# EDITORIAL

**Dr. Leena Lokras**

The happiest childhood memories are more often than not, of celebrating festivals with family and friends.

In today's world, there is so much of monotony and pressure in everyone's life that every once in a while we all want to escape from it, and what better way to do so other than celebrating festivals?

Every festival not only has mythological value but has a social message too.

Ganesha Chaturthi, which is a very auspicious day celebrated to pray to the God so that every new activity that is started is successfully completed without any obstacles. Adored by the children as the God of knowledge, Tilak started celebrating it on a public platform to bring together the hindus to be united against the British Raj. Even today the tradition continues and if the organisers have a vision, they can still motivate our people for a cause and give our youngsters a direction so they lead a focused life and become better citizens.

Symbolizing victory of positivity over negativity, Navratri literally means 'nine nights' in Sanskrit; Nav - Nine and Ratri - nights. During these nine nights and ten days, the goddess -Durga and Saraswati - are invoked which are symbols of power and knowledge.

Dussehra has a great significance. People believe that this is the occasion when goddess Durga killed Mahisasura and saved the people from the clutches of a great demon. This is also an occasion to fight against all that is evil and establish truth.

Deepawali, the festival of lights that's marked by four days of celebration, literally illuminates the country with its brilliance, and dazzles all with its joy.

Each day of Diwali has its own tale, legend and myth to tell. The first day of the festival Naraka Chaturdasi marks the vanquishing of the demon Naraka by Lord Krishna and his wife Satyabhama. Amavasya, the second day of Deepawali, marks the worship of Lakshmi, the goddess of wealth in her most benevolent mood, fulfilling the wishes of her devotees.

Whether one believes in mythological stories, or religious beliefs related to the festivals is a completely different story and not debatable. But definitely, the festival celebrations teach a moral lesson to the people and unite them. People forget all their differences and observe these festivals with a sense of togetherness. The festivals teach them how to forget their enmity, narrowness and bitterness and join hands with each other for the sake of their society and for the sake of friendship and universal brotherhood.

So this festive season, let us all resolve not only to illuminate our homes but our hearts as well. Let us move from darkness into light — the light that empowers us to commit ourselves to good deeds, that which brings us closer to each other, develop universal brotherhood and thus bring ourselves closer to divinity.

I wish Each one of you a very happy and Dusshera and a very prosperous Diwali.

See you soon

**Dr. Leena Lokras** **Dr. Sangeeta Dandekar**

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# BARIATRIC OR METABOLIC SURGERY : THE NEWER MODALITY OF TREATMENT FOR DM TYPE II

Dr. Shashank Shah

**Dr. Shashank Shah is the eminent Bariatric Surgeon and is one of the Pioneer bariatric surgeons of India. He has performed more than 35,000 successful surgeries so far. He has done his fellowship in bariatric surgery from USA, Italy, France, Brazil and various renowned centres of the world. He has recently received 'Vivian Fonseca Scholar Award 2016' from American Diabetes Association (ADA)'s president Desmond Schatz for his research work in surgical cure of diabetes. Other than bariatric surgery he has developed his own technique of Total Thoracoscopic Thymectomy for the treatment of myasthenia gravis. He has his name in Limca Book of World Records for performing 45 hernia surgeries in 10 hours. Currently he is the director of his Laparoscopic- Obeso centre, Pune.**

## DIABETES TYPE 2 (T2DM): INDIA LEADING :

India, heading to be soon the diabetes capital of the world [1], it is important to be able to find useful options to treat the same, with successful results. It is not only important to control the glycaemic levels but also important to be able to prevent or slow down the negative effects of Diabetes on various important organs of the body, to improve the quality of life of the patients living with this disease.

## BARIATRIC TO METABOLIC SURGERY:

Bariatric surgery was started as a weight loss surgery about 50 years ago, for the morbidly obese.

It was seen to help resolution of the various obesity related comorbidities.[2] It was also noticed that the diabetes improved or resolved even without the use of sugar lowering drugs. Interestingly it was observed that this effect was seen even before substantial weight loss[3,4]. This encouraged more research to study this particular effect of the surgeries on (T2DM) and metabolic syndrome. Because of this effect on the metabolic syndrome Bariatric Surgery is also called as Metabolic Surgery.

## THE THIN FAT INDIANS: T2DM PRONE :

It has been observed that ethnically Indians (and Asians) are more prone to T2DM at a much lower BMI than the Europeans. Studies show that Indians are prone for T2DM even at a BMI as low as 25 kgs per/m2.[5,6,7,8] However, the bariatric surgery guidelines by NIH 1992 recommends bariatric surgery for people with BMI > 35 kgs/m2.[9] In 2009, a panel of physicians, diabetologists, and bariatric surgeons from India recommended a lower cut off for obesity treatment and especially for bariatric surgery for Asians, making it 33.5 kgs /m2 with co morbidities.[10,11] But yet these guidelines failed to cover the vast majority of Indian diabetic patients with BMI between 25 to 33 kgs/m2. As it's the total body fat % and presence of central obesity rather than the weight or BMI, which is associated with diabetes in Indians and Asians,these two criteria should be taken into consideration while treating /selecting a treatment option for the patient.[12,13]

There are very few RCTs (Randomised Clinical trials) (which are the level one evidence) which compare surgery with Medical and lifestyle interventions for T2DM, of which there are no clinical studies for the lower BMI Asians patients, till now.

## TYPES OF PROCEDURES: (Figure 1)

These are procedures done laparoscopically on the stomach and /or the intestines, which involve a partial gastrectomy and or a gastro-jejunostomy and jejuno-ileal anastomosis, which leaves only a small part of the terminal ileum for absorption of nutrients. Various Procedures have almost similar effects on the improvement or resolution of T2DM and Metabolic syndrome.

1. Sleeve Gastrectomy (SG)
2. Roux-n-Y Gastric Bypass (GBP)
3. Bilio- Pancreatic Diversion (BPD)
4. Duodenal Switch (DS)
5. Newer procedures with good results:

   - Single anastomosis Gastric bypass/Mini Gastric Bypass (MGB)

   - Ileal transposition with diverted Sleeve gastrectomy. (SGIT)

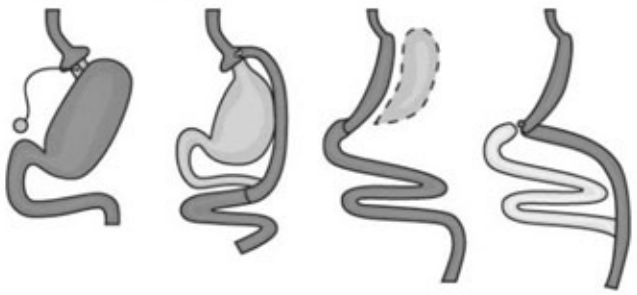


Image : Dr. Walter Pories

**MECHANISM OF ACTION:**

Studies on humans and animals have shown evidence for resolution or remission in T2DM14 –defined as HbA1c in nondiabetic range without use of anti-diabetic medicines.

As the results are seen before substantial weight loss, mechanisms other than weight loss with calorie restriction, malabsorption, have been identified and studied.

Multiple mechanisms for resolution/ improvement in the glycemic status have been observed/ identified/ speculated – some have been studied, while others are still being studied. There is some evidence for –

- Rapid stomach emptying and intestinal transit20 – resulting in favourable changes in gut hormone secretion- GLP 1, PYY. Incretino-mimetic effect21 – where the source of the incretin remains physiological.
- Decrease in Ghrelin hormone secretion22 as the fundus of the stomach secreting Ghrelin is removed as in Sleeve gastrectomy/ MGB. Gives better hunger control, satiety as well decreases Insulin resistance etc
- Changes in Gut Microflora*,
- Changes in Intestinal gluconeogenesis which decreases insulin resistance.23
- Increase in Energy expenditure and lowering of set point of highest weight.24
- Changes in Bile acid and salts circulation etc.

**LONG TERM RESULTS:**

A systematic review and Metaanalysis by H. Buchwald published in 200914, mentions 78.1% had complete resolution and 86.6% improved or resolved . The results were best for the most malabsorptive procedures like BPD and BPD-DS, then for RnY GBP and least for the Gastric band.

Various randomised control trials (RCTs) testing surgical procedures versus Medical and life style interventions have shown superior results of surgery for patients of BMI > 35kgs/m2.

One of the longest duration follow up study SOS (Swedish Obesity Subjects)25,26 is an ongoing, nonrandomized, prospective, controlled study conducted at 25 public surgical departments and 480 primary health care centers in Sweden of 2010 obese participants who underwent bariatric surgery and 2037 contemporaneously matched obese controls who received usual care, recruited between Sep 1, 1987, and Jan 31, 2001. (13.5 yrs). Results show that the diabetes remission rate was increased several fold at 2 years and 10 years, whereas high insulin and/or high glucose at baseline predicted favourable treatment effects, while high baseline BMI did not, indicating that current selection criteria for bariatric surgery need to be revised.

Few of the RCTs for patients with BMI <35kgs/m2 (25 to 35 kgs/m2) also show superior results.

This superiority persists in the mid-term results viz STAMPEDE trial with its 3 year results27, MINGROVE et al study from Rome28,.

A review/ metaanlysis of the RCTs done for lower BMI, conducted by Jane Buchwald 29, published in 2014, suggests that lower-BMI patients may also be able to experience the T2DM-reduction benefits of bariatric surgery long observed in higher-BMI patients.

A pilot study was conducted in 2008 by Shah et al30 in India, which included a small group of T2DM patients between BMI 22 to 35kgs/m2 with severe T2DM, HbA1c > = 10.1%, 80% on Insulin. Results show 80% were off insulin during the first month postop and 100% were euglycemic by 9 months without any antidiabetic drugs.The group therefore has conducted a RCT - COSMID, Comparision of Surgery v/s Medical/lifestyle intervention for Indian Diabetes, the primary results of which were presented at the ADA international

conference 2016. The study included patients with BMI 25 to 40 kgs/m2. It shows superior results in the lower BMI patients too.(to be published).

In spite of proven superiority of surgery over medical and lifestyle intervention, these procedures arehowever not included by the physician world as an option for T2DM care protocols. Long term results of the RCTs will probably help change the algorithm of treatment.

**PATIENT SELECTION: THE DSS GUIDELINES[31].**

Recently, a Joint Statement has been issued by variouss International Diabetes Organizations: 'Metabolic Surgery in the treatment Algorithm of Type 2 Diabetes', at the Diabetes Surgery Summit (DSS), published in Diabetes care June 2016. It mentions that metabolic surgery should be recommended to treat T2D in patients with class III obesity (BMI ‡40 kg/m2) and in those with class II obesity (BMI 35.0–39.9 kg/m2) when hyperglycemia is inadequately controlled by lifestyle and optimal medical therapy.

Surgery should also be considered for patients with T2D and BMI 30.0–34.9 kg/m2 if hyperglycemia is inadequately controlled despite optimal treatment with either oral or injectable medications.

These BMI thresholds should be reduced by 2.5 kg/m2 for Asian patients.

It concludes that 'Although additional studies are needed to further demonstrate long-term benefits, there is sufficient clinical and mechanistic evidence to support inclusion of metabolic surgery among anti diabetes interventions for people with T2DM and obesity'.

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**IMA Dombivli : EDUCATIONAL INSTITUTE CONTACT PROGRAM (7th July 2016)**

Inaugural Session:

**"How to Communicate with Today's Teens"**

**या मुलांशी वागायचे तरी कसे ?**

प्रमुख वक्ते : डॉ. आनंद कुलकर्णी

Speaker: Renowned Psychiatrist & Founder Member of IPH, Dr. Anand Nadkarni

Date & Venue: 7th July 2016 at Shubh Mangal Hall

Dr. Anand Nadkarni enlightened the audience on how to tackle psycho-social problems of Adolescents.

Beneficiaries: 236 People including Teachers & Parents of Teenagers whom we had invited attended the Program.

# INFERTILITY - SOCIAL PROBLEM (for doctors)

**Dr. Sushil Shinde**

**Dr. Sushil Shinde**
**M.S. Obst. & Gyn.**
**Fertility Consultant,**
**Eva Women's Clinic & Lab**
**Dombivli**

Human being a social animal needs to stay with people around. Procreation being one of the basic need of humans, so that their progeny continues and their legacy gets carry forward in next generation. This has brought up the human civilization to today's era. But when this basic functioning of individual gets disturbed, the individual or couple gets under tremendous pressure as they are called 'Infertile'.

We avoid the word Infertile patients, as they are usually not suffering any physical or mental disease. They are only passing through a period in life called as Infertile. This tough period in life can be shortened or ended by proper counseling and treatment so as to enjoy the parenthood.

These couples who have fertility problem are not comfortable enough to come to doctor for consultation directly. Many of the times the couple doesn't even share their problem with each other or in family. The first person to consult is friend, not a doctor. Many patients take advice from a married friend or do Internet search and get all incomplete knowledge and waste their time in this way. Suppose a couple decides to go to a doctor they first find a quack who can give some magical medicine and again waste their precious time. By this way, couple wastes many years in wrong direction, and then finally decides to visit a proper qualified doctor.

Doctor needs to give proper counseling to such couples and after going through history and investigations, advice should be given accordingly. Only few of these couples, are referred to a fertility specialist for advise. In short, due to this relay race, what the couple looses is nothing but most important thing- 'Time'.

In fertility treatment, lot of time needs to be given to couple to understand the basic problem of them. The sexual history along with other investigations help the doctor to do proper management of the couple. But during this management, doctor needs to follow certain rules and regulations as per medical ethics and government.

As in everyday news, PCPNDT laws are being challenged daily to make them suitable for doctors so as to serve the people in harmony. Every doctor follows the PCPNDT rules, but still get harassed by few incidence the reaction, which indirectly will harm the service to people. To add into this, ART Bill which is still pending to be passed in parliament has many clauses which are very stringent criteria to be met during treatment to a couple. e.g. It mentions no ART treatment for women < or > 50 years, so a patient with bilateral tubal block at age of 20 should years to be eligible for taking treatment ? There are many clauses which are very vague and need to be redefined. One of the clause also says that No ART (Assisted Reproductive Technology) clinic should accept the sperm or egg donor by a relative or known friend of either parties. This clause is fine, but to contradict this new Surrogacy Bill which was recently formed has created lot of fuzz among INFERTILITY specialist. The surrogacy Bill, mentions ban on commercial surrogacy and only a "close

relative' surrogate, that too only in altruistic form. This altruistic surrogacy shall be allowed to only Indian nationals married couple who have been certified as Infertile for atleast 5 years. In altruistic surrogacy, the commissioning couple needs to be dependent on sympathy of relative, it's not a transaction of equals. Also in country like India, the thought of having the woman who carries the child in her for relative, might bring emotional complications within the family and also in child's future. The close relative not necessarily blood relative, this term will give scope for forging documents of relationship with couple, which again will increase the scrutiny of documents by doctors, indirectly increasing work load. What if in a family, daughter in law is forced to carry child for another daughter in law by family pressure. The time period years is not necessary, suppose a married women with congenital absent uterus of heart disease seeking for child, why should these couples wait for 5 years to go for surrogacy treatment. The single parent also cant go for surrogacy according to the Bill, The surrogacy treatment for foreign couples, or homosexual couple has already been stopped this has caused decline in medical tourism for surrogacy. The medical tourism is boon to the government, as the foreigners not only take treatment in hospital. they stay at hotels, do sight seeing, eat Indian cuisine, travel using transport. So benefits to the Indian image of "Incredible India ".

The laws should be made for the people and not forfeit people. The person is from birth, it's like right or left handedness. Gay couples h have their own child using ART. Also if a single person who is fulfill the responsibility of being a parent should have right to ART.

To beget a child is no luxury to the infertile couple, but one of the basic instinct of human being. All such stringent laws are depriving this right of humans, and might even force them to commit something wrong rA illegal which will do more harm then help to both the parties. The world is moving forward, and we are taking step back. Hope that, after only altruistic surrogacy, traditional surrogacy should not be the only, option left for couples, as were in pre ART era.

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3rd CME : Dr. Poornima Mhatre
**"Advanced Treatment for Anti-aging"**

3rd CME : Dr. Raghunandan Torsekar
**"Common Dermatological Problems in Office Practice"**

4th CME : Dr. Sameer Parekh
**"Management of Fatty Liver Disease"**

4th CME : Dr. Chetan Kantharia
**"Pancreatitis - Acute and Chronic"**

डॉ. सतीश अ. कानविंदे

१९७६ साली ग्रँट मेडिकल कॉलेज मधून एम.बी.बी.एस्. उत्तीर्ण. त्यानंतर प्राथमिक आरोग्य केंद्रात वैद्यकीय अधिकारी म्हणून काही वर्ष ग्रामिण जनतेची सेवा केली. १९८२ मध्ये आयरे गाव डोंबिवली (पूर्व) येथे स्वतःचा दवाखाना सुरु केला. शालेय जीवनातच कविता लेखनाचा प्रारंभ. आता पर्यंत तीनशेहून अधिक कविता लिहील्या. त्यापैकी २४० कविता लोकसत्ता, महाराष्ट्र टाईम्स, डायलॉग, नवशक्ति, सामना, सारस्वत चैतन्य या विविध नियतकालिकांमधून प्रकाशित झाल्या आहेत. तसेच लॉलीपॉप, ठक् ठक्, चंपक आणि ज्ञानरंजक टॉनिक या मुलांसाठीच्या मासिकांमधून प्रकाशित झाल्या आहेत. २०१३ मध्ये अमेरिकेत गेलो असताना, शिकागो येथील बृहन्महाराष्ट्र मंडळाच्या मासिकांमधूनही माझ्या चार कविता प्रकाशित झाल्या आहेत. बालकविता लेखनात विशेष रस असला तरीही मराठी तसेच मालवणी भाषेत आणि विडंबना गीतेही लिहीली आहेत.

## झिंग झिंग झिंगाट

ह्याच्या हृदयात होतेय धडधड टूडीएको करुन घ्या
छातीचा एक्स-रे आणि ईसीजी काढून मग घेऊ
ब्लड टेस्ट करु या, लिपीड प्रोफाईल बघू या
आणि शुगर सुद्धा याची आपण पाहून घेऊया
आन् उडू या गुंगाट, पळु या चिंगाट, रंगात येऊ या
झालंय झिंग झिंग झिंग झिंग झिंगाट
झिंग झिंग झिंग झिंग झिंगाट
झिंग झिंग झिंग झिंग झिंग

हा उतावीळ झालाय याला आयसीयू त घेतो
लावतो सलाईन आणि त्यातून त्याला इंजेक्शन देतो
आक्सिजनवर ठेऊ या, व्हेंटिलेटर पण लावू या
सगळ्या भोकात याच्या आपण आता नळ्या घालू या
सिरीयस करुन, खटपट करुन, नंतर वाचवू या
झालंय झिंग झिंग झिंग झिंग झिंगाट
झिंग झिंग झिंग झिंग झिंगाट
झिंग झिंग झिंग झिंग झिंग

लई दिसानी माझ्या हॉस्पिटलात पेशंट आलाय
त्याला बघून मला सांगू किती आनंद झालाय
चल बाटली मागवू या, मग पार्टी करु या
अन् रात्री आपण झिंगून सारे तराट होऊ या
हसूया गालात, नाचूया तालात, पिंगाच घालूया
झालंय झिंग झिंग झिंग झिंग झिंगाट
झिंग झिंग झिंग झिंग झिंगाट
झिंग झिंग झिंग झिंग झिंग

## मी मिठाई खाल्ली नाही

मी मिठाई खाल्ली नाही, मी भातही खाल्ला नाही
मी साखर घालून हल्ली कधी चहाही प्यायलो नाही
मी मिठाई खाल्ली नाही...

