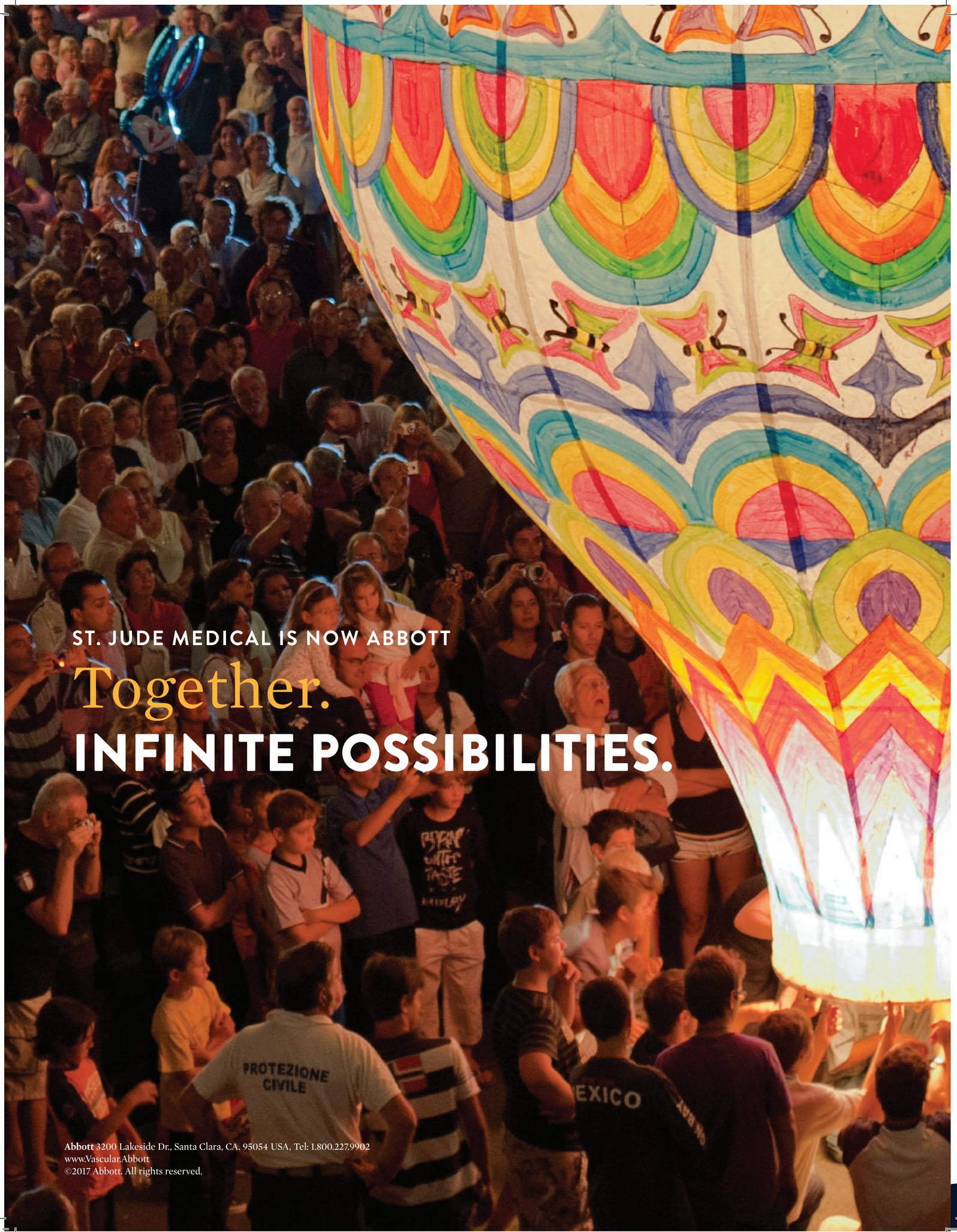
AAPI Journal

American Association of Physicians of Indian Origin

Fall 2017

www.aapiusa.org



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EDITOR'S REPORT

Ravi Jahagirdar, MD
Editor, AAPI Journal

It is an honor to be part of this team at the AAPI Publication Committee. They have spent time, energy and goodwill to glean through extensive material for this issue, and are presenting a collection for your review and enjoyment.

The response for this Journal was beyond our expectations. We look forward to enhancing this intellectual endeavor .

I am proud to introduce the Members of the Committee who have made this a reality in record time.

Dr. Ravi Nathan, M.D. .. has edited this Journal for more than 9 years, and is a Cardiologist living near Tampa Florida. His experience has been of immense value in this production.

Dr. Radhu Agrawal, M.D., is a GI Faculty in University of Pittsburgh. He is always at the forefront of Academic Philanthrophic and Socio-Cultural activities and is a great mentor and guide in Journal and editing matters..

Dr. Beejadi Mukunda, M.D. is an Internist from Cleveland, and is actively involved in the Journal affairs at the University and at the Cleveland Clinic. He has been the Local Chapter President, and is part of the blossoming younger generation in AAPI.
Dr Tarang Sharma M.D. is an alumnus of Maulana Azad Medical College, New Delhi, India. She currently practices as an endocrinologist in Dublin, OH. She is the editor for AAPICO Pages, the online newsletter of AAPI-Central Ohio, and also edits the online magazine of MAMCOAANA, her alumni association in the United States.

Dr. Nirupama Madduri, M.D. is in Houston, and has a flair and an eternal desire for reviewing as many articles as can be offered. She has a long term experience in this field, and her mentor is Dr. Sivakumar Madduri who we know from past Journals.

Dr. Ravi Jahagirdar, M.D., is the Past President of AAPI, and brings the experience of reaching out to this talented team to achieve the best for our organization.

We admire the enthusiasm with which the authors have contributed 21 articles, 7 poems and 6 reports. Some editing was unavoidable, but we have made all efforts to retain the originality. A few are on hold for logistical reasons, but will be available on the E - Journal plans on the AAPI Website. The bibliographies will also be available in their entirety on the website.

AAPI Journal will transition to an exciting continuous mode of submission for articles. This will enable all contributors to send in articles and poems all year round, and minimizes the avoidable pressures of deadlines. Further details will be sent by the AAPI President in his newsletter when this feature is available.

I thank all the sponsors with whose support this issue was possible, and to Dr. Gautam Samadder M.D., our AAPI President for his confidence in me. Last of all, thanks to AAPI Office and Ms. Vijaya Kodali for her sacrificing many hours - mostly off duty- in this effort, and to Ms. Arpita Chedda for her creativity in designing the layout of this product.

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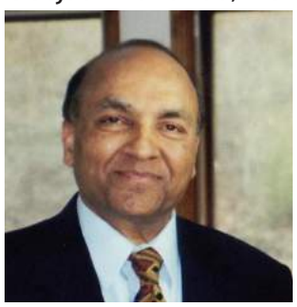

Radhu Agrawal, MD

Ravi Nathan, MD

Tarang Sharma, MD

PRESIDENT'S MESSAGE

Gautam Samadder, MD
President, AAPI

As physicians of Indian origin, garner critical positions in the healthcare, academic, research and administrative positions across our nation, we have built a visible network of dedication and compassion in the US healthcare delivery system.

Our dynamic Executive Committee and I are proud to be part of this noble community and consider it an honor to lead this respected organization, which represents over 100,000 physicians of Indian origin in the United States. The past few months have been very enriching for me to serve as President of AAPI and have had the unique opportunity to meet, interact, learn and share in the development of initiatives under the current leadership.

"The past few months have been very enriching for me to serve as President of AAPI and have had the unique opportunity to meet, interact, learn and share in the development of initiatives under the current leadership."

At the start of August, we embarked on an enriching adventure to the exciting destinations of South Africa, Zimbabwe and Botswana, strengthening our common bonds of friendship and respect during our travels.

On August 19th, following the tour of the African continent, AAPI organized an outstanding Leadership Conference & Luncheon, which included renowned speakers, on the topics of Learn Team Building Skills; How to Succeed as an Entrepreneur; and, Why Giving Back to your Community Helps You as a Leader. It was followed by a press conference, at the Indian Consulate in New York, with AAPI members from around the nation, media leaders and representatives from the tri-state region. I highlighted the significant role of Indian-American physicians in the growth and stability of America's healthcare landscape. I am honored to share with you, Consul General Sandeep Chakravorty's words, "You have excelled in your fields of medicine, and thus make significant contributions through hard work, commitment and dedication to your profession and the people you are committed to serve."

Consul General Chakravorty spoke extensively about the growing health sector, particularly the pharmaceutic industry in India. He lauded the efforts of AAPI, particularly for the free clinics across India, and the new clinic, to be inaugurated in West Bengal. He conveyed his greetings and best wishes to AAPI leaders for the success of the 11th Annual, Global Healthcare Summit in Kolkata from December 28th – 30th, 2017, the pre-summit tour and CMEs in Dubai as well as to the post summit tour to Assam.

At the summit, AAPI will lead and facilitate collaboration with leading experts of India origin from all over the globe, exchanging best practices, knowledge, and experiences to develop sustainable, actionable programs, skills development and training that enhance capability and enable access to affordable and quality healthcare.

On August 20th, AAPI joined the Federation of Indians in New York City and the India Day Parade with a multi-color float spreading the message of health and wellness. AAPI delegates from across the US joined the parade as well as the meet and greet on the following day, with Grand Marshal Rana Daggubati, in Edison, NJ.

While one part of our nation celebrated our growth and expansion, our hearts reach out to those affected by the devastation caused by Hurricanes Harvey and Irma. For the past two months, AAPI has been at the forefront to raise funds to support and help people affected by the unprecedented damage from the storms. Along with the AAPI Charitable Foundation, Board of Trustee and Executive committee, I would like to thank all those who have helped raise the $ 50,000 and those who continue to support this worthy cause.

Talat Aziz, the popular playback singer of Indian cinema, composer, and actor, from Hyderabad, India, is bringing a storm of a different kind, on his nine-city musical tour of the US. The proceeds from the tour will be donated to both Leukemia & Lymphoma society and AAPI Hurricane Relief Fund. The tour met great success in San Antonio, TX on October 6th. Aziz, the great Ghazal Maestro is scheduled to perform on Wednesday, Oct. 11 2017 in Fresno, CA; Friday, October 13th in Huntsville, AL, Saturday, October 14th in Houston, TX; Sunday, October 15th in Augusta, GA; Friday, October 20th in Columbus, OH; Saturday, October 21st in Chicago, IL; Sunday, October 22nd in St. Louis, MO; Friday, October 27th in South Jersey, NJ; and Saturday, October 28th in Atlanta, GA.

I encourage you all to join us for all the activities throughout the year including the 2017 Global Summit in Kolkata, India and our 2018 annual convention in Columbus, Ohio.

CHAIR BOT MESSAGE

Ashok Jain, MD
BOT Chair, AAPI

My dear AAPI Colleagues,

The AAPI 2017/2018 year has started with flurry of important events and overseas trip under the able leadership of Dr Gautam Samadder and his young and energetic executive team.

The South Africa CME trip was a success and very well organized. It was a monumental task with 250 member and family members joining the trip.

During Independence Day celebration week, our YPS/ MSRP group arrangeda a very informative leadership retreat at Indian consulate in New York. As always our young and dynamic BOT member Dr Kusum Punjabi mentored and coordinated the retreat that was a full house. Thank you Drs. Roshan Shah, Atul Nakhasi and Pooja Kinkhabwala for a job well done.

My dream is development of AAPI leadership academy under leadership of the young physicians. They are our future.

Our BOT has dynamic members. Dr Amit Chakrabarty is engaged in fundraising efforts for AAPI to support hurricane Harvey rebuild efforts, and support the Lymphoma and Leukemia Society by arranging Talat Aziz shows in nine cities.

Dr Hemant Dhingra is working hard on develop a new osteopathic medical school in California where AAPI and its members would be active participants, in addition to start a new primary care residency program in Fresno, California.

Many thanks to Dr Madhu Agarwal for a successful year as BOT chair and many accomplishments. She has been mentoring me this year.

Dr Samadder is working hard to make GHS in Kolkata a big success. He has the full support from all at the BOT

MISSION:

AAPI is a forum to facilitate and enable Indian American Physicians to excel in patient care, teaching and research and to pursue their aspirations in professional and community affairs.

MOTTO:

Unity of Purpose
Collegiality in Action
Commitment to Excellence and
Compassion towards Fellow-being

VISION:

Promote professional solidarity in the pursuit of excellence in patient care, teaching and research. Bring American medicine the distinctive contributions from India, and advance the American creed of one nation under God, indivisible with liberty and justice for all.

