The Hippocratic Oath (Original Version)

"I swear by Apollo the Physician and Asclepius and Hygieia and Panaceia and all the gods, and goddesses, making them my witnesses, that I will fulfill according to my ability and judgment this oath and this covenant:

To hold him who has taught me this art as equal to my parents and to live my life in partnership with him, and if he is in need of money to give him a share of mine, and to regard his offspring as equal to my brothers in male lineage and to teach them this art—if they desire to learn it—without fee and covenant; to give a share of precepts and oral instruction and all the other learning to my sons and to the sons of him who has instructed me and to pupils who have signed the covenant and have taken the oath according to medical law, but to no one else.

I will follow that system of regimen which, according to my ability and judgment, I consider for the benefit of my patients, and abstain from whatever is deleterious and mischievous. I will give no deadly medicine to any one if asked, nor suggest any such counsel; and in like manner I will not give a woman a pessary to produce abortion.

With purity and with holiness I will pass my life and practice my Art. I will not cut persons labouring under the stone, but will leave this to be done by men who are practitioners of this work. Into what ever houses I enter, I will go into them for the benefit of the sick, and will abstain from every voluntary act of mischief and corruption; and, further from the seduction of females or males, of freemen and slaves.

WHATEVER, IN CONNECTION with my professional practice or not, in connection with it, I see or hear, in the life of men, which ought not to be spoken of abroad, I will not divulge, as reckoning that all such should be kept secret.

WHILE I CONTINUE to keep this Oath unviolated, may it be granted to me to enjoy life and the practice of the art, respected by all men, in all times! But should I trespass and violate this Oath, may the reverse be my lot!
“DHANVANTARI” – The Hindu God of Medicine

“DHANVANTARI” is regarded as the original exponent of Indian Medicine. DHANVANTARI has many myths and legends woven around him. He emerged with the pot of ambrosia (symbolic of medicine) in his hand from the ocean when it is churned by the contesting gods and demons. He is viewed as the very incarnation of God VISHNU.

Legends make him reappear as “DIVODASA”, the prince of Benaras (Kasiraja), in the family of Ayus, Dhanvantari, Divodasa and Kasiraja are names of same person who is “the first God and who freed the other Gds from old age, disease and death” and who in his Himalaya retreat taught surgery to Susruta and other sages. DHANVANTARI appeared on earth in Benaras in the princely family of Bahuja and became known as DIvodasa: he wandered about as a mendicant even during his early years.

DHANVANTARI is regarded as the patron-God of all branches of medicine. While DHANVANTARI is not credited with any medical treatise of his own, in the early accounts, there is voluminous glossary and materia medica in nine sections known as Dhanvantari Nighantu: it is a compilation which is probably contemporaneous with the famous Amara –Kosha (A.D. 100).
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<td><strong>24 Govt. of Maharashtra</strong></td>
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Pranaam to all my respected teachers, guiding guides and all the members of Indian Medical Association all across my state of Maharashtra.

Our bodies are our gardens to which our wills are gardeners. The root of all health is in the brain, The trunk of it is in emotion, The branches and leaves are the body, The flower of health blooms when all parts work together. Natural forces within us are the true healers of disease. Let your food be our medicine and not medicine our food. There are some remedies worse than the disease. An ounce of prevention is worth a pound of cure. Hence in this inaugural issue of Mahima we are fortunate to have Dr Pratiksha, a dynamic first preventive women cardiologist of our country, as our Guest Editor. Her crusade to support actively a non-invasive cardiac treatment as EECP {Enhanced External Counter pulsation}, which is safe, long lasting, affordable, non-medicated, out-patient & US FDA approved evidence based treatment for coronary artery disease, is commendable beyond time & space.

If you want to live, you must walk, if you want to live long, you must run. This is beautifully taught by the Rehabilitation team of Institute of Preventive Cardiology Heart Care Centre as a package in their treatment for coronary artery disease. Over the years, medical science has identified all the primary systems of the human body, the circulatory, nervous, respiratory, gastrointestinal, urinary, endocrine immune system etc. but two other systems which are central to the proper functioning of a human being need to be emphasized. These are The healing system and the belief system. The two work together. To get the body in tune get the mind in tune and at IPC Heart Care Centre there is a awesome Yoga program customised to heal the mind, body and souls of the critically ill cardiac patients.

I am convinced beyond an iota of doubt that we have a splendid pharmacy inside us that is absolutely exquisite. It makes the right medicine, for the precise time, for the right target organ with no side effects. Poor health is not caused by something you don’t have, its caused by disturbing something that you already have. Healthy is not something that you need to get it, its something you have already if you don’t disturb it. So Prevention and Wellness should be implored upon by every physician and IPC Heart Care Centre excels in positively promoting the same. The world is in a constant conspiracy against the brave. It’s the age old struggle. There is a roar of crowd on one side and the voice of your conscience on the other said Dr Pratiksha who rose to every occasion to listening to her conscience to build IPC Heart Care Centre to such a magnitude which matchlessly makes her a daring Lady entrepreneur. So truly today life is either a daring adventure or nothing. After all one isn’t necessarily born with courage genes, but one is born with potential and Courage
faces fear and thereby masters it. It's this unique moral quality of Dr Pratiksha which makes her irresistible to fly as high as to kiss the sky.

I have read and understood Dr Dean Ornish, who hails in Western World and has successfully proved reversal of the heart diseases with all his non invasive techniques and life style modifying science. In India we have our Dr Pratiksha who trains and treats all her patients with similar in fact better scientific instruments and has been splendidly successful in curing over 5000 patients in her passionate journey to heal without a needle or scalpel. One who has health has hope and one who has hope has everything. Every ailing heart’s hope is Dr Pratiksha.

The reason why birds can fly and we can’t is simply that they have perfect faith, for to have faith is to have wings. The air under our wings are the teachings of our teachers. One such teacher who is our best teacher who still continues to teach with undying zeal and passion is Dr O P Kapoor. This year Dr O P Kapoor’s lectures shall begin at Birla Matushri Auditorium from June onwards every Sunday morning. I feel that there are two types of teachers on this planet, One is Dr O P Kapoor and second are all the others. This should settle the debate if any, on who is the greatest teacher of all time. Some are born with a silver spoon but my best teacher Dr O P Kapoor is born with teaching in his soul.

It is easier to produce ten volumes of philosophical writings than to put one principle into practice believes Dr Bakulesh Mehta, our dearest, dynamic president, who has vowed to turn every stone upturn to lift up, built and strengthen not only the pillars of IMA MS and make State office a self reliant and evergreen for ever. The one thing which I assure our IMAites is that under the tenure of Dr Bakuleshbhai as Pilot of our State Office all the branches of our state shall flourish boundlessly.

In matters of style, swim with the current, but in matters of principle stand like a rock explained our versatile and dynamic Hon State Secretary Dr Hozie Kapadia whose innate qualities of integrity, commitment and consistency makes all of us feel really proud of him.

In this issue we have tried to emphasize the importance of non invasive treatments for coronary artery disease, available for our patients and leading interventional cardiologists tell us woes of interventions. This leaves us with a cold choice between two alternatives. Our creator has given us five senses to help us survive the threats from the external world, and a sixth sense to survive the internal threats. Its how you spend your choice is all that matters.

Words fail me to express my wholehearted thanks to Dr Jayesh Lele , Dr Akil Contractor, Dr Suhas Pingle, Dr S K Joshi, Dr Ajoy Saha, Dr Prabhakaran Rao, Dr Anil Suchak, Dr Niranjana Vaidya & our dearest President, Dr Bakulesh Mehta, for their unconditional support and dependable commitment to every little thing in making of this issue of MAHIMA, as they all believe that no one is useless in this world who lightens the burden of anyone else. After all those who wish to sing always find a song.

With loads of love and light,

Dr. Deepak K. Jumani
President’s Message

With profound gratitude & great humbleness, I wholeheartedly thank you for your recognition, love, respect & affections, in making me the president of our esteemed Indian Medical Association Maharashtra State branch. Thank you all for everything. Thank you for this wonderful moment. I am expressing my views, my dreams & my ambitions for IMA Maharashtra State to all the members.

Before this 2010, my life was like any ordinary person, but now it has turned into an extra ordinary experience. I admit, the air beneath my wings is you all friends, the intent of every action of mine as usual have always been for the benefit of every member & uplifting the image, strength & spirit of our organization.

“Half the world is composed of people who have something to say but can’t & the other half who have nothing to say but keep on saying it.”

During my campaign, I visited over 90 branches in Maharashtra & I was welcomed everywhere with open arms, I learnt a lot, I felt a lot needs to be done & lot can be done.

I have certain innate moral responsibilities & I am sure I shall fulfill these during my tenure. I have a solid battalion of strong, right thinking heads, which shall always unconditionally be my magic wand to bring about the good & best needed to be done. My friend Dr. Hozie Kapadia, Dr. Jayesh Lele, Dr. Shivkumar Utture, Dr. Anil Pachnekar, Dr. Prabhakar Rao, Dr. Niranjan Vaidya, Dr. Ajoy Saha…. All of them are known for their timeless commitment are my real energies.

To name some of them which are our dire needs are:-

1. Increase our Life member Membership strength.
2. To initiate concrete steps in improving Doctor - Doctor & Doctor – Patient relationships, as in this changing times, we have seen that most of the untoward incidents of ransacking of nursing homes, hospitals, bashing up of doctors etc, could have been avoided. We must also understand our own social responsibility, as we today see the media blows up to glory what ever little wrong unintentionally any of our brethren does.

3. How to achieve this, I want suggestions from you. Our mouth piece of the IMA, MAHIMA shall be published at least thrice in a year and sent to as many members as possible. This will help us to keep all the members involved & shall be able to pass on the information of activities of IMA regularly.

4. To make website popular among all branches & members, the new & fast technique to convey information / communication. I request all the branches to develop E-Mail facility & to have as many members connected by this emails regularly.

5. Forum for senior citizens, to deal with their problems & to start activity and take care about their health and social well being.

These challenges can’t be met by any one leader or any one branch. Hence our administration has to work to establish a new era of engagement in which all branches must take responsibility for the world we love to see.

I must put on record that whenever I have been called as Guest /Guest of honor / Chief Guest has received excellent response, welcome. All branch members are very cordial & receptive, eager to know working of IMA. They want to participate & take active role. All the members want more news & information. We are planning to have 3 to 4 regional meeting, I will try to visit as many branches as I can cover. We will continue to send E-news letter on regular basis. Please form habit to open e-mail on regularly & provide your friends e-mail addresses to Dr. Jayesh Lele who has initiated this ‘IMA MS eNews letter’

I also like to compliment all the branches visited by me. They have been carrying out excellent activities & take part in commonly welfare projects. As an individual we do lot of social work in general & in particular for our patient, but unfortunately we do not report & make proper document. We should inform to IMA MS State office, so we can publish & send
information to our members, friends. Please devote time to you self & family & to IMA.

**President’s Diary**

A) Visit 29/11/2009 at Alibag 1st ever IMA scientific conference which was well attended/planned & excellent hospitality & very practical / informative scientific topic.

B) Visit Nagpur Branch NIMICON

C) Visit Raigad Medical Association Scientific Conference

D) Meeting with Health Minister Shri Suresh Shetty

E) Attended New Year eve programme at Mumbai (Haji Ali) Branch.

All branches which I visited carry out at many good activities for members & community. Each branch has unique way of functioning. We need to bring on record of their activity with documentation.

1. Pune – Special mentality.
   
   This branch is in front for doing exemplarily work. I must put it on record & appreciate it following work by Pune.

   a. Launch ‘Suryanamaskar Abhiyan’, about 400 city young doctors participated & have take oath to do everyday 13 suryanamaskar & for one year & end of one year finding rescue will be IMA Pune.

   b. Take lead with FOGSI & local NGO ‘Rugna Hakka Samiti’ is formed.

   c. ‘Patient – doctor’ relation & ‘doctor – doctor’ relationship programme, Patient’s rights in Maharashtra in private clinic / hospitals is being formed. The detailed charter was published in journal on 09/02/2010. This detail will be circulated to all, once we approved in 1st Executive meeting on 7th March, IMA MS will propagate and recommend to all branches to adopt & circulate to all member. We will also forward to HQ.