घरी आणतो कोणी पेढे, कुणी आणी मेसूर, हलवा
कुणी कानी सांगे दुसऱ्या 'बाबांना बाहेर घालवा'
मन घट्ट करुन मी माझे बाहेर जातसे जेव्हां
ते खावे ऐसा माझ्या मनी विचार आला नाही
मी मिठाई खाल्ली नाही...

लग्नाच्या पन्नाशीला ते जमले होते सारे
कापला केक मी मोठा, कुणी म्हटले 'थोडा खा रे'
मी ठाम राहिलो तेव्हा, चाखला सुद्धा मी नाही
अन् तोंडालाही माझ्या मुळी पाणी सुटले नाही
मी मिठाई खाल्ली नाही...

मी पथ्य पाळतो सगळी, गोळ्याही घेतो साऱ्या
जेवून दुपारी, रात्री मारतो मी येराझाऱ्या
पण अजून साखर माझी खाली खाली का येतच नाही
तुम्ही सांगा डॉक्टर मजला असे उपाय यावर काही!
मी मिठाई खाल्ली नाही...

# हम किसी से कम नही

डॉ. संगीता दांडेकर

**Dr. Sangeeta Dandekar**
**Editor : Dialogue**
**Co-ordinator : Corporate v/s Individual Nursing Home : A Survey**

छान वाटलं ना heading वाचून ? पण हे 'हम' म्हणजे कोण ? आणि किसी से म्हणजे कोणापेक्षा ?

कोणीही असू दे. पण हे एक स्पर्धात्मक वाक्य आहे आणि कोणीतरी कोणाला तरी यात आव्हान दिलेलं आहे हे निश्चित. पण 'ज्याला' आव्हान दिलंय ते त्याने उत्तम रित्या पेललं आहे आणि तो 'विजेता' ठरलाय. हरवलंय त्याने आव्हान देणाऱ्या प्रतिःस्पर्ध्याला !! पण कोण आहे तो भाग्यवान विजेता ?

मित्रहो आपणच ! Individual nursing home owners ! आणि प्रतिःस्पर्धी आहेत नवीन बलाढ्य हॉस्पिटल्स ! Corporate hospitals.

सध्या तरी 'हम उनसे कम नाही' हे वाक्य आपल्यासाठी "future tense" मध्ये आहे. पण भविष्यात हे वाक्य खरं होणार हे निश्चत !

पण त्यासाठी आपल्याला स्वतःमध्ये अनेक सुधारणा करण्याची नितांत गरज आहे. सध्याचं युग हे 'Consumer' चं युग आहे.

आपलं profession हे noble profession नसून आपण एक 'service provider' आहोत ही आता जुनी गोष्ट झाली. ती मान्य करण्याशिवाय कायद्याने, सरकारने आणि समाजाने आपल्याला पर्याय ठेवलेला नाही. म्हणून "consumer is the king" हे आपण ध्यानात ठेवले पाहिजे.

त्या दृष्टिने एकंदरीत समाजाची मानसिकता काय आहे याची चाचणी करावी आणि ती सर्वांपुढे मांडावी असं आम्ही ठरवलं.

त्यासाठी एक questionnaire तयार केली व ती सर्वांना पाठवून त्याची मते मागविली. Questionnaire अशी होती.

With the emergence of big corporate hospitals in recent days it has become a debate as to smaller nursing homes belonging to single doctor are preferred or the corporate hospitals like fortis are preferred. Want to review the opinions of important lot of society. 1. In your opinion do you get better care when under individual doctor or when in a corporate hospital? 2. Is the personal touch lost when you are getting treated at bigger set up? 3.Do you feel you are safer under the roof of corporate set up or do you feel you are equally safe in the hands of individual doctor ? 4. Given a choice what would you prefer for your own treatment or for treatment of your near and dear ones. 5. What are the reasons which will drive you to corporate hospitals and what are the reasons which make you feel old is gold and individual doctor is better. १२ जणांनी यात भाग घेतला.

मान्य आहे की हा sample size खूपच छोटा आहे आणि एका विशिष्ट socio-economic category मध्येच समाविष्ट होतो. पण तो सुशिक्षित, सुसंस्कृत आणि विचारी आहे. त्यामुळे त्यांची मते ग्राह्य धरायला हरकत नाही.

या survey मध्ये खूप positive inputs मिळाले.

त्यातल्या अनेकांना individual set ups मध्ये असणारा, personal touch, individual doctor चं approachable असणं आणि accountable असणं हे फार महत्त्वाचं वाटतं. डॉक्टर पेशंट नातं त्यांना आजही, इतक्या प्रतिकूल सामाजिक वातावरणातही विश्वासाचं वाटतं हे खूप उत्साहवर्धक आहे.

ज्यांनी Corporate set up ला पहिली पसंती दिली त्यातही खूप महत्त्वाचे positive points मला

जाणवले ते असे –

1. No one has doubts regarding competency of doctors whether individual or working at big set ups
2. No one says that doctors working under Corporate set ups are more competent than individually working doctors.
3. What they want is the services of the same doctors under professional infrastructure.

त्यांनी महत्त्व दिलंय ते शिस्त पालनाला. 'डॉक्टर' हा Health Care System चा आधारस्तंभ आणि तो भक्कम आहेच हे त्यांनी गृहित धरलेलं आहे. प्रश्न आहे तो आजूबाजूच्या support system चा. हा छोट्या हॉस्पिटल्सचा infrastructure चा डोलारा कमकुवत आहे. असा निष्कर्ष त्यातून निघतो. तो जर भरभक्कम केला तर हाही वर्ग individual doctor set up कडे वळणार हे निश्चित.

या infrastructure ची पुनर्बांधणी करणं हे आपलं मुख्य काम. आणि तीच मोठी अडथळ्यांची शर्यत आहे.

Clinical Establishment Act, मुर्खपणान बनवलेले इतर कायदे आणि तेवढ्याच बिनडोकेपणाने केलेली त्याची केलेली अम्मलबजावणी, त्यामुळे समाजात डॉक्टर्स बद्दल पसरत चाललेल्या गैरसमजूती, समाजातल्या काही घटकांनी मुद्दाम, हेतुपुरःस्सर पसरविलेल्या गैरसमजूती या सर्वांवर मात करण्यासाठी आपल्याला प्रयत्नांची पराकाष्ठा करावी लागणार आहे.

यासाठी एकजूटीने राहणे आणि संघटितपणे प्रयत्न करणे महत्त्वाचे. त्याच बरोबर वैयक्तिक पातळीवर प्रयत्न करणे हे तितकेच महत्त्वाचे आहे. आपले विचार, सूचना आणि प्रयत्न एकमेकांपर्यंत पोचवीणेही तितकेच महत्त्वाचे.

या प्रकियेला चालना मिळावे म्हणून हा छोटासा प्रयत्न. छोटा प्रयत्न असला तरी सर्वांना विचार करायला लावेल आणि मार्गदर्शक ठरेल अशी अपेक्षा आहे.

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**Aao Gaon Chale, 3rd Camp on Sunday, 28th August 2016 at Village Mhaskal, Tal Kalyan.**

## CORPORATE HOSPITALS IS THE BEST CHOICE

**Dr. Sandhya Kulkarni**

**Dr. Sandhya Kulkarni**
**Practicing chest physician since last 20 years. After M.D. she was working in Shastri nagar municipal hospital for some time and afterwards was professor at Rajiv Gandhi Medical College, Thane. Currently along with her own practice she is attached to Fortis Hospital, Kalyan.**

Attachment to a corporate world is always advantageous whether you are a full timer or a visiting consultant. They provide the best infrastructural and ancillary services and qualified assistance which makes your job easier and enables you to give best results. Though the type of work is target oriented, the targets depend on the area of your practice. Corporate hospitals fulfill brand consciousness, providing best services at the same time. The multidisciplinary approach in certain cases can be maintained at its best under one roof. Qualified assistance of intensivists and RMOs is available as and when required resulting in reduced stress and good sleep. Sometimes doctors can get exploited in monetary terms as a huge share of consultation fees is diverted towards hospital administration.

You have to be very careful and updated with your knowledge to be able to answer the series of questions prepared with easily available information over internet by health conscious patients.

The faith in the doctor in a small setup leads to less FAQs as against corporate hospitals where doctors are considered service providers. Though the setup is small in private clinics, genuinely poor and needy are benefitted in all areas. Hence one has to have a combination of corporate attachment, a teaching attachment as well as a private clinic to cater to different economic strata of patients which provides you knowledge, experience and job satisfaction.

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# CORPORATE HOSPITALS IS THE FUTURE

**Dr. Sandeep Patil**

**Dr. Sandeep Patil**
**MD, IDCCM.**
**Physician & Intensivist**
**Fortis Hospitals Kalyan**
**Orion Multispeciality Hospital Dombivli.**
**Education: MBBS**
**Seth G S Medical College Mumbai, Year 2000.**
**MD ( Medicine) - Dr V M Medical College Solapur Year 2005.**
**Indian Diploma in Critical care medicine from Jaslok hospital Mumbai.Year 2007.**
**Indo Australian fellowship in critical care medicine from Jaslok Hospital, Mumbai. Year 2007.**
**Work Experience- 10 years of experience in critical care from Jaslok Hospital Mumbai, Wockhardt hospitals Mulund and currently as Cheif Intensivist and Physician Fortis Hospitals Kalyan.**

I like my individual practice though corporate hospitals is the future:

I am Dr Sandeep Patil attached to Fortis hospitals Kalyan as Chief Intensivist & Physician and practicing as Physician at Orion Hospital Dombivli. These are my personal views about corporate hospitals and private hospitals.

I had joined wockhardt hospitals mulund as intensivist then shifted to Fortis kalyan. Later was allowed to practice as physician at Fortis. Private practice started later.

In corporate hospitals , as long as you can provide good business to them, you would be entertained.

Remuneration is less in corporate hospitals, but work satisfaction is more important as critical patients can be better managed in corporate setup.

I like my private hospital as I have freedom to practice & manage as per my ease.

In corporate hospitals you are dependent on hospital administration for resources and manpower.

It is always safer to work in a corporate set up because multidisciplinary team of expertise is available, infrastructure & equipments are available under one roof required for managing critical patients.

Now most patients / corporate company patients ask for cashless facility, infrastructure (CT/MRI), Multidisciplinary expertise in one place.

Corporate hospitals have NABH/JCI accreditations, maintain patient quality care by internal quality training programs for staff and doctors for TPA and corporate attachments.

Marketing as a Brand to attract patients.

Treatment in corporate hospitals is expensive ,relatives expectation are more for money spent.

Still patients approach to nursing homes first then are shifted to higher centres. Small nursing homes to survive , will have to provide

- multidisciplinary team of expertise.
- NABH Accreditation
- TPA attachments.
- Training of staff and resident doctors.
- Training of resident doctors.

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## INDIVIDUAL NURSING HOME : THE BEST SERVICE PROVIDER

**Dr. Niteen Dandekar**

**Dr. Niteen Dandekar**
**Practicing Urologist**
**Having done his M.S.(surgery) and. M.Ch. (urology) and fellowship in onco urology he has been in individual practice till date. His aim is to acquire newer and advanced techniques and utilize them for better treatment of patients. He believes that learning is ongoing process and one should constantly update oneself in his fields.**

I am happier in my individual set up:

You feel so much independent when you work in your own set up. You are in one to one touch with your patients. You can decide your own policies and protocols. In a small set up you can monitor everything by yourself. Patients come to you for your treatment and not driven by the so called professional infrastructure. In my opinion these are the most comfortable circumstances. You can deliver the best medical treatment in such scenario.

As far as training of staff is concerned, it is actually one to one teaching and you know the capability and limitations of your own staff and accordingly you can hand over the responsibilities to them. The patient grievances can be resolved then and there. They don't have to run from department to department for the same.

Hi tech diagnostics you don't need it in all the patients and you can arrange for it whenever required. You can seek opinion of other specialists whenever needed. **One thing is that you should always keep yourself updated with the newer advances. You should be futuristic and always learn and adapt cutting edge technology**.

**For that you may have to keep on investing in newer machinery. You should never go into 'old timers' category**. Also try and abide by the contemporary laws and regulations. Good communication with the patients is one more key factor which you must learn. Day by day the government policies are tightening and trying to wipe out individual practice. But you should be ready to fight it out. If we succeed to retain the nursing home practice nothing like it.

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## OUR VIEWS ABOUT INDIAN HEALTH CARE SYSTEM

### I prefer Corporate set up

**Mr. Shivaji Dange**
Joint commissioner, Kolkata.
Now-a-days medical procedures involve many technologically advanced requirements which are available in corporate hospitals. Experts of various branches are on call in such hospital. Emergency conditions can be handled better way. Insurance etc. looked after by separate sections..so corporate hospitals are my choice between two. But I will prefer a corporate hospital where a doctor who I know also works as consultant,so that I get best of both streams.

**Srijit Poothen**
Automobile Engineer, Dombivali.
For smaller ailments, individual doctor.
For major procedures, corporate care.
Corporates are better equipped with a team of doctors and para medics at their disposal for emergencies, so much safer there
Holistic treatment available at corporates. Facilities and further documentation much better and the concept of family doctor and individual care slowly dying.
Today a super specialist doctor feels safer to attach himself with a corporate, rather than undergo the pressures and risks of running a set up himself.

### I prefer Individual Nursing Home

**Mrs. Swati Kulkarni**
M. Com., House wife.
1) We will get better care under individual doctor.
2) Yes i feel so. We lost personal touch in bigger set up.
3) Safe in hand of individual doctor.
4) I will prefer our family doctor instead of going to bigger set up.
5) individual doctor is better because he knows all our problems and bondings are strong with our family doctor. We feel safe secure in his hand. so generally we avoid bigger corporate hospitals.

**Mrs. Smriti Gulwadi**
Director, Shyamrao Vitthal Bank, Thane.
1) Individual doctor is preferred
2) Yes. personal touch lost in bigger setups
3) Safe under individual doctor
4) Corporate hospitals have required infrastructure in case of emergency, Individual docs, you will not be fleeced as in corporate n personal attention given.

**Mr. Bharat Sachdev**
C. A. Thane
1) Yes individual is better,
2) Yes,
3) Equally safe with individual doctor,
4) Individual,
5) Reasons which will drive me to corporate hospitals is only advanced facility for now but if some dose of human touch and empathy is added will go to corporate hospital. Secondly I visual doctors who r senior will try basic medicine first and not directly jump to advanced medicines which instead of curing I feel suppress illness only.

## I prefer Corporate set up

### Mr. Vinay Bhole

Professor, Model College, Dombivali.

1). Better care depends upon individual Doctor. For professional services patients prefer corporate hospitals.

2) Patients are concerned about better treatment. Personal touch is not important for them.

3) Corporate set up has a team of doctors. In case of individual doctor people always complaint that no doctor comes to clinic or hospital in time. They don't have any value for patients time. They are more interested in so called social activities.

4) It depends upon the treatment required, how the doctor has earned the qualification, his expertise, greed about money, name or fame, social responsibility and dedication.

5. Knoweledge of doctor is important, it may be corporate or individual. People scared of money making tendency and irresponsible behaviour.

### Mr. Sangram Joshi

Pharma Distributor, Thane.

1) Individual Doctor always gives better care. But a better infrastructure is available at a corporate hospital. All facilities under one roof. Other speciality doctors are available. Not on call or as per conveniences:

2) Ease in Insurance claim being processed. No malpractice of extending stay.

3) Corporate hospital is preferred by me.

## I prefer Individual Nursing Home

### Mr. Atul Desai

Businessman, Dombivali.

I shall always prefer smaller setups, for obvious reasons.

Personal touch.

Easy access to directly the doctor concerned.

Safer with individual doctors.

Given a choice I shall always go to smaller setup.

Affordable and trust worthy ness are the biggest factors.

### Mr. Sanjay Tembe

IIT Graduate, Dombivali.

1) Individual doctor gives better care. He is more responsible, attached and answerable

2) In corporate run hospitals personal touch is lost

3) You are equal safe or at equal danger in either setup

4) I will prefer individual doctor

5) Only when the treatment needs equipment which cost so high that an individual doctor can't afford to invest or the treatment is such that too many specialists from multiple areas of specialisation are needed to be involved then corporate hospital is ok. Even in such case I would prefer government hospital over corporate hospital.

In all other cases, for most of usual complications I feel individual doctor is better

### Mrs. Kirty Wadalkar

Civil Software Trainer, Dombivali.

1) Better care under in both, depends upon the doctor

2) Yes, personal touch is lost at bigger setup

3) Equally safe with individual doctor

4) Small nursing home is preferred by me

5) Old is gold, doctors individually take proper care, become family friends, consistency makes them understand the patient better

The big hospitals are like big malls, running only for money

### Mr. Niteen Shembekar

Electrical Engineer, Dombivali.

1) In my opinion I get better care in individual

2) Of course lost

3) Differs from illness to illness but feel safer under individual hands.

4) Again depends on the situation but Upton limited diseases individual is better but for critical situations corporate is advisable.

5) Corporate is good for casuality and critical conditions and especially if you are covered under mediclaim. But in case of malaria, dengue, typhoid etc individual seems to be better.

# सध्याचा काळ तारांकित रुग्णालयांचाच

सानिका कुसुरकर

**सानिका कुसुरकर**
**तरुण नवपत्रकार. सध्या महाराष्ट्र टाईम्स मध्ये आरोग्य आणि सांस्कृतिक विभाग सांभाळते. धडाडीने काम करत असल्यामुळे थोड्या काळात बराच अनुभव जमा केलेला आहे. त्यामुळे तिच्या मताला नक्कीच महत्त्व आहे.**

अनेक मजली भव्य इमारती, त्यातील अत्याधुनिक सुविधा. तज्ञ डॉक्टरांचे पथक अशा वातावरणात रुग्णाचे नातेवाईक उपचारांच्या बाबतीत काही काळासाठी निर्धास्त होतात. मात्र त्यानंतर आलेल्या बिलाचे आकडे पाहून त्यांचे धाबे दणाणते. सुपर स्पेशालिस्ट रुग्णालयांची वाढणारी संख्या हे शहराच्या आरोग्य क्षेत्राचे विकासाचे लक्षण असले तरी त्यामुळे माणसाचे महाग झालेले आयुष्य अधोरेखित होते. काही वर्षांपर्यंत शहरातील चौकाचौकात उभी असणाऱ्या छोट्या नर्सिंग होम्स सध्याही कार्यरत असली तरी त्यांच्याकडे पाहण्याचा दृष्टिकोण बदलला आहे. मोठ्या रुग्णालयात मिळणाऱ्या सुविधा छोट्या दवाखान्यात मिळू शकणार नाहीत. या एकाच विचारामुळे आज मोठी रुग्णालये आपले अढळ स्थान निर्माण करत असल्याने छोट्या नर्सिंग होम्सना या स्पर्धेत टिकण्यासाठी आटापिटा करावा लागत आहे.