PRESIDENT - ELECT MESSAGE

Naresh Parikh, MD
President-Elect, AAPI

Year 2017 has started with many new projects under the stewardship of our President, Dr Gautam Samadder, to enhance AAPI's image especially in Community outreach. I am honored to support him and be part of this team.

In August. AAPI signed a Memorandum of Understanding with Life project Rajkot,. Gujarat. Thalsassemia Major is a Lethal genetic disorder which is entirely preventable by screening , at the cost of a meager 500 rupees as revealed by Mr. Koticha CEO of Life. Project . AAPI has been instrumental in providing the statement to Health ministry of India to make this mandatory screening .

Further projects are underway including AAPI and Health segment in Media .

I welcome you to join us for the AAPI tour to Northern Europe and Iceland next summer from July 21st to 31st, 2018 .

All always, we encourage your active participation in AAPI, and are open to suggestions and comments for further improving our organization.

YOUNG LEADERSHIP REPORT

...a glimpse of our future

Kusum Punjabi, MD
BOT, AAPI

On August 19th, 2017, American Association of Indian of Physicians origin (AAPI) hosted its leadership conference for current AAPI leaders at the Indian Consulate in NYC. This year the conference was titled Leadership for Impact and it was well attended by over 125 AAPI leaders from all over the country including several young physicians, medical students, residents and fellows. The purpose of the conference was to teach new emerging leadership skills to AAPI leaders and to foster conversations for AAPI future strategic goals.

The elite group of speakers for the conference included

Dr. Mary Alice Mazzara (Director of Educational programs at SUNY Global Center in NYC) who spoke on Leadership as Service; Dr. Ravi Goel (Practicing Opthalmologist from Cherry Hill, NJ, Past Chair of AMA Young Physicians Section, and Instructor at Wills Eye Institute in Philadelphia) who spoke on how leaders need to protect their on-line reputation; Dr. Gita Johar (Professor of Consumer Psychology at Columbia Business School) who spoke on how to incorporate creativity in leadership and Dr. Neil Aggarwal (Cultural Psychiatrist , Assistant Professor of Clinical Psychiatry at Columbia University in NYC and author of several books on culture and mental health) who spoke on the cultural and psychological dimensions to successful leadership. Amongst these amazing talks they were several team-building activities with important take-home lessons for the participants.

For the past several years in AAPI, leaders like Dr. Narendra Kumar, Dr. Jayesh Shah, Dr. Ravi Jahagirdar, and Dr. Ajay Lodha have promoted meetings/ round table discussions/ town halls and conferences for leadership training for AAPI leaders. These forums not only encourage camaraderie amongst AAPI leaders but also help the AAPI team understand the unique strengths of each leader and help us all work together towards building a unified, influential organization. This year Dr. Gautam Sammadar, Dr. Ashok Jain, Dr. Raj Bhayani and Dr. Kusum Punjabi were the main organizers of the conference and we truly hope to make this an annual AAPI tradition.

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AAPI ACTIVITIES AT THE AMA

.. connecting to our sister organization

Vijaya L Appareddy, M.D.
AAPI Delegate to the AMA

In the 1990's several AAPI leaders started the process of obtaining a seat at the AMA House of Delegated (HOD) for AAPI. This was the time when AMA did not pay much attention to the International Medical Graduates. In 2001 AMA made history by admitting AAPI as the first Ethnic Medical Organization to the Special Services Section (SSS) of the AMA. This is the first step before being admitted to the AMA HOD. Subsequently in the fall of 2005 AAPI was given a delegate seat at the AMA. This was a major milestone for AAPI to be recognized by a mainstream medical organization in the USA.

The HOD is the policy making body of the AMA. The members of the HOD are comprised of Delegates from all the State Medical Societies, Specialty Societies, various sections of the AMA and representatives from other Mainstream Medical Organizations. HOD meets twice a year, the Interim meeting held at different cities in November and the Annual meeting is always held at Chicago. The HOD elects the Board of Trustees for a 4-year term and the President for a 1-year term.

Several AAPI members have served as AAPI Delegates and Alternate Delegates to the AMA since 2005. I am fortunate to have served as the Delegate and Alternate Delegate at the HOD representing AAPI and several other organizations over the years. The Delegate represents and advocates for International Medical graduates (IMG) and US graduates of Indian origin.

AAPI introduced the following resolutions as a Sponsor / Co-Sponsor at the HOD over the years authored aby me (while representing AAPI and various organizations over the years) which were adopted as AMA Policy:

1. Resolution to classify people with Intellectual disabilities as a Medically Underserved Population (MUP).
2. Resolution for redistribution of unused J1 visas of the Conrad 30 program to states that have exceeded the limit and still in need of more J1 visas.
3. Reintroduced a resolution advocating to make J1 Visa Waiver program permanent.
4. Resolution to have a national database of Conrad 30 J1 visas issued.
5. Resolution to prevent arbitrary prevention of J1 Visa holders from reentry into the US.
6. Resolution on Health Care reform on physician workforce shortage.
7. Resolution on Faith and Mental Health. This is one of the top resolutions broadcast in the AMA Wire to over 200,000 AMA Members recently.

As AAPI delegate I testified on various reference committees on issued related to both IMG and US medical graduates. This includes; increased GME funding, increase residency slots and Health care reform to mention a few.

As AAPI Delegate (A) I served on the Prestigious AMA reference committee on legislation and advocacy at the 2009 AMA interim meeting where OBAMA care was discussed. After hours of intense discussion with the delegates, the committee presented its recommendations to the House of Delegates and was voted as AMA policy.

AAPI as an organization representing both International and US Medical graduates of Indian Origin has also signed up with the AMA to support certain legislations advocating for Physicians and the Patients we serve.

AAPI has continued to work with the AMA IMG governing council through the years to support IMG physician issues and cosponsored resolutions. AMA leadership has been regularly invited to AAPI conventions and legislative days. AAPI members and Delegates hold several leadership roles at the AMA.

Several AAPI leaders are recipients of the AMA Leadership awards notable of which is the "Dr. Nathan Davis International Award in Medicine".

AAPI members may submit their ideas for potential AMA resolutions to be introduced at the AMA HOD. You may send it to the Appareddy@ramtec.com.

AAPI RECOGNIZES AUA

AS THE LEADER IN INTERNATIONAL MEDICAL EDUCATION

The American Association of Physicians of Indian Origin (AAPI), after conducting a comprehensive site visit, awarded **American University of Antigua (AUA) College of Medicine**, a division of Manipal Global Education Services, with this distinction.

Based on their observations, AUA's numerous state approvals, the strength of its curriculum, resources, and faculty, and its graduate success, AUA has become the only medical school to receive this "preferred" status and recognition.

AAPI and AUA offer a scholarship for students of Indian descent, which has given many distinguished students the opportunity to become physicians.

DR. KALPANA GOPALSWAMY
CLASS OF 2014
INTERNAL MEDICINE RESIDENT
UNIVERSITY OF PITTSBURGH
MERCY HOSPITAL

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LEGISLATIVE PARTICIPATION

.. voices on Capitol Hill.

Dr. Vidya Kora, Chair, AMPAC Board of Directors

AMPAC is a bipartisan political committee that exists to elect medicine-friendly candidates to the United States Congress. Our advocacy priorities include issues that have a lasting impact on physicians and our patients. Some examples of these issues are health system reform, EHR compliance deadlines and penalties, MACRA implementation, opioid misuse, graduate medical education funding and eliminating independent payment advisory board.

AMPAC was created in 1961. The AMPAC board works closely with the state medical society political action committees to identify medicine-friendly candidates for the United States Senate and House. In the 2016 election cycle, AMPAC invested nearly two million dollars and made direct contributions to 348 medicine-friendly candidates for the United States Senate and House from both parties.

In the 2016 election, AMPAC conducted independent expenditures on behalf of four physician candidates, Neil Dunn (R Florida 2), Roger Marshall (R Kansas 1), Joe Heck (R Nevada Senate), and Ami Bera (D California 7). Three of these four candidates won. Ninety-one percent of the candidates supported by AMPAC won their races.

In addition to directly supporting the candidates, AMPAC also helps educate and train physicians, residents, students, medical society staff and the spouses of physicians to run for elected office or help on a campaign. Political education programs, the candidate workshop and campaign school help train physicians to run for office or to work on campaigns. The school features a bipartisan group of speakers who are high level political operatives, campaign experts and media consultants who provide the tools to be successful in politics.

Friends have asked me why a guy like me, born and raised in India before immigrating to the United States 35 years ago, got involved in the political action committees. As an emigrant who studied American political history, I learned that the many rights and freedoms guaranteed by the United States come with responsibilities. Of these, the most important is the responsibility of getting involved in the political process; the responsibility to step forward when we see the opportunity to impact our communities for the better; in short, the responsibility to participate. This realization led to my decision to run for public office. Regardless of our personal political views, PAC contributions help support key decision makers in both parties including those whose districts we might not live in. PACs educate our legislators about the issues and concerns that affect our profession and they help us build solid relationships with our government officials.

Anyone who is a member of the AMA, state medical society or county medical society can contribute to AMPAC and become a Capitol Club member. There are three levels of Capitol Club participation: silver for $500, gold for $1000 and platinum for $2500.

By becoming a Capitol Club member of AMPAC, you will strengthen our voice in Washington, Participation is power.

AAPI TOUR OF SOUTH AFRICA

AAPI members had the honor of touring South Africa, Zimbabwe, and Botswana this past August. Over 250 AAPI members, including members of the Executive Committee, were joined by their spouses for an extravagant adventure beautifully organized by Pollina Tours.

After landing in Johannesburg, AAPI members were taken to Kruger National Park for a three-day safari excursion. The accommodations were inside the game reserve and are known as the "luxury home in the bush". Service was excellent, and guests were treated to delicious Indian cuisine. Each day began at sunrise with a safari tour in an

open Land Rover led by a trained driver and ranger. Guests could observe exotic animals in their natural habitat with the ranger's guidance. The evening concluded with a nighttime safari as well. Guests had the opportunity to view lions, elephants, rhinoceros, and hippopotamuses. In addition, zebras, giraffes, wildebeests, and crocodiles made appearances on the safari tours.

The group returned to Johannesburg to take in the history of Mahatma Gandhi's humble beginnings as a practicing attorney in the Johannesburg Law Courts. His office was located in the central business district, now renamed "Gandhi Square". A statue of Gandhi, erected in October, 2003, depicts him as the young lawyer adorning a legal gown over his business suit. The inscription notes that Gandhi founded his Satyagraha movement in Johannesburg in 1906, which he then carried to India in 1914. Outside of Johannesburg, AAPI members visited Soweto, home of the Soweto Uprising of June 16, 1976 when mass protests erupted over apartheid. Almost twenty years following, Nelson Mandela was elected the first South African President of African descent in 1994. Guests were able to visit the monument commemorating the Soweto Uprising as well as the home of Nelson Mandela.

AAPI members journeyed to Zimbabwe to witness one of the seven natural wonders of the world, Victoria Falls. The majestic waterfall gracefully flowed into a sea of rainbows and beauty. Then, guests traveled to Botswana, for a beautiful safari in Chobe National Park. Guests were able to observe some of the 70,000 elephants in Chobe at close proximity, which is the highest concentration of elephants in the world. Guests had another opportunity to view exotic animals native to the area in close range, including impalas, spotted hyenas, lions, and leopards.
The journey concluded in Cape Town. AAPI members had a memorable visit to Robben Island, where Mandela spent eighteen of his twenty-seven years in prison for protesting apartheid. Guests were guided on a tour of this UNESCO World Heritage Site by a former political prisoner.

AAPI members visited Cape Peninsula, to enjoy Cape of Good Hope on the Atlantic Coast as well as Cape Point, a promontory on the southeast corner. The southern most point of the African mainland is in Cape Agulhas, which is 150 kilometers from Cape Peninsula, and it is there where the Atlantic and Indian Oceans meet. Finally, the journey concluded at Table Mountain. This elevated plateau provides a vista point overlooking the city of Cape Town, the Atlantic Ocean, and the Indian Ocean. Table Mountain is now listed as one of the seven new wonders of nature. Guests had the honor to celebrate India's Independence Day in Cape Town as well.

In addition to the breathtaking sights and natural beauty, AAPI members enjoyed traditional dance programs with African dancers and a special Indian musical program by AAPI talent. The CME program offered well-attended sessions with excellent speakers. Members with birthdays and anniversaries coinciding with the voyage were also honored and celebrated. AAPI members enjoyed this vacation, with a healthy combination of business and pleasure, returning to their homes with beautiful memories.

FLEEING THE FURY OF HURRICANE IRMA

.. the Heavens hath seen no fury than.