2. IMA Ahmednagar – Small vibrant branch & enthusiastic branch. The branch members are very active & wish to become active at State / centre. The branch is launch to get ½ acre land & Bhoomipujan was done on 14/02/2010 & proposed to have new building, where will be mutiutility center. I congratulate the members of Ahmednagar.

3. IMA Mumbai west Branch along with CGP faculty and IMA Maharashtra State branch CGP faculty held ‘GERICON 2010’ on 20 and 21st Feb 2010. This was a unique conference dedicated to Geriatrics. IMA national Hony Finance secretary Dr D R Rai inaugurated the conference.

   By the time MAHIMA was in press, IMA Jalgaon branch arranged ‘Sports Mela’ which I attended with some office bearers. It was a great event.

**BRMS COURSE**

Short term Media course for rural area is proposed by MCI / Government.

IMA central council passed a resolution against this course, the same is being circulated. Meeting was called on 15/02/2010. Every member present suggested few alternative proposals & suggested National President to pass it on to government & the support the proposal.

**MCI NOTIFICATION**

Regarding acceptance of personal gift & sponsorship: The notification is published in this magazine, please go through.

In conclusion I request all branches to increase your branch membership to strengthen our IMA activity.

   I am at this platform vouch of my unwavering commitment to strive hard as the Commander in Chief of IMA State Branch to assure every Doctor of the security, that you wont have to live in fear of violence, I shall try & see that we resolve conflicts peacefully & not to let general public confront in ruthless & adverse way which not only threatens our image but our lives too.

My friends I believe that,

   **Work is worship I is motto of mine  
   I can & I will work all the time**  
   **To produce for IMA something very fine  
   And leave my print on the fading time.**

With all my heart I wish all a great & wiser 2010.

Warm regards,

[Signature]

Dr. Bakulesh Mehta
President IMA MS
Hon. State Secretary’s Message

Thanks very much for electing me to the august office of Hon. State Secretary of IMA, MS. I hope and wish that I fulfill all your expectations.

We heartily congratulate all the National IMA, HQ award winners at MEDICON 2009 at Hyderabad. (Detailed list is given elsewhere in this issue).

We are actively trying to have our own premises and in this I would like all the honourable members to help us in this noble project.

We congratulate IMA Jalgaon branch for carrying out THE ANNUAL SPORTS EVENT 2010 very enthusiastically and successfully.

MEMBERSHIP PROMOTION DRIVE

Please hurry up to enroll as many members as possible at the old existing rates, as from April 1, 2010 IMA, HQ is going to increase the HFC rates by around 25%.

We genuinely feel that we must invigorate our I.M.A. Maharashtra State Branch by increasing our membership. Hence my personal request to all members of IMA to increase the strength of Life Members as fast as possible, by March 2010. We should focus all our energies for this vital project. In a democracy, strength matters.

The Maharashtra Medical Council Register shows about 80,000 doctors on its rolls, but I.M.A. Maharashtra State membership is barely 23,000. Taking into consideration that some doctors may have expired or migrated abroad or practicing in other States, still we have to enroll about 30,000 eligible doctors in Maharashtra State.

“The Assault on Doctors’ Ordinance” was due to our grit, determination and unity. I appeal to each and every member to consider as his/her solemn and moral duty towards our association to enroll at least one member each this month (more are welcome). By this we hope to double our strength. I have a sincere feeling that you will all rise to the occasion to fulfill your social obligation, spend some more of your valuable time and energy in roping in as many members as possible.

Members are also requested to enroll for the IMA, MS and IMA, HQ Social Security Schemes & Professional Indemnity Schemes.

DRH COURSE

BRMS is to be now “Diploma in Rural Health”

A meeting of State IMA leaders was held at New Delhi on 15th February 2010 to finalize the Rural Health Care model for India. It was decided that the New Rural Health Course should be a Health Sciences qualification and not a Medical Science qualification. It will be a Diploma with three letters only.

1. Diploma in Rural Health – DRH
2. Institution will be named as: Rural Medical School – Rural Health School
3. Title shall be Rural Health Provider (RHP)
4. Registration not in State Medical Councils & MCI under Schedule I
5. Separate Register as a State Rural Health Register
6. Posting will be in villages of birth – PHC, CHC, subcenters
7. Only in Govt. service for 5 years
8. Re-register every year for 5 years
9. Selection Criteria, Infrastructure, Faculties & Curriculum all to be defined by the MCI
10. They will be given exposure to work in Rural areas during the Course / Internship
Their Competencies – Dos & Don’ts will be clearly stipulated by MCI.
The above were unanimously agreed by the members present.

**MCI NOTIFICATION REGULATION 2009**

The MCI with the previous sanction of the Central Government has amended the Indian Medical Council (Professional Conduct Etiquette and Ethics) Regulation 2002. A medical practitioner shall not receive any gifts, shall not accept any travel facility, any hospitality like hotel accommodation, cash or monetary grants from any pharmaceutical and allied health care industries. He has to maintain professional autonomy in dealing with pharmaceutical and allied health care industry and maintain high ethical standards. He cannot endorse any drug or product of the industry publicly.

We have carried out successfully several **Swine Flu projects and RNTPC projects** in various parts of the State.

Let us all serve the suffering community with ethics and compassion particularly, the poor and downtrodden.

For any IMA work please feel free to contact me or the office bearers of IMA, MS;

_Signed_  

**DR. HOZIE D. KAPADIA**
Hon. State Secretary, IMA-MS

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**INDIAN MEDICAL ASSOCIATION, MAHARASHTRA STATE TIME TABLE FOR ELECTION OF PRESIDENT & VICE PRESIDENTS FOR THE YEAR 2010 - 2011**

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<td>20.06.2010</td>
<td>SUNDAY</td>
<td>1st Notice Of Election &amp; information to be sent to all Local Branches about HFC Status &amp; Membership Strength (Branches may inform if there is any discrepancy in HFC status, latest by 04.07.2010)</td>
</tr>
<tr>
<td>2</td>
<td>09.07.2010</td>
<td>FRIDAY</td>
<td>Receipt of Nominations up to 5.00pm.</td>
</tr>
<tr>
<td>3</td>
<td>11.07.2010</td>
<td>SUNDAY</td>
<td>Scrutiny of Nomination Papers by Election Commission (HFC to be paid up fully)</td>
</tr>
<tr>
<td>4</td>
<td>12.07.2010</td>
<td>MONDAY</td>
<td>To inform individual candidates about valid list of Nominations alongwith withdrawal forms</td>
</tr>
<tr>
<td>5</td>
<td>31.07.2010</td>
<td>SATURDAY</td>
<td>Withdrawal of Nominations up to 5.00 pm.</td>
</tr>
<tr>
<td>6</td>
<td>02.08.2010</td>
<td>MONDAY</td>
<td>Effective Strength of membership &amp; HFC Status of all Branches to be informed to Contesting Candidates</td>
</tr>
<tr>
<td>7</td>
<td>04.08.2010</td>
<td>WEDNESDAY</td>
<td>To send Election papers / Ballot Papers to all branches</td>
</tr>
<tr>
<td>8</td>
<td>10.09.2010</td>
<td>FRIDAY</td>
<td>Last date of receipt of Ballot Papers up to 5.00 pm.</td>
</tr>
<tr>
<td>9</td>
<td>19.09.2010</td>
<td>SUNDAY</td>
<td>Counting of votes from 10.00 am. Onwards &amp; Declaration of result</td>
</tr>
</tbody>
</table>

**DR. N. N. MURKEY**  
Chairman  
9422918853

**DR. C. M. GUPTA**  
Member  
9422826117

**DR. SUHAS H. PINGLE**  
Member  
9322250830

**INDIAN MEDICAL ASSOCIATION MAHARASHTRA STATE ELELCTION COMMISSION**
MEDICAL COUNCIL OF INDIA
NOTIFICATION
New Delhi, the 10th December, 2009

No.MCI-211(1)/2009(Ethics)/55667 - In exercise of the powers conferred by Section 33 of the Indian Medical Council Act, 1956 (102 of 1956), the Medical Council of India with the previous sanction of the Central Government, hereby makes the following Regulations to amend the “Indian Medical Council (Professional Conduct, Etiquette and Ethics) Regulations, 2002 : -

1. (i) These Regulations may be called the “Indian Medical Council (Professional Conduct, Etiquette and Ethics) (Amendment) Regulations, 2009 - Part-I”.
(ii) They shall come into force from the date of their publication in the Official Gazette.

2. In the “Indian Medical Council (Professional Conduct, Etiquette and Ethics) Regulations, 2002”, the following additions/modifications/deletions/ substitutions, shall be, as indicated therein:

3. The following clause shall be added after clause 6.7:-

“6.8 Code of conduct for doctors and professional association of doctors in their relationship with pharmaceutical and allied health sector industry.

6.8.1 In dealing with Pharmaceutical and allied health sector industry, a medical practitioner shall follow and adhere to the stipulations given below:-

a) Gifts: A medical practitioner shall not receive any gift from any pharmaceutical or allied health care industry and their sales people or representatives.

b) Travel facilities: A medical practitioner shall not accept any travel facility inside the country or outside, including rail, air, ship, cruise tickets, paid vacations etc. from any pharmaceutical or allied healthcare industry or their representatives for self and family members for vacation or for attending conferences, seminars, workshops, CME programme etc as a delegate.

c) Hospitality: A medical practitioner shall not accept individually any hospitality like hotel accommodation for self and family members under any pretext.

d) Cash or monetary grants: A medical practitioner shall not receive any cash or monetary grants from any pharmaceutical and allied healthcare industry for individual purpose in individual capacity under any pretext. Funding for medical research, study etc. can only be received through approved institutions by modalities laid down by law / rules / guidelines adopted by such approved institutions, in a transparent manner. It shall always be fully disclosed.

e) Medical Research: A medical practitioner may carry out, participate in, work in research projects funded by pharmaceutical and allied healthcare industries. A medical practitioner is obliged to know that the fulfillment of the following items (i) to (vii) will be an imperative for undertaking any research assignment / project funded by industry – for being proper and ethical. Thus, in accepting such a position a medical practitioner shall:-
(i) Ensure that the particular research proposal(s) has the due permission from the competent concerned authorities.

(ii) Ensure that such a research project(s) has the clearance of national/ state / institutional ethics committees / bodies.

(iii) Ensure that it fulfils all the legal requirements prescribed for medical research.

(iv) Ensure that the source and amount of funding is publicly disclosed at the beginning itself.

(v) Ensure that proper care and facilities are provided to human volunteers, if they are necessary for the research project(s).

(vi) Ensure that undue animal experimentations are not done and when these are necessary they are done in a scientific and a humane way.

(vii) Ensure that while accepting such an assignment a medical practitioner shall have the freedom to publish the results of the research in the greater interest of the society by inserting such a clause in the MoU or any other document / agreement for any such assignment.

f) Maintaining Professional Autonomy: In dealing with pharmaceutical and allied healthcare industry a medical practitioner shall always ensure that there shall never be any compromise either with his / her own professional autonomy and / or with the autonomy and freedom of the medical institution.

g) Affiliation: A medical practitioner may work for pharmaceutical and allied healthcare industries in advisory capacities, as consultants, as researchers, as treating doctors or in any other professional capacity. In doing so, a medical practitioner shall always:

(i) Ensure that his professional integrity and freedom are maintained.

(ii) Ensure that patients interest are not compromised in any way.

(iii) Ensure that such affiliations are within the law.