सध्या कल्याण डोंबिवलीमध्ये सुपर स्पेशालिटी हॉस्पिटलची चर्चा सुरु आहे. त्याचबरोबर पालिकेची रुग्णालयेसुद्धा सर्व सुविधांनी सुसज्ज करण्यात येणार आहेत. या वलयांकित रुग्णालयांच्या नावामुळेच पेशंट साधा सर्दी-खोकला असेल तरीही भितीपोटी तपासणीसाठी मोठ्या रुग्णालयात जातो आणि एकदा या ठिकाणी प्रवेश झाला कि छोट्या रुग्णालयांवर कायमची फुली बसते.

छोटे हॉस्पिटल घराजवळ असले तरीही तेथील कमी सुविधांमुळे आणि मोठ्या हॉस्पिटलच्या नावामुळे दहा किलोमिटर लांब असलेल्या हॉस्पिटल्समध्येसुद्धा जाण्याची आजच्या लोकांची तयारी असते. याला कारण म्हणजे मर्यादित जागेमुळे असणाऱ्या कमी सुविधा. सहसा छोट्या हॉस्पिटल्समध्ये वेगवेगळ्या तपासण्या आणि चाचण्या करण्याची सोय नसते. त्यामुळे पुन्हा चाचण्या करण्यासाठी पेशंटला फिरावं लागतं मग त्यापेक्षा मोठ्या हॉस्पिटलमध्ये ही फरफट थांबवी म्हणून जोस्त पैसे मोजूनसुद्धा चांगल्या सुविधा मिळाव्यात यासाठीच हल्ली रुग्ण छोट्या दवाखान्यांना बगल देत मोठ्या होस्पिटलची निवड करत आहेत.

पण या मोठ्या हॉस्पिटलची निवड करण्याचा फायदा काही मोठे हॉस्पिटल्ससुद्धा घेतात. पेशंट आपल्याकडे येत आहे हे बघितल्यावर अधिक रक्कम त्यांच्याकडून वसूल करणे, पैसे भरल्याशिवाय उपचार सुरु न करणे, वेळप्रसंगी उगाचच आर्थिक फायद्यासाठी उपचार लांबवणे यासारखे प्रकार हल्ली मोठ्या रुग्णालयात सुरु आहेत. पण तरीही नावामुळे मोठ्या रुग्णालयांना पसंती मिळत आहे.

मोठ्या रुग्णालयांना मिळणाऱ्या या पसंतीमुळे शहरातील छोट्या हॉस्पिटल्समध्ये जागा भरपूर उपलब्ध असताना सध्या दिसत आहे. गेल्या महिन्यामध्ये साथीच्या रोगांचा फैलाव वाढलेला असतानाही हेच चित्र दिसून आले. कल्याण डोंबिवलीतील मोठ्या रुग्णालयांमध्ये त्यावेळी जागा उपलब्ध नव्हती पण त्याचवेळी शहरातील छोटे दवाखाने मात्र मोकळेच होते. अशा वेळी मोठ्या रुग्णालयांमध्ये वेटिंगसाठी रांगा लावून जास्त पैसे भरुन तेथे उपचारांची तयारी लोकांची हाती पण छोट्या रुग्णालयाकडे मात्र लोक कमी वळले. त्यातूनच पुढे रुग्णालयामध्ये जागा मिळविण्यासाठी दलालीच्या घटना घडतात.

वास्तविक पाहता रुग्णालय छोटे असो वा मोठे तेथील डॉक्टरांचा अनुभव आणि रुग्णालयातील सुविधा या गोष्टींकडे वळून मगच पेशंटनी निवड केली पाहिजे. त्याचबरोबर आपल्या स्वतःच्या डॉक्टरचा त्याचबरोबर अनुभवी व्यक्तींचा सल्ला रुग्णालयाची निवड करताना करण्याची गरज आहे. त्यातूनच चांगली सुविधा पेशंटना मिळू शकते. जटील आजारांवर उपाय शोधण्यासाठी अत्याधुनिक उपचारांची अपेक्षा करणे रास्त असले तरी त्याचे वाढणारे प्रस्थ कितपत स्विकारावे आणि ज्या आजारांना छोट्या नर्सिंग होमचा पर्याय उपलब्ध असूनही त्यावर लाखो रुपये का खर्चावे यासाऱ्यांचा विचार रुग्णांसह त्यांच्या कुटुंबियांनी करणे ही काळाची गरज बनली आहे.

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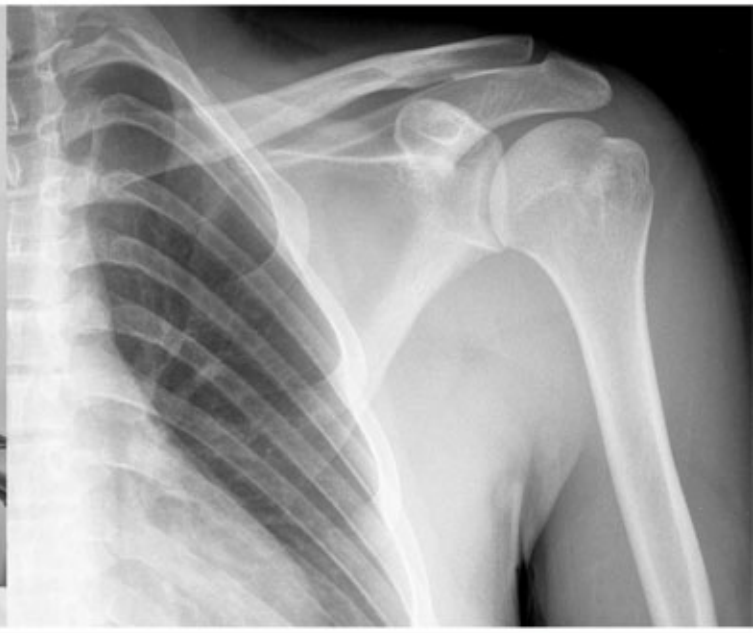

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- Hospital Infection control Screening
- Training of Healthcare workers
- Infection control Surveillance activities

**Others :**
- *Pathology and biochemistry services also provided.*



# LIVER TRANSPLANT AND ITS CURRENT STATUS IN INDIA

**Dr. Chetan Kantharia**

**Dr. Chetan Kantharia**
**Professor and Head of the Department of Surgical Gastro enterology at Seth G. S. Medical College and KEM hospital, parel, Mumbai. He is in-charge of Liver Transplant Department at KEM hospital. He is also a consultant at Global Hospital Mumbai in liver transplant, HPB and liver surgery. He has a rich experience of 20 years in surgical gastroenterology.**

Liver transplantation is a panacea and the only available curative treatment for patients suffering from end-stage liver disease. Liver Transplantation was introduced as a clinical procedure over 40 years ago in USA and other developed parts of the world. The first attempt at clinical liver transplant was made in 1963. The first human liver transplant was performed in 1963 by a surgical team led by Dr. Thomas Starzl [1] of Denver, Colorado, United States. Dr. Starzl performed several additional transplants over the next few years before the first short-term success was achieved in 1967 with the first one-year survival post transplantation. Despite the development of viable surgical techniques, liver transplantation remained experimental through the 1970s, with one year patient survival in the vicinity of 25%. The introduction of cyclosporin by Sir Roy Calne markedly improved patient outcomes, and the 1980s saw recognition of liver transplantation as a standard clinical treatment for both adult and pediatric patients with appropriate indications.[2] By 1983 the expertise in liver transplantation finally reached a point where it was widely accepted as a suitable clinical option for patients. All over deceased donor Liver Transplant was being performed. There remained a perpetual paucity of the organ, with ever increasing gap between the need and availability of the organ. This paved the way for Live Donor Liver Transplant.

After initial unsuccessful attempts in Brazil, the first successful living donor liver transplantation (LDLT) was performed in Australia from parent to child using the left lobe in 1989. This was followed by similar successful attempts in the United States. This gave a hope for children suffering from end-stage liver disease, who no longer had to wait for a reduced deceased donor liver to become available and the procedure was adopted with fervor all over the world. With the success of left lobe transplants and their expertise in liver resections, Japanese surgeons pioneered adult-to-adult LDLT (AALDLT) using the right lobe in 1993. This to some extent helped to bridge the gap of demand-availability of organs. With increasing experience, innovations like the modified right lobe graft, the extended right lobe graft, the right posterior sector graft, the left lobe (including the caudate lobe) graft and the dual graft have made it possible to provide adequate functional hepatic mass in any situation including high-urgency situations with a high degree of success and donor safety. Since 1985 there has been a rapid increase in the number of centers performing liver transplants. Liver transplantation is now performed at over one hundred centers in the USA, as well as numerous centers in Europe and elsewhere. One-year patient survival is 80–85%, and outcomes continue to improve, although liver transplantation remains a formidable procedure with frequent complications.

**Types of Liver Transplant:**

1) **Deceased Donor Liver Transplant (DDLT) (Cadaveric Liver Transplant)**

   In this procedure the entire liver is implanted from a brain dead patient belonging to the same blood group.

This is the desired option, as the whole liver is transplanted, besides there is no question of risk to the donor, as the liver is being obtained from a brain dead patient

2) **Live Donor Liver Transplant (LDLT)**

In this procedure a part of the liver is implanted from a first degree relative belonging to the same blood group.

The ability of the Liver to regenerate to its near normal size is the basis of the Live Donor Liver Transplant.

**Indications of Liver Transplant:**

Any progressive and irreversible diseases leading to end stage liver disease need transplant. The conditions requiring transplant are:

1) **Viral Hepatitis induced cirrhosis-**

Hepatitis B

Hepatitis C

2) **Alcohol induced cirrhosis**

3) **Inborn errors of metabolism**

Hemochromatosis

Alpha-Antitrypsin deficiency

Wilson's disease

Glycogen storage disease type I/III

4) **Cholestatic diseases**

Biliary atresia

Primary biliary cirrhosis

Familial cholestasis Byler's syndrome, arteriohepatic dysplasia

Cystic fibrosis Insipissated bile syndrome leading to cirrhosis

Primary sclerosing cholangitis

Secondary biliary cirrhosis

5) **Congenital abnormalities**

Urea cycle enzyme deficiency

Homozygous hypercholesterolemia

Primary hyperoxaluria type

Familial amyloidotic polyneuropathy

6) **Developmental abnormalities**

Polycystic liver disease

Caroli's disease

7) **Tumours-**

Hepatocellular carcinoma

Metastasis to liver

8) **Acute fulminant hepatic failure-**

Drug induced- paracetamol poisoning

Fulminant Hepatitis A or E

9) **Vascular-**

Budd Chiari Syndrome

**Complications of transplant surgery**

Liver transplantation is a major surgical and medical undertaking and can be associated with significant complications and risks. The risks vary for individual patients depending on a number of factors such as age and general health and the type of liver disease you have. The complications can be encountered either

During the operation

Immediately after the operation

First three months

Long term

**During the operation**

Throughout the surgery, the heart is stressed and its ability to pump blood around the body may be impaired. This can cause a heart attack or a stroke during the operation. This is why as a rule, careful assessment of the heart function is done .

Given the complexity of the procedure, bleeding is also a major concern.

**Immediately after the operation**

Bleeding, Infection or a leak from a suture.

Pulmonary Complications

Reversible kidney damage can occur as a result of the operation. The kidneys will gradually recover but dialysis may be necessary for up to six weeks.

A block in brain arteries or veins may develop which can lead to hemi paresis or Para paresis due to clotting abnormality.

Hepatic artery Thrombosis: Part of the blood supply to the new liver may be cut off (clot) and this may prevent it from working properly. A second transplant at times may be necessary.

Very occasionally the transplanted liver does not work at all following the whole process of transplantation. This is known as a **Primary graft Non function**. The only treatment for this condition is an emergency retransplantation.

**First three months**

Acute rejection is a result of the immune system's response to the transplanted liver. If suspected, a liver biopsy will be needed. It is very common and is treated with high dose steroids.

The patient may remain susceptible to infection which may require drug treatment as an in-patient.

Loss of appetite and nausea are common.

Bile leak

Emotional ups and downs can affect the patient and the family throughout the recovery.

Patient may become diabetic following transplantation, partially because of the new medication-immunosuppression.

**Long term-**

Chronic rejection of the transplanted liver can occur gradually over a long period of time although it is not common. Unlike acute rejection it does not respond to steroids but there are other drugs available that may be helpful. A second transplant is often the best treatment.

There may occur, narrowing of the bile duct joint/ anastomosis causing jaundice. This will require further treatment.

Certain liver diseases can recur in the transplanted liver especially viral hepatitis. This will require further treatment and sometimes a second transplant.

**Immunosuppression drugs**

These drugs suppress resistance power of recipient's body to prevent rejection of liver graft from other person. They are essential for sustaining liver graft and are to be taken for life long.

**Why are they needed?**

One's body doesn't accept other's organ. It is body's defence system to try to attack and destroy other's organ. Anti rejection drugs makes defence mechanism weak against donor's organ and allow liver graft to sustain and work normally.

**How do they work?**

The immune system is our body's natural defense mechanism. It is programmed to recognize and destroy anything unfamiliar. This includes the cells of a transplanted liver as well as the bacteria and organisms that cause infection. Following a liver transplant, specific drugs are needed to prevent the immune system from rejecting the new liver. These are called Immunosuppression drugs, and you will have to take them every day for the rest of your life. A combination of the following immunosuppressant medications is prescribed

Cyclosporine

Prednisolone

Azathioprine

Tracrolimus

Mycophenolate Mofetil

Sirolimus

**Life after Liver Transplant:**

Liver transplant offers better quality of life and extends life expectancy. About 85-90% patients survive after one year and 75-80% survives till five years. Patients have to visit hospital at intervals and take Immunosuppression drugs lifelong. One can do physical activities as a normal person can do, after 3 months. Survival after liver transplant depends on many factors like patient's initial condition, disease for which transplant is being done, other associated diseases and so on. Longest survivor of liver transplant at present is of 27 years. However it varies from patient to patient. Family support is very crucial to live active and productive life.

**Evolution of liver Transplant in India:**

Liver Transplant was introduced in India about 15 years ago. Still less than 1000 liver transplants in India are performed as required to more than 20,000 needing transplant. After 2 unsuccessful attempts in 1995 and 1996, the first successful deceased donor liver transplant (DDLT) was performed in 1998. However, due to the sporadic availability of deceased donor organs, a patient requiring liver transplant would almost certainly die before an organ could become available. Liver transplantation remained a realistic option only for the

few who could afford the astronomical costs of travelling overseas for the procedure.

The success of LDLT world over, particularly in Asian centers like Korea and Japan, prompted Indian centers to adopt LDLT. The first successful LDLT in India was performed from an adult donor to a pediatric recipient in 1998. This was the prelude to establishing LDLT in India. It was followed by several procedures at select centers that met with mixed success. At present a total of 25 centers are performing liver transplants in this country, of which 14 have performed at least one LDLT procedure with success ranging from 0–92%, according to a survey. The success story of Liver Transplant in Asia, has if not surpassed, definitely equaled to that in west. Thus it can be said without doubt that, though Liver transplant originated in Western countries, its future direction is being and will be guided by Asian countries.

At the present time the centers offering Liver Transplant in India are:

1) All India Institute of Medical Science: New Delhi
2) Amrita Institute of Medical Science: Kochi
3) Apollo Indraprastha-New Delhi
4) Apollo Hospital-Chennai
5) Army Hospital-Research and Referral-New Delhi
6) BL Kapur Hospital-New Delhi
7) Christian Medical college-Vellore
8) Fortis Hospital-Mumbai
9) Fortis Hospital-New Delhi
10) Global Hospital-Chennai/Hyderabad
11) Hinduja Hospital-Mumbai
12) Institue of Liver and Biliary Science (ILBS)-New Delhi
13) Jaslok Hospital-Mumbai
14) Jupiter Hospital-Mumbai
15) KEM Hospital-Mumbai
16) Kokilabhen Dhirubhai Ambani Hospital-Mumbai
17) KG Hospital-Coimbatore
18) Lakeshore Hospital-Kochi
19) Madras Mission Hospital-Chennai
20) Medanata-Medicity Hospital-New Delhi
21) Narayan Hrudayalaya-Bengalaru
22) Sanjay Gandhi Post Graduate Institute-Lucknow
23) Sir Gangaram Hospital-New delhi
24) Stanely Medical College-Chennai
25) St Johns Hospital-Bengalaru

**Liver Transplant at KEM Hospital:**

In the year 2010, KEM became the first public hospital in Western India to start the Liver Transplant program. It has a well equipped state of art modular theatre and ICU, with all relevant equipments necessary for the Transplant surgery.

It has a dedicated team of Surgeons, Hepatologist, Anesthetist, Intensivist, Transfusin medicine, Pathologist, Biochemist and Trained staff nurse.

To date we have performed 9 liver transplant, including two LDLT. At present we have 11 patients registered with ZTCC who are completely worked up and awaiting DDLT.

We offer a package of 9 Lakhs Rupees which includes the operative procedure and immunosupression for one month.

**Bibliography:**


1. Starzl T, Marchioro T, VonKaulla K, Hermann G, Brittain R, Waddell W (1963). "Homotrans-plantation of the Liver in Humans". *Surg Gynecol Obstet* 117: 659–76. PMC 2634660.PMID 14100514.
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- Laproscopic Surgery
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- ENT Surgery
- Orthopedic Surgery
- Plastic Surgery
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- Pap Smear

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- Paramount Health Care
- Apollo Munich
- Religare
- Star Health
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## Dr. Hemant S. Wahane

M.D. (Medicine)
Consultant Physician, Cardiologist & Diabetologist
(Special Interest Echocardiography)
**M. 9820272722**
Timing : 10 a.m. to 1 p.m. & 6 p.m. to 10 p.m.

## Dr. Amol U. Sonawane

M.S. (General Surgery)
Consultant Laproscopic, Endoscopic, General Surgeon
**M. 9820957970**
Timing : 10 a.m. to 1 p.m. & 6 p.m. to 10 p.m.

## Dr. Charusheela H. Wahane

D.A.
Anaesthesiologist

## Dr. Shalaka A. Sonawane (Mungekar)

M.D., D.G.O., F.C.P.S.
Consultant Obstetrics & Gynaecologist
**M. 9322825637**
Timing : 11 a.m. to 1.00 p.m.

# नावात काय आहे ?

डॉ. प्रमोद बेजकर

डॉ. प्रमोद बेजकर
गेली ३३ वर्षे जनरल प्रॅक्टीस, २५ वर्षे कविता, गीत, लेखन. लोकसत्ताच्या बालरंग पुरवणीत आरोग्य विषयक लिखाण, हास्यरंग पुरवणीत अनेकदा विनोदी साहित्य प्रकाशित.
हिंदी, मराठी गाण्यात आल्बम, काही मराठी चित्रपयांसाठी गीत लेखन.

