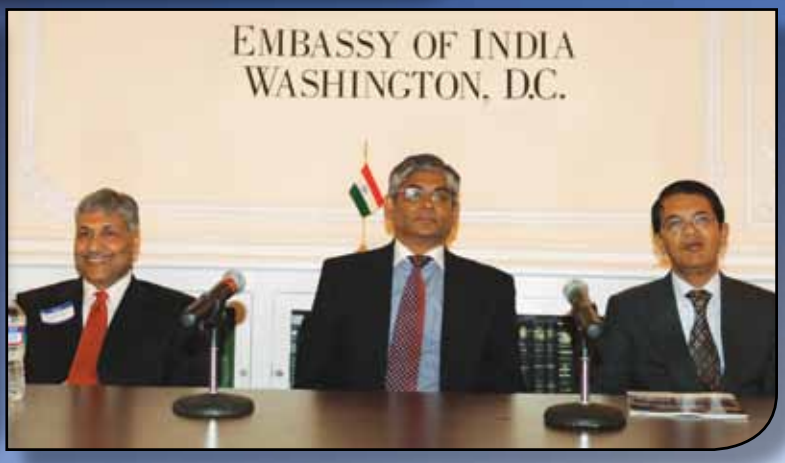
SUMMER 2011

AAPI Journal

THE JOURNAL OF INDIAN AMERICAN PHYSICIANS



INSIDE:

- Legislative Day at Capitol Hill • Health India Think Tank
- AAPI CME Accreditation • Dermatology at AIMS, India
- MSRF/YPS Corner • AAPI & Poetry

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AAPI Legislative Day at Capitol Hill
Discussing with Health Care Leaders

President's REPORT

Ajeet R. Singhvi, MD, FACG

As the President of the American Association of Physicians of Indian Origin (AAPI), it is my privilege to present the President's report. This has been a remarkable year for our Organization. AAPI has climbed steadily to become one of the premier medical organizations, not only in the U.S.A. but beyond our shores. Today, other medical organizations look to us for vision and value. One of the reasons for this is that we have consistently delivered on our plans and promises. Our competency and decisive delivery on these issues could have not been possible without the remarkable grass roots support we have received from the members of my team. I want to share some of these initiatives and accomplishments with you.

FOCUS ON THE YOUNGER GENERATION

Active participation of the younger generation in AAPI is critical for the survival and growth of our organization. We added over 1800 patron members this year, of which over 85% are young physicians. That is a staggering growth of over 25% in a single year over the past 28 years combined. Our leadership seminars were held in Newport Beach, CA, Long Island, NY, Dallas, TX, Chicago, IL and Detroit, MI were very much appreciated. Our Capitol internship Program will help these Young Physicians to learn about health policy and legislation. My earnest hope is that our young physicians will be better leaders not only in the medical field but will be our representatives in the US Congress and the Senate. The Medical Rotations to India program has also taken off extremely well, and I expect it to expand many folds in coming years. The International Missions and Community Service initiative is already paying dividends. Our Observership and Mentorship program has helped quite a few International Medical Graduates get into Residency program.

LEGISLATIVE AGENDA:

Our organization has been very active on Capitol Hill. We now have a Legislative Office in Washington D.C. with Legislative Director to help us address the important issues and achieve our goals. A physician supported Political Action Committee separate from our organization was established this year. Our Legislative Day attracted a large number of Congressmen to come and address our concerns and issues. We have been focused on the issues of increasing the Residency slots, permanent J1 Visa waivers, and the economic well-being of physicians. I feel we have made some strides in this direction. We also had a policy related health forum at which Dr. Cecil Wilson, President of American Medical Association (AMA) was the keynote speaker. Then, in the evening we held a Capitol Hill reception which was attended by a large number of Congressmen. This was followed by the dinner at the Indian Embassy where community leaders also joined to address the issues of mutual concerns.