(iv) Ensure that such affiliations / employments are fully transparent and disclosed.

h) Endorsement: A medical practitioner shall not endorse any drug or product of the industry publically. Any study conducted on the efficacy or otherwise of such products shall be presented to and / or through appropriate scientific bodies or published in appropriate scientific journals in a proper way”.

(Lt. Col. (Retd.))

Dr. A.R.N. Setalvad)

Secretary

Medical Council of India

MEMORANDUM

IMA opposes Govt. proposal of “Bachelor of Rural Medicine & Surgery (BRMS)—3 ½ yrs. Course”

1. Central Council of Indian Medical Association (The Supreme decision making body) during its annual meeting on 27th December 2009 held during 56th All India Medical conference at Hyderabad (AP) deliberated on the proposal of starting Bachelor of Rural Medicine & Surgery (BRMS) a 3 ½ yrs. course contemplated by Health Ministry (Government of India) to cope with the shortage of doctors in rural area.

2. Medical Council of India (MCI) for this purpose is trying to evolve an alternative model for teaching, training & learning in medical schools attached to district hospitals, where there are no medical colleges. It is contemplated to have a separate register for these graduates (BRMS).

3. After deliberating at length for over 2 hrs, it was opined unanimously that the scheme is totally ill-conceived, impractical, retrograde, disorganizing and undemocratic step. Being started in the name of rural masses, it will produce substandard half baked doctors who due to compromised education and training at institutions with compromised infrastructure & teaching facilities, will be unable to provide best only compromised care to the rural masses.

4. How can there be two different standards for health care, one ‘State of Art’ (comparable to best in western countries) for urban population and second a substandard care for rural masses, jeopardizing the latter’s health & life. This is highly dehumanizing and against the fundamental right of health of every citizens of the country.

5. While appreciating the GOI concern for ‘Rural Masses’ and agreeing that there is shortage/distribution of medical & paramedical manpower in rural and remote areas and doctors are reluctant to go and serve in these areas, it is pointed out that just providing the requisite numbers of doctors is not enough and this alone won’t work as obvious solution to the real problem.
6. The necessary political will, visionary political leadership, responsive administrative machinery, financial support & budgetary allocations are essential in addition to looking after the adequate facilities for producing trained nurses with care workers (HCW), basic infrastructure, and public health provision like sanitation, safe drinking water, sanitation as well as providing safety and community support in rural areas, etc. Prime Minister (Dr. Manmohan Singh) while inaugurating the National Rural Health Mission (NRHM) on April 12, 2005 confessed that "We have grievously erred in designing our health programme, most importantly we have paid inadequate attention to public health issues". Aren't we repeating the mistake again?

7. At CHC level short fall of specialist manpower, facilities and infrastructure is glaring. Obstetrician 56%, Surgeon 56%, Physician 39%, Pediatrician 67% with no provision for anesthetists. How will present scheme of things help in meeting this specialist services, over & above the shortage of para medical health workers, facilities as well as infrastructure.

8. MCI is the custodian of standards of medical education as a statutory body setup by 'Act of Parliament' and is responsible for ensuring uniform standard of medical education. MCI stopped all Licentiate courses like LMP, LMS, LCSFS, etc., created 2 yrs. condensed course to bring them at par with MBBS & all medical schools were upgraded to medical colleges. How can it contemplate now a short term 3½ yrs course against its own charter.

9. 3½ yrs. BRMS course is going to produce half baked inferior quality doctors who will lack confidence & capability to lead the team of other health worker like Nurses having diploma (3½ yrs.) / Bsc Nursing (4 yrs) or Paramedical (4 yrs. course).

10. This BRMS course is nothing except providing back door entry of substandard doctors to practice of medicine. These rural medical graduates over the time will form a parallel stream/organization and through political patronage or intervention of law, will succeed on grounds of discrimination & free themselves of all restrictions provided in the present scheme. Otherwise also the record of enforcing rule of law in our country is very poor.

11. As the Modern Medical Science is fast advancing, even the present day Modern Medicine Doctors after undergoing a training of 4½ years plus one year internship find it difficult to cope up with knowledge explosion. Early detection of complicated disease conditions and appropriate treatment will suffer if the service of the qualified doctor is denied to the Rural Population.

12. As per the objective of Indian Medical Association - "To work for the abolition of compartmentalism in medical education, medical services and registration in the country and thus to achieve equality among all members of the profession", the Association has vociferously opposed whenever any state government tried to introduce short term medical courses in one or other form, this being the consistent policy of IMA.

13. IMA is the largest voluntary organization of medical practitioners of modern scientific system and is an important stake holder in all issues pertaining to health and medical education. On such an important issue having bearing on nation's health delivery system and standard of medical education, how some Government of India has not taken IMA into confidence. We till date have not received any official communication & our observations are based on information on internet or media.

14. Under the circumstances IMA has strong objection to the proposal of starting scheme of Bachelor of Rural Medicine & Surgery (BRMS) and central council adopted the following resolution unanimously:
“TMA strongly opposes the implementation of EHRIS short-term medical course”.

SUGGESTIONS:

Some of the suggestions & alternatives which should be considered for improving rural healthcare are:

1. Increasing age of retirement to 65 or allowing re-employment of doctors after retirement on attractive salary & incentives in rural areas only.
2. Holding district level selection to enable locally available residents doctors whose families are already settled in that area.
3. Giving incentives & attractive salaries and allowances on loss of army for working in remote areas.
4. Linking rural service for in-service career prospects and promotions and posting of spouses in same place/district.
5. Compulsory working for 2 yrs. in rural areas before permanent registration by MCI and 2-3 years compulsory service in rural areas before allowing post-graduate admission.
6. Providing reservation to at least 25 seats in medical college to students from notified “Rural Districts” accredited by deccanissees authorities with Bond for 5 yrs. service in rural area.
7. Opening more medical colleges in rural areas, by allowing Pvt. Public participation with support of corporate sector.
8. Giving soft loan to the practitioners who establish themselves in rural areas and provision for soft loan to be made for personal requirement like building houses, hospital, clinic, vehicles etc.
9. Weakest point in Rural Health Services is CEBs. All CEBs should be upgraded to EPHS (India Public Health Standard) and funds provided for infrastructure equipments, mobile dispensary OT/LAB & blood bank storage facility etc. In addition to medical paramedical manpower.
10. Specialist shortages in CEBs can be alleviated by internal mobilisation/ posting/deputation/leasing for Pvt. Sector for short term.
11. Reservation for P.G. Admission for doctors who have served in rural areas for a minimum of 5 years.

To sum up, the solution for meeting the EHR (Human Resource on Health) challenges for provision of health services in rural areas includes:

1. Creation of sustainable “Health Care System” with provision of training & enhancing skills.
2. Outreach program for vulnerable population of remote areas.
4. Work culture commitment and community support and safety.
5. Medical & Financial provision to provide proper facilities and working conditions.
6. Budgetary allocation for health should be increased both at State and Central level from present 0.5% of GNP which is very very inadequate.
7. Form sectoral cooperation – coordination between all stakeholders from doctors to rural masses through Panchayati/District.

Let's hope that ministry of health and MCI will not take this stand on a prestige issue because any intervention in health care delivery sector should be planned on long term basis and not an ad hoc or volume. It must have wider consultation with all stakeholders, experts, TMA and other medical organisations before introducing or pushing through EHRIS Course.

(Signature)
National President

(Dr. G. Saumya)

(Dr. Diwan Prakash)
Henry, Secretary General
ADVT
When is intervention not required?

Intervention is required for relief of ischemia, therefore subjective or objective evidence of ischemia is required to perform intervention. If there are no symptoms and no evidence of ischemia on stress imaging then the patient is unlikely to benefit even if there is a lesion. Sometimes, on angiography, it is difficult to judge if the lesion needs to be treated. In this case a technique of coronary flow measurement using a flow wire with maximum vasodilatation with intra coronary adenosine is performed. There is a clear diagnostic cut off point on the basis of which decision to intervene or not is made. If patient is symptomatic and has non critical lesions in two vessels, this technique helps to decide if only one or both lesions need to be stented.

Intervention should also not be performed if there is no viable muscle. PET scan and MRI testing are the most valuable tools for detecting viability. Even if the lesion is severe but patient has no angina and no viability is demonstrated, intervention is not indicated. This situation is most commonly seen in post infarction cases. However neither of these two modalities are 100% sensitive or specific and all clinical parameters need to be taken into account.

A plaque need not be severe to result in rupture and precipitation of an acute MI. However aggressive treatment with antiplatelets and statins to stabilize the plaque is the more appropriate to prevent an MI and intervention can be reserved till evidence of ischemia develops.

If patient has severe co morbid conditions which are more likely to result in early death or has severe cerebrovascular or pulmonary pathology that would significantly increase the risk or morbidity of the coronary intervention, it would be wiser to treat medically.

Eventually the decision to intervene takes into account all factors, the age, clinical findings associated disorders and investigatory results. An informed decision is then taken by the patient, his relatives and the doctor.

Dr. Jamshed J. Dalal  
Director-Cardiac Sciences  
Kokilaben Hosp.

Complications of Interventions

In 1988, coronary intervention was done for first time in India and the first organized workshop for multivessel diseases treated with coronary interventions was done at Jaslok Hospital and Research Centre in 1989. Although it is an attractive opinion to bypass surgery, it has its own shortcomings and it is not completely free from complications.

Recurrence rate with balloon angioplasty was close to around 30%. With invention of stents, it came down to 15% but with drug eluting stents this rate dropped to 8%.

Acute stent thrombosis observed in 1% of the patients is a very serious complication and can cause either death or Myocardial Infraction in as many as 45% of the cases. Apart from this, edge dissections, groin complications following arterial access, perforations and blood loss are also known complications, although they are rare.

Recently stent thrombosis occurring even after one year is also described. This is called late stent thrombosis and can be observed even after 3 or 4 years. Its rate is estimated to be 0.6% per year.

New generation stents are likely to overcome this problem and in future it may significantly reduce stent related complications.

Dr. Ashwin Mehta  
Director-Cardiology  
Jaslok Hospital & Medical Research Centre
IMA MS SOCIAL SECURITY SCHEME HON. SECRETARY’S REPORT

Date: 01/02/2010.

- The Scheme was launched on 1st October 1990.
- The Effective membership as on 01st Feb. 2010 - 5250 +

Total No. of death since 1990 – 124 (Barring 1 member, nominees of all are paid the death benefit) In the year 2009-2010 No. of deaths 12. & the nominees of each of 12 expired members is paid Rs. 3,38,190/- within few days of getting information of the death.

This year
(1) Member from Mumbai West Branch joined the scheme in May 2008 & expired in October 2008. Even though the death was within 365 days of joining the scheme because it was accidental death (Crushed while crossing railway tracks). The nominee was paid Rs. 3,08,930/- within a fortnight. The member had paid Rs. 6200/- while joining.
(2) A member from Parbhani Branch joined the scheme in December 2007 & expired in the car accident in October 2008. His nominee was paid Rs. 3,08,930/- inspite of not completing 365 days in the scheme – A young man of age of 34 years. He had paid Rs. 2200/- while joining the scheme.

Young members, do not over look the security of family, thinking we are too young to die. Mishaps & deaths can occur anytime unpredictably.

You join the less you pay – the more you accrue benefit for your members.

Request to members of the scheme :-
- Please keep the IMA MS SSS certificate in secured place with all FFC receipts.
- Please keep your nominee informed of your membership of the scheme & how to act in case of unfortunate death to get the death claim amount.
- Please note – The notices for FFC – 2010 will be dispatched latest by 15th April 2010 to all members, if one does not get the notice by 10th May 2010 he has to inquire with the office. Without late fee the FFC must reach to the office latest on 31st May 2010. No excuse of notice not received will be entertained.