कुणाच्या स्वप्नात कोण कधी येईल याचा काही भरवसा नाही. आता बघाना, काल रात्री माझ्या स्वप्नात शेक्सपियर आला. खरंतर माझा आणि या महाशयांचा संबंध इंग्लिश पेपरातल्या चार मार्कांपुरता. त्यानंतर त्यांच्या वाटेला कधी जायचा धीरच झाला नव्हता. त्याची ती आगगाडीसारखी लांबलचक कठीण वाक्य माझ्या डोक्यातून फास्ट ट्रेनसारखी निघून जायची. बरं त्याचं एखादं साधसं वाक्य घेतलं, उदाहरणार्थ नावात काय आहे, तरी त्यामध्ये मला कधी ना दिसलेलं प्राध्यापकांना काय काय दिसायचं. त्यामुळे मी शेक्सपियरपासून आपला चार हात राखूनच असलेला. त्यामुळे हा आपल्या बेडरुममध्ये डायरेक्ट कसा घुसला याचं मला जरा कुतूहलच वाटलं. फक्त दाढी आणि टक्कल यावरुन त्याला मी ओळखू शकलो ते बहुदा तो माझ्या स्वप्नात आला म्हणून. दुसऱ्याच्या स्वप्नात त्याला ओळखलं असतं का हा प्रश्नच आहे.

तसा मी लोकांमध्ये बुजराच असतो. पण कुणीतरी म्हटलं आहे ना की अपने ख्वाबों मे हर एक कुत्ता शेर होता है. कुणीतरी म्हटलं आहे म्हणून स्वतःचंच काहीतरी घुसडून द्यायची माझी खोड एव्हाना चाणाक्ष वाचकांच्या लक्षात आली असेलच. तर मी न बुजता शेक्सपियरचा हात बळेबळे माझ्या हातात ओढून जोरजोरात हलवून म्हटले, 'हौ आर यू शेक्सपियर ?'

आपला हात शांतपणे माझ्या हातातून सोडवून घेत दोन्ही हात जोडून तो म्हणाला, 'नमस्कार, तुम्ही कसे आहात.' तेव्हा माझ्या मराठी मनाला अभिमानाची पालवी फुटली. मराठी बद्दल बहुतेक मराठी माणसांना बाकी काही वाटलं नाही तरी अभिमान वाटतो, तसा मलाही वाटायला लागला. शेक्सपियरलाही मराठी रितीरिवाज माहित आहेत हे बघून मी आश्चर्यचकित झालो. मी अधिक चकित होण्याच्या आधीच तो म्हणाला, 'माफ करा, मी तुम्हाला ओळखलं नाही.' यावर खरंतर मला रागच आला. एकतर माझ्या स्वप्नात यायचं आणि तुम्हाला ओळखत नाही म्हणायचं, हे जरी शेक्सपियर असला तरी आगाउपणाचच.

मी जरा घुश्श्यातच म्हटलं, माझं नाव काहीही सोम्या गोम्या असलं तरी काय फरक पडतोय ? नाहीतरी मी म्हटलं आहेच, नावात काय आहे ? आता आश्चर्यचकीत वगैरे व्हायची त्याची पाळी होती. "Excuse Me" शेवटी तो इंग्लीशच्या मूळपदावर आला. "मला वाटतंय, हे मी सांगून गेलोय, नावात काय आहे ?" "Exactly, that is what I want to say" मग मी ही, मला हौ आर यू च्या पलिकडलं इंग्लीश येतं हे दाखवून म्हणालो, मलाही हेच म्हणायचंय, नावात काय आहे ? म्हणजे हे वाक्य विल्यम म्हणाला काय नी प्रमोद म्हणाला काय, काय फरक पडतो ? म्हणून तर या वाक्यावर मी माझी मालकी सांगितली. तेव्हा खास ब्रिटीश कुत्सितपणे हसत शेक्सपियर म्हणाला, मग आता माझी नाटकं स्वतःच्या नावावर छापायला घेतलीस की नाही ? तेव्ही मी देखील खास मराठी कुर्रा दाखवत म्हणालो, "प्रयत्न केला, पण कोणी जुनाट नाटकं छापायला तयार होईना. शेवटी घरातल्या Hamlet नाटकाच्या पुस्तकावर लेखल म्हणून माझ्या नावाची पट्टी डकवली."

"पण मला आधी एक सांग, तू गणिताचा मास्तर होता का रे ?" मी विचारलं.

माझ्याच वाक्याची स्टाईल चोरत तो म्हणाला, 'पण मला तू आधी हे सांग, हा प्रश्न तुझ्या बालबुद्धीला कसा काय पडला ? कारण मी जीवनाची गणितं सोडवायचा प्रयत्न केला तरी हा मास्तकीचा उद्योग नाही रे केला कधी.'

'हे बघ, आमचे गणिताचे एक शिक्षक होते. ते आम्हाला जाम अवघड गणित सोडवायला द्यायचे. आम्हाला काही केल्या ते सुटलं नाही की आम्ही म्हणायचो, सर सांगा ना कसं सोडवायचं ते. तेव्हा ते शांतपणे म्हणायचे, माझं गणित जर इतकं चांगलं असतं, तर तुम्हां शेंबड्या पोरांना शिकवत या बुद्रुक गावी मी राहीलो असतो का रे मुर्खांनो. तू पण असाच विक्रमच्या खांद्यावर असलेल्या वेताळासारखे प्रश्न विचारत बसतोस, उत्तर मात्र देत नाहीस. तुम्हा लोकांचं एक मात्र छान फावतं, प्रश्न विचारणाऱ्याची मूठ झाकली राहते, त्यामुळे प्रश्नकर्ता हा उत्तर देणाऱ्यापेक्षा हुशार गणला जातो. अगदी त्याने प्रश्नपत्रिकेत प्रश्न विचारले तरीही. तुमच्या इंग्लंड मध्ये सुद्धा अशीच पद्धत आहे का रे, प्रश्न पत्रिकेत चुकीचे प्रश्न विचारुन पत्रिकेतल्या राहूसारखं विद्यार्थ्यांना छळायची ?

"मला काही ते माहित नाही, पण एक सांगतो, माझ्याच नाटकावर लिहिलेला प्रबंध मात्र इंग्लंड मधल्या प्राध्यापकांनी नाकारला होता." तर हे ऐकून मला छान वाटायला लागलं. मग माझीही भीड की काय म्हणतात ती चेपली. मी माझ्या जन्मजात उद्धटपणाने त्याला विचारलं "काय रे, तू तर नाटकांतून नुसतेच प्रश्न विचारत बसलास, नावात काय आहे, जगावं की मरावं हाच प्रश्न आहे, असे कितीतरी." खरंतर मला या दोन वाक्यांपलिकडे शेक्सपीयर माहितच नाही. पण आपल्या तुटपुंज्या माहितीच्या आधारे कुणावरही तुटून पडायचं हे टिव्हीवरच्या मुलाखतकर्त्यांकडून मी बघून बघून शिकलो असल्यामुळे हा प्रश्न मी त्याच्या अंगावर अक्षरशः भिरकावला.

"या साऱ्या प्रश्नांची उत्तरं कुणी द्यायची ? याचं उत्तर सारा महाराष्ट्र मागतो आहे." मी गर्जना करीत माझ्या परीने बिनतोड प्रश्न केला. काटेकोरपणाने सांगायचं तर तेव्हा सारा उभा महाराष्ट्र आडवा पडून घोरत पडला होता. पण या प्रश्नावर शेक्यपियरची दांडी गुल होणार आणि तो आपल्या कानाची पाळी पकडून, माझं चुकलं म्हणत उठाबशा काढायला लावणार असं मला नक्की वाटायला लागलं. आता एक दोन तीन म्हणायचं की वन, टू, थ्री हा मी विचार करत होतो तेव्हा बिलंदरपणे हसत तो म्हणाला, 'मीच जर उत्तरं दिली असती तर एवढे प्रबंध लिहून इतकेजण डोक्टरेट कसे झाले असते?' हा टोमणा त्याने प्राध्यापक असलेल्या माझ्या बायकोला मारला असल्याचं कळल्यामुळे मला आनंदाची उकळी फुटली. त्या उकळीमुळे मी जरा घामाघूम झालो.

पण माझ्या उपजत मख्ख चेहेऱ्यामुळे माझा आनंद त्याला कळणार नाही याची मला खात्री होती. आता मी त्याच मख्ख चेहेऱ्याने मख्ख आवाजात त्याचं बौद्धिक घ्यायला सुरुवात केली. 'अरे राजा, असं कसं म्हणतोस तू की नावात काही अर्थ नाही. आमच्या इथे बघ, शेताच्या सातबाऱ्यावर आपलं नाव घुसविण्यासाठी लोकं जीवाचं रान करतात. पंतप्रधानाचं आणि आपलं नाव एकच आहे या निकषावर एखादा फाटका माणूस कोट्यावधींच्या कर्जाचं तारण देऊ शकतो. आपल्याला स्वप्नातदेखील मिळू न शकणाऱ्या नटीचं नाव घरात आलेल्या नववधूला ठेऊन आनंद मिळवता येतो. रस्त्याची, शहराची नावे बदलून मोठी मर्दुमकी गाजवल्याचं समाधान मिळवता येत. नाव बदलावं की नाही या मुद्यावरुन रण पेटवून आपली पोळी भाजता येते. नावावरुन समोरचा आपल्यातला की बाहेरचा हे ठरवता येते. अरे कुणीतरी म्हटलं आहेच,

**"नावात काय आहे ?**
**नावात सर्व आहे.**
**उरणार शुन्य तरिही नावात खर्व आहे."**

मी जातीवंत कवीसारखं स्वतःच्या ओळी घुसडवत म्हटलं. इतकं सारं एका दमात बोलल्यामुळे मला जरा दम लागला.

माझी उठायची वेळ झाल्यामुळे शेक्सपियर जायला निघाला. जाता जाता जरा थांबून तो मला म्हणाला. "माझ्या झोपेचं खोबरं करुन तू ढाराढूर झोपेत छान टाइमपास केलास. खरंतर तुझ्या ऐवजी एखादा शहाण्यासुरत्या माणसाच्या स्वप्नात गेलो असतो तर काही विद्वत्तापूर्ण चर्चा करता आली असती. तू तर फटकळ बोलून माझी बोळवण केलीस" त्याने मला फटकळ म्हटल्याचा मला खूप खूप राग आला. तरी मी त्याला उदार मनाने क्षमा केली. कारण कुणीतरी म्हणजे बहुदा मीच म्हणून गेलोय की आपण स्वतःला क्षमा करायला हवी. मात्र फुटकळ हा डाग धुऊन काढण्यासाठी शेक्सपियरला खूप गुगल करायचं म्हणजे पुन्हा तावडीत सापडलाच तर त्याची चांगलीच धुलाई करता येईल, हे ही मी स्वप्नातल्या मनातल्या मनात ठरवून टाकलं.

"पण एका बाबतीत तुझे आभार मानायचे आहेत. तुमच्या मराठीतल्या एका कवीसारखं तू मला विल्या म्हणाला नाहीस." शेक्सपियरचं (खरंतर माझंच) मराठी कवितेचं ज्ञान पाहून मी चकीतच झालो. माझी मराठी छाती पुन्हा अभिमानाने फुगवत मी म्हटलं, "तुला विल्या असं आमचा ग्रेट पोएट तुकाराम यानं म्हटलं असं दुसऱ्या ग्रेट विंदांनी लिहिलंय."

"तरी पण तुझे आभार, कारण तिसरा ग्रेट तू आहेस." शेक्सपियरच्या तोंडातून स्वतःचं कौतुक करुन घेतांना माझी छाती एकदा अभिमानाने फुगली. माझी छाती अशी सारखी वरखाली झाल्यामुळे मला नेहमीचा दमा लागलाय की काय या भितीने बायकोने मला उठवायचा प्रयत्न केला तेव्हा काढता पाय घेत शेक्सपियर शेवटचं म्हणाला, "असा अर्धवटरावा, मी नावात काय आहे असं म्हणालो होतो, आडनावात काय आहे असं नव्हतो म्हणालो. तुला हवं तर प्रमोद शेक्सपियर नावाने माझी नाटकं तुझ्या नावावर करतो."

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# CONQUERING THE THIRD SPACE

**(Third space endoscopy - new horizons in Therapeutic Endoscopy)**

**Dr. Rahul Mahadar**

**Dr. Rahul Mahadar**
**Having done his post graduation in General Surgery at Government Medical College, Miraj, he acquired his basic laparoscopic training in Mumbai and advanced laparoscopic training from Coimbatore and was awarded "Diploma in Advanced laparoscopic Surgery". He was also awarded " Fellowship in Minimal Access Surgery" by " Association of Minimal Access Surgeons of India" and " Diploma Chirurgie Laparoscopy" in France. He has also completed basic and advanced course in Colo- proctology. He has also done Fellowship in Colo-rectal cancer surgery in from Korea. Currently he is the director of his own "Jeevan Shree" Hospital Dombivali.**

Gastrointestinal Endoscopy has had a spectacular run in Last Few decades with advances in technology that have redefined both Gastroenterology & Gastrointestinal Surgery. Going forward, its contributions are likely to be even more meaningful as new procedures expand both the indications as well as the user base &contribute to bending the curve of healthcare costs.

In this article, I hope to extract some lessons I have learned during this period from recent innovations as well as from observing the brilliance and entrepreneurship of the many talented colleagues from whom gastrointestinal specialty has been so fortunate to benefit.

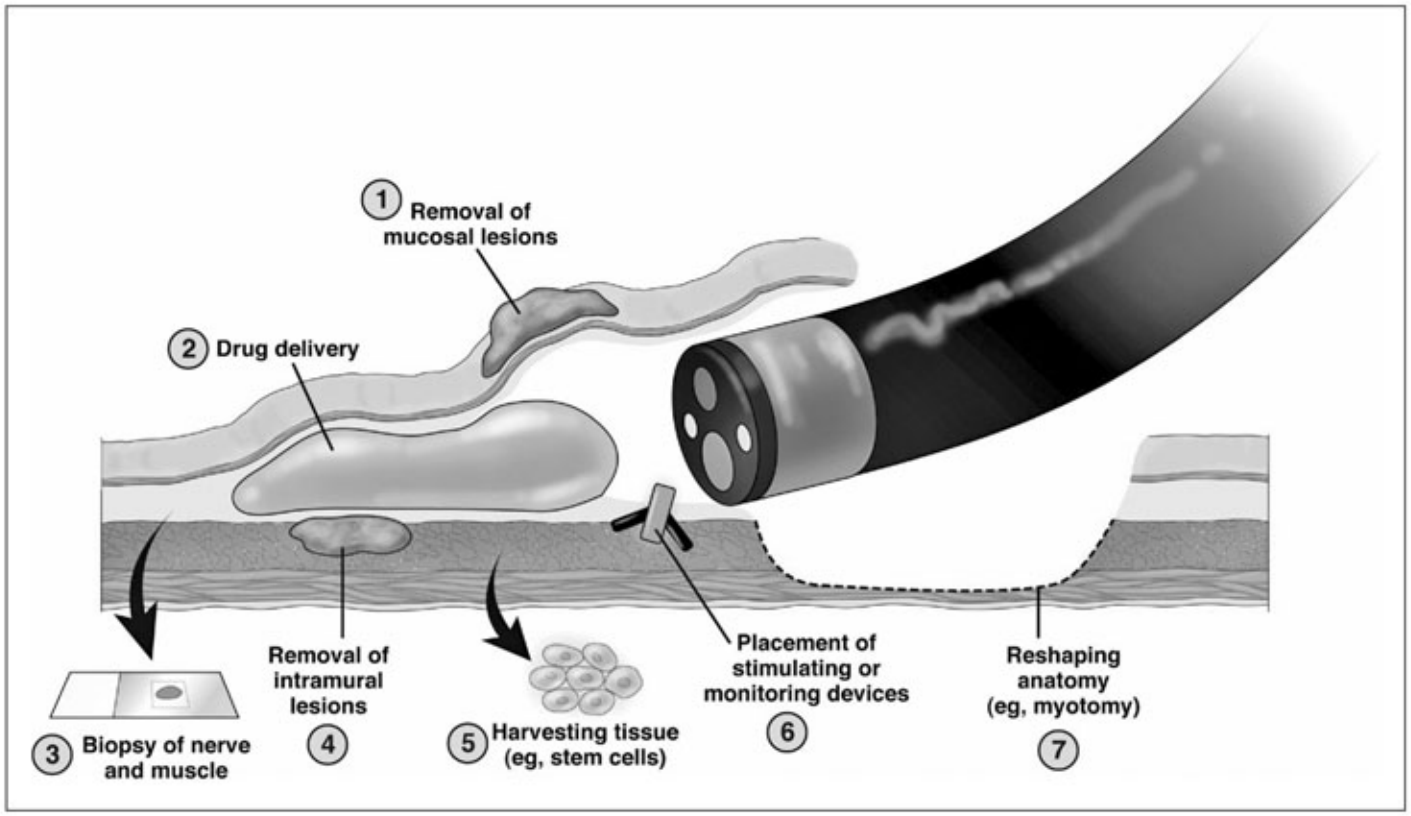
Before embarking on a journey into the future, it may be instructive to examine where we were 20 years ago. In 1992, the first video endoscopes were beginning to be introduced and widely hailed as one of the most important breakthroughs in the field of Gastroenterology. At the same time, surgeons were adopting the revolution in this field, Laparoscopic surgery. Endoscopic ultrasound was an exotic tool whose utility had yet to be established. And capsule endoscopy would have been dismissed as science fiction. On therapeutic side, varieceal band ligation was introduced as safer alternative to sclerotherapy & considered a major advance; endoscopic ablation of Barrett's esophagus had not yet caught anyone's imagination. Since then much progress has been made on many fronts but some developments have truly let the stage for transformative change.

**Third Space endoscopy**

The development of Tunnel endoscopic surgery is inspiring for both Gastroenterologists and GI surgeons. The future of flexible endoscopy is not only operating in natural orifice but also within & outside the gastrointestinal wall. If the lumen was Historically the first & peritoneal cavity the second then intramural space has come to represent the " Third Space ". GI Endoscopy has finally entered the (Third space age!)

Until very recently, the use of endoscopes was confined to either the lumen or peritoneal space. However, there are other spaces amenable for endoscopic intervention, the most notable of which is the sub mucosal space. The technique involves making a nick in the mucosa, then lifting it away from the layer beneath, and inserting the endoscope into the space in between. Once the endoscope is withdrawn, the initial mucosal entry site is closed, sealing off the space once again. The creation of this "third" space and its recognition as a novel arena for endoscopic intervention have opened up a slew of opportunities, as exemplified by the procedure known as peroral endoscopic Myotomy (POEM) for achalasia. Modifications of this approach in other regions of the gut can be used for removal of either mucosal or intramural tumors as well as for drug delivery among other applications.