CME:

For the first time in 29 years, AAPI has become ACCME accredited CME provider. This has been a long standing effort and I want to recognize everyone who contributed towards that goal. Having watched our efforts for past 5 years, I was committed to bring it to the fruition and made it a top priority of my term. Let me

emphasize that although getting this accreditation was seemingly difficult and long, maintaining our accreditation will require even greater effort and diligence if we are to provide CME both at the National and International levels. This will definitely benefit our umbrella organizations a great deal.

We were also able to hold 5 regional CMEs in Fresno, CA, Chattanooga, TN, Charleston, SC, South Padre Island, TX and Detroit, MI. This turned out to be a great outreach effort and was very much appreciated not only by our members and would be members, but also by physicians of other ethnicities as well.

AAPI GOVERNING BODY

Both the Fall and Spring Governing Bodies were very well attended. Long Beach, CA Chicago, IL and San Antonio, TX were awarded the future AAPI Convention sites for the years 2012, 2013 & 2014. It was heartening to see all of the 10 current AAPI Board of Trustees members, the 7 AAPI Officers, the 6 current Regional Directors, the three past Presidents from Chicago, and several past AAPI and local leaders at the Chicago Governing Body. Plans to form the first ever Health India Think Tank were approved.

AAPI CHARITABLE FOUNDATION

This has been our flagship arm. This year, besides raising funds for several charitable causes at various chapter meetings, AAPI Members assumed an active role in helping the victims of the Alabama disaster. The AAPI Chair personally presented a check of $5000 on behalf of the AAPI-CF to the Governor Robert Bentley for the victims of the Alabama Disaster.

Several missions were also taken on by AAPI members in various countries, including Egypt, Haiti, China, South Africa etc. We also offered to extend our help to Japan's Earthquake and Tsunami victims and were listed as number 3 on call to be the providers. Our ambitious program to install Automatic External Defibrillators in each and every Indo-American community center in the Country to improve the survivability of sudden cardiac arrest victims was recently launched. The first Automatic External Defibrillator was presented to be installed at the Indian Consulate in New York. We hope to expand this program to several community centers around the country in the next several months. Your generous contributions toward continuing and expanding these AAPI-CF programs will be greatly appreciated.

MOU letter being handed over by Hon'able Minister Dinesh Trivedi to Dr. Singhvi at his office in New Delhi, for starting Health India Think Tank

INDO-US HEALTHCARE INITIATIVES

Our 4th annual Indo-US Healthcare Summit was a great success. Besides Diabetes, CVD, Lung Health, Maternal & Child Health, this year's summit highlights were Health Tourism, Status of Organ Transplantation in India. Six projects that were deemed particularly desirable during the summit that required minimal follow-up and resources that could be undertaken by various states and NGOs in India are:

- Prevention, early detection & Management of Cervical cancer
- Prevention of Oral Cancer
- Prevention of Blindness in Young Children
- Sevak Project
- India Specific guidelines for Medical Tourism
- Organ Transplant Guidelines

I also had an opportunity to address the 86th Annual Indian Medical Association conference as the chief guest at the award ceremony on December 27th, 2010 in Jaipur to talk about the "Future of Organized Medicine."

I participated as a panelist during the 9th annual Pravasi Bharatiya Divas held in New Delhi to talk on – Health Next - Public Private Partnerships in India. AAPI took initiative to establish the Health India Think Tank at the request of Honorable State Minister Shri Dinesh Trivedi. This will create

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a forum for the public awareness and advocacy to accessibility and affordability of optimal healthcare, health care delivery, health care financing, and beyond. I am happy to report that first ever health related Think Tank, an autonomous body has been established as an AAPI initiative in New Delhi, India. We are now ready to open an office in India to coordinate and expand our services to the profession and to the people of India.

To improve our office infrastructure and to provide much needed continuity, we have hired an Executive Director who I hope will be a bridge between AAPI, the pharmaceutical industry, vendors, and other mainstream organizations, and to also enhance the financial security of the organization. We have also worked diligently to provide several membership benefits which has helped serve our membership better.

AAPI ANNUAL CONVENTION

This year the AAPI convention is being held in the Big Apple after over a decade. We are planning an outstanding educational program, various interactive forums, and great entertainment and food. We will also get to listen to important guests from the United States and India and possibly three Nobel Laureates.