M. P. Ravindra Nathan, MD
FACP FACC FRCP

For the past thirty five years I have lived in Florida without ever having to evacuate during hurricanes. So you can imagine my anxiety when Governor of Florida, Rick Scott, issued an order for all those living in the coastal areas to evacuate before Hurricane Irma, a category 5 and the most powerful storm ever to develop in the Atlantic ocean, arrives. Being close to the west coast and surrounded by huge oak trees our house in this wooded area in Brooksville, FL, was a sitting target for the fury of this monster. So we had no choice other than packing our bags and leave to Detroit to stay with our daughter.

Wednesday September 6, 2017

Initially we thought of riding out this storm as we have done before although none had been this big. But this time, my children, both physicians, practicing elsewhere, said in one breath,

"Are you crazy, this is the most powerful hurricane, it can demolish your house and flood the entire region … you must get out now when you can."

Having learned a lesson from the dangerous Harvey that caused untold misery in Houston, nobody wanted to take a chance. My son put it in no uncertain terms, "When the storm hits, you will cringe like a trapped animal, putting your own life in peril." Finally my wife and I felt it was not wise to stay around and decided to catch a flight to Detroit to be with our daughter.

"Not so quick," came the reply from all the airlines. To our horror we found out we couldn't get a single flight from Tampa international airport, the closest one for us, all of them taken by fleeing evacuees.

So, we had to drive all the way to Jacksonville, FL, to catch the flight—a four and half hour journey that usually takes only 3 hours tops. Needless to say the traffic was bumper to bumper, gridlock on every major highway leading north. To top it off gas was in short supply, the waiting lines in some gas stations stretching for almost a mile! But we managed. After surviving all the hassles, we landed in Detroit in the early hours of morning.

9 14 17 Thursday morning

Irma came and went and three days later we returned back to our house in Brooksville only to see we still didn't have power, cable TV or internet services. Do you know how it feels when you are *"digitally isolated."* The yard looked like a battle field with so many fallen tree branches and debris. One of my neighbors wasn't so lucky—an entire tree in his yard got uprooted and fell blocking his driveway. Fortunately in a couple of days, the power returned and life resumed its usual rhythm.

I learned one lesson from this experience. It's better to evacuate sufficiently early before the airports close and escape roots get clogged up with fleeing vehicles.

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HURRICANE IRMA

A TRAGEDY AT ST. MAARTEN, CARIBBEAN

.. "with the mighty hand of chance"

I am a medical student at the American University of the Caribbean (AUC). On September 5, 2017, the Island of St. Maarten, my second home, was directly hit by Hurricane Irma. As a category 5 hurricane, Irma slammed the island for a continuous thirteen hours that fateful day. Although I took shelter along with several of my colleagues in a campus building, there was total devastation and destruction all around us even as we struggled with inhuman conditions and challenges ourselves.

As Irma began its landfall, the building used to house cadavers and where students practiced clinical skills with patients became our refuge. We had to tie up the doors using computer wires and brace against the winds. Shortly after, our building began to flood. There was no running water, Internet or phone connectivity. For several days we could not contact our family members who were worried about our well being and safety. Living conditions became horrifying as the cadavers rotted, toilets overflowed and food and water supplies diminished.

Meanwhile, our head physician sought volunteers from anyone with medical experience to take care of emergencies and sickness that were bound to arise with such a natural disaster. I volunteered to help as I already had several years of exposure to the medical world as a certified EMT as well as a scribe from my days in Plano, TX prior to my medical schooling. I, along with a team of dedicated physicians and students, created, organized and ran a makeshift OR with EMT, triage and security teams. We worked long hours without breaks or sleep to offer care around the clock to expecting mothers, patients with existing medical conditions and those who were injured during the hurricane. We supervised search and rescue teams for neighboring areas. Our focus was to help as many people with the limited resources we had. We used common items in various creative ways for patient care. I recall using something as simple as a dry cardboard to create a makeshift splint for fractures.

We were desperate for evacuation but the outside conditions were dangerous because of all the debris, collapsing buildings, and looting by the looters who had weapons in spite of the curfew. The weather conditions, on ground and at sea, were dangerous which caused a huge delay in evacuation as planes were unable to land and boats unable to dock. Day by day, the danger and the desperate need for help intensified. At times, we felt that none of us would make it out alive.

After several days of waiting, conditions finally improved for safe evacuations to begin. The first three US military flights that arrived took care of mothers, their children and those injured. I was fortunate to be evacuated by the US military on its 4th flight out in their c130 aircrafts to Puerto

By Dr. Tina Sharma

Rico. On the other hand, there were other colleagues of mine who risked their lives to travel 5 hours to St Kitts via a small boat. Conditions on the boat were dangerous as they traveled through treacherous waters. After two days, those in Puerto Rico, St Kitts, St. Maarten were flown to Chicago.

I would like to thank all my student team members, the physicians, AUC faculty & staff for putting their trust in me as I worked with them to organize and administer medical care. I would also like to thank AUC administration for working so diligently for getting us to safety. Upon arrival, we were received by The American Red Cross, The Salvation Army, local volunteers, and most importantly by AAPI. I would also like to thank Dr. Jain, Dr. Dhingra, Dr. Reddy, Dr. Samadder, Dr. Sachdev for rushing to our aid. Being on the receiving end of their contributions and kind gestures gave us comfort and began the process of healing for us.

On looking back, when I flew in to St. Maarten on Sunday Sept 3rd, happily looking forward to nothing more than the beginning of another semester I had no idea that would I find myself in the midst of a category 5 hurricane. It has been quite an emotional, physical and mental rollercoaster ride but this experience has taught me valuable lessons in endurance, patience and compassion that I am sure will make me a better person, student and physician.

MISHTI MELA

A Cornucopia of Sweet Delights

Udita Jahagirdar, MD

Dessert has always been the "piece de resistance" of the Bengali culinary arts. AAPI's Global Health Summit 2017 in Kolkata offers a unique opportunity to experience the varied sweet savories from aAmar Sonar Bangla. Beyond the ubiquitous Rossogolla, Cham Cham, Payesh and the hybrid concoction called Rasmalai- found in every desi joint, there is a mind boggling array of sweets, some not really known beyond the local regions, that are truly masterpieces of confectionery. A visitor to Kolkata usually returns with reminiscences of the lip- smacking Mishti Doi and the sublime varieties of Sandesh-so unlike the "pedas" of the rest of the country; however it takes a diligent effort to explore all the varieties of Bengali desserts, some of which are of the seasonal homemade variety- not to be found in any local stores anywhere.

Most Bengali sweets are cottage cheese or "chhanna" based unlike those of Northern India where you have usage of dried milk or "khoya". Some have coconut or semolina as additives. The sweetener is usually cane sugar though jaggery derived from palm trees often imparts its own distinct color and flavor. The fillers can be fruits ranging from litchi to mango and jackfruit or vegetables like the sweet potato and tomato. Yoghurt is of course paramount in the "doi" preparations.

Arguably, the prize-winner for the lesser known regional varieties would be Sitabhog and Mihidana of Burdwan. Sitabhog- legendary favorite of Sita, looks like grains of white or yellow rice and Mihidana looks like delicate yellow boondis, but are a melt in the mouth combination made by a Bhairab Nag whose descendants still run the local shops. Apparently this dessert was commissioned by the local royal family to commemorate Lord Curzon's visit to the area, who liked it so much that he made it the official sweet during his tenure. These rarely make it outside the region as refrigeration is taboo and they have to be consumed on the same day.

Langcha from Shaktigarh is an oblong fried combination of chhanna, khoya and flours of different cereals. According to Bengali author Narayan Sanyal's novel "Rupamanjari" the bride from Krishnanagar, married to a prominent Burdwan family, yearned to eat a certain sweet during her pregnancy, prepared back home by her lame cook. Unable to remember the name of the sweet she called it "Langcha" meaning "lame" in fond memory of her childhood attendant.

A favorite during Durga Puja season is Shorbhaja- fried layers of thickened cream originating in Krishnanagar and a close relative the Shorpuriya which resembles a milk cake.

Different from all of the above is the winter delicacy of puffed rice and date palm jaggery called the

Joynagarer Moa. A simple rustic sweet, it is sold door to door by street hawkers in this town in South 24 Parganas during the season. Not to be outdone, are the Jolbhora Sandesh of Chandernagore, Lal Doi of Nabadwip, Aamer Morobba of Siuri, Birbhum, Garbeta's Balushahi, Malda's Rashakadombo, and Berhampore's Channa Bora.

Ledikeni is a unique sweet commissioned by Lord Canning for his wife's birthday party. A team of confectioners worked for days to come up with an elegant variety, stuffed with elaichi and saffron and fried in ghee. Totally different in taste from the Langcha or Pantua, its name is pidgin for Lady Canning.

Every household in Bengal has its own favorite recipes for Naru, Pithey, Payesh and chutneys, and every Bengali will wax eloquent over how his favorite aunt or grandmother made a certain gokul or patishapta or raanga alur pithey, chushi pulli or nalen gurer payesh during the harvesting festival of Poush Parbon Sankranti.

The usually non- entrepreneurial Bengali has been able to develop, can, and export the iconic Rossogolla. In 1868 Nobin Chandra Das created the spongy tender Rossogolla and his physicist grandson Sarat Chandra Das created the technique of canning Rossogolla helping it to travel outside India. He was always looking for ways to innovate and introduced chocolate and fruit fillings after visiting Switzerland. From Japan he brought back machines to steam sweets instead of cooking on an open fire and machines to knead channa. K.C. Das's Rossogolla tins are a fixture in every Indian grocery store all over the world.

Now, to enter into a swirling, deep, dark controversy. It appears that the famous Rossogolla, mascot of Bengali mishti, may not have originated there but in Orissa in the 12th century. According to legend Lord Jagannath offered a variant of Rossogolla similar to kheer mohanna of Pahala to his wife Laxmi to appease her prior to his 9 day Rath Yatra. West Bengal has filed an application for Geographical Identification tag to stake its claim and preempt Orissa.

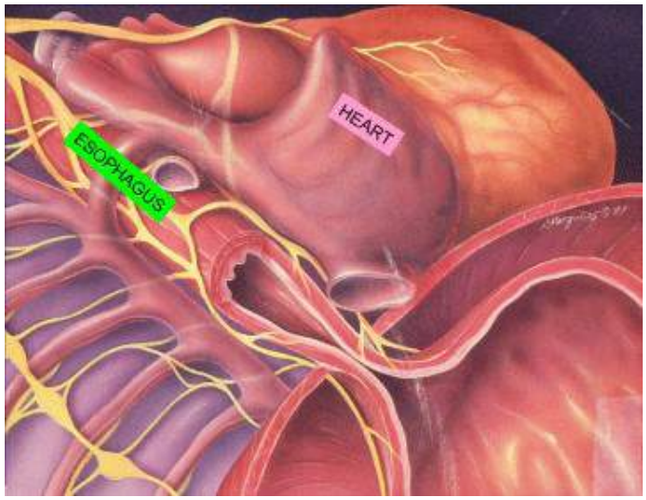
Newer flavors are now the rage in Bengali sweet making, catering to a young urbane multi-cultural palate - often fusing Indian and western recipes. When it comes to innovation and experimentation, the sky is the limit and the Bengali cuisine certainly has a head start.

NON CARDIAC CHEST PAIN (NCCP)

.. an ominous threat lurking.

Introduction:

Chest pain is the second most common cause for presentation to the ER. NCCP is a broad term that refers to recurrent chest pain, that is similar in characteristics to ischemic cardiac pain, however workup rules out underlying cardiovascular cause for the pain (Acute coronary syndrome, aortic dissection, pericarditis, and pulmonary embolism). It is also known as "atypical chest pain, soldier's heart, DaCosta's syndrome". Given their anatomic proximity, heart and esophagus share their sensory nerve supply and hence pain from either organ has similar characteristics *(Figure 1, courtesy American College of Gastroenterology)*.



Etiologies for NCCP are as follows:

Esophageal (most common)	GERD/esophagitis, Spastic motor disorder
Gastric	Ulcer , gastritis
Biliary and Pancreatic	Gallstones , Choledocholithiasis, Pancreatitis , Malignancy
Psychosomatic	Functional chest pain , Malingering, Panic attack
Musculoskeletal	Fibromyalgia, Costochondritis
Others	Herpes Zoster , Sickle cell crisis

Epidemiology:

Up to 1 in 3 individuals in the US have had NCCP in their lifetime.[1] Its prevalence worldwide is similar, with reported prevalence of up to 33 % in Australia and around 20% in India. It affects both sexes equally, however females are more likely to present to the ER or seek medical attention for chest pain. Patients tend to younger vs counterparts with ischemic heart disease.