Request to the President / Hon. Secretary of each Local Branch. :-
1) Please incorporate the above matters in your news bulletins / correspondence to members.
2) On death of any member inform & inquire with IMA MS Office, whether he / she was member of IMA MS SSS, if yes, please help in expediting the process of sending death claim benefit to the nominee.
3) Advise members to send proper amount as mentioned above along with filled in form with Xerox of age proof & IMA Life Membership certificate in case of new membership.
4) IMA MS SSS recognizes the Best Working of Local Branches for propagation of the SSS. Please enroll larger no. & receive award for your Branch.
5) The branch may collect FFC 2010 from their members & send collectively, so as to reach before 31st May 2010, without late fee.
6) Please note change of payment schedules.

From 1st April 2009

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Admission Fee</th>
<th>Advance FFC</th>
<th>Annual Subs. 2 yrs.</th>
<th>Total</th>
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</thead>
<tbody>
<tr>
<td>Up to 30 years Complete</td>
<td>Rs. 1000/-</td>
<td>Rs. 1000/-</td>
<td>Rs. 200/-</td>
<td>Rs. 2200/-</td>
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<td>30 yrs. Complete to 40 yrs.</td>
<td>Rs. 2000/-</td>
<td>Rs. 1000/-</td>
<td>Rs. 200/-</td>
<td>Rs. 3200/-</td>
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<td>40 yrs. Complete to 50 yrs.</td>
<td>Rs. 3000/-</td>
<td>Rs. 1000/-</td>
<td>Rs. 200/-</td>
<td>Rs. 4200/-</td>
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<td>50 yrs. Complete to 55 yrs.</td>
<td>Rs. 4000/-</td>
<td>Rs. 1000/-</td>
<td>Rs. 200/-</td>
<td>Rs. 5200/-</td>
</tr>
<tr>
<td>55 yrs. Complete to 60 yrs.</td>
<td>Rs. 5000/-</td>
<td>Rs. 1000/-</td>
<td>Rs. 200/-</td>
<td>Rs. 6200/-</td>
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</tbody>
</table>

Please Note: 1. The AGM 2009 has deferred the amendment of changing the advance FFC from Rs. 1000 to 2000., hence no change in our charges.
2. Dr. Shrikant H. Kotahri was declared elected unanimously as the Hon. Secretary – IMAMS SSS for the period 14th November 2009 to – November 2012. As Dr.Arun Bhagwat, (Akola) had sent his resignation, the office bearers had nominated Umesh J. Rewanwar (Pusad) as the managing committee member. Dr. Dilip V. Gokhale (Nashi), Dr. M. S. Patwardhan (Miraj) & Dr. Rajgopal N. Kalani (Parbhani) were re-elected unanimously for the term of 14th November 2009 to – November 2012.

Dr. Shrikant H. Kothari
Hon. Secretary, IMA MS Social Security Scheme.
**A VISIONARY WITH A MISSION...... Dr. Pratiksha**

Dr. Pratiksha, a multi-faceted young Preventive Cardiologist of Mumbai, is variously described as a missionary in preventive heart care, EECP Therapist and an activist supporting the movement for non-invasive cardiac treatment. After completing her MBBS from G. S. Medical College, KEM Hospital, Mumbai, she pursued with a M.D. degree from Mumbai University.

She is a Gold medalist in Public Health from the college of Physicians and Surgeons, also stood first with distinction in Diploma in Hospital Administration.

EECP Enhanced External Counter Pulsation Therapy was first introduced in Maharashtra by her and now IPC is having maximum EECP machines in India from Vaso Meditech, New York, USA where she is formally trained as EECP Therapist. She is the Founder and Chairperson of IPC Heart Care Center, which has got various branches. To address growing concern of the silent epidemic, which is afflicting millions, she has started an NGO ‘Institute of Preventive Cardiology Foundation’ which has launched a National program to prevent and reverse heart disease.

She has also met India’s Hon. Ex. President Shri. A.P. J. Kalam in the year 2006 for initiating this campaign at national level through support of government.

Impressed with her pioneering work in Preventive Cardiology Superstar Akshay Kumar supported in her mission of IPC of creating ‘Good Heart Ambassador’ in every home by creating campaign for Star Gold TV.

For her outstanding original contribution work in the field of Preventive Cardiology and Non-invasive cardiac treatments, she was felicitated as ‘Best Woman Entrepreneur of the year 2005-06’ by Hon. Finance Minister Mr. P. Chidambaram.

An excellent orator, she has been an invitee speaker at a number of Seminars and symposiums of medical practitioners worldwide. She was a Chairperson in Preventive Cardiology session in the World Congress on Interventional Cardiology, held in Mumbai. She has been invited by various corporate and social organizations to conduct preventive cardiology programs through which she has educated over fifty thousand individuals.

She has given her expert honest medical opinion to over 15000 cardiac cases during past ten years all over India through her 8 branches. Through her team she has managed over 5000 cardiac cases successfully without Bypass Surgery / Angioplasty with success rate over 90%. She is also Founder Member of EECP Registry in India along with Dr. Sanjay Mittal, Apollo & Dr. Cherrian Frontier Lifeline.

Dr. Pratiksha has written a book in Marathi called ‘Bypassla Paryay’ published by Rajhansa Publication. Also received ‘Karmvir Bhaurao Patil’ award by State Government for this book on 18th Jan 2009.

She is popular through her various TV programs & over three hundred publications in the various leading newspapers and magazines where her message has reached over millions of people. Her mission is to reach each and every home and create a Good Heart Ambassador in every home who will ensure heart disease is prevented so that WHO statistics of every fourth Indian succumbing to heart disease by the year 2010 will be just statistics and not a reality.
WHAT IS EECP

EECP or Enhanced External Counter Pulsation, is a Non-Invasive treatment for patients who are refractory to or inappropriate for other interventions in cases of angina and heart failure.

History and evaluation of EECP

While EECP is a newer medical innovation, the technology has existed for more than fifty years. In early 1950s, an internal counterpulsation device called the intraaortic balloon pump (IABP) was developed. IABP consisted of a catheter with a small balloon tip which is inserted through groin artery (femoral) and threaded into the main artery (aorta). The IABP supports circulation in critically ill cardiac patients by inflating during diastole, the heart’s resting phase, to help increase oxygen and blood flow to the heart muscle through coronary arteries. The balloon rapidly deflates just before the next heart beat, decreasing the heart’s workload. EECP works via exactly the same mechanism. Only difference is that IABP works internally, while EECP works external to body.

While the American medical establishment turned its attention in the 1970s to high tech surgical procedures, EECP was far from forgotten. Tremendous interest in the treatment was growing in China, where physicians were captivated by its non-invasiveness and cost-effectiveness. EECP is consistent with Eastern philosophy, which teaches that medical treatments should help the body heal itself, enhancing and aiding its natural tendencies rather than interfering with them. Cardiologists in USA began to show renewed interest in EECP upon the publication of a scientific paper in 1992 by Stony Brook from New York state university in inoperable patients where EECP treatment improved them.

FDA gives its stamp of approval

In the ensuing years, numerous studies were published and all reinforced EECP’s safety and effectiveness. In response, the U.S.FDA approved EECP in 1995 as a treatment for chronic stable angina and cardiogenic shock, as well as for use during a heart attack. These are the same FDA-approved indications for the IABP. In fact, EECP was slightly more successful in increasing blood pressure in collateral vessels and improving the strength of the heart’s contraction. In June 2002, FDA expanded the list of EECP approved uses to include the treatment of congestive heart failure.

Treatment Regimen

EECP involves 35 days of treatment. Each treatment session is for one hour and the patients are asked to come 6 days a week for 6 weeks. It is important that the patient adhere to the one hour time schedule fixed by the hospital or medical centre and the patient is expected to continue the treatment without break.

Mechanism of action of EECP

During EECP, Cuffs inflate sequentially from the calves to the upper thighs and buttocks to raise diastolic coronary perfusion pressure and increase venous return. Cuffs deflate at the onset of systole producing left ventricular unloading with an associated decrease in cardiac workload.

Acute Hemodynamic Effects

The acute hemodynamic effects of external counterpulsation are similar to those seen with an intra-aortic balloon pump with the addition of increased venous return.

Inflation resulted in:

- Increase central aortic diastolic pressure up to 92%
- Increase intracoronary diastolic pressure up to 93%
- Increase in coronary perfusion pressure
- Increase coronary collateral flow velocity
- Increase venous return and therefore preload
- Increase in cardiac output up to 25%
**Deflation resulted in:**

- Decrease central aortic systolic pressure up to 11%
- Decrease intracoronary systolic pressure up to 15%
- Decrease in LV end-diastolic pressure up to 25%
- Reduce systemic vascular resistance
- Decrease Left ventricular workload & afterload

Intracoronary tracing in catheterization Lab showing gradual increase in cuff inflation pressure resulting in increase diastolic pressure, mean arterial pressure and decrease systolic pressure

**EFFEKT OF EECP**

<table>
<thead>
<tr>
<th>EECP Effect on Radionuclide Stress Perfusion</th>
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</table>
| ![EECP Effect on Radionuclide Stress Perfusion](image)

**Case selection for EECP**

**Indications**

- **Chronic CAD**
  - Surgery / PTCA not contemplated
    - Diffuse distal disease
    - Target lesion is inaccessible
    - Co-morbid states create high risk
    - LV dysfunction—High risk CABG
    - Restenosis after PTCA
    - CABG graft occlusion
    - Patients who refused for invasive procedure
  - Preparation for Revascularization
    - Severe LV Dysfunction with lot of hibernation to Stabilize Heart Function
    - Waiting due to some other reason
- **Heart Failure**
  - Non-Ischemic cardiomyopathy
  - Ischemic Cardiomyopathy
  - Patient with LV Dysfunction
  - Patient with moderate to severe levels of CHF

**Microvascular Angina**
- Cardiac syndrome X

**Acute Coronary Syndrome**
- Unstable Angina
- Acute MI
- Cardiogenic shock

**Contraindications Check List**
- Significant AR
- DVT/active thrombophililities
- Congenital Heart Disease
- Gross CHF
- Uncontrolled arrhythmia AF, VT, Frequent VPC’s
- Extreme Hypertension (BP>180/110mmHg)
- Extreme Tachycardia (HR>120 BPM)
- Cardiac Cath in Prior 1-2 weeks
- Pregnancy
- Bleeding Diathesis

**Precautions**

In some patients with a history of congestive heart failure (CHF) or low ejection fraction, left ventricular function may be insufficient to compensate for increased venous return during EECP. These patients should have their fluid balance closely monitored. Cuff pressure and deflation timing should be optimized for achieving maximum after load reduction and reducing the possibility of pulmonary congestion.

EECP should be withheld if there is exacerbation of heart failure symptoms and may be resumed once the patient has been stabilized. In patient with manageable edema with LVEF>35% continuous monitoring of oxygen saturation should be initiated.

Severe peripheral vascular disease including significant iliofemoral arterial obstruction may limit the effectiveness of EECP treatment due to decreased blood flow.

Patient suspected of having an abdominal aortic aneurysm should be evaluated for its clinical significance prior to treatment with EECP.
IPC journey with EECPr

IPC introduced 1st EECPr in Maharashtra, 2004

- IPC is India’s largest EECPr treatment provider (5 units installed) in technical collaboration with Vaso Meditech, USA. These units are connected to a unique software to control and monitor parameters online to provide quality treatment.

- **EECP THERAPY POSITION STATEMENT**

EECP external counterpulsation therapy is a non-invasive treatment for patients with myocardial ischemia and is indicated for use in stable and unstable angina pectoris, congestive heart failure, acute myocardial infarction, and cardiogenic shock. The U.S. Food and drug Administration (FDA) cleared vasomedical EECP therapy systems in February 1995 for patients with stable and unstable angina. In June 2002, FDA cleared EECP therapy for congestive heart failure (CHF) other indications for use of EECP therapy include acute myocardial infarct (MI) and cardiogenic shock. EECP therapy is a non-invasive treatment for patients who are refractory to or inappropriate for other interventions.