Peroral Endoscopic Myotomy (POEM) has been developed as a non-incision, minimal invasive endoscopic treatment becoming the most effective option for




achalasia, may be the primary and permanent one. This procedure incorporates concepts of Natural orifice trans luminal endoscopic surgery & achieves endoscopic myotomy by using the sub mucosal tunnel as an operative space.

The emerging of POEM marked the rising of a new branch of therapeutic endoscopy – tunnel endoscopic surgery (TES), which includes several novel procedures utilizing a sub mucosal tunnel as an operating space. In 2010, Chinese surgeon innovated a new method by tunneling technique for treating upper Gastrointestinal (GI) sub mucosal tumors. (SMTs) originating from the muscularis propria layer & coined the anonym STER (Sub mucosal tunneling endoscopic resection). Other applications of tunneling technique inside peroral endoscopic submucosal pyloromyotomy for pyloric stenosis, endoscopic sub mucosal tunnel dissection for large esophageal neoplastic lessons etc.

It has never ceased to surprise me that although the gastrointestinal diseases are treated systemically and not topically. This is particularly true for regionally localized inflammatory bowel disease (with the exception of proctitis ); in the near future, we should see most of these conditions treated with specially formulated long lasting drug preparations or perhaps drug- device combinations applied directly to the lesions during endoscopy. This will result in less side effects, cost savings & probably improved efficacy. Implantation of drug delivery devices in the Sub mucosal space can also provide novel ways to treat diseases in organs that are in the portal stream such as the liver. Furthermore, augmentation of satiety and metabolic path ways to treat obesity and diabetes is probably more effective if the signals originate in the gut.

Finally, we will also see widespread use of endoscopes in primary care and general medical settings for basic procedures such as insertion of gastric or jejunal tubes, anal & prostate examinations and a variety of other procedures that are currently being done "blindly". Cheap battery powered endoscopes with LED technology will wirelessly transmit images that will be displayed and captured on smart screens (or phones) held in the other hand. Such procedures will eventually pave the way to broader and more widespread bedside use of diagnostic gastrointestinal endoscopy by non-gastroenterologists especially in developing countries.

However I believe the biggest impact of the "discovery" of the third space will be on disorders of motility, syndromes that until now had not been considered amenable to Endoscopic therapy.

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# ETHICS, MEDICAL-ETHICS AND THE INDIAN MEDICAL COUNCIL (PROFESSIONAL CONDUCT, ETIQUETTE AND ETHICS) REGULATIONS, 2002. (AMENDED UPTO 1ST FEBRUARY 2016)

**Anant B. Bobe**
B.E., MBA, LL.B.
ADVOCATE HIGH COURT

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**What is 'moral'?**

It's difficult to define. One can say it is the principle of right or wrong things. Morality is relative to personal, social or cultural standards.

**Ethics is the set of moral principles.**

The theory of morality proposed by German philosopher Immanuel Kant is relevant to professional behavior and appeals to rational minds. He says

1. **Treat others as you would like them to treat you.**
2. **Never treat another human being simply as means but always as an end.**
3. **The rightness or wrongness doesn't depend on the consequences but depend on whether they fulfill their duty or not.**

Kant believed that there was a supreme principle of morality and he referred to it as **The Categorical Imperative.** Now what's meant by "categorical imperative"?

To know this see these examples.

1. Don't kill animals… is an imperative.
2. Study biology if you want to go to medical school… is also an imperative, but doesn't apply to you if you don't want to go to medical school.
3. " Don't cheat on paying taxes". This is unconditional imperative. Even if not paying taxes may be more beneficial, you should not cheat on it.

**Third one is a Categorical Imperative.**

**Morality is Categorical Imperative because you can't opt out of it or claim that it is not applicable to you. Breach of this makes you ethically accountable.**

**This implied duty of medical professionals towards the patients and towards the society is the foundation of " Indian Medical Council (Professional Conduct, Etiquette and Ethics) Regulation.**

**The Indian Medical Council Act under section 20A empowers Medical Council of India to prescribe standards of professional conducts and to make rules there under.**

**Professional Conduct 20A**

1. The Council may prescribe standards of professional conduct and etiquette and a code of ethics for medical practitioners.
2. Regulations made by the Council under sub section (1) may specify which violations shall constitute infamous professional conduct that is professional misconduct and such provisions shall have effect notwithstanding anything contained in any law for the time being in force.

The important features of The Indian Medical Council (Professional Conduct, etiquette and Ethics) Regulations,2002 ( Amended upto 1st February2016) are produced as under.

**CHAPTER I**

1. **CODE OF MEDICAL ETHICS**

**A. Declaration**: Each applicant, at the time of making an application for registration under the provisions of the Act shall submit a duly signed Declaration as provided in Appendix 1.

**B. Duties and responsibilities of the Physician in general:**

**1.** To uphold the dignity and honour of his profession.

**2.** The prime object of the medical profession is to render service to humanity; reward or financial gain is a subordinate consideration.

**3. Maintaining good medical practice**

**a)** To improve medical knowledge and skills

**b)** Membership in Medical Society for the advancement of his profession

**c)** To participate in professional meetings as part of Continuing Medical

Education programmes, for at least 30 hours every five years,

**4. Maintenance of medical records**:

**a)** To maintain the medical records pertaining to his / her indoor patients for a period of 3 years.

**b)** On any request is made for medical records either by the patients / authorised attendant or legal authorities involved documents shall be issued within the period of 72 hours.

**c)** To maintain a Register of Medical certificates etc

5. **Display of registration numbers and** suffix to their names only recognized medical degrees / certificates / diplomas and memberships / honours.

6. **Use of Generic names of drugs**

**7. Highest Quality Assurance in patient care**

**8. Exposure of Unethical Conduct**

**9. Payment of Professional Services**: to announce his fees before rendering service and not after the operation or treatment is under way. It is unethical to enter into a contract of "no cure no payment".

10. To observe the laws of the country in regulating the practice of medicine and shall also not assist others to evade such laws. He should be cooperative in observance and enforcement of sanitary laws and regulations in the interest of public health. A physician should observe the provisions of the State Acts like Drugs and Cosmetics Act, 1940; Pharmacy Act, 1948; Narcotic Drugs and Psychotropic substances Act, 1985; Medical Termination of Pregnancy Act, 1971; Transplantation of Human Organ Act,1994; Mental Health Act, 1987; Environmental Protection Act, 1986; Pre–natal Sex Determination Test Act, 1994; Drugs and Magic Remedies (Objectionable Advertisement) Act,1954; Persons with Disabilities (Equal Opportunities and Full Participation) Act, 1995 and Bio-Medical Waste (Management and Handling) Rules, 1998 and such other Acts, Rules, Regulations made by the Central/State Governments or local Administrative Bodies or any other relevant Act relating to the protection and promotion of public health.

**CHAPTER 2**

2. DUTIES OF PHYSICIANS TO THEIR PATIENTS

1. **Obligations to the Sick**

Though a physician is not bound to treat each and every person asking his services, he should not only be ever ready to respond to the calls of the sick and the injured, but should be mindful of the high character of his mission and the responsibility he discharges in the course of his professional duties. In his treatment, he should never forget that the health and the lives of those entrusted to his care depend on his skill and attention. A physician sh ould endeavour to add to the comfort of the sick by making his visits at the hour indicated to the patients. A physician advising a patient to seek service of another physician is acceptable, however, in case of emergency a physician must treat the patient. No physician shall arbitrarily refuse treatment to a patient. However for good reason, when a patient is suffering from an ailment which is not within the range of experience of the treating physician, the physician may refuse treatment and refer the patient to another physician.

2. Medical practitioner having any incapacity detrimental to the patient or which can affect his performance vis-à-vis the patient is not permitted to practice his profession

3. **Patience, Delicacy and Secrecy :** the defects in the disposition or character of patients observed during

medical attendance should never be revealed unless their revelation is required by the laws of the State. Sometimes, however, a physician must determine whether his duty to society requires him to employ knowledge, obtained through confidence as a physician, to protect a healthy person against a communicable disease to which he is about to be exposed. In such instance, the physician should act as he would wish another to act toward one of his own family in like circumstances.

4. **Prognosis:** The physician should neither exaggerate nor minimize the gravity of a patient's condition. He should ensure himself that the patient, his relatives or his responsible friends havesuch knowledge of the patient's condition as will serve the best interests of the patient and the family.

5. **The Patient must not be neglected:** A physician is free to choose whom he will serve. He should, however, respond to any request for his assistance in an emergency. Once having undertaken a case, the physician should not neglect the patient, nor should he withdraw from the case without giving adequate notice to the patient and his family. Provisionally or fully registered medical practitioner shall not willfully commit an act of negligence that may deprive his patient or patients from necessary medical care.

6. **Engagement for an Obstetric case:** When a physician who has been engaged to attend an obstetric case is absent and another is sent for and delivery accomplished, the acting physician is entitled to his professional fees, but should secure the patient's consent to resign on the arrival of the physician engaged.

## CHAPTER 3

## DUTIES OF PHYSICIAN IN CONSULTATION

1. Unnecessary consultations should be avoided:
2. Consultation for Patient's Benefit
3. Punctuality in Consultation
4. **Statement to Patient after Consultation :** All statements to the patient or his representatives should take place in the presence of the consulting physicians, except as otherwise agreed. The disclosure of the opinion to the patient or his relatives or friends shall rest with the medical attendant. Differences of opinion should not be divulged unnecessarily but when there is irreconcilable difference of opinion the circumstances should be frankly and impartially explained to the patient or his relatives or friends. It would be opened to them to seek further advice as they so desire.
5. **Treatment after Consultation :** No decision should restrain the attending physician from making such subsequent variations in the treatment if any unexpected change occurs, but at the next consultation, reasons for the variations should be discussed/ explained. The same privilege, with its obligations, belongs to the consultant when sent for in an emergency during the absence of attending physician. The attending physician may prescribe medicine at any time for the patient, whereas the consultant may prescribe only in case of emergency or as an expert when called for.
6. **Patients Referred to Specialists:** When a patient is referred to a specialist by the attending physician, a case summary of the patient should be given to the specialist, who should communicate his opinion in writing to the attending physician.
7. **Fees and other charges :** A physician shall clearly display his fees and other charges on the board of his chamber and/or the hospitals he is visiting. Prescription should also make clear if the Physician himself dispensed any medicine. A physician shall write his name and designation in full along with registration particulars in his prescription letter head. Note: In Government hospital where the patient–load is heavy, the name of the prescribing doctor must be written below his/her signature.

## CHAPTER 4

## RESPONSIBILITIES OF PHYSICIANS TO EACH OTHER

1. **Dependence of Physicians on each other :** A physician should consider it as a pleasure and privilege to render gratuitous service to all physicians and their immediate family dependants.
2. **Conduct in consultation :** In consultations, no insincerity, rivalry or envy should be indulged in. All due respect should be observed towards the physician in-charge of the case and no statement or remark be made, which would impair the confidence reposed in him. For this purpose no discussion should be carried on in the presence of the patient or his representatives.
3. **Consultant not to take charge of the case:** When a physician has been called for consultation, the

Consultant should normally not take charge of the case, especially on the solicitation of the patient or friends. The Consultant shall not criticize the referring physician. He /she shall discuss the diagnosis treatment plan with the referring physician.

4. **Appointment of Substitute:** Whenever a physician requests another physician to attend his patients during his temporary absence from his practice, professional courtesy requires the acceptance of such appointment only when he has the capacity to discharge the additional responsibility along with his / her other duties. The physician acting under such an appointment should give the utmost consideration to the interests and reputation of the absent physician and all such patients should be restored to the care of the latter upon his/her return.

5. **Visiting another Physician's Case:** When it becomes the duty of a physician occupying an official position to see and report upon an illness or injury, he should communicate to the physician in attendance so as to give him an option of being present. The medical officer /physician occupying an official position should avoid remarks upon the diagnosis or the treatment that has been adopted.

## CHAPTER 5

## DUTIES OF PHYSICIAN TO THE PUBLIC AND TO THE PARAMEDICAL PROFESSION

1. **Physicians as Citizens:** Physicians, as good citizens, possessed of special training should disseminate advice on public health issues. They should play their part in enforcing the laws of the community and in sustaining the institutions that advance the interests of humanity. They should particularly co-operate with the authorities in the administration of sanitary/public health laws and regulations.

2. **Public and Community Health:** Physicians, especially those engaged in public health work,should enlighten the public concerning quarantine regulations and measures for the prevention of epidemic and communicable diseases. At all times the physician should notify the constituted public health authorities of every case of communicable disease under his care, in accordance with the laws, rules and regulations of the health authorities. When an epidemic occurs a physician should not abandon his duty for fear of contracting the disease himself.

3. **Pharmacists / Nurses:** Physicians should recognize and promote the practice of different paramedical services such as, pharmacy and nursing as professions and should seek their cooperation wherever required.

## CHAPTER 6

**UNETHICAL ACTS :** A physician shall not aid or abet or commit any of the following acts which shall be construed as unethical -

1. **Advertising:**

   A medical practitioner is however permitted to make a formal announcement in press regarding the following:

(1) On starting practice.

(2) On change of type of practice.

(3) On changing address.

(4) On temporary absence from duty.

(5) On resumption of another practice.

(6) On succeeding to another practice.

(7) Public declaration of charges.

Printing of self photograph, or any such material of publicity in the letter head or on sign board of the consulting room or any such clinical establishment shall be regarded as acts of self advertisement and unethical conduct on the part of the physician. However, printing of sketches,diagrams, picture of human system shall not be treated as unethical.

2. **Patent and Copy rights:** A physician may patent surgical instruments, appliances and medicine or Copyright applications, methods and procedures. However, it shall be unethical if the benefits of such patents or copyrights are not made available in situations where the interest of large population is involved.

3. **Running an open shop (Dispensing of Drugs and Appliances by Physicians) :** - A physician should not run an open shop for sale of medicine for dispensing prescriptions prescribed by doctors other than himself or for sale of medical or surgical appliances. It is not unethical for a physician to prescribe or supply drugs, remedies or appliances as long as there is no exploitation of the patient. Drugs prescribed by a physician or brought from the market for a patient should explicitly state the proprietary formulae as well as generic name of the drug.

4. **Rebates and Commission :** A physician shall not

give, solicit, or receive nor shall he offer to give solicit or receive, any gift, gratuity, commission or bonus in consideration of or return for the referring, recommending or procuring of any patient for medical, surgical or other treatment. A physician shall not directly or indirectly, participate in or be a party to act of division, transference, assignment, subordination, rebating, splitting or refunding of any fee for medical, surgical or other treatment These Provisions shall apply with equal force to the referring, recommending or procuring by a physician or any person, specimen or material for diagnostic purposes or other study / work. Nothing in this section, however, shall prohibit payment of salaries by a qualified physician to other duly qualified person rendering medical care under his supervision.

5. **Secret Remedies:** The prescribing or dispensing by a physician of secret remedial agents of which he does not know the composition, or the manufacture or promotion of their use is unethical and as such prohibited. All the drugs prescribed by a physician should always carry a proprietary formula and clear name.

6. **Human Rights:** The physician shall not aid or abet torture nor shall he be a party to either infliction of mental or physical trauma or concealment of torture inflicted by some other person or agency in clear violation of human rights.

7. **Euthanasia:** Practicing euthanasia shall constitute unethical conduct. However on specific occasion, the question of withdrawing supporting devices to sustain cardio-pulmonary function even after brain death, shall be decided only by a team of doctors and not merely by the treating physician alone. A team of doctors shall declare withdrawal of support system. Such team shall consist of the doctor in charge of the patient, Chief Medical Officer / Medical Officer in charge of the hospital and a doctor nominated by the in-charge of the hospital from the hospital staff or in accordance with the provisions of the Transplantation of Human Organ Act, 1994.

## CHAPTER 7

7. **MISCONDUCT :** The following acts of commission or omission on the part of a physician shall constitute professional misconduct rendering him/her liable for disciplinary action

7.1 **Violation of the Regulations:** If he/she commits any violation of these Regulations.

7.2 If he/she does not maintain the medical records of his/her indoor patients for a period of three years as per regulation 1.3 and refuses to provide the same within 72 hours when the patient or his/her authorised representative makes a request for it as per the regulation 1.3.2.

7.3 If he/she does not display the registration number accorded to him/her by the State Medical Council or the Medical Council of India in his clinic, prescriptions and certificates etc. issued by him or violates the provisions of regulation 1.4.2.

7.4 **Adultery or Improper Conduct:** Abuse of professional position by committing adultery orimproper conduct with a patient or by maintaining an improper association with a patient willrender a Physician liable for disciplinary action as provided under the Indian Medical Council Act, 1956 or the concerned State Medical Council Act.

7.5 **Conviction by Court of Law:** Conviction by a Court of Law for offences involving moral turpitude / Criminal acts.

7.6 **Sex Determination Tests:** On no account sex determination test shall be undertaken with the intent to terminate the life of a female foetus developing in her mother's womb, unless there are other absolute indications for termination of pregnancy as specified in the Medical Termination of Pregnancy Act, 1971. Any act of termination of pregnancy of normal female foetus amounting to female foeticide shall be regarded as professional misconduct on the part of the physician leading to penal erasure besides rendering him liable to criminal proceedings as per the provisions of this Act.

7.7 **Signing Professional Certificates, Reports and other Documents**: Registered medical practitioners are in certain cases bound by law to give, or may from time to time be called upon or requested to give certificates, notification, reports and other documents of similar character signed by them in their professional capacity for subsequent use in the courts or for administrative purposes etc. Such documents, among others, include the ones given at Appendix – 4. Any registered practitioner who is shown to have signed or given under his name and authority any such certificate, notification, report or document of a similar character which is untrue, misleading or improper, is liable to have his name deleted from the Register.

7.8 A registered medical practitioner shall not contravene the provisions of the Drugs and Cosmetics Act and regulations made there under. Accordingly,

a) Prescribing steroids/ psychotropic drugs when there is no absolute medical indication;

b) Selling Schedule 'H' & 'L' drugs and poisons to the public except to his patient; in contravention of the above provisions shall constitute gross professional misconduct on the part of the physician.

7.9 Performing or enabling unqualified person to perform an abortion or any illegal operation for which there is no medical, surgical or psychological indication.

7.10 A registered medical practitioner shall not issue certificates of efficiency in modern medicine to unqualified or non-medical person. (Note: The foregoing does not restrict the proper training and instruction of bonafide students, midwives, dispensers, surgical attendants, or skilled mechanical and technical assistants and therapy assistants under the personal supervision of physicians.)

7.11 A physician should not contribute to the lay press articles and give interviews regarding diseases and treatments which may have the effect of advertising himself or soliciting practices; but is open to write to the lay press under his own name on matters of public health, hygienic living or to deliver public lectures, give talks on the radio/TV/internet chat for the same purpose and send announcement of the same to lay press.

7.12 An institution run by a physician for a particular purpose such as a maternity home, nursing home, private hospital, rehabilitation centre or any type of training institution etc. may be advertised in the lay press, but such advertisements should not contain anything more than the name of the institution, type of patients admitted, type of training and other facilities offered and the fees.