Underlying pathogenic mechanisms:

A. Gastro Esophageal Reflux Disease (GERD).
B. Esophageal motility disorder / hypersensitivity.
C. Co-existing psychological comorbidity such as anxiety, panic disorder or depression.

Workup:

First priority in evaluation of chest pain, is to rule underlying significant life threatening cardiovascular abnormality .After a reasonable workup has been done to rule out unstable angina, aortic dissection, and pulmonary embolism etc., diagnosis of NCCP should be entertained. Workup may include one or several of the following

A. Upper Endoscopy (EGD)
Low grade erosive esophagitis is the most common finding.
Up to a third may also have a hiatal hernia. Barrett's esophagus and esophageal stricture may be present in up to 4% patients.

B. 24 Hr ambulatory pH monitoring
GERD is a frequently missed association with NCCP and present in up to half of the patients. Only one third of the patients with NCCP get referred to gastroenterologists for further testing.
Abnormal acid exposure may be seen in > 50 % of the patients on a pH study.
Proton pump inhibitors are efficacious in >80% of patients with abnormal pH study.
C. Esophageal High Resolution Manometry
Routine use is not encouraged, unless patients report symptom correlation with meals.
Manometric abnormalities may not correlate with symptoms.
When present, nutcracker esophagus (spastic high

amplitude contractions) is the most common underlying motor disorder.
Less than 10% patients have any abnormality seen on esophageal manometry.

Treatment:
A. Empiric trial of high dose PPI
Efficacious in up to two thirds of the patients and eliminates use of more expensive testing.
H2 blockers such as Ranitidine have lower efficacy.
Most patients will require long term therapy and risks of long term PPI use should be discussed.
B. Anti-spasmodic
Only to be used for proven esophageal spastic disorders on esophageal manometry.
Calcium channel blockers (Dilitiazem 60-90 mg QID and Nifedipine 10-30 mg TID) have shown efficacy.

C. Visceral Neuromodulatory agents
Alters sensitization of esophageal afferent nerves, leading to decreased response to physiologic/ pathological esophageal stimuli.
Tricyclics such as Amitriptyline is the most well-known and studied. Recommended starting dose is 10 mg at bedtime, with weekly increments up to 50 mg daily maximum, while monitoring for side effects (dry mouth, drowsiness, dizziness).
Trazodone 100-150 mg daily, SSNRI such as Venlafaxine and SSRI such as Citalopram have also been used with success.

Abhishek Gulati, MD
Gastroenterologist, Fresno, California

D. Referral to a mental health specialist should be made to screen for underlying psychogenic comorbidities (present in up to 75% patients), especially in patients who fail to respond to standard medical therapy.

OFF-LABEL USE OF DRUGS

The Physicians' Dilemma

The term "off-label" is used when a drug is prescribed for conditions other than those for which it has been approved by the US Food and Drug Administration (FDA). It should be noted that FDA regulates only approval of drugs for clinical use, but not how they are prescribed. So, technically doctors have the freedom to prescribe a drug for any reason or condition they consider it is medically appropriate, provided the drug is efficacious and safe to use in that particular disease condition. The economic benefits of the off-label use of medications are quite obvious and huge.

Off-label use of drugs is very common. In fact, virtually every drug has been used off-label in one or other conditions. Off-label prescriptions of medications account for 21% of all prescriptions. A vast proportion of these off-label prescriptions do not have scientific basis (Stanford Medicine News Center, Nov 24, 2008). These numbers suggest that physicians are relying more on their own experience with the drugs or their gut feelings and less on the scientific basis while prescribing off-label use of drugs.

.. beware of the unknown

One can raise the question, what are the consequences of such practices? To address this, we need to refer to two regulations and then examine their impact on the physicians and the drug manufacturers. The Food, Drug and Cosmetic Act of 1938 empowered the FDA to regulate promotional materials on medications. That means FDA can monitor what the drug manufacturers advertise about the use of their medications to both medical community and to the general public. This discouraged the drug manufacturers to advertise about the potential off-label uses of some of their medications, despite strong scientific basis. They could not even whisper that information to the physicians in their offices through medical representatives. Because, doing so would invite FDA on one hand, which will ask for further evaluation, a money consuming process, and on the other hand makes them fall into the clutches of the trial lawyers who can bring class action law suits for adverse effects of the advertised off-label uses. However, a ray of hope has come to the physicians, when the FDA Modernization Act of 1997 allowed drug manufacturers to distribute peer-reviewed journal articles about unapproved uses of their drugs to the health care providers without the need to evaluate those claims independently. Since those publications were not made by the pharma industry, their liability was also limited. This allowed the physicians to prescribe off-label uses of drugs.

Bellamkonda K. Kishore, M.D., Ph.D., MBA

Despite the above, the physicians have to exercise caution about the medicolegal aspects, especially while writing off-label prescriptions without strong scientific basis. Furthermore, ethical considerations require obtaining informed consent of the patients for off-label use. Finally, physicians should evaluate whether the off-label use of the medication is really efficacious and safe to use in the particular disease condition. Drug safety may vary depending on the health condition of the patient.

Take Home Message: We all make mistakes and we all pay the price (Dr. House in Fox TV series).

CALL FOR ACTION TO AAPI PHYSICIANS ON THE OPIOID EPIDEMIC

.. a colossal tragedy .

The nation is in midst of a monstrous crisis of Opioid Epidemic, for not just last one or two years, but almost for a decade, taking lives of more than 500,000 Americans - more than any war or terrorists attack. The number of deaths is just the tip of the iceberg. The disability and financial burden on the society is huge. Cost of the opioid prescriptions, ER visits and addiction treatment expense, in majority, paid for by health insurance and taxpayers is estimated to be trillions of dollars in expense over last 10 years of this terrible epidemic.

We in America only have 5% of the world's population but consumes 4 times more opioid than rest of the world combined. America writes more than 250 million opioid prescriptions.

> "We in America only have 5% of the world's population but consumes 4 times more opioid than rest of the world combined."

But in spite of this devastating problem, we as a nation have failed to stop this epidemic. Over last decade almost 100 billion dollars i.e more than 10 billion dollars per year have been spent trying to stop the epidemic, but number of deaths continue to increase. In year 2014, Death rate increased almost 14% as compared to 2013, in spite of a 1.6 Billion dollar increase in funding. The spending was further increased about 3 billion in 2015, but number of deaths again rose more than 14%. So, the bottom line is that just increasing the funding for fighting this epidemic is not the answer.

This epidemic has been kept under the rug for several years, without dedicating a full force task force on this issue.

Two years ago, we from "American Pain Association" requested President Obama and the Surgeon General Dr. Murthy to initiate a "Call to Action" on this epidemic. This action was supported by many including Congressman Gabbard and Norcross. We also started an online petition for the same, which was signed by more than 12,000 people asking president Obama and the Surgeon General to take Action.

Dr. Kavita Gupta
Chair Person, Opioid Task Force, American Pain Association

Our Nation's failure in curbing this epidemic in spite of spending more than 100 billion dollars and efforts, calls for a change in strategy, continuous intense monitoring and a dedicated task force to fight this war against the deadly epidemic. Providing increased access to addiction treatment is good strategy but that alone is not effective. Addiction treatment has a very high relapse rate and thus the focus need to be more on prevention of the problem, rather than try to reverse the addiction.

AAPI Physicians can play a very important role in the fight against this epidemic as they represent one of the largest group of physicians from diverse specialties and placed in almost every corner of US. I plan to compile and present this to the Bi-Partisan Opioid Committee and the White House.

AN APPROACH TO OSTEOPENIA AND OSTEOPOROSIS

.. bend only with humility, not with brittle bones.

Ways and means to maximize the absorption of calcium through passive para cellular transport system with the aid of bio available calcium – minor minerals and Multiple Mixed Strain Probiotics, to prevent or cure osteopenia and osteoporosis

Over one third of the world's population (roughly 2.3 billion) suffer from either osteopenia or osteoporosis, and both of these diseases are related to the calcium deficiency in the body. These two are silent diseases since bone mass is lost without any sign of sickness. According to the World Health Organization (WHO), the osteopenia is defined as follows: a bone mineral density (BMD), which is 1 to 2.5 standard deviations below the peak bone mass (20 years old healthy human) as measured by dual X-ray absorptiometry (DXM). Whereas, osteoporosis is 2.5 standard deviations below the peak bone mass. Both the osteopenia and osteoporosis are expressed by T scores.

These two calcium deficiency syndromes are more prevalent, with an early onset, in women than in men. Although, eventually both the sexes will develop with age. Dietary calcium is absorbed mainly through active (90%) and passive (10%) transport systems in duodenum and ileum correspondingly. Any calcium to be absorbed must be ionized. The ionization of calcium in the stomach varies from individual to individual and also sex dependent (male vs female), especially when taking supplements comprising exclusively calcium carbonate.

The absorption of calcium carbonate is highly unpredictable and if it is not properly ionized, rather than serving as a calcium supplement it will act as buffer or neutralizer, which will hamper the absorption of calcium, even through the passive transport system. Calcium deficiency most generally correlates with the decreased production of hydrochloric acid in the stomach, which in turn relates to drop in the estrogen levels in females. Consequently one in three women develop osteoporosis after menopause. Specifically this is true with Caucasians and Asians. Even among the Caucasians, the Northern European ancestry women will develop osteoporosis at significantly higher percentage level. Men also develop osteoporosis at andropause. Whereas, American women of the African heritage have less chances of developing osteoporosis because of their highest peak bone mass at their adolescence.

Malireddy S. Reddy, DVM, MS, Ph.D.

The next obvious question, why is this calcium deficiency more prevalent in women and elderly people, and how can we prevent this to improve the skeletal health and the quality of life? The dietary calcium must be bioavailable to get absorbed efficiently. The RDA (recommended daily allowance) for calcium is 1000 to 1200 mg. Yet, RDA does not specify, if the calcium is bioavailable or not. The bioavailability of calcium depends on several factors: 1. The degree of ionization of calcium in the stomach (which in turn depends on the level of estrogen); 2. Level of vitamin-D, magnesium, phosphorous, and parathyroid hormone to assist the absorption of calcium in the duodenum through active transcellular transport system; 3. The lower intestinal tract pH (5.3 to 5.5) and the concentration of Probiotics in ileum, which controls the calcium absorption through passive para cellular transport system. As people age (starting from 30 years age) the highly active and extremely efficient transcellular calcium transport system start to slow down. This could be due to low level of parathyroid hormones or old age or due to disease or improper ionization of calcium in the stomach (especially in women) etc. Since, the para cellular passive calcium transport system is naturally not as active as active transcellular calcium transport system, the calcium absorption significantly slows down. Since calcium cannot be synthesized in the body, the deficiency of calcium in food or ineffectiveness of active transcellular transport system, people start to develop the deficiency symptoms of calcium (due to

bone resorption), which are expressed by fragile bones, pain in the joints, hip fractures, insomnia, premature aging, fatigue, muscle spasms, stunted growth of nails, hair loss, and irregular heart beat etc.

The next question is, how can we improve the passive transport system to offset the slowness of active transport system due to age and other factors? This can be accomplished by supplementing the bioavailable calcium and other major, minor and trace minerals, along with proper Multiple Mixed Strain Probiotics. The supplementation of mixed bioavailable (more ionizable and chelated) organic calcium salts such as calcium citrate, lactate, maleate, gluconate, and acetate etc. greatly improve the calcium absorption. In addition, the supplemented and implanted Probiotics present in jejunum and ileum will utilize the organic fractions of the calcium salts as sole source of carbon and thus greatly improve the absorption of the elemental calcium through the passive transport system. The supplemented calcium phosphate (although not organic) will also react with the lactic acid produced by lactic acid producing Probiotics in ileum to form calcium lactate, which can be further metabolized by Probiotic bacteria belonging to genus Propionibacterium to liberate the elemental calcium, which can be transported effectively through passive para cellular transport system at the distal end of the small intestinal tract.

In summary, even though the calcium absorption is significantly reduced due to cessation or slowness of the most active trans cellular calcium transport system in duodenum due to old age or menopause or andropause or disease etc., it can be overridden by activating the para cellular passive calcium transport system in ileum through supplementation of the bioavailable calcium and other major, minor and trace minerals, along with the specific Multiple Mixed Strain Probiotics (including their bacteriocins), to reduce the incidence of osteopenia and osteoporosis, and thus premature aging. The Multiple Mixed Strain Probiotic cultures should comprise several strains belonging to different genera and species (along with their bacteriocins), rather than a single strain freeze dried Probiotic without its bacteriocins, which is unfortunately commonly available in commerce and consumed.

RESEARCH LINKS USE OF SALT TO ADULT ONSET DIABETES

.. is Namak .. Haraam?