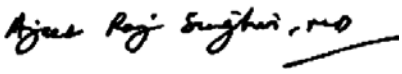
The purpose of the annual convention is also to review our past, correct any shortcomings and chart the future course of action for our organization. I invite all of you to participate and make the convention successful.

It has been a privilege to serve AAPI as your President, and I am grateful for the opportunity you have entrusted me with. I am very hopeful that there will be new and even better initiatives and that those already in the pipeline will come to a meaningful completion. These are the issues that matter to you, our membership, and we will remain committed to maintaining the progress made this year and ensuring that no job is left incomplete.

I am very thankful to my entire Executive Committee, various chairs, and the AAPI leadership for their steadfast support. I would like to thank Ms. Vijaya Kodali, Mr. Sam Fulambarker, Ms. Harshita Mukunda and Ms. Anam Arshad at AAPI office who have been a great asset to the organization.

I will be happy to receive and respond to your comments and suggestions.

Respectfully Submitted.



Ajeet R. Singhvi, M.D., F.A.C.G
president@aapiusa.org

EDITORIAL COMMITTEE

One Year, Lots of Progress

M. P. Ravindra Nathan, MD

This is the 4th and final issue of the AAPI Journal for this academic year. In spite of the many difficulties and unforeseen challenges, we have been able to publish all the issues, a proof of our commitment to you. Altogether, it has been a very successful year for the journal and we have had some notable accomplishments. Apart from launching the first ever MSRF/YPS contest, we were also able to feature many new authors and revive the sections of poetry, humor, 'A Glimpse of My Life' and others. Extensive coverage was given for the many significant AAPI events, especially Indo-US Health Summit, Charitable programs, MSRF/YPS activities and more.

Hope you enjoyed the spring edition dedicated MSRF/YPS, with the award-winning articles, poems and photos. This contest in creative arts for our young members has, indeed, galvanized their desire to write. Clearly, AAPI has got lots of talent. Many articles in this issue are also from the MSRF/YPS submissions and make fascinating reads as they touch on a wide array of topics.

Also in this issue, don't miss the details about the Legislative Day event at Capitol Hill, hosted by AAPI. It is very encouraging to see physicians in practice taking time off and coming to Washington DC to be involved in the political and legislative process. This is critical at the present time since health reform implementation is underway along with the changing dynamics of medical practice; we need to hear first-hand from policymakers about key issues.

I am always humbled by how far Indian physicians have progressed in the USA after they started the migration in the early 50's. Despite the many challenges posed by the new environment, racial discrimination, health care reforms etc., we have been very successful as a group. And AAPI has been pivotal in this progress as we all come together under one umbrella. I am sure you have a lot of stories to tell regarding your initial experiences in this county, subsequent progress and the lessons learned. I hope you will use AAPI Journal to bring them out. Always remember, the readers appreciate the enchantment of your story, beauty of your language and the messages you want to convey.

The annual AAPI Convention is here and we are all excited to be apart of the celebrations. And what better venue could we have hoped for than the vibrant New York City, known for its historic, artistic and cultural contributions? It is a resilient city too, as revealed after the 9/11 tragedy. It offers something for everybody, with all its art exhibits, museums, fashion parades and festivals, Broadway shows, street performances, gourmet restaurants, sporting events, and more.

After this issue I will step down as the Editor-in-Chief and will pass the editorial torch to my good friend and colleague Dr. Sivaprasad Madduri, an outstanding writer and a past editor of the journal. I am confident Dr. Madduri will lead the AAPI Journal to even greater levels of success.

Let me take this opportunity to thank all of you, members and readers, for your continued support and indulgence. A special thanks to those who sent their critiques and comments. It has been a great privilege to run this magazine. I must also acknowledge the dedication of our editorial team, total commitment of the publisher Mr. Galal Ramadan/GR Marketing and the whole-hearted cooperation from the Executive Committee and office staff. For me, it has been quite an enthralling journey.

I do hope you and I will meet again on the pages of this journal in the days to come. Best wishes and good luck to all of you.