- Dr Pratiksha, Chairperson IPC, is the founder member of IPER Registry. IPER is an organization to support EECP providers with advanced Clinical Support

- Dr Pratiksha represents India as one of the member IPER Expert Committee.

<table>
<thead>
<tr>
<th>IPER Expert Committee</th>
<th>Unites States of America</th>
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<td><strong>Dr. John Hui</strong></td>
<td>Dr. William E. Lawson</td>
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<td>Ph.D</td>
<td>M.D.</td>
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<td>Director and senior</td>
<td>Professor of Medicine</td>
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<td>VP Vasomedical Inc</td>
<td>Director interventional</td>
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<td>Asst Professor in</td>
<td>Cardiology Director,</td>
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<td>Department of Surgery</td>
<td>Preventive Cardiology</td>
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<td>State University of Stony Brook</td>
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<tr>
<td>Dr Pratiksha MD Institute of Preventive Cardiology, Mumbai</td>
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<tr>
<td>Dr. Sanjay Mittal M.D. DM (Cardiology) Indraprastha Apollo Hosp.</td>
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<tr>
<td>Dr Ashok Punjabi MD, DM Medical Director of Krishna Cardiac Care Center</td>
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- Dr Pratiksha as a **Guest Speaker in First International ECP symposium** held in Guangzhou, China on 13th and 14th of May 2006.

- Dr Pratiksha Invited as a **Guest speaker** on ‘Role of EECPr in treatment of heart patients’ in the **National Conference on Indian EECPr Registry** held at Chennai on 21st. Presented clinical research paper in First International EECP meet held in 2006 at China, where more than 400 EECPr Therapist from all over the World had participated.

- July 2007 and also in the **Expert Committee** who will frame the guidelines to the cardiologist community to use the EECPr treatment effectively to the needy patients.
• Invited for lecture at Annual conference of IMA Maharashtra, MASTACON 2009. Her topic of discussion was **Hope for Hopeless-Cardiac treatments in 21st century.**

• Invited for lecture at IMA Pune in January 2010
• Invited for lecture at IMA South Mumbai in January 2010
• Presented lecture at Bandra –Khar Medical Association in July 2009

• Presented lecture at Dahisar Medical Association in August 2010

### Long Term benefits of EECP

**EECP** is clinical proven, evidence-based therapeutic systems documenting the effectiveness and safety of EECP in the treatment of patients with coronary heart disease. There are various clinical studies demonstrating the long term effects with benefits up to five years follow-up. Few selected scientific studies are given as follows:

#### Must – EECP Trial Study

The MUST – EECP trial is a randomized, controlled, double-blinded, multi-center trial undertaken at seven leading university hospitals in the United States. Patients in the active EECP group demonstrated significantly increased in exercise duration and statistically significant increased in time to exercise-induced ST-segment depression when compared to sham group from baseline.

**Clinical Benefits:**

- Relief of anginal pain
- Reduction in the use of nitrates
- Improvements in Quality of life
- Improvements in Exercise tolerance
- Clinical benefits are sustained for up to 5 years after following treatment

### BARI trial Study

The Bypass Angioplasty Revascularization investigation or BARI study, largest randomized clinical trial to compare bypass surgery and angioplasty, found that 21% of bypass patients and 22% of angioplasty patients had MI or died during the first five years after surgery. In addition 8% required repeat procedures. These results were comparable with EECP therapy.

### EECP vs. Medical or Surgical Procedures

<table>
<thead>
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<th>Procedure</th>
<th>5-Year Survival</th>
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<tr>
<td>EECP</td>
<td>8%</td>
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<tr>
<td>Coronary Artery Surgery (CABG)</td>
<td>9%</td>
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<tr>
<td>Coronary Artery Bypass Graft Surgery (CABG) meta-analysis</td>
<td>90%</td>
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<tr>
<td>Bypass Angioplasty Revascularization Investigation (BARI)</td>
<td>88%</td>
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LATEST SCIENTIFIC STUDIES ON EECM

Abstract: 2818

Direct evidence for therapeutic induction of arteriogenesis in patients with stable angina pectoris via external counterpulsation: a prospective controlled proof of concept trial

Authors:
E. Buchmann1, P. Pagano2, W. Uetz3, I. Schmitz-Hansorge2, A. Giesler2, L. Thierer2, R. Dietze2, V. Klodt2, M. Gross1, I. Buchmann1, 1Franz-Volhard-Klinik, Department of Cardiology, Helios-Klinikum Berlin - Germany, 2Center for Cardiovascular Research, Charité/Universitätsmedizin Berlin - Germany, 3Cardiac Magnetic Imaging, Helios-klinikum-Berlin - Germany, Health Trust GmbH - Berlin - Germany, 1Charité - Campus Vilmann-Klinikum - Berlin - Germany, 2Department of Cardiology, Campus Benjamin Franklin, Universitaet von Berlin - Potsdam - Germany,

On behalf: Artemogenesis

Topic(s):
Angina pectoris, stable

Citation:
European Heart Journal (2009) 30 (Abstract Supplement), 452

Methods: A randomized study of 20 patients (age 62±2.5) with stable coronary artery disease (CAD) and at least one hemodynamic significant stenosis eligible for percutaneous coronary intervention were recruited. One group of patients underwent 351-hour sessions of ECP once weekly for 7 weeks. In the other group (control), the natural course of coronary circulation over 7 weeks was evaluated. All patients underwent a cardiac catheterization at baseline and after 7 weeks. The effect on collateral artery growth was assessed by invasive measurements of the pressure defined collateral flow index (CFI, primary end point) and pressure derived fractional flow reserve (PFR).

Results: In patients treated with ECP CFI improved significantly from 0.06±0.02 to 0.09±0.002 (p<0.001) and PFR from 0.84±0.03 to 0.87±0.03 (p<0.001). In the control group CFI and PFR did not change after 7 weeks. The ECP group showed a significant reduction of the CCS (p<0.001) and FMA (p<0.001) classification, whereas the control group remained clinically unchanged.

Conclusions: We hereby provide direct functional evidence for the stimulation of coronary arteriogenesis via ECP in patients with stable CAD. These data might open a novel non-invasive and preventive treatment avenue for patients with non-acute vascular obstructive disease.

Change of CFI from baseline to week 8

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Frequently asked questions (FAQ)

Q: What are the advantages of EECP?
Unlike bypass surgery, balloon angioplasty, and stenting procedures, EECP is non-invasive, carries no risk, is comfortable, and is administered in outpatient sessions.

EECP increases blood flow:
* To heart by 20-42%
* To brain by 22-26%
* To kidneys by 19%

EECP also increases heart’s output (stroke volume) by 12% by reducing after load. This improves LVEF.

Q: Are there any risks or side effects of EECP?
EECP is safe. Occasionally, some patients experience mild skin irritation under the areas of the blood pressure cuffs. Experienced EECP therapists address this irritation by using extra padding where needed to make the patient comfortable. Some patients experience a bit more fatigue at the beginning of their course of treatment, but it usually subsides after the first few sessions. In fact, patients typically feel energized by EECP.

Q: When can I expect to start feeling better from EECP?
Most patients begin to experience beneficial results from EECP between their 15th and 25th treatments. These benefits include increased stamina, improved sleeping patterns, decreased angina, and less reliance on nitroglycerin and other medications. There is variation, certainly, and some patients start to feel better as soon as their first week of treatment!

Q: Do the benefits of EECP last?
Yes. In patients followed for three to five years after treatment, the benefits of EECP, including less angina, less nitroglycerin usage, and improved blood flow patterns documented on stress tests, had lasted.

Q: How does EECP compare to angioplasty or bypass surgery?
The five-year outcomes for EECP patients are virtually the same as for angioplasty and bypass surgery patients.

Q: Is EECP FDA-approved?
What kind of research has been done on it?
EECP was approved by the USA-FDA in 1995 as a treatment for coronary artery disease and angina, cardiogenic shock, and for use during a heart attack. In 2002, the FDA approved EECP as a treatment for congestive heart failure. It has undergone rigorous clinical trials at leading institutes.

Published in European Journal of Clinical Investigation 2009

This study provided direct functional evidence for the stimulation of coronary arteriogenesis via EECP.

23 patients of stable coronary artery disease underwent cardiac catheterization at baseline and after 7 weeks of EECP treatment.
Measurements of pressure derived Collateral Flow Index (CFI) and Fractional Flow Result (FFR) were done.
CFI & FFR were significantly improved in patients who completed EECP therapy as compared to controlled group.

Most patients begin to experience beneficial results from EECP between their 15th and 25th treatments. These benefits include increased stamina, improved sleeping patterns, decreased angina, and less reliance on nitroglycerin and other medications. There is variation, certainly, and some patients start to feel better as soon as their first week of treatment!
universities around the country and EECP has been the subject of more than 100 scientific studies published in leading medical journals throughout the world.

**Q: I have already had bypass surgery/angioplasty/stents. Can I still have EECP?**

Yes! Most of our patients have already had one (or many) of these procedures. They come for EECP treatment because they still have angina.

**Q: Can EECP dislodge plaque and cause a stroke or heart attack?**

No. Our bodies obey the laws of physics, and one principle law is that fluid will follow the path of least resistance. Atherosclerotic plaques are calcified and hard, and they create an obstruction that detours the blood through alternate routes. During EECP, when your blood is flowing to your heart, it will naturally bypass arteries with plaque and enter healthy, non-diseased blood vessels to go around the blockages. Going around the blockages is a longer trip, but it is a much easier one. In time, these new pathways are reinforced and become lasting routes for blood to reach your heart beyond the blockages. Every EECP patient has had multiple, serious blockages. No one has ever had a heart attack or a stroke as a result of the treatment.

**Q: Does EECP aggravate high blood pressure (hypertension)?**

No. If you have hypertension that is properly managed, you may undergo EECP without difficulty. Oftentimes, patients with hypertension find that their blood pressure improves as they proceed with EECP. If your hypertension is uncontrolled, you must seek medical care to get your blood pressure under control with proper medications before proceeding with EECP.

**Q: If EECP works so well, why haven’t I heard about it before?**

For a few reasons First of all, as mentioned before the USA-FDA only approved the procedure as an accepted medical treatment two years ago. Since then we are working hard to let every heart patient know that there is an alternative to surgical interventions in the treatment of heart disease. Because EECP provides patients an opportunity to stay away from invasive surgery, it is precisely the reason you should not expect to hear too much about this safe and effective alternative from your regular cardiologist. However, many cardiologists are beginning to realize that their patients know about this alternative anyway, and are recommending EECP as a non-invasive natural bypass procedure, in patients that are high risk for surgery or have no other alternatives.

**Q: High pressure created during EECP will burst my arteries?**

No, this pressure is optimized and given in scientific way by monitoring your ECG during diastolic phase/relaxation phase of your vascular system. It will not burst your arteries.

### CASE STUDIES

**1) Case One:**

‘Mr.Patil, you have to sign this High Risk Consent with DOT(death on table) if we plan breast carcinoma surgery for your wife’ These words were said to Mr.Patil by his wife’s oncology surgeon. Mr. Patil became speechless and with tears in his eyes he left the cabin of surgeon. He felt helpless as her wife’s heart pumping capacity of 15%-20% for past 4 years was the reason for doctors asking for DOT. He didn’t know what to do as if she doesn’t get operated for carcinoma, the disease itself was progressing and if go ahead with surgery risk was too much. There was no treatment available to increase the pumping as well. Mr.Patil, cousin who just completed his treatment at IPC successfully for IHD, suggested them to consult at IPC. On her first day of visit to IPC, Mrs Patil was diagnosed as a case of Dilated Cardiomyopathy (catheter angio. Normal) She was in NYHA class II-III with EF of 15% with moderate PH on 2-D Echo. She had bigeminy / trigeminy on ECG. Team of doctors at IPC revised her medications and in consultation with experts at USA as well as team of oncologists decision to give EECP was taken. Mrs. Patil completed her EECP with intermittent follow ups with oncologists to keep a close watch on progress of carcinoma. Post EECP her angina class improved to NYHA I, ECG became regular and LVEF improved to 25% with mild PH. She was given fitness to get operated. She got operated and discharged with in a week from hospital.
This case explains the need of therapy for heart disease especially for cases who are either inoperable or where revascularization is not useful.