Surender Reddy Neravetla, MD

Have you noticed that Type 2 diabetes often develops in someone a few years after the diagnosis of high blood pressure? For at least a decade, I have been looking for reasons for the close association between high blood pressure and type 2 diabetes. New research links type 2 diabetes, one of the most disabling and deadly diseases, to our salt habit.

Pioneering research by Dr. Jens Titze, reveals a new way on how humans and other animals produce water from within to compensate for salt intake. He started looking at long term sodium balance in Russian cosmonauts. He continued the research as a faculty member at the University of Erlangen, Germany, and followed up the same research at Vanderbilt university.

Normally when you eat something salty, you go for water. However, Dr. Titze reported, based on his research on Russian cosmonauts and mice in the labs that the more salt was added to food, the less water they drank. Yet they still produced more urine to compensate for excess salt.

A second finding: The cosmonauts were hungrier and the mice ate 25 percent more food on a high salt diet. This was despite getting the same number of calories and nutrients.

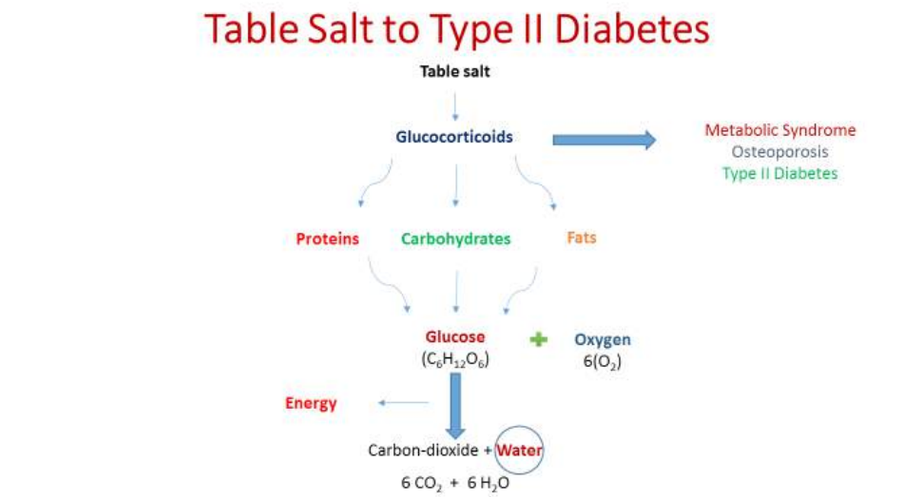
Third finding: There is increased production of glucocorticoid hormones with increase in salt intake. As quoted by Dr. Titze himself, excess glucocorticoid production is linked to osteoporosis, muscle loss, many metabolic problems and yes … Type 2 diabetes.

When you eat more salt, you have to somehow compensate for it with more water. Humans and other animals can and do produce water by breaking down glucose, fat and muscle. Glucose combines with oxygen to produce energy needed to run our body. In this reaction carbon dioxide and water are produced.

Having more water to compensate for excess salt does save the day. As quoted by Dr. Mark Ziedel, a noted nephrologist from Harvard Medical School, a camel survives the travel in the desert without water by breaking down the fat in its hump. There is no actual water in the camel's hump, in case you believed the old Arabian tales where the traveler cuts off the camel hump to quench his thirst.

So, in order to make more water, the body produces glucocorticoids to help break down the glucose into water. In this process, for one thing, more glucose is consumed. On a long-term basis, just as the kidney exhausts its ability to make up for the constant intake of table salt leading to high blood pressure, the glucose control mechanisms also get exhausted, leading to diabetes.

With the discovery of this link between table salt and diabetes, we need to step up the awareness of the dangers of table salt. Our body does need sodium, but don't confuse sodium with table salt. We need to get the sodium required from natural sources like fruits and nuts. No good can come from adding table salt to our food.



In response to table salt in food, we produce excess glucocorticoids to mobilize proteins, carbs, or fat into glucose, which is broken down to make water. These hormones lead to metabolic syndrome, osteoporosis, and Type II Diabetes.

DHACM (dehydrated amniotic chorionic membrane) in treatment of Osteoarthritis of Knee-Cutting Edge Techniques in Orthopedic Surgery

Ashish Anand.MD

The amniotic membrane is a constituent of placental tissue that protects and supports the fetus in utero. It is composed of extracellular matrix components such as collagen, fibronectin, and laminin, and contains many different growth factors and cytokines. The healing properties of amniotic tissue were first identi¬fied in 1910(1) where it was discovered that they help in healing refractory, stalled wounds. However this immunologically privileged structure was lost to scientific community for close to 90 years until techno¬logical advances led to its being"rediscovered"in early 2000. Since then numerous studies have identified their varied applications. Review of the pertinent literature reveals that these tissues have been used successfully for healing of wide variety of human tissues including skin(1,2), cornea,(3-5,) and ligaments(6) in clinical settings, as well as induce cartilage in preclinical animal models .

In order to harness the immense biological healing potential of the membrane, techniques have been devised to harvest and subject it to dehydration by a proprietary process. After dehydration the product is terminally sterilized. The final end product is called dHACM (dehydrated amniotic chorionic membrane). The dHACM retains and is able to supply the growth factors which are responsible for its healing properties. dHACM shot into limelight when it was demonstrated in randomized controlled trials, that it greatly improved healing of diabetic foot ulcers (2) and venous leg ulcers(1) compared with the appropriate clinical standard therapy. Numerous lab studies have revealed that the dHACM acts as a stem cell magnet to recruit stem cells which secrete growth factors and attract stem cells from bone marrow and other peripheral sources to promote healing at sites of tissue injury . The impact of this biological activity is to shorten the phase of inflammation in non-healing wounds and enable wound closure.

This cutting edge technology is also focused on applications involved in repairing orthopedic tissuesThese efforts involve the application of bioactive factors, such as tissue engineering strategies using growth factors, scaffolds and stem cells, that can promote healing and regeneration of the tissue itself(7,8). Stem cell magnet properties are important in these indications as well, which are varied, and increasing in number. Lab studies and clinical studies have shown the promising potential which promotes healing in poorly vascular orthopedic tissues like tendon, ligament, and cartilage(5). In addition dHACM reduces scar tissue formation which is beneficial in complex arthroplasty situations such as massive rotator cuff tears and hand tendon injuries(9). It also has found utility in Spine Surgeries where it has shown to prevent dural adhesions.

In vitro data suggest that dHACM may act as an effective scaffold for cell delivery in cartilage regenerative applications and also provide a supporting role in cartilage repair. Recently pub-lished(10) and non published data indicates that dHACM in injectable form is also effective in management of osteoarthritis. Injectable dHACM has been used for treatment of lateral epi-condylitis of the elbow ,partial rotator cuff tears and plantar fascitis(5).

For patients with osteoarthritis who cannot have or do not want steroids or viscosupplementation , this might turn out to be a powerful tool which will help the Ortho Surgeon in mitigating pain. It is too soon to predict if this approach may allow such patients to avoid or prolong the time to surgery. However clinical trials are in progress to study the long term efficacy. Currently dHACM is available in the United States and a limited number of countries outside of the US. As usage and experience increase and reimbursement and or costs become more supportable, this approach might prove to be an important new agent to improve OA outcomes in the baby boomers around the world.

THE MISSING LINKS

..reviving our glorious past.

Dr. V. K. Raju

The golden age of medicine and surgery in ancient India is attributed to the ingenious works of Charaka and Susruta. Susruta practiced and taught the art of surgery at the University of Banares. His monumental treatise, Susruta Samhita, established him as the father of Indian surgery and the first surgeon to systematize surgery by dividing it into separate fields like plastic surgery, cataract operation, laparotomy and vesical lithotomy. He also described Diabetes (Madhu meha).

Charaka a contemporary of Susruta compiled medical treatise known as Charaka Samhita, acclaimed as the finest document of ancient Indian medicine (600 BC to 200 AD). Charaka's fame spread to Arabia. Avicenna quoted him "Scirak", and Rhazes called him "scarak".Charaka's eight branches of medicine translated into Arabic were well known throughout Arabia. Susruta and Charaka's time has long been controversial subject among many medical historians. The original autographic manuscripts of Susruta and Charaka have not survived.

One of the most important documents in connection with ancient Indian medicine is the Bower Manuscript (Fig 1), which is housed in the Oxford University Library, found in eastern Turkestan in 1890 Hoernle transliterated and edited this document critically and placed its origin around Fifth Century BC. The fact that Susruta's and Charaka's names were mentioned in this document places them in the fifth century BC or earlier.

A respected group has concluded that India was indeed the birthplace of medicine and surgery. H.H. Wilson (1823) and J.F. Royle (1837) had inaugurated this study of the subject. T.A. Wise's commentary on the Hindu system of medicine (1845) gave the first complete survey. Before the investigations of these men Indian thought had received but scant attention from medical historians.

The Charaka Club (NY 1989): The translated works of Charaka reached the western world in the nineteenth century, at which time, these works made such profound impression on Charles Dana, noted neurologist and medical scholar, that he set out to found the Charaka Club dedicated to the literary, artistic and historical aspects of medicine. The proceedings of the Charaka Club contains many medical classics and are considered highly collectible by medical historians.

> "All in all Susruta must be considered the greatest surgeon of the pre medieval period."
> - Whipple

Hoernle contends that a larger portion of the Atharvaveda admittedly belongs to a period as early as 1000 BC, since the Hymn in question is included in the older portion.

EXAMPLES OF SOME SANSKRIT WORDS AND THEIR DERIVATIVES USED IN MODERN MEDICAL TERMINOLOGY.

Sanskrit	European
Hrud	Heart (English)
Nasika	Nose
Danta	Odonton (Greek)
Puya	Pus
Kapha	Cough
Sarkara	Saccarose(Greek), Sugar, Zucker

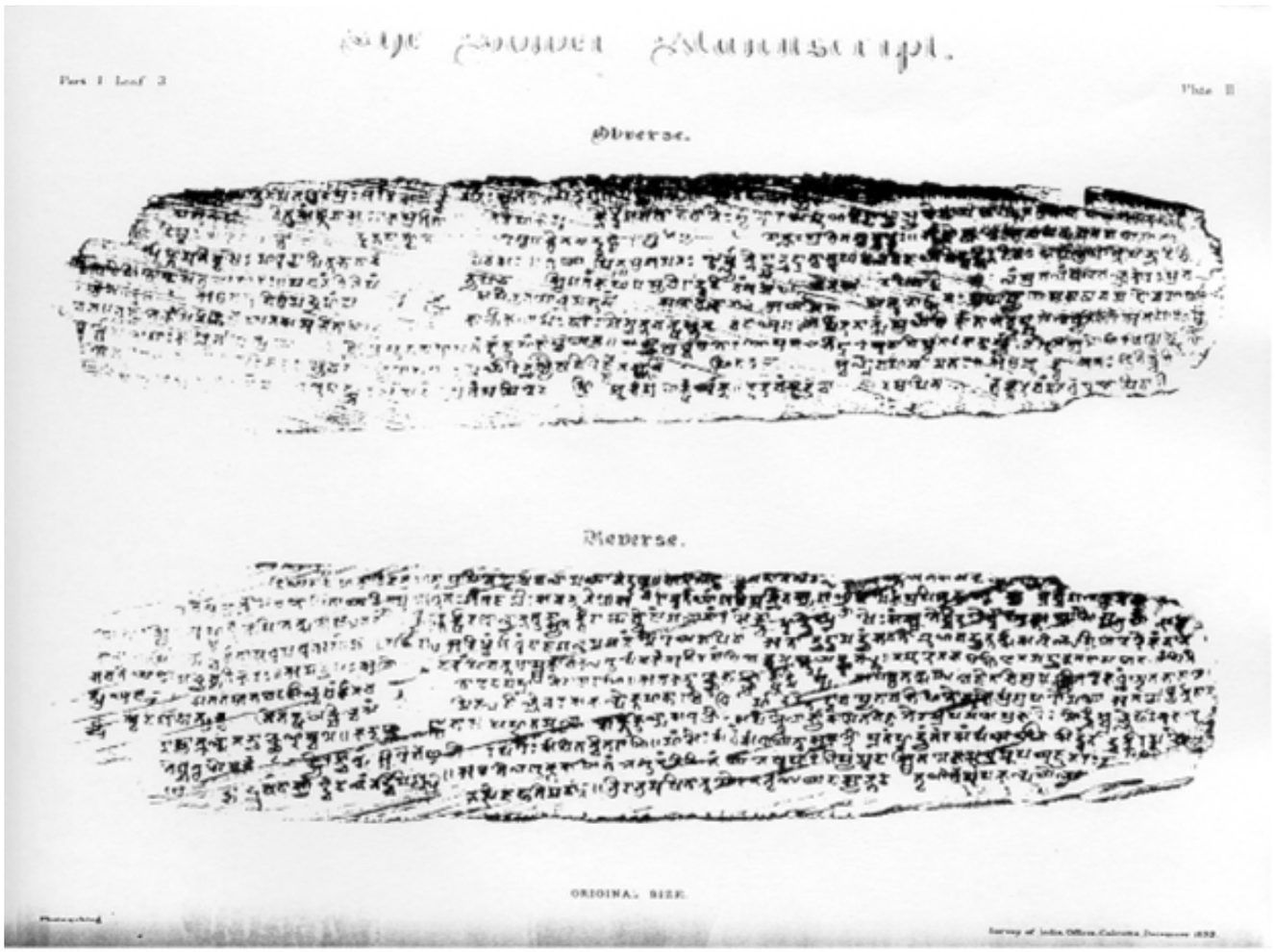
Ayurveda today: With the Muslim conquest during the Middle Ages, Indian medicine passed under the Arabic domination and its influence gradually declined. But Ayurvedic medicine still flourishes in India and there is a recent revival of Ayurvedic medicine.