Year-end Report from AAPI Secretary

Jayesh Shah, MD

As the Secretary, I have tried to fulfill my duties to the best of my ability in keeping the AAPI office and its records in proper order. Dr. Singhvi and all the committee members are kept appraised of all issues related to AAPI on a regular basis. Our office staff has been doing a phenomenal job. We have started doing weekly conference calls with office staff to ensure all office work is done in a timely manner. One of the exciting projects we are working on is to update the database of the entire AAPI constituency which will be available during AAPI's Annual Convention. Executive Director (Chief Operating Officer) search committee has worked hard and we already have a recommendation from the committee for consideration.

Besides keeping AAPI office functioning well, I have actively worked to:

1. Increase involvement of young physicians and enhance their participation at all levels of AAPI.

a) Planned for 5 leadership conferences this year

(1) More than 300 young leaders trained in last 5 conferences(Washington D.C., New Port Beach, long Island, Chicago, Dallas and Detroit)

b) Worked actively with YPS and developed plans for scholarships for legislative internship and for community service.

2. Develop and expand Observership program in the US.

- As the AAPI liason officer for the Observership Committee, I am working diligently with the Committee Chair to expand this program in this country.

3. Strengthen base of AAPI by empowering local chapters.

- As your representative, I attended multiple local chapter meetings.
- We organized successful 2nd AAPI Family Cruise in collaboration with IMASC and IMA Chicago.
- 3rd AAPI CME Program was organized in South Padre Island, Texas.
- Attended IMA annual meeting
- Attended long Island Annual Meeting
- Attended and helped in the organization of women's conference in Dallas
- Attended meetings with multiple pharmaceutical companies
- Attended Preconvention Planning meeting in New york
- Attended Pre Governing Body Planning Meeting in Chicago
- Attended MAPI meeting in Detroit
- Attended APMGA Meeting in Atlantic City, New Jersey
- Attended GAPI meeting in Georgia
- Attended IDA/TIPS State Level Annual Meeting

4. Further the goal to improve quality of health care in India.

- Addressed IMA Bombay in September 2010
- Participated in Diabetes Panel at Indo US Health Care Summit in Jaipur
- With the help of TIPS SW chapter leadership, 2nd fund raiser event for the AAPI Charitable Foundation organized in San Antonio on September 18, 2010, was very successful. $15,000 was donated to AAPI Charitable Foundation and $15,000 was donated to Fallen Heroes Fund.

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Chairman's Report

Ashok Fulambarker, MD

As I presented at the Spring Governing Body meeting in Chicago, the patron fund of AAPI is doing very well so far. Year-to-date, the balance is at $2,808,069 as of May 2, 2011 which represents a 5.1% net of fees return for this year and a total of 16.1% net of fees return (annualized). Further, the BOT Committees are working cohesively towards successful short and long-term futuristic goals of AAPI.

The Board has regularly met on schedule to discuss important issues facing AAPI. The meetings have been cordial and productive.

I believe AAPI's success depends heavily on cooperation and teamwork of both the executive committee and the Board of Trustees, and thus far we have had a successful year!

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- I got an opportunity to represent AAPI at the Indo US EM Summit in Vadodara, India and I was successfully able to procure grants for this program in India.

5. Closely work with organized medicine at state, national and subspecialty level

- I continue to remain the AAPI liaison to AMA as the Past Chair of IMG section and I will continue to advocate on behalf of IMG and other physicians. I was recently elected as Alternate Delegate from TMA to AMA which will keep me involved in organized medicine.

It is definitely a humbling and learning experience to work with all AAPI leaders and to serve as your Secretary. I thank you for electing me as your vice president, I will do utmost to bring AAPI to newer heights.

aapi EXECUTIVE OFFICERS

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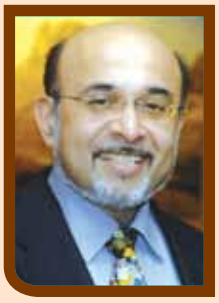

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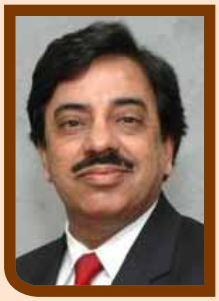