7.13 It is improper for a physician to use an unusually large sign board and write on it anything other than his name, qualifications obtained from a University or a statutory body, titles and name of his speciality, registration number including the name of the State Medical Council under which registered. The same should be the contents of his prescription papers. It is improper to affix a sign-board on a chemist's shop or in places where he does not reside or work.

7.14 The registered medical practitioner shall not disclose the secrets of a patient that have been learnt in the exercise of his / her profession except –

i) in a court of law under orders of the Presiding Judge;

ii) in circumstances where there is a serious and identified risk to a specific person and / or community; and

iii) notifiable diseases.

In case of communicable / notifiable diseases, concerned public health authorities should be informed immediately.

7.15 The registered medical practitioner shall not refuse on religious grounds alone to give assistance in or conduct of sterility, birth control, circumcision and medical termination of Pregnancy when there is medical indication, unless the medical practitioner feels himself/herself incompetent to do so.

7.16 Before performing an operation the physician should obtain in writing the consent from the husband or wife, parent or guardian in the case of minor, or the patient himself as the case may be. In an operation which may result in sterility the consent of both husband and wife is needed.

7.17 A registered medical practitioner shall not publish photographs or case reports of his / her patients without their permission, in any medical or other journal in a manner by which their identity could be made out. If the identity is not to be disclosed, the consent is not needed.

7.18 In the case of running of a nursing home by a physician and employing assistants to help him / her, the ultimate responsibility rests on the physician.

7.19 A Physician shall not use touts or agents for procuring patients.

7.20 A Physician shall not claim to be specialist unless he has a special qualification in that branch.

7.21 No act of invitro fertilization or artificial insemination shall be undertaken without the informed consent of the female patient and her spouse as well as the donor. Such consent shall be obtained in writing only after the patient is provided, at her own level of comprehension, with sufficient information about the purpose, methods, risks, inconveniences, disappointments of the procedure and possible risks and hazards.

7.22 Research: Clinical drug trials or other research involving patients or volunteers as per the guidelines of ICMR can be undertaken, provided ethical considerations are borne in mind. Violation of existing ICMR guidelines in this regard shall constitute misconduct. Consent taken from the patient for trial of drug or therapy which is not as per the guidelines shall also be construed as misconduct.

The following Clause No. 7.23 & 7.24 are deleted in terms of Notification published on 22.02.2003 in Gazette of India.

7.23 If a physician posted in rural area is found absent on more than two occasions during inspection by the Head of the District Health Authority or the Chairman, Zila Parishad, the same shall be construed as a misconduct if it is recommended to the Medical Council of India/State Medical Council by the State Government for action under these Regulations.

7.24 If a physician posted in a medical college/institution both as teaching faculty or otherwise shall remain in hospital/college during the assigned duty hours. If they are found absent on more than two occasions during this period, the same shall be construed as a misconduct if it is certified by the Principal/Medical Superintendent and forwarded through the State Government to Medical Council of India/State Medical Council for action under these Regulations.

## CHAPTER 8

8. PUNISHMENT AND DISCIPLINARY ACTION

8.1 It must be clearly understood that the instances of offences and of Professional misconduct which are given above do not constitute and are not intended to constitute a complete list of the infamous acts which calls for disciplinary action, and that by issuing this notice the Medical Council of India and or State Medical Councils are in no way precluded from considering and dealing with any other form of professional misconduct on the part of a registered practitioner. Circumstances may and do arise from time to time in relation to which there may occur questions of professional misconduct which do not come within any of these categories. Every care should be taken that the code is not violated in letter or spirit. In such instances as in all others, the Medical Council of India and/or State Medical Councils have to consider and decide upon the facts brought before the Medical Council of India and/or State Medical Councils.

8.2 It is made clear that any complaint with regard to professional misconduct can be brought before the appropriate Medical Council for Disciplinary action. Upon receipt of any complaint of professional misconduct, the appropriate Medical Council would hold an enquiry and give opportunity to the registered medical practitioner to be heard in person or by pleader. If the medical practitioner is found to be guilty of committing professional misconduct, the appropriate Medical Council may award such punishment as deemed necessary or may direct the removal altogether or for a specified period, from the register of the name of the delinquent registered practitioner. Deletion from the Register shall be widely publicized in local press as well as in the publications of different Medical Associations/ Societies/Bodies.

8.3 In case the punishment of removal from the register is for a limited period, the appropriate Council may also direct that the name so removed shall be restored in the register after the expiry of the period for which the name was ordered to be removed.

8.4 Decision on complaint against delinquent physician shall be taken within a time limit of 6 months.

8.5 During the pendency of the complaint the appropriate Council may restrain the physician from performing the procedure or practice which is under scrutiny.

8.6 Professional incompetence shall be judged by peer group as per guidelines prescribed by Medical Council of India.

## APPENDIX - 1

A. DECLARATION

At the time of registration, each applicant shall be given a copy of the following declaration by the Registrar concerned and the applicant shall read and agree to abide by the same:

1) I solemnly pledge myself to consecrate my life to service of humanity.

2) Even under threat, I will not use my medical knowledge contrary to the laws of Humanity.

3) I will maintain the utmost respect for human life from the time of conception.

4) I will not permit considerations of religion, nationality, race, party politics or social standing to intervene between my duty and my patient.

5) I will practice my profession with conscience and dignity.

6) The health of my patient will be my first consideration.

7) I will respect the secrets which are confined in me.

8) I will give to my teachers the respect and gratitude which is their due.

9) I will maintain by all means in my power, the honour and noble traditions of medical profession.

10) I will treat my colleagues with all respect and dignity.

11) I shall abide by the code of medical ethics as enunciated in the Indian Medical Council (Professional Conduct, Etiquette and Ethics) Regulations 2002.

I make these promises solemnly, freely and upon my honour.

Signature .....

Name .....

Place .....

Address .....

.....

.....

Date .....

## APPENDIX – 2

## 1. FORM OF CERTIFICATE RECOMMENDED FOR LEAVE OR EXTENSION OR COMMUNICATION OF LEAVE AND FOR FITNESS

Signature of patient or thumb impression .....

To be filled in by the applicant in the presence of the Government Medical Attendant or Medical Practitioner.

Identification marks:-

1. .....

2. .....

I, Dr. ..... after careful examination of the case certify hereby that .....whose signature is given above is suffering from ..... and I consider that a period of absence from duty of ..... with effect from ..... is absolutely necessary for the restoration of his health.

I, Dr. ..... after careful examination of the case certify hereby that ..... on restoration of health is now fit to join service.

Place ..... Signature of Medical attendant.

Date ..... Registration No. .....

(Medical Council of India / State Medical

Council of ..... State)

**Note :-** The nature and probable duration of the illness should also be specified . This certificate must be accompanied by a brief resume of the case giving the nature of the illness, its symptoms, causes and duration.

## APPENDIX-3
## FORMAT FOR MEDICAL RECORD
(see regulation 3.1)

Name of the patient : .....

Age : .....

Sex : .....

Address : .....

.....

Occupation : .....

Date of 1st visit : .....

Clinical note (summary) of the case : .....

.....

.....

Prov. : Diagnosis : .....

Investigations advised with reports : .....

Diagnosis after investigation : .....

Advice : .....

Follow up : .....

Date: Observations : .....

Signature in full : .....

Name of Treating Physician : .....

## APPENDIX –4

## LIST OF CERTIFICATES, REPORTS, NOTIFICATIONS ETC. ISSUED BY DOCTORS FOR THE PURPOSES OF VARIOUS ACTS / ADMINISTRATIVE REQUIREMENTS

a) Under the acts relating to birth, death or disposal of the dead.

b) Under the Acts relating to Lunacy and Mental Deficiency and under the Mental illness Act and the rules made thereunder.

c) Under the Vaccination Acts and the regulations made thereunder.

d) Under the Factory Acts and the regulations made thereunder.

e) Under the Education Acts.

f) Under the Public Health Acts and the orders made thereunder.

g) Under the Workmen's Compensation Act and Persons with Disability Act.

h) Under the Acts and orders relating to the notification of infectious diseases.

i) Under the Employee's State Insurance Act.

j) In connection with sick benefit insurance and friendly societies.

k) Under the Merchant Shipping Act.

l) For procuring / issuing of passports.

m) For excusing attendance in courts of Justice, in public services, in public offices or in ordinary employment.

n) In connection with Civil and Military matters.

o) In connection with matters under the control of Department of Pensions.

p) In connection with quarantine rules.

q) For procuring driving licence.

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## RELEVANT SECTIONS OF THE INDIAN MEDICAL COUNCIL ACT, 1956 AND MAHARASHTRA MEDICAL COUNCIL ACT, 1965 ARE REPRODUCED HERE BELOW

## THE INDIAN MEDICAL COUNCIL ACT, 1956
## REMOVAL OF NAMES FROM THE INDIAN MEDICAL REGISTER

24 (1) If the name of any person enrolled on a State Medical Register is removed there from in pursuance of any power conferred by or under any law relating to medical practitioners for the time being in force in any State, the Council shall direct the removal of the name of such person from the Indian Medical Register.

(2) Where the name of any person has been removed from a State Medical Register on the ground of professional misconduct or any other ground except that he is not possessed of the requisite medical qualifications or where any application made by the said person for restoration of his name to the State Medical Register has been rejected, he may

appeal in the prescribed manner and subject to such conditions including conditions as to the payment of a fee as may be laid down in rules made by the Central Government in this behalf, to the Central Government, whose decision, which shall be given after consulting the Council, shall be binding on the State Government and on the authorities concerned with the preparation of the State Medical Register.

Disha Kidney Care
Path To Quality Care

# Dr. DINESH P. MAHAJAN

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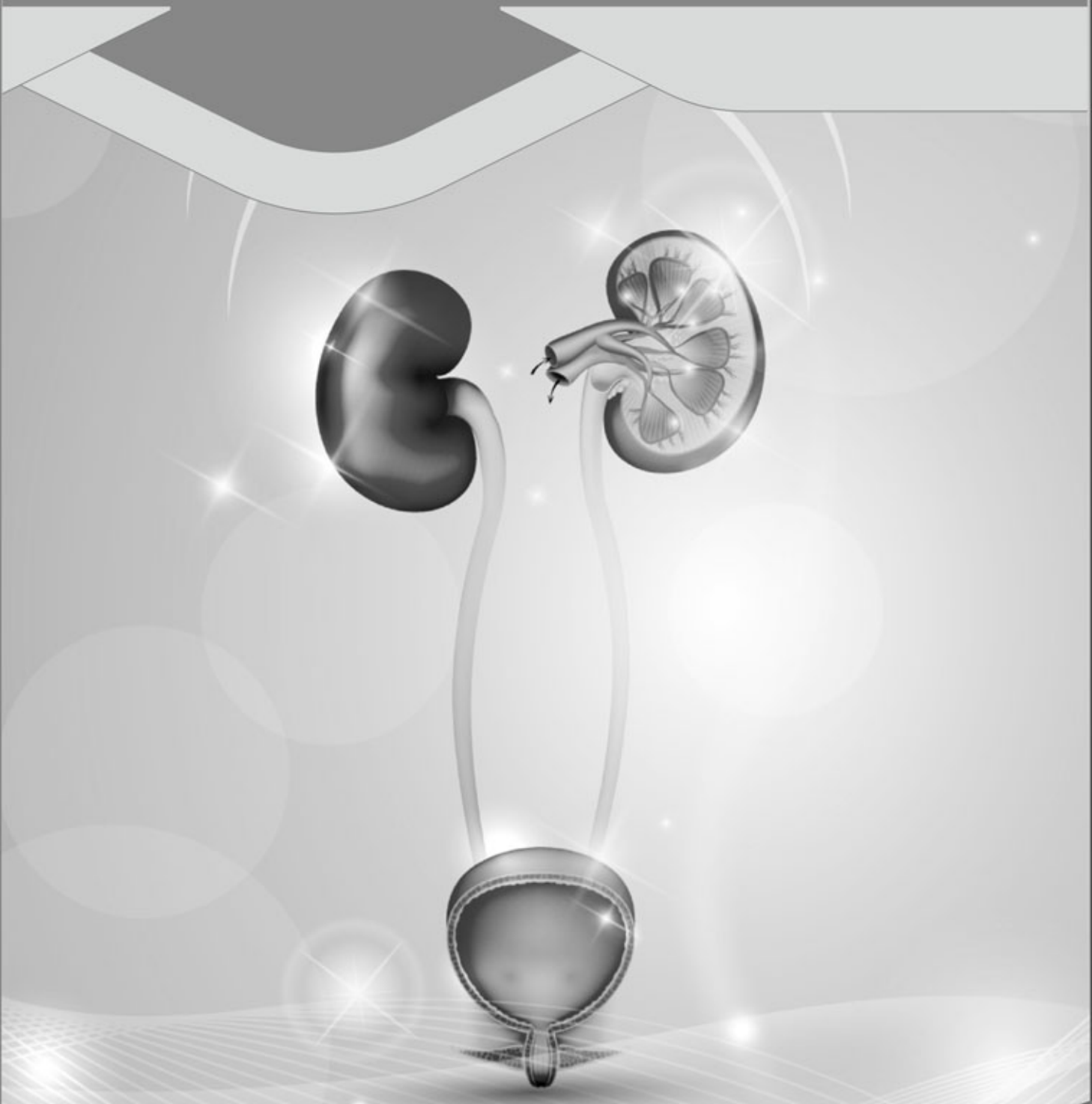
Consultant Nephrologist & Kidney Transplant Physician



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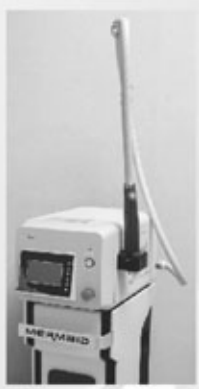


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# THE "TIME OUT" CAPSULE

**Pratik P. Khismatrao**

**Pratik P. Khismatrao**
**Consultant,**
**Practice Management & Promotions**
**One of the pioneers of 'Practice Management' in India**
**Has been associated with various private practitioners as a consultant for over 10 years**

"I want to play golf!" my client in his mid 50s was telling me.

"My brother is an optician. He starts his day with a round of golf…" then came a big sigh. "My day starts with planning for my surgeries and typically ends with worries and plans for the hospital", he continued.

Most of the doctors I meet, express the similar concern –"No time for myself or my family"

"Well, when you say time, do you mean physical time or mental time?" I asked my client who looked confused following my question. "Let me explain. When you say you don't have time, you actually may have enough. But you spend it thinking of your hospital concerns or answering calls from your junior doctors even if you are with your family"

Most of our doctor friends must be sailing in the same boat. You may somehow manage to spend quality time (so called) with your family taking them to the latest movie or amazing destinations in the world, attending annual day of your kids or enjoying frequent dinners at the finest restaurant in the town… and so on!

**Delegate your work**

The big question, here, is what do you want for yourself? Do you have a well thought destination for your practice and most importantly for yourself few years down? When we struggle to steal moments from our busy schedule for our family and for our own interests, it is wise to revisit your schedule. The objective is to optimize your time and refrain spending time in certain activities that probably do not require your involvement.

"I plan my day the previous evening. The schedule is perfectly followed so that I am at peace" a senior orthopaedic surgeon was telling me, "I see a limited number of patients and give quality time to each one of them."

"Sir, can we spare some time from this chair time and add it to the time reserved for yourself and your family?" I politely asked him.

"My patients visit my hospital for me. I can't compromise on my time reserved for them." He refused to cut down on his chair time per patient. I had to demonstrate how effective delegation can help him save his valuable time. When he agreed to make certain changes, we developed a whole new counseling system for his patients wherein a counselor would detail patients about their condition, plan of action and expenses. When you are counseling patients yourself, you will always have a limitation of time. A neutral counselor would be better idea even from patient's perspective as they can discuss in detail and with much openness.

It is not just the chair time, we tend to spend our own physical time on so many activities that can be taken care of by someone who is actually meant and

employed for that. One of my clients, a leading ophthalmologist in interiors of Maharashtra, used to clean his delicate instruments and costlier equipment parts on his own after each OT.

**Identify activities eating up your time**

"We do not get a trained staff here. It's a different story in Mumbai…" he countered my suggestion of deploying this non clinical non surgical task to someone.

"You won't always get a trained staff sir. You need to train your staff for certain things. There are agencies that can take care of such trainings without your involvement."

The need is to identify such activities that are eating out of your precious time and deploy effectively to your subordinates. You can always involve a professional agency for identification of these activities and addressing them properly. And you will be surprised to see the list of such activities… right from proof reading of stationary to finding a proper supplier… from designing of an invitation card to preparation of invitees list… from meetings with a software guy to the discussions on your branding…

**Deploy your activities effectively**

Recently we finalized a new brand look for one of our ophthalmology clients. It took almost eight months and hundred hours of discussion with the client during this period. Involvement of top management and owner is absolutely essential for such activities. But spending almost three hours per meeting discussing finer aspects of branding is not what is necessary. At the same time, leaving it totally to the branding agency also may not be a good idea. We must strike a balance and control the whole exercise to yield desired output.

**Define parameters for effectiveness of your efforts**

One of my cosmetologist clients was complaining about her time being wasted in training the hospital staff and getting them to the level where she wanted them to be.

"I have been training them every day. I have changed the front desk staff at least three times. But what you get every time is same."

"It's not waste of your time madam. It's just that you need to utilize it in a better way."

Changing the staff is not solution to your staffing concerns. What you have in your hands is training them properly. If you can get a professional help for the same, nothing like that. But if you decide to do that on your own, try developing certain performance monitors within the system. Though training is a continuous process, regular trainings without monitoring will not fetch what you are looking for.

This, in fact, stands true for every effort that you make and every moment that you spend for your practice. Well defined indicators would not only give you feedback about effectiveness of your efforts, but they will help you reduce your involvement in such activities with time.

**Enjoy the saved time**

"What do I do with this saved time?"

Well, I am yet to come across a person asking this question, neither have I found many with the answer to this. The answer lies in your efforts itself. Someone may opt to play golf or someone may prefer to see more patients in same time. It could be anything… related or not related to your work… an academic research or study, development of new hospital project… an online exam or specialization… pursuing your hobby or interest… If nothing else, this would at least give you additional peaceful mental time for working on your dreams!

It is your time! It's you who decides to spend it on the things that are in your priority list. Just check once again if you yourself appear topmost in that list. Believe me, the real 'you' in you is worth it!