Ayurveda embodies the collected wisdom of Sages who began their tradition many centuries before the construction of the pyramids and carried forward generation after generation. A modernized system of Ayurveda, based on their insights, came to the west in 1985. Blending Ayurveda and western medicine brings together ancient wisdom and modern science and the two have proved completely compatible.

As far as the west is concerned, there is continued non-recognition of early Indian-contributions to medicine.

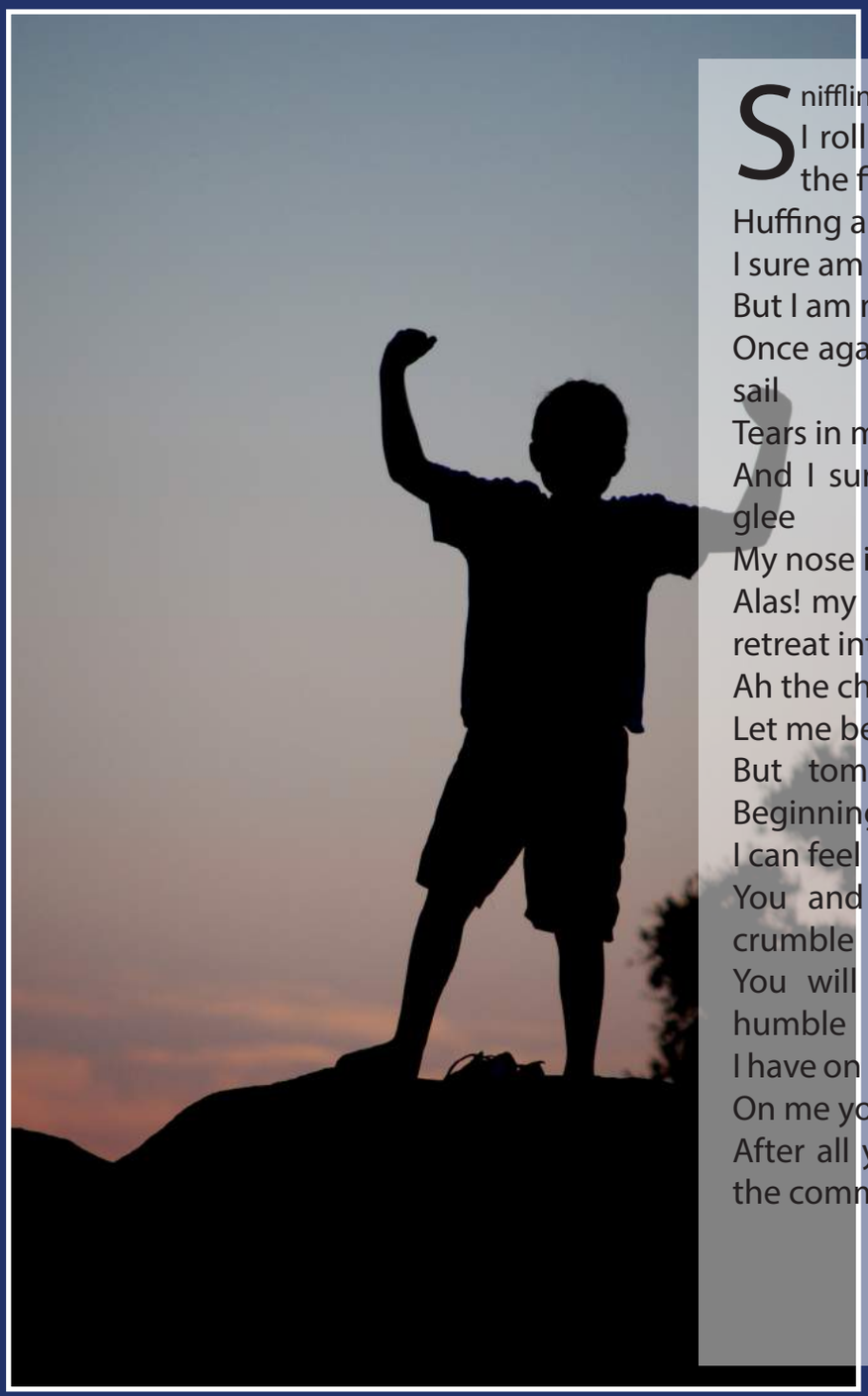
Last Word: European scholars, perhaps prejudiced by the present position of India have been reluctant to admit the claims of the Hindus as to the antiquity of their civilization.

While claims have been made regarding India's place in medical history, research showing concrete connections supporting these claims are what is needed to help sway the majority of opinions. The lack of ancient written history of India should not cloud the views and blur the brightness and clarity of ancient Indian medical knowledge and wisdom.



Victorious

By Meera Menon MD



Sniffling and sighing I sit bolt upright
I roll up my sleeves and get ready for the fight
Huffing and heaving you come up to me
I sure am struggling as you can see
But I am not defeated, I will prevail
Once again I will stand up like a ship in full sail
Tears in my eyes not able to see
And I surely know you are shouting with glee
My nose is running not able to smell
Alas! my machinery is weary and I have to retreat into my shell
Ah the chill in my bones, my body is weak
Let me be for now, I can barely speak.
But tomorrow will come with a new Beginning
I can feel already that things are changing
You and your army will fall down and crumble
You will have to accept defeat and be humble
I have on my side the Power of the Almighty
On me you do not have a hold
After all you are just the virus that causes the common cold !!

WHY SHOULD PHYSICIANS LEAD HEALTH SYSTEMS?

.. but lead, we must

At the turn of the 20th century physicians were decision makers and led about one-third of hospitals. By 2008, only 3% of 5000 hospitals were led by physician CEO's. (1) In 2014, only 10% of senior leadership teams included a physician. Yet, over 50% of hospitals report difficulty filling leadership positions with physicians. Clearly, our educational system is not producing physicians skilled in competencies desirable to hospital leadership. Medical school curricula and residency programs are packed with subject matter appropriate to producing clinicians. As a result, we are led by 'accidental' leaders promoted from among competent physicians, who learn on the job but are not ready for a different skill set required in today's chaotic healthcare scene.

Bhagwan Satiani
MD, MBA, FACHE, FACS

Are physicians well suited to lead health systems? A study by McKinsey showed that hospitals with the most clinician involvement in managing hospital affairs performed 50% higher on effectiveness performance indicators. Amanda Goodall's research tracked personal histories of 300 chief executive officers of the top 100 hospitals in 2009 ranked high in cancer, digestive diseases and cardiovascular disease. Hospital quality scores were about 25% higher in physician run hospitals compared to manager run hospitals. Bloom and colleagues analyzed data on management practices for operations, targets and human resources in 2,000 hospitals in Brazil, Canada, France, Germany, India, Italy, Sweden, UK and the US. Significantly higher management scores were noted in hospitals with more clinically trained managers.

> "I suppose leadership at one time meant muscles; but today it means getting along with people.
> - Mohandas K. Gandhi"

There are good signs for more physicians potentially able to participate in leadership positions in hospitals. The number of medical students in combined MD/MBA programs and physicians either obtaining an MBA or certification in healthcare executive programs is on the rise.

What skills are needed for physicians to succeed? Although leadership competencies are not taught in medical school or training they can be developed. A traditional MBA program may not suffice. Our Faculty Leadership Institute at The Ohio State University Wexner Medical Center has a 12- month curriculum emphasizing emotional intelligence, strategy, teamwork, negotiation principles, financial acumen, communication, problem solving, change management, quality of care and other needed personal leadership skills. (https://medicine.osu.edu/faculty/fame/programs/leadership/pages/index.aspx) Physicians, for the most part, work in silos. Therefore, listening skills, self-awareness and a collaborative attitude is being taught to all our faculty graduates.

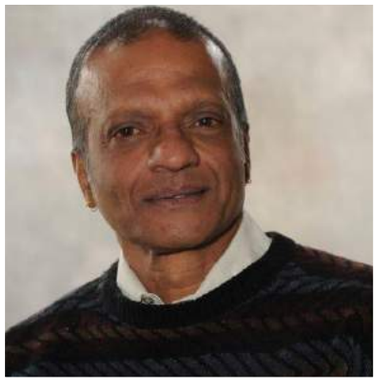
The traditional method of selecting physician leaders is a relic and needs replaced by new paradigms and proficiencies rather than just clinical or technical skills. Medical schools and residency programs need to shift some time to promoting leadership skills. Academic institutions should consider establishing a leadership track in addition to clinical, research and teaching tracks.

When well trained and physicians educated in the business of healthcare lead, good things happen. I predict a significant increase in physicians taking charge of our health systems. Ultimately, this should benefit our patients and our national health system.

THE NEW EPIDEMIC

Violence against Doctors

.. a menace we can ill ignore



Pudupakkam K Vedanthan, MD

During this auspicious time of Navarathri, honoring the Hindu Goddess power, recent news of a 30-year-old pediatrician who was a victim of an acid attack shocked his friends and former professors. He was regarded highly in his community and respected as a physician, however, is now suffering the physical, emotional, and financial consequences of repairing his injuries. In Wichita, Kansas, a highly-respected psychiatrist who immigrated from Hyderabad, India, recently lost his life after being stabbed by his patient. Many times, there is no known reason or motive that is uncovered, and the mystery plagues the loved ones who are left behind. The incidence of violence towards healthcare workers is disturbingly more prevalent. Healthcare workers should be aware and educate themselves, to ensure safe work environments.

Despite the limited research, violence against healthcare workers is a growing international phenomenon. In the United States, between 1980-1990, 100 healthcare workers lost their lives as a result of healthcare violence. In 2008, the British Medical Association surveyed 600 doctors, and one-third of the participants revealed that they had been a victim of a violent verbal or physical attack within the previous one year. Of these respondents, 52% did not report the incident to authorities3. A study published by the Indian Medical Association reports over 75% of physicians have been victims of violence in their workplace. These events occur daily, resulting in critical injuries to the victim. Even premier medical institutions, such as the All India Institute of Medical Sciences, has experienced violence to physicians. Very few cases reach the judicial system, and many times, the perpetrator avoids punishment. The Medicare Service Persons and Medicare Service Institutions Act was developed, and is a state-mandated law developed to protect physicians from violence exhibited by patients or their family members. The law, for example, in Maharastra, states that any person who attacks a physician will be sentenced to a fine of 50,000 Rupees and up to three years in jail. However, many physicians feel that this law does not provide appropriate protection and that law enforcement officials do not honor this law.

Physicians should have an active role in communicating to government officials that assaulting a physician is equivalent to assault on a public service worker in active duty. In addition to changing the Indian Penal Code and the Criminal Procedure Code, law enforcement officials should consistently maintain the legal statutes and strictly reinforce the consequences for perpetrators. The government should work with physicians and healthcare ministers to provide a safe environment for physicians to care for their patients at the high standard of care ingrained by their medical education and training.

SPIRITUALITY

.. into our core beliefs.

Dr. Sunny Kar

A human life is a complex entity, and therefore, difficult to define. On the most basic level, despite being dynamic in its nature, the individual human presence can be separated into a physical, tangible component and a metaphysical, intangible component. While both parts depend on and adapt in relation to one another, the physical component, in its very designation, is much easier to calculate. The non physical component, on the other hand, is certainly much more complex; it defies the senses, and as such is impossible to empirically locate. There is no doubt, though, that despite any metric indication of its existence, the non physical component of life is the root of human nature, and for all practical purposes, the source of the infinite diversity that characterizes 'humanity'. The variations that occur in the physical body, while great, can be quantified, and are simply the result of combinations and recombinations of genetic data expressed on vast, albeit finite, spectrum.