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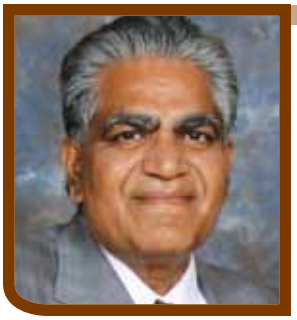
Health India Think Tank



Pawan Rattan, MD*

Dr. Ajeet R. Singhvi, President of American Association of Physicians of Indian Origin during his address at the Pravasi Bharatiya Diwas Health care session in New Delhi, 'Health Next – Public Private Partnership' looked at the Hon'ble State Minister of Health, Shri Dinesh Trivediji and said, "Indian Health Care System, can only change, if there is a *political will* ....."

I am not sure if he had intended to, or it just happened, but it seemed he touched a sensitive nerve. Hon'able Mr. Trivedi was eager to engage and look for ideas!

Let us talk about Health Care in India

Everyone in the audience had an opinion as to how we can fix Indian Health Care system. After some time I also raised my hand and got a chance to speak. "Well sir, Indian health care system is one of the most complex in the world. From Ancient, Tribal, Ayurvedic, Homeopathic etc. to the most modern and everything in between and every combination possible thereof. This is not a setting to find a solution let alone an answer for this complex national problem. We need a dedicated team of the best qualified professionals to find a workable solution. We need a 'Think Tank,' to come up with ideas that can be then debated at length. I had said my two cents worth and sat down."

Hon'ble Minister Trivediji, liked the idea and AAPI team was invited to his office the very next day which happened to be a weekend with his two staff members working. A letter was dictated and a Memorandum of Understanding (MOU) was signed immediately. AAPI will initiate setting up of a "Think Tank" in India, dedicated to health care.

That was the easy part.

Having been assigned the task at the AAPI Spring Governing Body meeting in Chicago in April 2011, I was off to Delhi in May 2011, not realizing it is really oven hot during this time of the year in Delhi. Along with the task came instructions, you must meet so and so, you must do this…etc. "These are some very important people and they can help you and so on." So I made the list and made a few contacts before leaving. I felt it was indeed a privilege to meet some of these great minds. I will share just one such meeting to start with and rest I will save for later.

If the weather was really hot, the *(continued on page 12)*

Group of top cardiologists during the meeing in India.

(continued from page 11)

reception by some of the important people was really cold or should I say blunt? One such key person said in no uncertain terms, "So you want to improve health care and healthcare delivery in India? Young man, do not waste your time. Just go back. ***Bandook utha ker aa gaye ho, ye to Tank Brigade ka kam hai***. Nothing will change in India." What a response to my well meaning questions and concerns about the health care in our mother land!

Let me say this much. I was fully aware that this great man started as an IAS officer under Prime Minister Jawaharlal Nehru. He obviously knew the system well. After all he had been Health Secretary and also had worked for the World Health Organization. Should I just go back? The thought did cross my mind, but I have an assignment from AAPI and a commitment to keep. *No I was not going back.*

So I said, "But Sir I mean..... some things have changed? India is an emerging world power, and change is a constant in nature, isn't it?"
He looked at me with a steady gaze and steely eyes and asked, "So, you really want to do something?"

To which I replied, "Well sir, I mean we, the organization, ***AAPI***. It will be a group effort and I hope you will be part of it too."

Suddenly there was a faint smile on his face. I could sense a softening in his attitude.

"Well, I am too old but I see a commitment in you. Well, if there is a commitment, yes things can change. I will help in any way I can," he said much to my relief. We had a very good discussion that lasted over an hour. His advice was very valuable. He walked me to the gate to say Goodbye. He had warned me that it will be tough, and tough it was. Just to get it registered, it will take ten days.

Well, we did finally get it. "Health India Think Tank," a not for profit, autonomous body, was registered in New Delhi, India. This will be just the first step.