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# RECOGNISING THE MULTIPLE FACES OF OBSTRUCTIVE SLEEP APNEA IN CLINICAL PRACTICE AND ITS MANAGEMENT

**Dr. S. Ramnathan Iyer**

**Dr. S. Ramnathan Iyer**
**MBBS 1974**
**MD( MEDICINE) 1978**
**Fellow Indian College of Physicians.**
**Fellow Geriatric Society of India.**
**Fellowship Sleep Medicine (ISDA)**
**Practising Consultant Physician & Consultant Sleep Medicine.**
**50 Publications in National and International Journals**
**Awarded several orations for original research contributions in Diabetes, Sleep Medicine, Suggested several hypothesis. (Development and Progression of diabetic retinopathy due to obstructive sleep apnea)**
**Delivered several lectures in India and abroad.**
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**Introduction-**Sleep of good quantity and quality is essential for physical, mental and emotional well being. There are nearly 88 disorders of sleep. Obstructive sleep apnea(OSA) is one of the most important disorder identified in the last 50 years which has several systemic effects. Sleep disordered breathing (SDB) comprises of snoring, upper airway resistance syndrome and sleep apnea. Obstructive sleep apnea is a common disorder but not well recognized in clinical practice. Study In India has revealed the prevalence of SDB as 19.5% while the prevalence of SDB with daytime hypersomnolence as 7.5%.Studies done abroad indicate the prevalence of SDB as 9% for women and 24% for men. OSA can affect all ages. The prevalence increases as the age advances. The prevalence in postmenopausal women is also high.

**Risk Factors for OSA**- These include obesity, narrow upper airway due to anatomical reasons in the face like macroglossia, retruded chin crowded pharynx, advancing age and menopause. Hypotonia of pharyngeal dilator muscles cause pharyngeal closure in sleep. This hypotonia is more marked in REM sleep. Chronic sleep deprivation contributes to pharyngeal hypotonia. Alcohol consumption also promotes hypotonia. **It must be appreciated the OSA affects both obese and non-obese subjects.** OSA is known to run in families. (Family history of type 2 diabetes, hypertension, IHD may also signify underlying OSA.)

**What Happens in OSA?**-In OSA there is repetitive pharyngeal collapse in sleep resulting in cyclical hypoxemia, sympathetic stimulation and cyclical hypertension adversely affecting the functions of several body systems. ( Fig 1 and Flow Chart)

**Symptoms-Nocturnal**

(a) Snoring often loud and habitual. Snoring can be mild in elderly and subjects who sleep prone.

(b) Restless sleep. Constantly changing posture. Requires head elevation with pillows, choking, breathlessness

(c) Jerking and feeling for falling from bed.

(d) Talking, biting teeth and sleep walking

(f) Drooling

(g) Nocturia

(h) Dry throat. Drinking water at night.

(i) Excessive dreams can be seen.

(j) Burning in chest-hyperacidity.

**Daytime Symptoms**

A. Unrefreshed sleep.

B. Headache and /or bodyache on awakening.

C. Daytime sleepiness.( daytime sleepiness can be abolished by consuming tea, coffee and tobacco). Can sleep while driving vehicles and operating machinery. There is a high risk for accidents.

D. Irritable behavior

E. Increased appetite- can exhibit fast eating, binge eating.

F. Increase in body weight.( OSA can lead to obesity) OSA patients find it difficult to lose weight.

**OSA in Women -** OSA in women can present as fatigue, insomnia, headaches, mood disturbances, lack of energy, depressive feelings and mild snoring. Depression is often diagnosed.

Following are the consequences of OSA on various body systems.

1. **Cardiovascular** –

(a) **Hypertension**.OSA is one of the important causes of secondary hypertension.

(b) **Ischemic heart disease**

(c) There is a high prevalence of sleep disordered breathing in patients with **congestive heart failure** (CHF).Studies have revealed that in CHF patients with reduced ejection fraction the prevalence of SDB ranges between 47%-76%

(d) **Cardiac arrhythmias.** ( atrial fibrillation, ventricular tachycardia and others)

(e) **Venous thrombosis** and varicose veins.

2. **Endocrinal** - ***Insulin resistance -which ultimately causes Type 2 Diabetes Mellitus.*** Insulin resistance has several adverse effects on the body systems. In clinical practice the following needs attention.

a. **Elevated Fasting blood glucose levels** with normal post lunch blood glucose levels.( A post glucose blood glucose (82.5 gms of commercial glucose) level is often high in these cases signifying impaired glucose tolerance)

b. **Fatty Liver.**

c. **Puffy and tired face** can be confused with hypothyroidism. OSA and hypothyroidism can co-exist. It is to be noted TSH levels may be high in patients with poor sleep. Administration of thyroxine in untreated OSA can precipitate cardiac arrhythmias.

d. **Polycystic Ovary Syndrome** is commonly associated with SDB-OSA.

e. **Erectile dysfunction** possibly due to REM Sleep deprivation.

f. **Obesity:** Obesity is both a consequence and a risk factor of OSA. Children suffering from OSA can become obese with poor academic performance.

3. **Gastrointestinal** – Fatty liver, Gastro-esophageal reflux disorder.

4. **Respiratory**- Nocturnal aspirations can occur at the termination of apnea leading to respiratory complications- viz bronchial asthma. In fact, OSA should be suspected in all asthmatic patients.

5. **Psychiatric** -Mood swings, depression, insomnia, Bipolar affective disorder, paranoid psychosis and acute delirium have been reported.

6. **Hematological** - Unexplained polycythemia.

7. **Neurological** - Cerebrovascular accidents. Sleep disordered breathing and CVA have a bidirectional relationship. Management of SDB in CVA gives rewarding results. Loss of memory and reversible dementias are the other consequences. OSA has been reported to worsen neurological disorders like Parkinsonism.

8. **Pregnancy-** SDB in pregnancy can lead hypertension, preeclampsia resulting in intrauterine growth retardation .

9. **Ophthalmic**- OSA has been associated with several eye disorders viz floppy eyelid syndrome, anterior ischemic optic neuropathy, optic neuropathy, glaucoma, papilloedema, For the first time in 2003, the author had proposed- that, since retina is highest oxygen consuming part of the body cyclical hypoxia in OSA can lead to angiogenesis in patients with diabetic retinopathy. Several workers have confirmed this hypothesis. Diabetic patients often have sleep complaints. It is advisable to suspect OSA in all diabetic patients. Correction of cyclical hypoxia in OSA by continuous positive airway pressure (CPAP) is expected to give good results.

10. **Cancer**-Recent reports suggest an intriguing link between SDB and cancer.

In clinical practice it is necessary to record sleep history which can guide the physician to suspect a sleep disorder.*(There are nearly 88 disorders of sleep)*.If required, a polysomnogram may be done. Polysomnography (PSG) is the gold standard test for diagnosing OSA. The test is best done in a hospital under

supervision. (Level 1 study). Once diagnosed a second night PSG of CPAP titration is essential.

**Management** Management of OSA mainly rests mainly on the usage of Continuous Positive Airway Pressure(CPAP). Recently several advances have been made on the mask and CPAP unit which have made them more user friendly. Several workers have demonstrated the efficacy of CPAP in treating OSA. Also there is improvements in the associated diseases like diabetes, hypertension, IHD and others. CPAP improves insulin sensitivity and therefore the doses of anti-diabetic drugs, also reduce.

**Conclusions**: It is important to recognize OSA in a given clinical setting .The consequences of OSA are the guiding forces to identify OSA since treatment of OSA is highly rewarding in terms of , not only treating the sleep disorder but giving significant beneficial effects to body systems.

**Acknowledgements**- Dr.Revati R Iyer, Dr.Bhagyalaxmi Venkatraman

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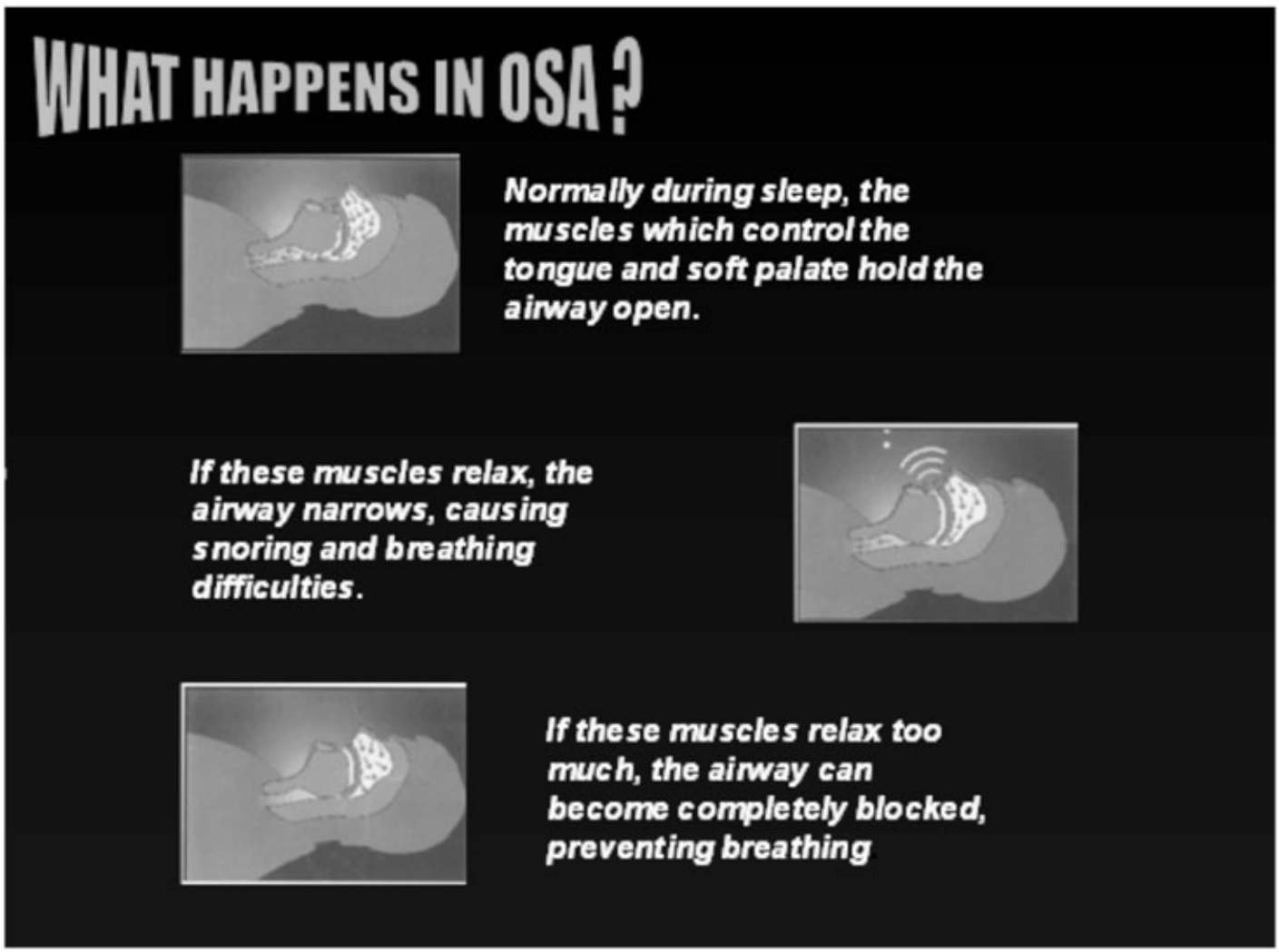

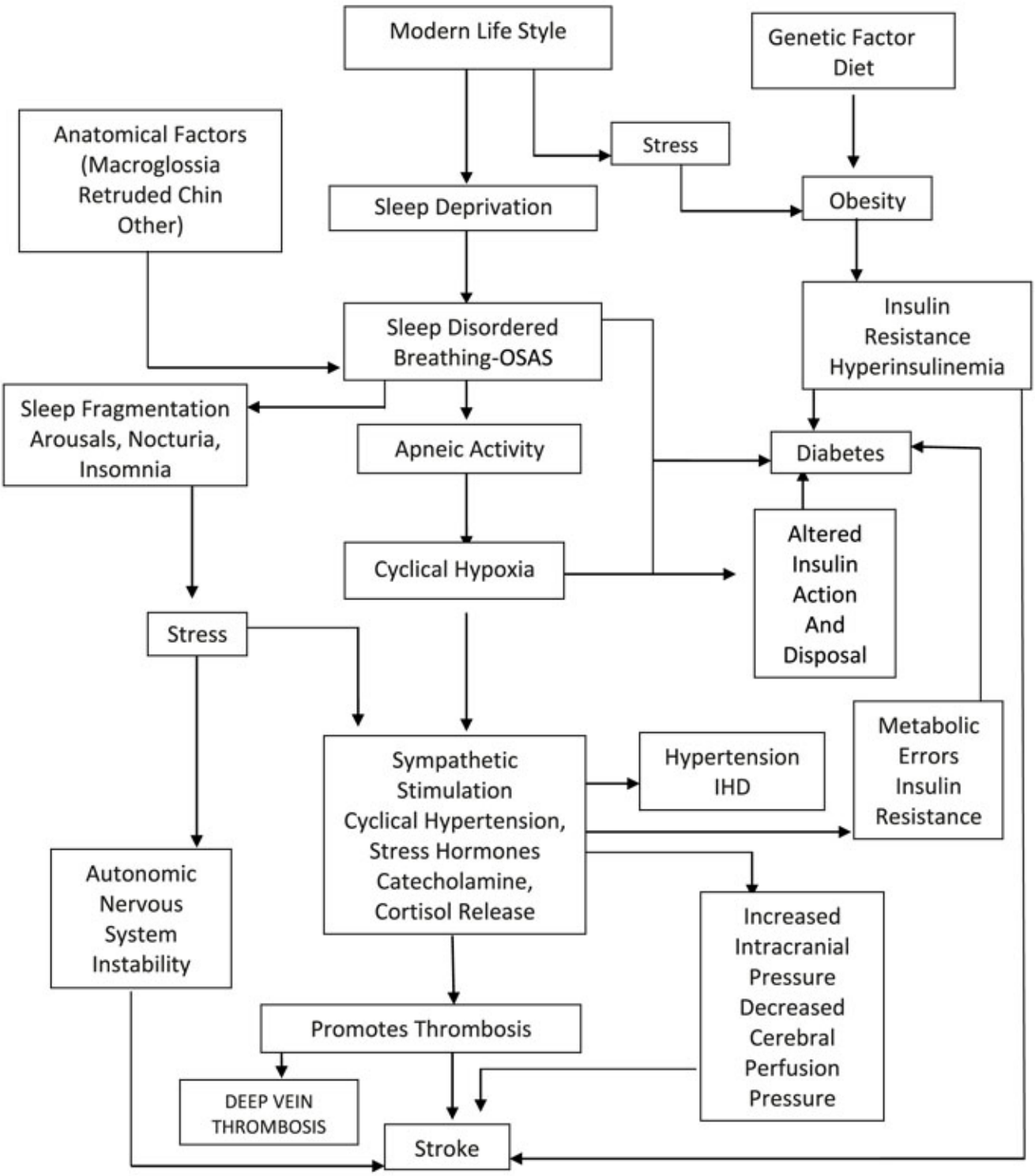


**Flow Chart**
Highlighting the Path Taken by Nocturnal Events in Sleep Disordered Breathing OSA Culminating in Cardiovascular,Metabolic Consequences and Stroke.

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# दोन लघुकथा

डॉ. अमर पोवार

**व्यवसायाने मी भूलतज्ञ. वैद्यकीय व्यवसाय म्हणजे रोजच नवीन आव्हाने पेलणे. एकंदरीतच आयुष्य म्हणजे नवीन आव्हानांचा सामना रोज करणे असे माझे मत. कलासाधना हा मनावरील ताण दूर करणारा हमखास उपाय आहे. त्यामुळे कथा, कविता आणि साहित्यात रमणे मला आवडते.**

**त्यातलाच हा एक प्रयत्न तुमच्यासमोर मांडला आहे.**

## कांता आणि ट्रेन

अरं, असं काय करतोस ? पाचशे रुपयांचा हेअर ब्रश होता तो. ब्राण्डेड. फुटकळ तीन पस्तीस रुपयांचा नव्हे. आणि अजून फाइव मिनिट्स आहेत ट्रेन सटायला. तू पटकन आण शोधून बरं... तोपर्यंत मी सीटवर बसते चिऊला घेऊन. जा धाव कांता.

कांता म्हटलं की चंद्रकांत विरघळतो हे स्नेहाला चांगलंच ठाऊक होतं. चंदू उतरला. कुठं बरं पडला असेल या भवानीचा हेअर ब्रश. नाही मिळाला तर दोन दोन महिने बोलून दाखवेल. शेवटच्या डब्यापर्यंतर तरी चिऊच्या हातातच पाहिला होता अरे यार...

स्वतःशीच बोलत बोलत चंदू शेवटच्या डब्यापर्यंत पोचला. एक एख चाक, अख्खा रुळ शोधत शोधत तो ट्रेनच्या मागे पोचला.

सोनेही काहीतरी चमकलं.

हो, तिथंच, शेवटच्या बोगीच्या मागच्या चाकाखाली. एक क्षण त्याच्या डोळ्यांवर त्याचा विश्वास बसला नाही. बायकोचा हेअर ब्रश.

त्यावर चमकणारं Spronette चं सोनेरी लेबल. त्याने हात पुढे करुन तो उचलला. दोन क्षण उभा राहिला. हुश्श. आत्ता स्नेहाची कटकट मिटली.

भोंगा वाजला. ट्रेन सुटली. चंदू भानावर आला. काहीच न सुचून जिवाच्या आकांताने धावत सुटला तो. ट्रेन पुढे. चंदू मागे. सातवा डबा. सहावा. या दोघी दुसऱ्या डब्यात. अचानक ट्रेनचा वंग वाढला. चंदू मागे पडला. जोर लावून पुन्हा वेगाने धावू लागला. चिऊ टाळ्या पीटू लागली...

'बाबा मागे राहिला,

बाबा मागे राहिला!!'

चंदूच्या कानात धडधड धडधड असे आवाज यायला लागले. तो मटकन खाली बसला. पुन्हा उठला. डोक्यात एक आयडीया फ्लॅश झाली. सात मिटर उलट दिशेने धावून एका खांबाशी उभा राहिला.

आणि गोलाकार वळून त्याच्याच दिशेने येणार या गार्डन फेमस टॉन-ट्रेन मध्ये दुसऱ्या डब्यात चंदूने उडी मारली.

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## दोन शेंडीवालं कासव आणि लाल डोळ्यांचा ससा

सशा, आता तू झोप. मला शर्यत जिंकायची आहे. टबात बसलेलं झोपाळू कासव म्हणालं.

'पण तू कासव आणि मी ससा का ? माझे डोळे काही लाल नाहीत.'

अरे!!

कासव नेहमी जिंकतं ना, म्हणून मी कासव.

एक हात कमरेवर ठेवून, दुसरा हात यांना काही समजतच नाही छाप अभिनय करत कासव उत्तरलं.

मग ठरल्याप्रमाणे ससा झोपतो. कासव डोळ्यांच्या कोपऱ्यातून बघत बघत दात घासायची शर्यत पूर्ण करतं. मध्येच ससा डोळे किलकिले करुन पाहतो, तर त्याला डोळे मोठे करुन रागावण्यात येतं.

मग कारंज्यांच्या, शॉवरच्या आणि पाईपने आंघोळ करण्याच्या गमतीजमती सांगत कासवाची आंघोळ आटपते. शेवटीशेवटी तर्जनी सशाच्या डोळ्यासमोर दाखवत दम दिला जातो. तुला माहितीय आता सगळीकडे पाणी कमी असणार, आपण पाणी वाया नाही घालवायचं. ससा मान डोलावतो.