It is the non physical component of a life that is often referred to as the spirit. The spirit, in effect, is the amalgamation of an individual's life; a direct consequence of environment, experience, and interactions, and therefore cannot possibly be categorized in any way. The complete understanding of the spirit, its various parts, influences, and contributors, is spirituality.

Medicine, in the modern sense, is the science that is largely concerned with the understanding and treatment of physical ailments. Healing that relies on only the physical symptoms and remedies is incomplete, as it fails to take into consideration the remainder of the human experience. It is spirituality that fills the gap.

Because both the physical and non physical parts of life are equally essential to be alive, the spiritual side of healing is of utmost importance. In the medical profession, spirituality ought to be considered an integral part of the healing process. On the most basic level, it first begins with acknowledgement of the spirit in itself. In the same way that life cannot go on with a failure in the physical being, a deficiency of spirit may also contribute to the unwell condition.

Spiritual health relies in large part on being at peace with the inner self. In order for a physician to encourage health in a patient, consideration must be given such as to facilitate the sense of peace and identity that contribute to spiritual and ultimately overall health.

As a medical student, the importance of spirituality is more than obvious. The difficulty is in understanding how to implement spiritual health into both the etiology and treatment of disease. The first step, of course would be to acknowledge that spiritual health does in fact influence physical health. This is exemplified by changes in health related behavior that often follow near death experiences. However, complete spiritual health would require a more comprehensive understanding and approach. The pursuit of inner peace and understanding through self study is considered an important component of spirituality and subsequently, spiritual health. It is the duty of any member of the medical field to facilitate and encourage such self healing. It must be understood that spirituality is an important tool through which higher levels of well being can be attained.

PRANAMA

a respectful greeting made by putting one's palms together and often touching the feet of the person greeted.

Dr. Monita Soni

We invited the chief minister of Rajasthan, Jugal Kishore Mathur to my son's wedding. We had tea and gathered for a picture. My daughter held her arm around him in a half hug but he shrugged and said: We don't do this. She was puzzled by her American faux pas. I told her: In India, we don't hug elders. We offer a respectful salutation called: Pranama.

Pra: forward, anama: bending. This bowing before deities, elders, gurus is tradition.

There are six pranamas
Ashtanga: eight points touching.
Shastanga: six points touching.
Panchanga: five points touching.
Dandavat: prostrating from forehead to toes.
Abhinandan: bending forward with folded hands at the chest offering congratulations.
Namaskar-Namaste: folded hands touching the forehead.

Another salutation in the gurukul tradition is charanasparsha: touching the feet. When I returned home to Bombay, and having studied many feet, I examined the feet of my tall father. To my sheer delight his feet were as beautiful as a poem. Adorable baby feet, pink and white perfectly shaped with translucent nails. I had never seen him tend to his feet in my presence, and I knew he hated emollients. What was his secret? I came to the conclusion that my dear father was a dervish and in his swirling trance between the heaven and earth his feet never touched the ground.

> "My eyes are transfixed on your lotus feet"

One day he disappeared into the white clouds. I stretched to touch his toes but I couldn't. Now his feet are always in my vision. I am the bumbling devotee who gets the chant mixed up. Instead of: "My eyes are transfixed on your lotus feet" keep repeating "Your lotus feet are transfixed in my eyes"!

Naresh Parikh, MD
President-AAPI
2018-2019

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* Deluxe air-conditioned motor coach for transfers, sightseeing & excursion tours
* Professional and experienced English speaking guide
* All train/ferry tickets
* Sumptuous Buffet breakfast and dinner daily
* All entrance fee to the places of visit
* All airport taxes
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* Take a dip in the world famous Blue Lagoon, marvel at natural thermal Geysers, Volcanic lunar like landscapes, Mid-Atlantic Ridge, & much more in Iceland
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The Precious Pearl
"The Future Mother"

By Dr. Ram Kesari

.." a mother and motherland are higher than Heaven"

Author's note: Unfortunately killing of the female fetus - "Female Feticide" is prevalent in India. Do we love to hate girls/ women? After the discovery of Ultrasound, feticide became so prevalent. There is shortage of girls in India. For 1000 boys - there are only 940 girls. Diu Daman- only 770, Chandigarh- 818, Delhi- 868 girls (2011 census). In Kashmir ~129 boys for 100 girls. In Haryana ~120 boys for 100 girls. So we need to highlight the problem and tell the ignorant the importance of our precious – noble girl – "The Future Mother". If it has a voice - an unborn fetus/ a little baby girl will question you / us like this .....

Yeah man,
U gave me chromosomes XX
and so I belong to fair sex
Then my mom, why you blame
for giving birth to me a dame?

Did you come into this world without a mom?
Don't you understand this & remain calm?
Didn't your mom born as a girl?
Then when I was born as a girl
Why U get angry, twist and twirl?

You tried to kill me in my mom's womb
And to construct for me a tomb
Don't u know without me your life will be in gloom?
You are certain to meet your doom.
Without a girl how can a man become a groom?
For humanity there's no room.

You pray the female Goddess Lakshmi day & night
With all devotion, prayer & light
Ask her to make your life bright
Why don't you celebrate a girl's birth with delight?
Don't you know I take you to a greater height?
Don't you recognize my 'birth' right?
Of course with all my might
With you I am ready to fight.

What is your problem if I am a girl?
Why you twist in anger & curl
You mourn, give a twirl?
Why your body swirl n whirl?
Why those violent insults on me you hurl?
Don't you know I am a "Precious Pearl"?

When you say the earth is a female - the mother
When a girl is born - her why you want to smother?
Why you get angry and frown?

And in a bucket of water- me you drown?

When you worship the "mother earth"
Why don't you be happy at a girl's birth?
Why you don't go merry and into mirth?
Am I not one rupee's worth?
Why the girls are in dearth?

Wasn't Rani Jhansi a girl, who rebelled on the British empire?
Wasn't she, who put it under gunfire with her kindled desire?
Wasn't Mother Theresa a girl, who saved many an orphan?
But you tried to subject me to abortion!

Do we need Goddess Durga?
To perish your 'monster idea' Mahishasura?

There's a woman behind the success of every man
Know that woman is the origin of man
Girl is the secret of human clan
That's the God's plan
That's how the creation began.

So celebrate a girl's birth
With endless mirth
Enjoy the precious 'future mother',
the beautiful tiny feather.

HIGH INTENSITY FOCUSED ULTRASOUND THERAPY FOR PROSTATE CANCER

.. emerging technology to the fore.

Nick Shroff, MD

Prostate cancer is the second most common cancer in men worldwide and is responsible for over 300,000 deaths every year. In the US approximately 180,00 new cases of prostate cancer were diagnosed in 2016. Treatment of prostate cancer is one of the most challenging public health issues. Problems include undergrading and understaging, overtreatment of nonsignificant cancers, and treatment-related toxicity with escalating costs.

The trend in all surgical disciplines is for less invasive procedures. High-Intensity Prostate ultrasound (HiFu) can be used to treat localized prostate cancer non-invasively with precise destruction of tissue and minimal collateral damage to adjacent structures. Using image-guided controlled energy
HiFu can treat the cancerous portion of the prostate while leaving the remainder of the prostate intact with minimal side effects of sexual function and continence. The FDA approved HiFu for prostate tissue ablation in October 2015. HiFu devices have been approved in 41 countries, and the procedure has been performed in over 65,000 men with follow-up of over 20 years.

Similar to a magnifying glass that can concentrate sunlight to burn an object, HiFu uses focused sound waves to heat and targets cancerous areas of the prostate. The concentration of pressure waves at the focal point causes energy. The energy generated is a thousand times higher than that for imaging.

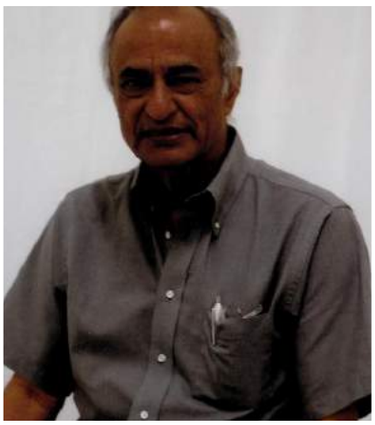
HIFU is a cutting edge treatment that results in necrosis of cancer tissue after applying energy to a focused area with the action of thermal energy and cavitation. HIFU can be considered as an ultrasonic version of three-dimensional radiation such as cyber knife and gamma knife.

The HIFU machine such as Ablatherm have numerous safety features incorporated to stabilize the rectal wall during transducer movement, maintain a safe distance between the heat treatment and rectal wall and to prevent movement. Focal treatment is also possible for recurrent and primary prostate cancer. HiFu is delivered as a single session outpatient therapy under anesthesia for about two hours. Normal activity can be resumed within a couple of days.

HiFu preserves potency in 80% of men and has less than 3% incontinence. Post-radiation recurrence can be treated with HiFu with minimal side effects compared to Cryosurgery or Robotic surgery. Major complications like stricture urethra are rare. According to Dr. Perinchery Narayan, Chief Medical
Medical Officer, HiFu Solution, *"there is an unmet need for men with newly diagnosed prostate cancer who are seeking treatment alternatives that are curative but do not include severe long-term side effects such as impotence and incontinence. HiFu procedures may fulfill many of these expectations."*

A STORY OF BARBIE DOLL

.. a "touching" story .



Sanat Gandhi, MD

A young girl in Junior High in a suburb of Chicago got an idea during last Christmas time that every little girl should have a Barbie doll for Christmas. Her idea on internet went viral, so much that Mattel Company sent several crates of Barbie dolls- lot more than can be distributed locally.

Her mother who worked in a hospital found out that several physicians were going to India in early January for a medical mission in remote village areas. She offered Barbie dolls to them to distribute to kids in India, which they gladly accepted. She asked them to send pictures of kids who got them.

The theme of the mission (organized by AAPI, WI) was to eradicate child blindness, as such, most of the patients were children coming from faraway places to be treated at the regional hospital. Volunteers distributed dolls to these kids who hardly had any toys let alone Barbie dolls. Their faces lit up at the sight of dolls which volunteers captured by clicking cameras.

They put up those pictures for all to see at the end of a camp, when they were back home, after the mission. Amongst them there were few pictures of a six year old girl who was emotionless when receiving a doll. One can see in her next picture, when asked to look up, that she is blind with corneal opacity in both eyes.

The pictures were seen by everyone in medical mission along with their family members. One of the young family member asked if something can be done to restore her eye sight. The group decided to collect money so she can be sent to a finest hospital to be treated in India with money collected.

The problem was, mission had seen almost 2000 patients in a week and not knowing her name, locating the patient just from photograph was almost impossible, as per hospital staff. Well not quite, the volunteer who had taken the picture told the day and time picture was taken. That was helpful as one can narrow down the number and with gender and approximate age it was easy to locate her papers. She had come from a faraway village. The family was told that their daughter will be cared for and all expenses will be taken care of.

No one in these villages know anything about Christmas or Santa Claus. A little girl on the other side of the globe gets and idea to collect dolls for Christmas and one of those dolls end up with a blind girl from a remote village of India whose photo is seen by kids here in the USA who ask their family members to act and hopefully get her vision restored after corneal transplant. To a perennial question "is there a Santa Claus?" someone may reply 'see Virginia, there is Santa Claus"!

Readers' comments and desire to participate in future missions will be appreciated. Sanat Gandhi, sandmansg@hotmail.com.

The place we were in Gujarat had very large Muslim population, half the patients we saw were Muslim. All the patients and family members were catered lunch and dinner and family members of operated patients were provided beds at nearby Gayatry temple.

VANBANDHU AROGYA DHAM

Gateway to Healthcare for Tribal Population

Vanbandhu Arogya Dham (VAD), a world class Healthcare facility and Research and Training Center, is a sincere attempt to improve quality of life for the tribal people of Dang, Gujarat, India, by providing a platform to deliver community-based healthcare services. It is being built in Ahwa, Dang, for the benefit of thousands of underprivileged tribal people of Dang district and surrounding areas. More than 95% of the inhabitants of Dang are tribal and barely survive with the help of government programs. There is almost a complete lack of healthcare, education, and employment opportunities. Honorable Prime Minister, Shree Narendra Modi has a personal interest in helping the impoverished people of India.

Dr. Ashok Patel with Prime Minister of India Narendra Modi

VAD has already started to provide free medical and dental care to children and needy adults. The goal is to thoroughly screen all 53,000 school children of Dang. VAD will feature a well-equipped hospital with a state-of-the-art dental clinic, oral cancer research center, pathology lab, and all other amenities. VAD complex will also have a separate residential facility for 30 tribal girls to be trained as medical and dental auxiliaries.