2) Case Two:
Mrs. Swati Kambli, clerical staff at a Bank, suffered from Heart attack in 1997 at the age of 32 yrs. She underwent Coronary Angiography in the same year which showed blockage in one major vessel & Balloon Angioplasty for that. But this was not the end of her suffering as her Femoral artery from where the probe was passed during angioplasty was blocked with a large blood clot & she started getting unbearable pain in the leg. Doctors performed emergency operation to remove that clot & it was for around 7-8 hrs. She was bedridden for 3-4 months as a result of that. She suffered a lot financially & Psychologically as she couldn’t resume the duties during that period.

The patient was maintaining on medications till in 2007 she again started getting the Anginal pain. She underwent Angiography which showed 90% blockages in two major vessels. Now that she was advised CABG which was beyond her imagination as she was very young, had no money, taking leave from office was difficult & no support from Family. Although she bravely decided that she will maintain on medicines only but her increasing symptoms were troubling her.

AT IPC she got the hope for life. Dr. Pratiksha evaluated her case & advised for EECP. She started with EECP in Nov’07 & by the time she completed the treatment in Jan’08 she was quite normal. Her stress test was Negative, 2 D Echo showed improvement in pumping capacity from 35% to 40%.

3) Case Three:
Mr. Vishwanathan, 68 yrs old gentleman was a chronic case of Diabetes. He underwent surgery for liver abscess in 1980 & subsequently Aortic Valve replacement in 1983.

Later on he started C/O chest heaviness, fatigue in 1998. Doctors advised for Angiography which showed LM-Normal, LAD-40% before D1,75%(ostium),LCX-75% ,RCA-90% . Then he underwent Bypass Surgery in 1998 and at the same time, Doctors found that his Prosthetic Aortic valve started getting damaged which was then replaced by metallic valve.

He was better after 1998 surgery, but again started with weakness, fatigue & pain in Lt. hand on exertion, palpitation in Oct. 2007. Doctors did Angiography which showed LM-Normal, LAD-90%(prox), 79-80%(mid),80% (distal), LCX-99%(mid),RCA-total occlusion of the graft. Hence underwent Angioplasty immediately.

He was not better after angioplasty. He was still C/O weakness, chest pain, Doctors told him that it is because of Keloids due to Bypass operation.

Then finally in Sept 2008 he did the Dobutamine Stress Echo which was positive. Doctors advised him to undergo Preventive treatment & EECP as he was not fit for any surgery then. They started with Skin treatment for Keloids. He started EECP at IPC.

His heart beats were irregular which was under control then & EECP worked Effectively.

He completed EECP successfully with the stress test improved & he traveled to USA at his son’s place that was a greatest achievement for him. EECP is a hope for the hopeless.

4) Case Four:
Mr. Nooruddin Shaikh, 42 yrs old gentleman, a tailor by profession came with a complaint of breathlessness after 1-2 min walking even after the angioplasty which was done only 6 months back. After angioplasty he was hardly better for 1 month and again he started getting breathlessness after little exertion. After 6 months of his angioplasty he was advised to undergo 2nd angiography and bypass. He couldn’t even repay the loan which he took for his angioplasty and the another big problem was in front of him in the form of 2nd angiography and bypass surgery with which he was really frustrated.

In May’08 he came to IPC with keeping ray of hope in his mind that he can avoid 2nd CAG & bypass surgery. He immediately advised
hospitalization to correct the excessive fluid accumulated in his body & after 15 days he started with EECP, noninvasive treatment to improve heart’s blood supply.

After 35 sessions of EECP over his 2 D echo was repeated and there was marked improvement in his LV systolic function (EF-35%) which was only (25-30%). Even after 1 yr of completing EECP he is able to carry out all his routine activities without any discomfort with daily walk of 20-25 min. He didn’t even require a single admission in this last 1 yr, for cardiac complaint.

5) Case Five:

Mr. Vijay Salvi, a young businessman, a Typical Type A Personality person. In these type of people their Hurry, Worry & Curry are the fuel in the fire.

He got heart problem in the year 2000, at the age of 47 yrs. His Left sided major artery showed 99% blockage which had severely affected his heart, dropping the Pumping capacity to 35%. He underwent Angioplasty at that time but as he continued the same lifestyle the result was that he required 2nd Angioplasty in the same artery in 2001 i.e. merely in a year time. He developed the block lower to the previous Angioplasty site.

He didn’t learn anything out of it as the Business was the major factor for him & his problem was solved by getting Angioplasty done. The concept of prevention & control was not yet in his mind till he started getting Anginal symptoms again in 2008. He read about Dr. Pratiksha & IPC in Newspaper & the concept of EECP & Cardiac rehabilitation programme for prevention wad convincing for him.

He started with the treatment at IPC but he was not ready to understand the importance of Cardiac Rehabilitation programme (Diet, yoga, Meditation, Exercise) as it is too time consuming. It was the hard work & dedication of our professionals that he realized the importance of it & to our surprise he started religiously following everything.

As a result his Pumping capacity of heart improved significantly to 60% & stress test was Negative.

In his feedback form he wrote that the combination of Cardiac Rehabilitation Programme with the treatments is really needed for the good results & maintaining. He felt that he wasted his time all these years, if he would have got the treatment earlier his Heart condition would have been controlled. He specially thanked Dr. Pratiksha for the Yoga meditation.

It shows that getting repeated angioplasty is not the only solution. It may temporarily benefit but we need to remove the root cause.

6) Case Six:

Mr. Annasaheb Vasagdekar, 65 yrs old gentleman, a criminal lawyer by profession was advised to undergo a second bypass surgery 8 yrs of his first bypass and he was really against of it.

He is having history of dyslipidaemia since 20 yrs for which he was taking regular medicines and there was lot of mental stress because of his profession.

In 1996 first time he experienced chest pain while traveling to court, as the pain was increasing he rushed to a nearby hospital. there his ECG was taken and it was a heart attack(IWMI) for which he was immediately hospitalized and treated. after MI he was well for next 2 yrs. he was taking regular medicines. In 1998 he started Ext.angina. he was advised CAG which revealed sever TVD and immediately his bypass surgery was done. Till year 2005 he was comfortable but since Dec’06 again he started getting ext.angina. He had episode of unstable angina for which he was hospitalized and his angiography was done. after his second angiography he was advised to undergo second CABG immediately as his all the 4 grafts were totally occluded. Pt. was really against of taking another painful experience of bypass surgery and he came
in IPC to consult Dr. Pratiksha. After the evaluation of his cardiac status, he was advised to undergo ECP. He completed 35 days of EECP treatment in Dec'06 and he felt remarkable improvement in his chest pain & dyspnea on exertion.

After EECP, he again started his law practice and all his routine without any cardiac complaint. Even after 3 yrs of completion of EECP, he is living a healthy life without any cardiac events and not even single hospitalization required for cardiac complaint. In July'09, he underwent a major surgery of Lumbar spine tumor without any cardiac complications.

7) Case Seven:

Mr. Ashok Savtale, 70 yrs old gentleman, having his own business, was advised to undergo a second bypass surgery but because of his low pumping of heart, it was a high risk surgery for which pt. was not ready.

Pt. is having history of hypertension and dyslipidaemia since last 10-12 yrs for which he was taking regular medicines. His obesity and history of chronic smoking, almost more than 30 yrs was added another strong risk factor for development of IHD. In 1996, he started experiencing difficulty in breathing while brisk walking and climbing upstairs. He went to a cardiologist and it was diagnosed as Ext. angina. His 2D echo done at that time showed significant reduction in his heart's pumping action (EF-10-15%). His CAG revealed severe DVD for which he was advised early CABG which he immediately underwent. He was put 2 grafts. Next 10 yrs till 2006 he was under medical management and he was doing all his routine activity satisfactorily. Occ. he used to get breathlessness on exertion. In 2006 again he started c/o marked breathlessness on walking, he was unable to walk for 2-3 min for which he was hospitalized and it was diagnosed as episode of unstable angina. His CAG was done for second time and it revealed progression of the disease inside. He was again advised to undergo a second bypass surgery with high risk consent as the EF-25%. As redo CABG was a risk for pt, he was advised medical management.

Patient got information about IPC from his friend and he came to IPC with hope in his mind that IPC treatment will help him to improve his condition. He was advised EECP treatment after assessment was done by Dr. Pratiksha. He finished 35 EECP in Sept'07. After EECP, his EF improved to 25-30% and he was able to walk for 20 min regularly without breathlessness. Even after 2 yrs of completion of EECP, he is daily walking for 30 min & doing all his activity without any chest discomfort or breathlessness. In this last 2 yrs, he has not even required a single operation for cardiac complaint.
various Corporates, Non Profit Organisations, NGOs & some prestigious Associations & Societies of India.

- Conducted Seminars and Workshops since 10 yr and more then 50,000 people were covered through seminar and public talk to spread the message of prevention
- Message reached to people through electronic media, Newspaper, TV channel and Radio
- Gives Honest opinion to each and every case and select cases which will be benefited by EECP treatment
- India’s largest EECP provider and only center in world with complete holistic approach under one roof
- Dedicated team of doctors in each and every branch providing utmost patient satisfaction.

Other programmes at IPC

IPC is the most cost effective centre in the country that provides non-surgical Holistic & Integrated treatments for Heart diseases and for those people who want to prevent themselves from this silent killer. IPC has over 90% success ratio in reducing blockages, improving blood flow to the heart thus vastly reducing the possibilities of heart attack and premature deaths.

At IPC we try to reach the root cause of disease we focus on lifestyle modifications through our various programmes with the help of our team members. IPC’s Preventive programs, diabetes, blood pressure, and cholesterol programs are for all where modern medical management is combined with alternative medicines and therapies of Yoga, diet management, meditation and stress management to reduce the risk factor causing “Heart Disease and Heart Attack” and to improve the blood flow to heart and bring about reversal of Coronary Heart Disease.

CARDIAC REHABILITATION PROGRAMME

Rehabilitation programm is a customized program of exercise and education. The goals of cardiac rehabilitation are to help you regain strength, to prevent your condition from worsening and to reduce your risk of future heart problems. And this will lead to a better quality of life. Cardiac Rehabilitation team comprises of

- MD physician
- Cardiologist
- Cardiac rehabilitation therapist
- Stress Counselor
- Nutritionist
- Yoga Instructor

Rehabilitation has two main components:

- **Medical evaluation:** A thorough evaluation by MD doctor including TMT, 2D Echo helps us to assess your physical abilities, medical limitations and other conditions you may have. Your team explores what risk factors you may have for cardiovascular diseases. All of these findings help your team tailor a cardiac rehabilitation program to your individual condition, making sure it’s safe and effective.

- **Physical activity:** On the basis of medical assessment, an exercise protocol is designed by the rehabilitation therapist. You will be risk stratified first and then (THR) target heart rate is set which is at optimum intensity as well as safe. Your cardiovascular fitness is improved through walking, cycling and other endurance activities. You may also do strength training to increase your muscular fitness. Don’t worry if you’ve never exercised before. Your cardiac rehabilitation team will make sure the program moves at a pace you’re comfortable with.

Who is eligible to join Cardiac Rehabilitation?

