleine Estryn-Béhar**, hospital practitioner in occupational medicine (APHP Hôtel Dieu), responsible for France in the European survey PREST-NEXT (Health and satisfaction of Healthcare Workers in France and Europe) and the SESMAT survey (Health and Satisfaction of Doctors at Work).

The PREST-NEXT survey concerned 40,000 healthcare professionals from 10 European countries from 585 institutions, of which 56 are in France. The SESMAT survey was requested by doctors following the first survey. It involved 3,200 French doctors representing all specialisations.

The two surveys contributed to the same report:

- intention of leaving the profession: 17.4 % think about it each month, and this intention is linked to a higher burnout score,
- quality of care: 1 in 2 believes not to be giving all patients the treatment and care they need:
- psychological support: 67 % of doctors and paramedics say they are dissatisfied with the support they receive at work;
- work areas equipped for tasks: Less than 50 % are satisfied with their environment.

[www.prest-next.fr](http://www.prest-next.fr)  
[www.prest-next.fr/SESMAT/](http://www.prest-next.fr/SESMAT/)



**Dr Jean-Marc Boivin** head of lecturing in general medicine, General Medicine Department, Nancy, Henri Poincaré University

## The education of the patient is more important than the education of the healthcare professional

As for Dr Monfort, he believes that it would be futile to determine which healthcare professionals are susceptible because he has *"the intuition that one decides to enter into caring professions for reasons which reveal vulnerability factors rather than risk factors ..."*. Dr Galam agrees with this and considers himself to be vulnerable and both of them admit, or claim even, that a certain fragility can fit well with the qualities which make a good healthcare professional.



Martine Pacault-Cochet, Social worker.

### The doctor-patient relationship

Sharing goes with exchange and trust; at the heart of medical professions but also between patients and healthcare professionals. How can this link be rediscovered which gives meaning to this 'unique symposium'?

**Martine Pacault-Cochet** says: *"We must make the patients as independent as possible on a psychological and physical level. And this occurs through education. But older people have not been trained in this: if the healthcare professionals progressively manage to be educators to make those that they are caring for understand the need to take responsibility for themselves when possible, the vulnerability issues of healthcare professionals will be reduced in coming years"*.

Corine Pieters, for her part, insists on *"educating the patient, which is much more important than the training of all healthcare professionals!"* What would happen if we did not have to wait to be a patient (who is always in a position of weakness, need, incomprehension, refusal...) to analyse the attitude of most of us when faced with the people receiving the least patient-carer respect, specifically elderly people requiring care and those who society makes responsible for them?

### Preventative educational action

Even if burnout is not yet a training module in its own right, several courses still facilitate increased awareness, but only if the trainer him or herself is aware of it, clarifies **Prof Pierre Meyer**. Thus he has found, as part of the initial training of healthcare professionals, modules 'vulnerability', 'pain, palliative care, inter-university diploma (IUD) in palliative university specialisation course).

The general medicine special study diploma, by means of clinical case studies which for problems to be resolved.

Training for nursing care has also opened stress', a new topic on the curriculum (FMI). In hundreds of schools (nursery physiotherapy...), discussion groups, psychosociology etc. address the these are primarily in Centres to Fight Cancer (CLCC) where the stress and suffering of healthcare professionals have been long established. Some of them even initiated forty hours of training 'suffering at work, preventing occupational exhaustion'.

Even when starting from the principle that *"in our healthcare system the healthcare professional is never alone, and if he finds himself alone, it means that there is a gap in the human relationship"*, Dr Meyer makes several educational suggestions:

- provide all students with an awareness information booklet;
- develop an interactive training module on burnout risk factors;
- insist on ethical requirements: mutual respect of the doubts of all members of the healthcare teams;
- never face problems alone and learn not to let yourself be overwhelmed.