मऊ मऊ टॉवेल गुंडाळून, घरभर फिरताना. कपडे करुन आईच्या मांडीवर घास खाताना आणि केस विंचरुन घेतानाही बोलणं चालच असतं. मला एक पोनी नको दोन बांध. मग मी गोड गोड माऊ दिसेन.

शेवटी सगळं आवरतं, आईला सूचना देत देत बॅग भरली जाते. आणि बाईकवर बसताना आईला निरोप दिला जातो.

मग बाईकवर गाणी! तीनच मिनीटाच्या प्रवासात आमची सहा गाणी म्हणून होतात, मध्येच एखादी ओळ स्वतःची घुसडूनबिसडून.

शाळेची व्हॅन येते. शहाणं कासव बॅग पाठीला घेऊन चटकन चढतं. मागे वळून बाय म्हणतं. बॅग ठेवता ठेवता मध्येच काही आठवतं.

एक पाऊल मागे येत, गळ्यात पडतं सशाच्या आणि गालावर एक गोडं पापा देतं.

आता मात्र लाल झालेले सशाचे डोळे पाण्याने भरतात.

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# AAO GAON CHALEIN

**Dr. Ghanashyam Shirali**

**PROJECT CHAIRMAN**

**Dr Ghanashyam Shirali completed post graduation from LTMMC, Sion and then worked as Fulltime Lecturer & Asssociate Professor for 10 years in same college. Practicing ENT Surgery in Dombivli for last 24 years. President of Association of Otolaryngologists of India (AOI), Kalyan branch (2015-17) Has Passion for community service, active Rotarian since 2004**

**Dr. Raju Gite**
**Co-Chairperson,**
**Aao Gaon Chale Committee**

**"Aao Gaon Chalen"** was introduced before the Central Working Committee of IMA in , 2004. Was formally launched on 8th August, 2004 at Village Lakhvad in Mehsana District, Gujarat.

**"Aao Gaon Chalen"** Project is a challenge taken up by Indian Medical Association under Public Private Partnership Programme with an objective to contribute its bit in whatever way possible to compliment the efforts taken up by the Ministry of Health & Family Welfare, Government of India for improving the health care delivery system in the rural scenario of India.

IMA Dombivli had adopted one village near Hajimalang in 2006 under Presidentship of Dr Adwait Padhye. Bimonthly 6 camps were held in that year.

Dr Hemraj Ingale, President IMA 2016-17 has taken up this ambitious Rural Health Project (RHP) under Aao Gaon Chale. The area in the outskirts of Kalyan Dombivli Municipal Corporation was surveyed. The rural area along Murbad road beyond Titwala was selected. This project is coordinated through a local NGO 'Hindu Seva Sangh'.

The project consists of mainly villages selected are as follows to provide diagnostic facilities and to make people aware (diagnose) of their ailment, treat wherever possible. A team of doctors consisting of Family Physicians and different specialties visit the designated camp site and examine the patients. Various Following investigations are also carried out.

Haemoglobin % in all ladies above 15 years of age

Blood Sugar for all patients above age 40 years

ECG for all above the age of 50 years

Refraction for all having vision problem

Bone Marrow Density (BMD) as indicated.

Free Medicines are distributed. Medicines are provided by Pharma companies and generic medicines by Dombivli Chemists Association.

Patients requiring surgical treatment will be operated free of cost or at concessional rates in Dombivli in Shastinagar Hospital or Other charitable institutes. Help of other NGOs like Rotary will also be saught.

We have completed 3 camps so far under RHP

First camp was held at village Mamnoli where 27 doctors, 12 Medical Representatives and 2 technicians visited. Village Mammoli comes under Z.P. Thane, Panchayat Samiti, Kalyan outside KDMC. Village Belpada : Z.P. Thane, Panchayat Samiti, Murbad, Village Mhasale : Z.P. Thane, Panchayat Samiti, Murbad.

Second camp was held at Masale village where 16 doctors, 9 Medical representatives and 5 technicians visited

Third camp was held at Mhaskal village where 20 doctors, 15 Medical representatives and 2 technicians visited.

| Camp Site | Member Participation | No.of Patients | ECGs Total/Abnrmal | Hb Test Total/Anaemic | Blood Sugar Total/Diabetics | Eye Catrcts/Refrct |
|---|---|---|---|---|---|---|
| Mamnoli 15/05/16 | 27 | 127 | 18/01 | 49/27 | 72/07 | 12/22 |
| Mhasale 19/06/16 | 16 | 259 | 72/10 | 58/ | 68/ 14 | 30/20 |
| Mhasakal 28/08/16 | 20 | 323 | 55/17 | 73/27 | 134/19 | 18/28 |

Some other ailments detected in these camps were Uterine prolapsed Inguinal Hernia, Otitis Media, Corneal opacities, Pterigyum. Many Hypertensives were detected for the first time.

The increasing number of patients shows the popularity of this project.

Surgical treatment will be planned after monsoon (farming season).

**Acknowledgements**

Credit of the success of first three camps goes mainly to our Members who are whole heartedly supporting this activity.

Medical representatives are mainstay of RHP. They voluntarily attend the camp, work enthusiastically and help in registration , blood testing , medicine distribution and overall coordination. They also provide with medicines.

Dombivli Chemist's Association provides few generic medicines.

Pharma companies provide medicines and also arrange for Blood Sugar test, ECG, Haemoglobin, Bone marrow Density (BMD) tests

Local Social workers, Gramsevaks, Sarpanch and Grampanchayat members help in advertising about the camp by distributing leaflets, provide for place to hold the camp and also provide beakfast and lunch to all more than 40 participants.

Thanks to Dr Krishnakumar for providing 3 months course of Iron + Folic acid tablets to all patients diagnosed of anaemia in previous 2 camps

Last but not the least , thanks to our main coordinator locally Mr Kaka Jage of Hindu Seva Sangh who helps in overall local management.

**Appeal**

**We appeal to all our members to join this community service activity in large numbers. Those who cannot attend physically can contribute by way of sponsoring other camp related activities which come at a cost. (e.g. spectacle distribution). For details contact President or Project Chairs.**

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# IMA MAHARASHTRA STATE : 2ND STATE EXECUTIVE MEETING (S.E.M)

**Dr. Mangesh Pate**

**Dr. Mangesh Pate**
**Central and State representative of IMA Dombivli branch.**
**He is also the treasurer of IMA, HBI and is immediate past IMAPresident of Dombivli branch.**

2nd State Executive Meeting of IMA MS for the year 2015-2016 was held on Sunday 21st August 2016 at Jalgaon.

The SEM was attended by President of IMA Dombivli branch Dr. Hemraj Ingale, Vice President of IMA Dombivli & IMA MS WW Chairperson Dr. Archana Pate, President-elect for IMA Dombivli Dr. Niti Upasani, Dombivli Branch state representatives, Dr. Anand Hardikar and Dr. Mangesh Pate, IMAHBI.

Dr. Arjun Bhangale, President IMA Jalgaon, started the SEM by welcome speech. IMA MS Vice-President Dr. Anil Patil lost his father just previous day. Homage was paid to him in the beginning.

Dr. Jayesh Lele, President IMA MS started the meeting by welcome note.

Minutes of 1st SEM held on 24.01.2016 at IMA Mumbai west were confirmed.

IMA MS office report was submitted by Hon. Secretary of IMA MS Dr Sanghavi.

Status of MMC Election was informed & discussed. Dr. Jayesh Lele informed the court proceedings about the same. The timely efforts were taken by IMA MS which was detailed by Dr.Lele. It was uniform response of the house to resist the vested interests from sabotising the statutary body.

Sub-committee Chairpersons submitted their respective reports; the detailed subcommittee report shall be published in MAHIMA. Social SecuritySchemes, AMS & CGP working, and HBI working was discussed in details by respective committee members.

Dr. Anand Hardikar presented serious concerns about fire issue faced all over.

Dr.Archana Pate from our own branch, presented IMA MS women's wing report as Chairperson of IMA MS Women Doctors' Wing. She detailed the house about State Conference 'Evecon' being hosted by our branch.

President Dr. Hemraj Ingale invited everyone for the Evecon as a host branch President.

Meeting ended with announcements for Mastacon 2016 which will be held at Baramati.

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# DIET MYTHS

**Mrs. Rochita Date Gondhalekar**

**Mrs. Rochita Date Gondhalekar**
**CLINICAL NUTRITIONIST, MUMBAI**

**" YOU ARE WHAT YOU EAT" a young enthusiast with this belief finds her way to help the society be healthy and fit.**
**Completed her bachelors in Food science and Nutrition from SNDT university, Mumbai followed by PG in clinical nutrition from University of Roehampton, London (UK).**
**A member of INDIAN DIETETIC ASSOCIATION, MUMBAI for last 4 years.**
**She has bagged various awards for her clinical research's in the field of nutrition and food since graduation. Has 4 published research articles in international journals. Has experience of working as Junior Dietician with Tata memorial hospital and LTMG sion hospital. currently established her own venture named "DIET DIVA" through which she undertakes workshops on healthy lifestyle and nutrition, A part of ongoing research on PCOS with fellow dieticians and consults various patients with specific disorders. Her interests are diet in pregnancy, childhood obesity and Geriatric nutrition.**

**9833548229**

- **MYTH: Fad diets will help me lose weight and keep it off.**

  **FACT :** Fad diets may be unhealthy. They may not provide all of the nutrients your body needs. Also, losing more than 3 pounds a week after the first few weeks may increase your chances of developing gallstones (solid matter in the gallbladder that can cause pain).

  **TIP:** Research suggests that safe weight loss involves combining a reduced-calorie diet with physical activity to lose ½ to 2 pounds a week (after the first few weeks of weight loss). Make healthy food choices. Eat small portions. Build exercise into your daily life. Combined, these habits may be a healthy way to lose weight and keep it off. These habits may also lower your chances of developing heart disease, high blood pressure, and type 2 diabetes.

- **Myth: "Low-fat" or "fat-free" means no calories.**

  **Fact:** A serving of low-fat or fat-free food may be lower in calories than a serving of the full-fat product. But many processed low-fat or fat-free foods have just as many calories as the full-fat versions of the same foods—or even more calories. These foods may contain added flour, salt, starch, or sugar to improve flavour and texture after fat is removed. These items add calories.

  **TIP:** Read the Nutrition Facts label on a food package to find out how many calories are in a serving. Check the serving size, too—it may be less than you are used to eating.

- **Myth: If I skip meals, I can lose weight.**

  **Fact:** Skipping meals may make you feel hungrier and lead you to eat more than you normally would at your next meal. In particular, studies show a link between skipping breakfast and obesity. People who skip breakfast tend to be heavier than people who eat a healthy breakfast.

  **TIP:** Choose meals and snacks that include a variety of healthy foods. Try these examples:

  1. For a quick breakfast, make oatmeal with low-fat milk, topped with fresh berries. Or eat a slice of whole-wheat toast with fruit spread.
  2. Pack a healthy lunch each night, so you won't be tempted to rush out of the house in the morning without one.
  3. For healthy nibbles, pack a small low-fat yogurt, a couple of whole-wheat crackers with peanut butter, or veggies with hummus.

- **Myth: Fast foods are always an unhealthy choice. You should not eat them when dieting.**

  **Fact:** Many fast foods are unhealthy and may affect weight gain. However, if you do eat fast food, choose menu options with care. Both at home and away, choose healthy foods that are nutrient rich, low in calories, and small in portion size.

  **TIP:** To choose healthy, low-calorie options, check the nutrition facts.

These are often offered on the menu or on restaurant websites. And know that the nutrition facts often do not include sauces and extras. Try these tips:

1. Avoid "value" combo meals, which tend to have more calories than you need in one meal.
2. Choose fresh fruit items or nonfat yogurt for dessert.
3. Limit your use of toppings that are high in fat and calories, such as bacon, cheese, regular mayonnaise, salad dressings, and tartar sauce.
4. Pick steamed or baked items over fried ones.
5. Sip on water or fat-free milk instead of soda.

- **Myth: Eating meat is bad for my health and makes it harder to lose weight.**

  **Fact:** Eating lean meat in small amounts can be part of a healthy plan to lose weight. Chicken, fish, pork, and red meat contain some cholesterol and saturated fat. But they also contain healthy nutrients like iron, protein, and zinc.

  **TIP:** Choose cuts of meat that are lower in fat, and trim off all the fat you can see. Meats that are lower in fat include chicken breast, Fish meat, Red meat with bone. Also, watch portion size. Try to eat meat or poultry in small portions. Avoid coconut based gravies, consume 2-3 meat pieces instead of Gravies.

- **Myth: Dark bread is always better than white.**

  If a loaf of bread is darker, it doesn't necessarily mean it's made with whole grains — it could simply contain caramel colouring or a little extra whole wheat — and be no healthier than white bread. Look for the words "whole grain" or "100% whole wheat" on the package, and make sure the first ingredient listed is: whole wheat, oats, whole rye, whole-grain corn, barley, quinoa, buckwheat, or brown rice.

- **Myth: 100% fruit juice is best for you.**

  It counts as a serving of produce, but ideally, you should opt for whole fruit over a glass of juice. A glass of juice has more calories than a piece of fruit and lacks fill-you- up fibre. Because whole piece of fruit provides vitamins and fibre it tends to curb your intake of other food.

- **Myth : Eliminate Fat From The Diet.**

  Eliminating fat from the diet during weight loss is not advisable and, on the contrary, can also be dangerous. Fats are essential for energy and for the transportation of fat-soluble vitamins like Vitamin A, D, E and K. Certain fatty acids are needed to manufacture certain hormones. You can also read more about vitamins here. Minimize the consumption of fat, if you want to lose weight. Prefer healthy fats like olive oil, fish, nuts and flax seed oils. Cut down on unhealthy fats like saturated fats in full-fat dairy, red meat, butter, Trans fats found in processed foods. Healthy fats inhibit the production of certain enzymes that are needed for fat production and slow down the fat storage.

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## FEW OTHER DIETARY MYTHS

### GREEN TEA

**MYTH 1: YOU LOSE WEIGHT FAST WHEN YOU DRINK GREEN TEA**

**FACTS**

- Replacing extra cups of tea/coffee/aerated sugary drinks with green tea helps in cutting down those empty calories and hence helps in managing ones weight.
- Losing weight is a combined effect of regular exercise and eating balanced diet with proper sleep and enough water intake so drinking green tea alone doesn't help.

Fitho

### CINNAMON WATER

**MYTH: IT HELPS IN WEIGHT LOSS**

**FACTS**

- Several studies have shown effects of cinnamon in controlling elevated blood glucose levels.
- It helps in improving insulin resistance which is beneficial in type 2 diabetes
- It has no compounds that burn fat
- It is very effective for indigestion, nausea, vomiting, upset stomach, diarrhea and flatulence.
- It is diuretic in nature and helps in secretion and discharge of urine.

Fitho

# NUTS AND SEEDS - POWER PACK MEGA JEWELS

**Manjusha Seludkar**

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Over the years & even today, nuts & dry fruits have been considered to be consumed mostly at the time of festivals & on rare occasions. Even it as an expensive purchase, although let's not overlook at the benefits & nutritional value that nuts have to offer. Let's understand how effective are a handful of nuts consumption for the human body.

Coconuts are the world's leading nut crop, followed by peanuts, which are actually legumes but often classified and consumed as nuts. Nuts are emerging as nutritional super stars as scientists continue to find positive health benefits by consuming them.

**Nutritional values:**

Most nuts are rich source of vitamins, especially folate, B vitamins, E vitamins, minerals such as iron, calcium, selenium, magnesium, manganese, phosphorus, zinc & potassium, fiber, essential fatty acids, plant compounds such as flavonoids and plant sterols.

Certain nuts are higher in certain nutrients. A half cup serving of almonds, peanuts, pine nuts, pistachios or sunflower seeds for instance, provides more than 500mg of potassium.

One serving (30mg) of almonds provides almost 50% of the recommended dietary allowance (RDA) of vitamin E. Nuts & seeds are one of the best food sources of vitamin E, an important antioxidant that enhances the immune system, protects cell membranes and helps make red blood cells. Pumpkin, sesame seeds and flax seeds are good source of iron. A cup of almonds has 400mg of calcium more than is found in a cup of milk. Brazil nuts are high in antioxidant selenium. Walnuts are especially rich in ellagic acid, an antioxidant that may inhibit the growth of cancer cells. Walnuts are also rich in omega-3.

Hazel nuts are rich in vitamin E, fiber, copper and potassium. Sunflower seeds are rich in selenium, copper, fiber, iron, zinc, folate and vitamin B6.

Most nuts provide good amount of protein. With the exception of peanuts, however, they lack lysine, an essential amino acid necessary to make a complete protein. This amino acid can easily be obtained by combining nuts with legumes. Nuts can provide a good source of protein in a vegetarian diet. Nuts and seeds are a good source of dietary fiber.

Researchers have been looking at the health benefits of nuts, including their cholesterol lowering effects, their association with a lower risk of stroke and weight management. Their healthy qualities may be attributed to their fatty acid profile along with their protein, fiber, vitamin E and magnesium content. Nuts also contain plant sterols that can lower cholesterol and may offer sum protection against cancer. A regular intake of nuts protect against heart disease.

**THE ISSUE OF FATS:**

Nuts have two major drawbacks; they are high in calories and fats. But with

exception of coconuts and palm nuts, their fat is mostly mono or polyunsaturated. These are considered heart friendly fats, especially when they replace saturated fats. That is why nuts should be consumed in moderation. Nuts and seeds contain about 700-850 calories per cup. Never use/consume nuts that are moldy or have an off taste, molds, especially of peanuts, those are aflatoxins substances which may cause liver cancer. Refrigerate or freeze shelled nuts, or their oil quickly turns rancid.

Sum nuts especially peanuts provoke allergic reactions in many people. Symptoms range from a tingling sensation in the mouth to hives and in extreme cases to anaphylaxis, a life threatening emergency. But because the different varieties are not closely related, a person who is allergic to walnuts, may not be allergic to other type of nuts or seeds.

Let us modify the monotonous saying, to, 'A handful of nuts can keep a doctor away'.

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|---|---|---|
| **Nuts ans Oil Seeds** | **15gms** | **gives 100 K Cal** |
| **Sesame Seeds** | **15gms** | **2½ tbsp** |
| **Flax Seeds** | **15gms** | **3 tbsp** |
| **Ground Nuts** | **15gms** | **1 tbsp** |
| **Godambi** | **15gms** | **1 1/3 tbsp** |
| **Cashew Nuts** | **15gms** | **10 pieces** |
| **Walnuts** | **15gms** | **3½ Walnuts - 7 pieces** |
| **Almonds** | **15gms** | **9 pieces** |

सत्व
THE NUTRITION CENTER

# Manjusha R. Seludkar

Diet Counsellor

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**Dietician for Weight Management**
**Diabetic Cardiology Nephrology**
**Clinical Disorders**

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