VAD will focus on prevention, early intervention, and corrective procedures, including necessary rehabilitation and follow-up services. Furthermore,

Proposed Building - Vanbandhu Arogya Dham

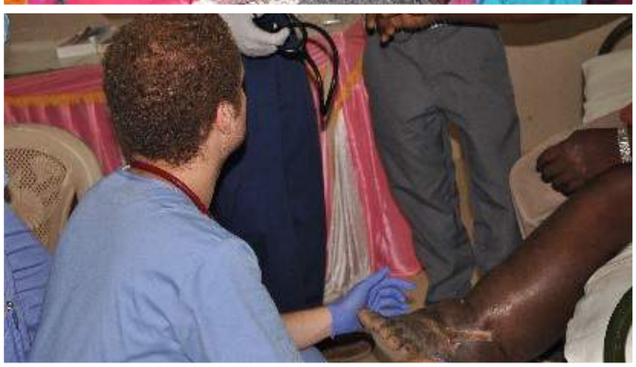
the facility will offer unique volunteer opportunities for medical and dental students and young doctors, especially from USA. With features such as sanitation, instruments, equipment, and materials that live up to international standards, VAD will be the perfect setting for retired doctors and dentists to carry out research projects.

The project is already partly functional. A section of the facility is currently being used to carry out thorough medical, dental, and sickle cell anemia screening of school children from local schools in Dang. In addition, VAD clinic currently has a medical outreach program. Using well-equipped mobile vans, teams of doctors and paramedical staff regularly visit remote villages of Dang to provide primary healthcare. The vans are also used to transport the most destitute patients to the clinic for further evaluation and necessary treatment.

In December 2014, a medical team from Nova Southeastern University (NSU), Florida visited Ahwa, Dang under the leadership of Dean, Dr. Anthony Silvagni, for a week-long healthcare camp. Dr. Silvagni and team members were truly moved by the sufferings of over 1,000 patients and saw great potential for future activities. As a result, another team from NSU visited Dang in December 2015 with great success. In December 2016, a medical team of 70 members including faculty members, residents, interns and

medical students from NSU, Florida and ACOM, Alabama provided medical care to more than 1,225 patients. NSU is currently developing a program to increase the presence of interns and residents at VAD year-round. Motivated by NSU camps, specialist medical doctors from surrounding cities of south Gujarat participated in a comprehensive healthcare camp on February 14, 2016. The organizers were overwhelmed to see 1,040 patients who exhibited many preventable medical problems. About 26 patients were transported to Ami Hospital in Bardoli for various surgeries, three being life-saving in nature. AAPI participation will make a difference in the project.

For further information, please contact Dr. Patel at ashokdmd@hotmail.com or 603-892-0872, or Kathryn Carney at 603-897-5832.



CHAITANYA SARADHI

.. a true Karmayogi.

Educating the impoverished children in rural India

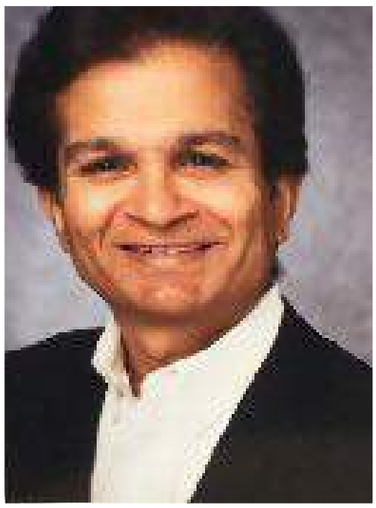
People often ask me what made me start the project, "Chaitanya Saradhi and Awareness USA." Well, here is the story behind it.

As a son of a poor farmer in Telangana, I witnessed hard work and poverty first hand. I was a farm hand more days than I went to school. I wasn't a bright student but with hard, entered Gandhi Medical College, Hyderabad. With free tuition, a small government scholarship, and a true benefactor I becoame a physician. After completing M.D in general medicine in India, MRCP (U.K), and a fellowship in Gastroenterology in New York, I had a successful Gastroenterology practice in Crystal River, Florida and retired after 30 years. I then embarked on a non-profit mission for life. formed a nonprofit trust, Chaitanya Saradi, and to help the disadvantaged students in the USA, a second non-profit trust,

Mentoring High School students

Awareness USA. Education is the mother of all human progress. "Like a rising tide lifts all the boats," said J F Kennedy, education punctuates wholesome economic, social and lifestyle progress in the world.

Chaitanya Saradi started in Telangana and Andhra Pradesh about two years ago. We hire computer instructors, set up labs, and arrange technical support in the government schools in rural districts. Our goal is to train all the students to handle computers well and become self-learners. Our mission is to enable the students in government schools to be competitive with private institutions. Our vision is to foster a safer, healthier and a more civilized Indian society.



Purna Bikkasani, MD, MRCP (UK)

We visit schools periodically, check on their computer labs, and see firsthand what the students were learning. We motivate, guide and check in on the digital educators' quality of performance. The teachers file monthly reports on their work in the computer labs and digital libraries, and also share their initiatives and experiences among themselves.

We give interactive motivational speeches and handouts to inspire the students to dream big, and develop good listening, speaking, reading, and writing skills. We teach and demonstrate, to the students, how to express themselves during these sessions. We partner with school staff in various ways and receive outstanding cooperation from them. So far we have set up 18 schools.

On my recent visit to India, we drove 30 miles

deep into a nameless village in the middle of a forest. This village has no modern facilities: electricity, water, concrete, electronics, etc.

WHO ARE THESE PEOPLE? OUR LOST COUSINS!

The villagers asked me to speak to them through their interpreter, but I was speechless --lost in sad thoughts in trying to figure out their plight. Who are these people? Why are they here? How come they are stuck in the past? Why doesn't the government help? Why don't fellow humans help them? Just sitting with them and seeing their plight I became speechless for couple of minutes. They were engrossed in watching us, the strangers!

These tribal people have recently moved in from Chhattisgarh and built 17 homes for100 people with their cattle and chicks. Children stay at home all day long to play and watch the nature. They don't have a school to go, can't read or write. Their parents are out grazing cattle, gathering fruits, roots, nuts, and honey, and doing some natural farming as our ancestors lived once 15,000 years ago, while the rest of us followed a progressive socioeconomic path with the help of science and technology. They refused to risk their identity for modernization.

They are our lost cousins without citizenship rights on the lands they live; they can't farm or dig bore wells for drinking water. They are stateless. They bathe in a river nearby; have to carry the water back from it for drinking and cooking. A campfire is their only means of warmth in the cold, yet they sing, dance, have festivities, and celebrate life.

The tribal people in India and us are descendants of the same original immigrants from E. African to the Indian subcontinent. Our common ancestors parted their knowledge, skills, and tools with each other in crossing the treacherous waters of Red Sea's Bab-el-Mandeb straits and moving along the coastal ways to India. Our DNA, survival, and welfare were once liked together. I think it is time to extend a helping hand.
As a happy ending since then, an enlightened donor came forward to fund this primary school in the village.

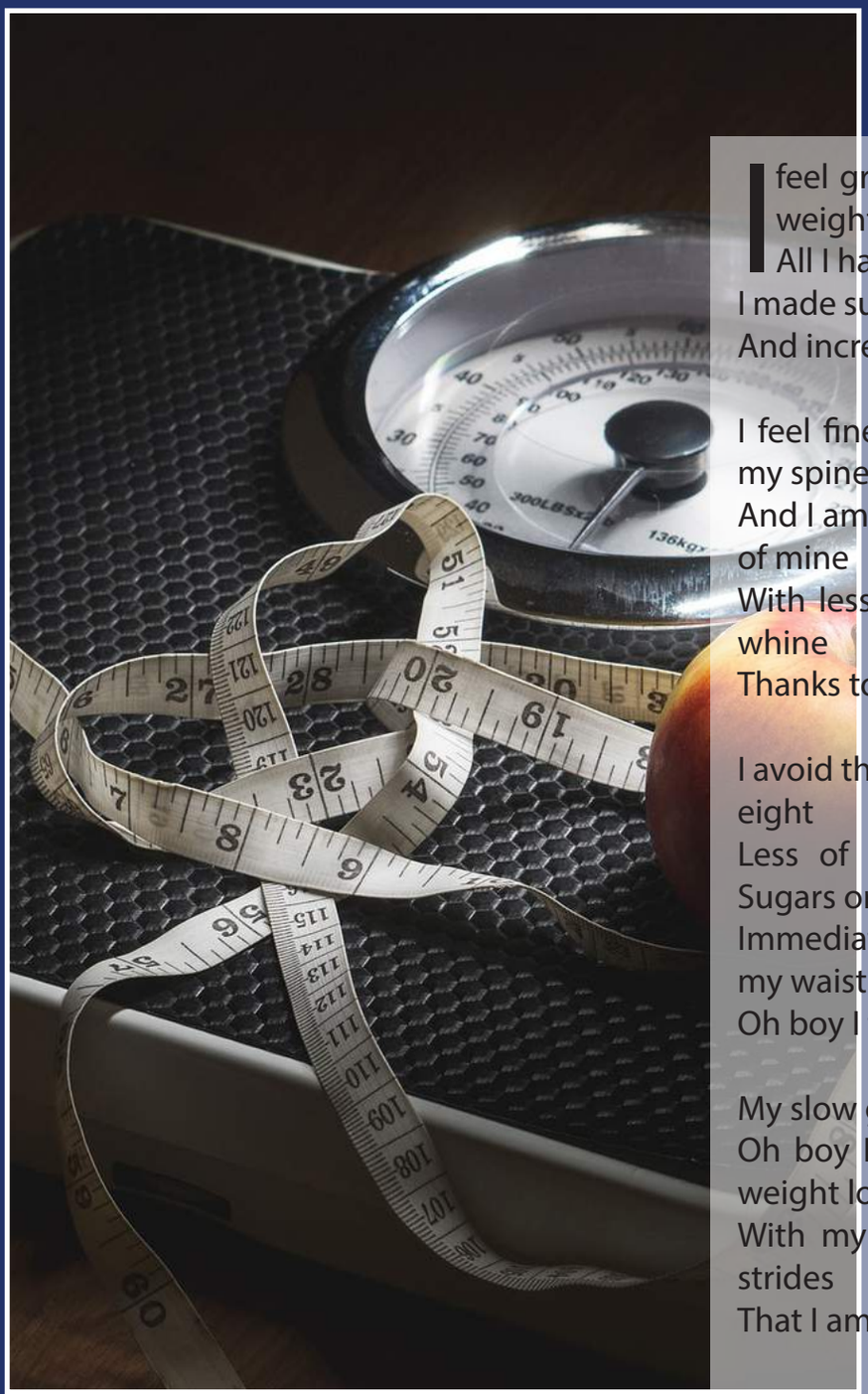
I wish to share a few of my thoughts with fellow AAPI members. We were lucky to have enjoyed a free education in India, and have had the chance to immigrate to the USA. All of us have worked hard, and built outstanding careers. We have enjoyed the unique opportunities to become wealthy, healthy and happy in our lives. I feel it is time to give back to our motherland (INDIA) and to the Adopted country (USA). The upward social mobility and the acclaimed success we have attained did not result only because our intelligence and hard work, but also due to the support we have enjoyed from the family, educators and society. As students of science and liberal arts you all know how scientists, explorers, adventurers, philosophers, reformers have amassed the knowledge and wisdom that had culminated in building the modern society. They gifted us with a silver platter and our job is to hand down the same – a richer, healthier and happier life style – to the future generations. No amount of family wealth will guarantee the safety and security of our grandchildren and great grandchildren than to help build wealthier, happier and harmonious society. So I urge you to donate your money, time and advise whatever you can for the charitable causes to make this planet a better place.

I thank my compatriots and fellow physicians from India for letting me share my charitable work in India. I hope my story will resonate with many members in the AAPI.

I feel Great
I lost a lot of Weight

By Ragavendra R Baliga, MD

.. yes, we can do it!



I feel great having lost twenty pounds of weight
All I had to do is to watch what I ate
I made sure that I put very little on my plate
And increased the pace of my gait

I feel fine because there is less weight on my spine
And I am able to better flex this aging back of mine
With less weight off my back, I no longer whine
Thanks to paying attention on what I dine

I avoid the GAPPSS late in the evening after eight
Less of Grains, Alcohol, Potatoes, Pasta, Sugars or Starchy food on my plate
Immediately resulting in the shrinking of my waist
Oh boy I feel great

My slow gait morphed into a glide
Oh boy I am going to go along with this weight loss ride
With my weight I have made such great strides
That I am bursting with pride

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