Who is Responsible for this Entire Hustle Bustle: Let's Put on the 'Blue Hat'

She attended my pain clinic with severe pain and inability to do her daily activities. Being a young mother, what bothered her the most, was her inability to look after her One and half year old child. She cried and narrated how she noticed a lump in her breast immediately after her child birth and consulted a local practitioner; where she was diagnosed as breast abscess, treated with a drainage procedure and asked 'not to worry' for same. But here she was, a year and half later, in my outpatient department (OPD) with a workup of metastatic carcinoma breast.

Next in line was a middle-aged female with a diagnosis of cervical cancer, referred for palliative care and pain management. She had a two year history of postmenopausal vaginal bleeding, which she kept ignoring due to poor socioeconomic and educational background wherein life has other priorities like a daily wager husband and three school going children. Only after a local nonprofit organization helped her, this 40-year female attended the hospital.

What's this???? Gaps of 'provider' and 'patients'!!! It was an unusual feeling of disturbing silence within me in the midst of this chaotic OPD. It was like a feeling of impending doom.

In spite of the majority of cancers in India being at clinically accessible sites viz. head and neck, cervix, and breast; most of our patients present in late stages; not amenable to curative treatment. Do we accept this fact?

Bridging this screening gap will be an uphill task but the social impact; worth to cherish. Let's accept that too.

Some of the screening gaps are:
Poor cancer-related awareness of professionals at all levels, rural background, poverty, illiteracy, nonavailability of transport, cultural taboos, social stigmas, lack of stern political will, absence of accessibility of organized primary healthcare infrastructure, non-registered local practitioners or quacks, poor record keeping and logistics, lack of quality, lack of guidance in referring to right place, resource constraints, family burden, and many more. Personal beliefs like 'I am ill-fated to have cancer', 'cancer is a curse', and 'trivial ulcers in mouth or breast lumps are self-limiting' further add on to widen this gap.

Edward de Bono's parallel thinking six hat model suggests finding solution to a problem by looking at it from various angles, that is, parallel thinking for effective problem solving and exploring new ideas. Each hat represents a different type or mode of thinking. Switching to a different colored hat symbolizes a different way of thinking. Six distinct types of thinking are identified and assigned a color each.

- *Information* (White) - considering purely what information is available or needed, and what are the facts?
- *Emotions* (Red) - intuitive or instinctive reactions or statements of emotional feeling (but without any justification)
- *Discernment* (Black) - logic applied to identifying reasons to be cautious and conservative, that is, looking at the actual and potential difficulties (disadvantages)
- *Optimistic response* (Yellow) - logic applied to identifying benefits, seeking harmony (advantages).
- *Creativity* (Green) - statements of provocation and investigation, seeing where a thought goes, that is, possibilities, new ideas
- *Blue hat?*
  Sessions always begin and end with a 'Blue hat' wherein the groups agree together to how and what they will think. So let's put on the blue hat. Let's take combined responsibility and act in coherence. Let's collect our available data to begin with, including the possible hurdles in education and awareness programs.

Let us make innovative use of print and electronic media, encourage out of box thinking and find novel ways to propagate our message. Let's make a great animation

Access this article online
Quick Response Code:
Website: www.jpalliativecare.com
DOI: 10.4103/0973-1075.121519

movie and educate children at grass root level. Let a high quality musical awareness video go on air. Let folk arts of different cultures propagate cancer awareness. Let unemployed pool of educated youth assist us in logistics. Let us sensitize the community about the significance of the disease and its early detection through simple messages in accordance with local culture and traditions. Let us seek help from rural administrative heads, political leaders, religious leaders, and other peer groups to motivate the target population. Let us plan to use national funds for betterment of society.

Let us start with 'screening in a lifetime' approach. But try to 'call and recall' the patient. If screening results are negative, let us explain the importance of the result, reassure the patient, and motivate to report if any symptoms occur in future. Let's propagate health education and hygiene practices in all camps and talk about early symptoms of cancers in various targeted camps. Let's realize that the ultimate purpose of screening is to detect the disease at a stage amenable to simple treatment and cure. So let us minimize the dropouts of screen positive patients in further treatment. Let us maximize information, education, and communication. Be sensitive and supportive. So, let us bridge the screening gaps, let us put on the 'Blue hat'. Otherwise the day will come when many more patients would present in advanced stages of disease, demanding much more, out of pain management and palliative care, which in itself, is quiet a nascent specialty, to cater to the increasing burden of such patients.

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How to cite this article: Bhatnagar S. Who is responsible for this entire hustle bustle: Let's put on the 'Blue Hat'. Indian J Palliat Care 2013;19:129-30.

Source of Support: Nil. **Conflict of Interest:** None declared.