- Heart Attack
- Angioplasty
- Bypass Surgery
- Heart Failure
- Angiography showing blockages
- Heart Valve Replacement
- Stable Angina
- Pacemaker

YOGA

Yoga Therapy is a part of this Treatment. Yoga therapy has play very important role in this treatment. Nowadays, everybody has done yoga in his/her life sometime or the other. There are classes, camps, crash courses and TV shows teaching you ‘Yoga’. At IPC we have over 5000 cases who have practiced the yogasanas in this book and have shown successful results in their physical and mental health. But now, as you’re in IPC for reason, it is most important to make fresh look at your yoga practice in spite of your past knowledge. Please remember that every Asana may not be suitable for your heart condition. At times, it my even do more harm than good. Hence, it is strongly recommended that you do only those Asanas which are taught to you by IPC Yoga Team and do them in the same prescribed way.
Since ages, yoga is being practiced by millions of people worldwide. The efficacy of the same has been researched and documented by Medical science in India as well as western countries. Yoga is science and way of life completely based on wonderful scientific truths.

Hence one should understand that ‘Yoga’ is not limited to particular sect, cult of religion. It is also not merely an exercise. It is unidirectional way of life lading to state of pure health. It is also not for only heart patients or ailing people. Even the healthy people must practice it.

As there is not only one Asana, Pranayam or Relaxation to control the disease so one should do the yoga practices for the Heart Disease as advised by IPC Yoga Team.

HEARTY DIET

Creating awareness among patients, their family member, friends & relatives regarding right choice of food is aim of Diet Department & is carried out by Dieticians in IPC. Dietician emphasizes role of food in providing adequate nutrition for healthy heart.

Faulty food habits can cause hypertension, Atherosclerosis, Dyslipidemia, Obesity, Heart attack, Early Ageing & several other metabolic disorders. Keeping in mind key principles of Dietetics & Nutrition, Dietician assist in preventive & curative role. Special

Healthy Diets are given

- To maintain Ideal body Weight
- Controlling Hypertension
- Preventing & reducing Heart Blockages.
- Increasing Good Cholesterol
- Increasing Blood Circulation
- Preventing damage caused due to Obesity, Diabetes Arthritis.
- Slowing down Ageing process (Free Radical Damages)

In IPC Dietician gives one to one basis Diet Consultation, group meeting, Discussion, Cooking workshop in order to facilitate healthy lifestyle

IPC HONEST MEDICAL OPINION

- Being a pioneer in non-surgical cardiac treatments our constant Endeavour is to guide our patients honestly whether the treatments offered by us how much will be the benefit and if required urgently we propose surgical revascularization as first line of treatment.
Dr. Rajendra R Chawhan, Past President IMA Boisar branch in last five years, have collected more than 1000 bags of blood every year through camps and donated it to State Blood Transfusion Council (Government hospital). Dr Rajendra Chawhan has been awarded twice by Dy. Chief. Minister for this social work in 2007 & 2008. This year he has a record collection of 2028 bottles of blood and hence is our

**Great Samaritan of Maharashtra.**

Dr. Bakulesh Mehta At the 3rd Sports Mela organised by IMA MS (Medisport 2010) at Jalgaon.

Inauguration of Mastacon 2009
Dr.Bakulesh Mehta, Dr. Arun Pawade, Dr. Anil Award, Dr. Jayesh Lele

Dr.Bakulesh Mehta addressing during his acceptance as President Elect IMA MS.

Chief Guest & Finance Secretary of IMA HQS
Dr. D. Rai inaugurating Gericon 2010
Coronary heart disease (CHD) is one of the most prominent health problems at a global level. By 2020, it is expected that CHD will be the largest cause of disease burden worldwide. In the developing world, demographic and lifestyle changes are resulting in an "epidemiological transition" from infectious diseases to non-communicable diseases such as CHD.

Risk factors for CHD can be divided into biological parameters such as lipoprotein levels, blood pressure, body fatness, cardiopulmonary fitness, etc and lifestyle parameters such as exercise, daily physical activity, diet, obesity, smoking and tobacco consumption. There is now a large body of evidence showing that the risk of CHD events can be significantly reduced through modification of these risk factors.

Recent guidelines have also clearly defined the importance of changing the lifestyle and treatment with prophylactic drugs. In the West, the identification of risk factors for CHD has led to preventive efforts with some measure of success. In contrast, exposure to the same risk factors appears to be increasing in Asian countries like India via a "globalization" of dietary habits, and urbanization. Unfortunately, systematically documented data on both CHD prevalence and incidence in countries like India are scarce. Despite this paucity of data, there is sufficient information to suggest an impending epidemic and preventive measures to control various lifestyle risk factors for CHD need to be actively pursued by physicians in developing countries like India.

Lifestyle Risk Factors

The primary lifestyle risk factors for CHD which can be actively modified or monitored by the physician include:

- Exercise and daily physical activity
- Smoking
- Diet
- Obesity

Exercise and daily physical activity

The relationship between physical activity and chronic disease morbidity and mortality has been the focus of much scientific research. Results from these studies have generally been mixed. One potential explanation for the inconclusive findings is that activity levels were often estimated from participants’ job descriptions with no individual measures obtained. This could increase the risk of misclassification since different persons with the same job title may have a large variability in physical activity. Other potential explanations include the types of activities performed on the job (i.e., isometric vs. isotonic), limited variability in activity at work, and the fact that physical activity outside of work was not considered. Studies of leisure time physical activity have been more consistent in finding a protective effect of increased activity on a number of disease endpoints including both fatal and non-fatal coronary heart disease (CHD).

Few studies have investigated the joint effects of occupational and leisure time physical activity. Individuals with sedentary jobs likely perform the bulk their activity during leisure time, whereas, those in physically demanding occupations may be more active during work than leisure. For women, particularly those who do not work outside the home, typical leisure time activity questions may not appropriately characterize overall activity levels. Studies that do not consider work and leisure time activity may fail to appropriately characterize activity levels. In this context, the Buffalo Health study reported a strong significant interaction between physical activity and Body Mass Index (BMI) in regards to mortality. This study showed that beyond a certain BMI threshold, the benefits of activity on mortality cannot override the harmful effects of excess weight.
This lack of a positive association in heavy men was attributed to the strong anaerobic component (i.e., lifting 25 pounds or more, shoveling, etc.) in their daily activities.\(^2,4\) This showed that anaerobic activities did not influence mortality risks in the same manner as predominantly aerobic activities usually performed during leisure time in the form of exercise. This was also attributed to the observation that obese men tend to report significantly higher activity levels leading to a measurement error. A potential exception could be that obese men were less likely than lighter men to adopt a physically active lifestyle after retirement.

These findings from this study suggested that an incremental increase of 1 kcal/kg/hr would represent a doubling of energy expenditure and could be achieved in various ways.\(^2,4\) An individual who sleeps seven hours on average and is completely sedentary during the remainder of the day could achieve such an increase by spending:

- all waking hours in light activity and eight hours at a level slightly above rest or
- two hours in very vigorous activity and remaining quite sedentary throughout the rest of the day

**Smoking:** Cigarette smoking is a major cause of cardiovascular diseases and is responsible for approximately 140,000 premature deaths from cardiovascular diseases each year.\(^6\) Smokers have a 2.5-fold increase in the incidence of coronary heart disease compared with non-smokers.\(^6\) Accordingly, the relative risk of myocardial infarction is 2–3 times higher in men who smoke, and 1.5–3 times more common in women who smoke than those who do not.\(^6\) Cigarette smoking also influences levels of other cardiovascular risk factors, most notably serum lipid levels, but the effect of smoking on disease risks is independent of its effects on other risk factors. The risk attributable to smoking persists even when adjustments are made for differences between smokers and nonsmokers in levels of these other risk factors.

Data from the Framingham Study suggest that smoking cessation can reduce the risk for coronary heart disease up to 64%, and that there is a 10-fold higher risk for sudden coronary death in smokers and 4.5 times higher in women who smoke.\(^5\) This study also demonstrated that filtered cigarettes are not protective.\(^6\)

Considering the overwhelming evidence against smoking, the cardiologists must necessarily intervene by always asking about the smoking status of their patients and it is their duty to firmly and clearly indicate to stop smoking.\(^5\) This conduct must be reinforced in successive visits or telephone calls.

The different methods to reach smoking cessation are:

- sudden suppression (the most common),
- gradual suppression,
- use of cigarettes with low nicotine & tar content
- Nicotine patches - active patch subjects were more than twice as likely to quit smoking as individuals wearing a placebo patch.\(^5\) Nicotine replacement is an effective smoking cessation aid and has the potential to improve public health significantly and should form the basis for treating moderate to heavy smokers.\(^5\)

**Obesity:** Obesity was identified as a risk factor for early mortality before being linked to CHD risk factors. During the last half-century, people of many countries including India have experienced an epidemic of obesity. So pervasive and persistent is this condition that it can be referred to as a pandemic with the proportion of adults and children who store excessive amounts of energy as fat, and who thereby become more likely than normal-weight persons to develop cardiovascular and other complications, having risen dramatically. Of the three actual cause-of-death categories—cardiovascular disease, cancer, or all other causes—risk of death from cardiovascular disease was most predictable from the overweight.\(^7\) Consequently, in 1998, the American Heart Association reclassified obesity as “a major, modifiable risk factor for coronary heart disease”.\(^7\)

In a recent study, among 201,622 deaths, the highest mortality rates were among the heaviest subjects who had no history of chronic disease and who had never smoked: the heaviest men had a relative risk of death of 2.68, and the heaviest women had a relative risk of 1.89.\(^7\) However, this finding is not unexpected because smoking and chronic disease promotes leanness, and a large proportion of these subjects died with lower-than-normal BMIs.

An important lifestyle factor which also contributes to obesity are the weight-related eating measures such as eating while watching television or doing homework, eating when not hungry, sneaking food, eating fast food, and so forth.
Diet: Recently, several intervention trials have demonstrated that dietary therapy with nuts, plant sterols, fiber, and soy protein is as effective as the first generation of statin drugs in lowering low-density lipoprotein cholesterol and C-reactive protein levels (approximately 30% reduction in both parameters for diet and drug treatment). There is now adequate evidence that types of fat are more important than the total amount of fat in determining the risk of diabetes and CHD. Substituting unsaturated fat for saturated fat has been shown to decrease low density lipoprotein cholesterol and improve insulin sensitivity in intervention studies. Higher intake of vegetable fat or polyunsaturated fat (from plant-based oils, nuts, and fish) is inversely associated with CHD risk in large prospective cohort studies. Secondary prevention trials have demonstrated that substituting polyunsaturated fat for saturated fat was effective in lowering serum cholesterol and reducing cardiovascular mortality in patients with existing CHD.

The total percentage of carbohydrates in the diet has generally not been found to predict CHD risk. However, several epidemiologic studies have found that diets rich in cereal fiber may protect against the development of CVD. Thus, metabolic consequences of carbohydrate intake depend not only on their quantity but also on their quality. Available evidence also suggests that a plant-based eating pattern rich in fruits, vegetables, whole grains, and nuts is effective in reducing risk of CHD.

Epidemiologic and clinical trial evidence supports the view that dietary and lifestyle factors play predominant roles in the development of major chronic diseases. Whereas cigarette smoking, obesity, and physical inactivity have long been established as major causes of chronic disease, the role of specific dietary factors had not been clearly defined until more recently. Evidence is increasing that the quality of fat and carbohydrate plays a more important role than the quantity, and thus health strategies should emphasize replacing saturated and trans-fats with unsaturated fats and replacing refined grain products and sugar with minimally processed grains.

CONCLUSION: Lifestyle and dietary modification have much more impact in preventing myocardial infarction and prolonging life than medications, interventions or bypass surgery. Many patients do not receive adequate lifestyle advice even after a cardiac event. Despite evidence that such actions reduce the further risk of morbidity and mortality; these preventive managements goals are not often achieved. Patient education must be formalised and acknowledged as an official part of the health care system.

Titbits

3 Ws to keep your Heart Healthy.

Walking, walnuts and wine can boost your HDL.