**Prof Pierre Meyer**, professor of general medicine, Reims Faculty of Medicine, University of Reims-Champagne-Ardenne.

oriented towards patients ('aging and support'...). It is also possible to enrol on an care and support as part of any DES (medical

which has existed for three years, evokes stress require specialists from other disciplines in order

up to 'managing healthcare professionals' being validated for Initial Medical Training nursing,

relaxation workshop, ergonomics courses, problems of healthcare professions. But

# How can we love those who do the 'dirty work'?

## Mutual respect

The geriatrics professor Marc Berthel (Strasbourg) defines establishments which care for elderly people requiring care as the characteristic example to explain the suffering of healthcare professionals: *"It reveals in the first instance the lack of recognition accorded to elderly people requiring care and furthermore to those who look after them, particularly auxiliary nurses"*.

The elderly themselves can be a source of suffering for the healthcare professionals (aggression, disrespect, racism), as well as their families who think the accommodation is expensive and treat the staff like servants. From their side the healthcare professionals (generally teams which are short in numbers) are confronted with complex and chronic illnesses, dementia, incontinence, deaths... daily work for which the American sociologist invented the concept of 'dirty work' in 1950 (such as refuse collectors or prison guards).

Marc Berthel asks himself:

*"How can we value those who are burdened with all the stigma of the dirty work and subjected to this indignity?"*

Naturally all sorts of norms, procedures, protocols etc. are in place to guarantee the functioning of the system. But this is not sufficient. Michèle Sauder, supervisory nurse in a nursing home, asserts her conviction: "Everyone should realise that we do not look after elderly bodies, we look after the bodies of the elderly". This notion of respect is also achieved via social recognition, as much as, if not more than, financial recognition. The staff furthermore needs confirmation from their superiors (and from society) that the work is hard. Michèle Sauder mentions the idea of creating a charter which would facilitate an improvement in the relationship between healthcare professionals. A charter, that means another protocol...

## Admit you are mortal and philosophise

In the absence of solutions the philosopher Corinne Pieters cites this sentence from the doctor and philosopher Georges Canguilhem (\*): *"illnesses are the instruments of life by means of which the living, when talking of man, are forced to admit they are mortal"* and this, she adds, concerns both the work of the healthcare professional and the patient. Jean-Claude Monfort concludes that: *"Dreaming or philosophising are methods of anti-suffering, both personal and collective. If everyone, including the institutions, worked towards making intelligence function, reconsidering caring professions, these could be pure joy, on the condition that we accept suffering and death."*

(\*) "Les maladies" (Illnesses), in "Ecrits sur la médecine" (Writings on medicine) Vrin Collection, Paris

Summary based on input from the following people at the conference organised by the Groupe Pasteur Mutualité, 4 December 2008, in the Maison de la Chimie Paris:

Dr Antoni Arteman, Dr Marc Bernard, Prof Marc Berthel, Dr Jean-Marc Boivin, Dr Patrick Bouet, Dr Jean-Marie Colson, Dr Madeleine Estryn-Behar, Dr Eric Galam, Dr Bruno Gaudeau, Mr Gwénaél Godin, Ms Fabienne Guerrieri, Dr Yves Léopold, Dr Alain Mary, Prof Pierre Meyer, Dr Jean-Claude Monfort, Ms Martine Pacault-Cochet, Ms Geneviève Picot, Ms Corinne Pieters, Ms Michèle Sauder, Ms Anne Vanhoutte

The site [www.souffrancedusoignant.fr](http://www.souffrancedusoignant.fr) remains open for personal accounts from physicians. It also offers you the chance to test your burnout level in 3 points as well as numerous articles and studies on questions relating to suffering and vulnerability of healthcare professionals.



[www.gpm.fr](http://www.gpm.fr)

## The U graph of mental illnesses

Dr Jean-Claude Monfort, practitioner in psychogeriatrics argues against the current trend on which regulations are based, which considers that mental illnesses, psychological problems disappear with age. *"The opposite is the case: psychopathology and psychiatry follow a U curve, that means a maximum number of mental illnesses can be found among the very young (those who do not die of them will be cured at 20, 30 or 50) but as they age they will once again require psychiatric care"*. He believes that if this curve were taught we would more easily accept that a very young and a very old person are ill.

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