Walnuts: These are unsaturated fats which are known to raise HDL.

Walking: Aerobics, walking have shown to increase HDL, Walking 2 miles is better than running 1 mile.

Wine: 60-80 ml of Red wine is known to raise HDL.

3 causes of Raised ESR beyond 100.

Extra pulmonary Tuberculosis, Malignancy, Connective tissue disorders.

3 drugs a must for all Type2 DM besides OHA/Insulin.

Statins, Ace Inhibitors or ARBs and Aspirin.

3 Hathiyaars without which a physician should’nt practice besides a stethoscope and BP app. are Ophthalmoscope, Pulse Oximeter and a ECG machine.

3 ways a Primary Care Physician can touch skies.

Examine each patient from top to bottom, Listen to your patient completely & Attend Dr O P Kapoor’s lectures.
ADVT
November 2009

CME on ‘Pain in Abdomen in Paediatrics by Dr. Modak Raza spoke and Dr. Vivek Rege

Pulse Polio vaccination, CME on “Liver and Pancreatic disorders” at Raheja Hospital, by Dr. D. R. Kulkarni.

CME on ‘Nephrology’ was organized at Bombay hospital.

A seminar on ‘HIV AIDS’ was organized at S. L. Raheja Hospital by Dr. D. G. Saple, consulting dermatologist.

Office bearers had a meeting with Chief Secretary, legal department of Maharashtra Government to discuss extension of the ordinance to prevent assault on doctors. The ordinance was extended in November 2009 for a period of 6 month.

Aao Gaon Chalen sub committee members visited Deewanmal Pada and examined 41 patients.

December 2009

Web Site of IMA Mumbai Branch www.ima-mumbai.com was inaugurated by our President Dr. Ramesh C. Shah.

World AIDS Day. We have organized CME on HIV AIDS and Malaria, the speakers were Dr. S. Jayram and Dr. H. Pardawalla.

District workshop on swine flu (IMA HQ) was organized, the speakers were Dr. Anil Pachnekar and Dr. Om Shrivastav.

Blood Donation Camp was organized on Dadar (W.R.) bridge in association with Western Railway Employees Union and Red Cross Society. About 60 bottles of blood were collected.

CME on Management of Backache, CME on Updates on Piles Fissures and Fistula at S. L. Raheja Hospital.

CME on Profile and Imaging was held at Bombay Hospital.

IMACON 2009 and Central Council meeting were held at Hyderabad. About 14 members represented IMA Mumbai Branch. I am pleased to inform you that IMA CGP Mumbai sub-faculty has received IMA Dr. C.L. Jagga Award for Best Faculty of IMA CGP for the year 2009 at the IMA National level. This year we have also received Sikchi Award for best IMA CGP at State Level. Dr. Rajendra H. Trivedi has received IMA President Appreciation Award for best Adjudged Secretary of local branch for the year 2009 and Dr. Hozie Kapadia was honoured with IMA News Bulletin Award (Editor, MAHIMA) from Dr. Ashok Adhao, our National President.

January 2010:

New year social get-to-gether was organized. At 7.00 p.m. “Ya Katarveli” drama written by Dr. Prakash Kawli, Directed by Dr. Kishor Khusale and performed by IMA Members was organized.

Written letter to Commissioner of Mumbai concerning Menace of Quacks and requested a meeting for discussing ways and means to tackle this problem.

A meeting with police inspector Kalpana Gadekar from Varsova Police Station regarding Munirkhan and Quack Doctors. She gave the details and progress about the case and asked for our co-operation.

Office bearers of our branch were invited by Police commissioner, Shri D. Sivanand on the occasion of redevelopment of Police hospital and other police welfare schemes. Police personnel checkup scheme in association Lintas India Pvt. Ltd., was also inaugurated. IMA members will be on panel of Police panel to prepare detailed data of Mumbai Police health hazards.

24 senior IMA Members took part in senior citizen run of 4.3 km in Standard Chartered Mumbai Marathon 2010. We had taken part under the banner of IMA Mumbai Branch and we spread the message of “Save the girl child”.

Super Sixes Cricket Tournament for the “Electrobin Trophy” was held at IMA lawns. Six teams participated.

CME Programme on “ENT” was organized at Bombay Hospital in association with GPA GB and Bombay Hospital. Free medical check up camp and distribution of free Jaipur foot was organized.

Flag Hoisting ceremony at the hands of our President Dr. Ramesh C. Shah was held at IMA
Lawns at 9.00 a.m. About 40 members were present for the function.

A CME on Recent Trends in Detection and Management of Psychiatric Disorder was held at Raheja Hospital. Dr. Hemangi Dhavale delivered a talk on “Depression – Current Scenario”

February 2010

39th Annual Conference of IMA Mumbai Branch was held that Ravindra Natya Mandir, Prabhadevi. The theme of the conference was “Save Lives – With Safe & Skilled Drives”. The conference was inaugurated by the Chief Guest Dr. Dharam Prakash, Hon. Secretary General, IMA HQ. Shri. Eknathraoji Gaikwad, Member of Parliament – Mumbai and Dr. Vijay C. Panjabi National Vice President IMA HQ, were Guests of Honour. We felicitated Dr. Bakulesh Mehta President IMA MS, Dr. Hozie Kapadia, State Secretary IMA MS and Dr. Shivkumar Utture, Hon. Treasurer IMA MS and MMC Member. About 500 delegates enjoyed the scientific sessions. Telephone Directory of members of our branch was inaugurated.

CME on “Hematology” at K. J. Somiya Hospital was organized.

CME on “Trends & Advances in Treatment of Breast Cancer” at S. L. Raheja Hospital.

For the 1st time IMA Mumbai Branch has arranged an International Tour to Bangkok & Pattaya for members and their families.

CME on “Chest Diseases” at Bombay Hospital.

We have received substantial donation for renovation of the Family Welfare Centre in IMA House to increase the facilities for Child Welfare Clinic, Elderly Welfare Guidance Centre and Family Welfare Centre.

REPORT of IMA Mumbai West FOR THE MONTH OF JANUARY & FEBRUARY - 2010

Cultural programme of HALDI KUM KUM & TILGUL SAMAROH was organized on THURSDAY, 21ST JANUARY 2010 at our branch premises and was well attended and appreciated.

An Orientation Workshop on “REPRODUCTIVE & CHILD Health” joint programme with MCGM was held on Thursday, 11th February 2010. Cooking Demonstration “Steal a Restaurant Secret” was held on Friday 13th February 2010. In this we learned different starter like Bruchetta, Volvonus, paneer Manchurian & paneer tikka etc.

Organize the programmes of decision on Medical Legal Issue held on Friday 19th February 2010.

GERICON – 2010 was organizes on Saturday & Sunday 20th & 21st February 2010. This conference dedicated to Geriatrics.

Holi Pooja & Hasya Kavi Sammelan was held on Sunday, 28th February 2010 on the occasion of Holi.

ACTIVITIES OF MULUND BRANCH OF IMA

November 2009

Special CME on “Sex and Marriage from G.P.’s Perspective by Dr. Rajan B. Bhonsle, Hon. Professor and Head of the Department of Sexual Medicine at Seth G. S. Medical College & K.E.M.Hospital, Mumbai

CME on “Cardiology – Clinical & Beyond” by Dr. Manjeet Juneja, Interventional Cardiologist

January 2010

One-Day Conference of Mulund IMA covering major Specialties of Medicine.
A meeting of the Advisory Committee, constituted by the National President, IMA Dr. G. Samaram to look into the short term medical course (BRMS) was held at 12 Noon on 15th February, 2010 at IMA House, New Delhi.

Dr. G. Samaram, National President, IMA informed the members about the ill-health of Dr. Dharam Prakash, Hony. Secretary General, IMA and requested Dr. D.R. Rai, Hony. Finance Secretary, IMA to be present on behalf of Hony. Secretary General.

Dr. G. Samaram, National President, IMA welcomed all the members present and informed them about the Resolution which was passed in the Central Council Meeting of IMA held at Hyderabad. He informed the members that as decided by the Central Council of IMA, he has made a Drafting Committee consisting of 5-members along with National President and Hony. Secretary General, IMA. This Committee met on 17th January, 2010 and prepared a Memorandum in this regard which was submitted to Hon’ble Prime Minister, Hon’ble Health Minister, Health Secretary, Govt. of India, all Central Council Members, Working Committee Members, State Presidents & Secretaries, Local Branch Presidents & Secretaries, IMA Standing Committee for Action, IMA Standing Committee for Medical Education, IMA Standing Committee for Anti Quackery, all Speciality Organisations and all Principals and Deans of Medical Colleges, MCI & all its members.

He also informed the members that a delegation of IMA also met the President, MCI on 28th January, 2010 to discuss the viewpoint of Indian Medical Association.

He again informed the members about the Workshop on Alternative Model for Undergraduate Medical Education, organized by Medical Council of India, on 4th & 5th February, 2010 at New Delhi which was attended by National President and the Hony. Secretary General, IMA. During this Workshop, they also had an opportunity to meet the Hon’ble Health Minister of India along with Health Secretary, Govt. of India.

In a brief meeting that lasted for more than 45 minutes, each and every aspect of the Memorandum was discussed with them in detail. The Health Minister was of the opinion that if IMA can take the responsibility of providing doctors to run primary health centers and sub centers in all the districts of the country, he can think of dropping this innovative short term course which is the need of the hour today.

Afterwards, National President then requested Dr. Ketan Desai President MCI and President-Elect WMA to present his viewpoint.

Dr. Ketan Desai, in detail, briefed the members about the genesis of this short term medical course from the year 1999 when a study group under the Chairmanship of Dr. G.P. Dutta, Past Editor, JIMA presented the alternative Rural Health Model to MCI. He also briefed the members the need of strengthening the rural health structure of the country.

He also detailed the members regarding the discussions/decisions taken in the MCI meeting held on 4th & 5th Feb. 2010 with educationists from the entire country including the Deans/Principals of all medical colleges, Vice Chancellors of medical universities, Director, Medical Education and State Health Secretaries, Govt of India officials, and MCI members where IMA National President and Hony. Secretary General were also invited and participated. (A copy of the PP Presentation is attached)
He also informed the members regarding the Short Term Medical Course started by Chattisgarh, Bengal and Assam Govts.

Thereafter members deliberated in detail regarding the decision of Central Council, IMA, the Proposal made by MCI and Govt. of India and various other related issues. After detailed discussions, it was decided unanimously that following changes be recommended to MCI & Govt. of India for acceptance in their proposed model of “Bachelor of Rural Healthcare”:

1. The proposed nomenclature of “Bachelor of Rural Health Care” by MCI be changed as “Diploma in Rural Healthcare”.
2. The term “Medical College” be changed to “Rural Health schools”.
3. A separate mechanism should be provided for registering diploma holders from this Course other than the State Medical Register.
4. Since IMA Kerala State Branch is a Party in a PIL filed against BRMS in Delhi High Court, they should be provided all administrative help and related documents required for the case.

The National President was requested to form an Action Committee, under his Chairmanship, consisting of 7 members representing one from each zone including HSG as the Convenor to take necessary steps to persuade the Govt. for its proper implementation.

The IMA HQs. shall forward the recommendations of this meeting to all the State Branches to take up IMA’s viewpoint with their respective State Govts. for its implementation.

The meeting ended with vote of thanks to the Chair.

(Dr. G. Samaram)  
National President, IMA

(Dr. D. R. Rai)  
Hony. Finance Secretary

Congratulations and Kudo’s to your dynamic self for being rightly elected as the President of World Medical Association.

Seasons may come, Seasons may go, Everything fades with time, this all of us know,

But one thing which freshly blossoms as fresh as dew,  
Is LOVE, RESPECT and AFFECTIONS for you.

We at IMA MS and the whole medical fraternity feel proud of you. India is proud of you.

May Lord shower upon you the essence of every choicest things you dream in life.