His words are still fresh in my mind, "Well, if there is a commitment…"

** Chair, Health India Think Tank dr.rattan@gmail.com*

Top: With Hon'ble Minister Dinesh Trivedi (in Black Indian Dress) in New Delhi
Above: Hon'ble Minister Dinesh Trivedi & Dr. Singhavi and others that were part of AAPI delegation at the office after the PBD,after discussions that led to the HITT, MOU.

AAPI leaders with Hon'able Minister Dinesh Trivedi

BUDGET BALANCING:

Why the President and Congress could not act boldly?

Aravind Pillai, MD*

Are you ready for the new stats? The projected deficit for US economy in the next ten years is 14 trillion dollars! Are the Congress and the President paying any attention? Are they serious? At least they are acting like they are! Our major expenses are Social Security, Medicare and Defense!

We will not reduce budget gap without cutting health care cost drastically!

The US has spent 2.5 trillion every year for health care. Health care cost per person is more than double when compared to Great Britain & Germany. In the USA, health care is rightly compared to the *"kid in a candy shop"*. There is no limit to your demand but you won't spend from your own pocket. Health care money is mostly spent on in-patient care, expensive tests and costly drug therapy. Everybody forgets that the doctors' payment amounts to only 7-8 percent of the total cost. Hospitals, insurance companies, pharmaceuticals and equipment manufactures consume the lion's share.

If Congress is serious they must do all of the following:

1. **Reduce administrative costs.**
2. **Stop doctors from practicing defensive medicine by capping non-economic damages.**
3. **Review the last 6 months' hospital admissions. Take punitive action against hospitals if they are found giving incentives to emergency room doctors for performing unnecessary tests and admitting patients without good enough reason.**
4. **Control pricing of essential medicines including anti psychotic drugs.**
5. **Stop indiscriminate use of sophisticated tests.**
6. **VA system should not duplicate services provided by Medicare & other private insurance.**

The popular study showing that we will save only 2.5% by stopping 'defensive medicine' is a totally false report. Most of the 600,000 doctors would testify that 50% of admissions and expensive tests could be avoided by capping non-economic damages. We are allowing manufacturers to price $500 for diabetic shoes and $4000 for a motorized wheel chair. Outrageous, isn't it?

The US has the reputation of having the highest number of people suffering from obesity. Death from Diabetes Mellitus has almost doubled in the past few years, in the US. Although our health care is undoubtedly the best in the world, it is also a victim of its own success. Heart disease, cancer and diabetic patients now live a lot longer. We must focus on preventive care, which is only 10% of money spent on various treatment modalities. Instead of building hospitals we should promote health and wellness clinics. Promote compulsory exercise, at least 30-45 minutes daily. Teach our kids in the schools the basic principles in dieting and nutrition, emphasizing on low carbohydrate, low to medium fat and low to medium salt diet. This should start right from the elementary schools. Let's prescribe ***healthy living*** to all Americans and save this great nation from going bankrupt!!

GOD BLESS AMERICA!

** FACP, president, AKMG, Orlando, FL*

Dermatology at the All India Institute of Medical Sciences

Amit Sharma, MD*

On my flight to New Delhi, I was filled with excitement. Not only had it been over five years since I visited "home," but I was also going to have my first experience with the Indian health care system. As a budding dermatologist, I was engrossed by the idea of actually seeing a range of tropical diseases that seemingly only existed in textbooks. Dr. Robert Schwartz, the Chair of Dermatology at my medical school, had arranged for me to spend one month with Dr. Neena Khanna and the other faculty members of the Dermatology Department at the All India Institute of Medical Sciences (AIIMS) in Ansari Nagar, New Delhi.

For the most part, my knowledge of AIIMS stemmed from references in movies and conversations with relatives. A revered institute, AIIMS was held as the gold standard of Indian medicine: only the best students graduated from that medical school and only the best physicians received Professorships in the affiliated hospital. As a soon-to-be doctor, I was curious to learn of the norms of practice in India and the expectations for care by patients and their families.

Though I was impressed by the development that had taken place in Delhi, there was nothing more practical than the expansion of the Metro. With a 5 minute walk to a nearby Metro station and a 10 minute air conditioned ride, I arrived at the entrance of the Hospital of All India Institute of Medical Sciences. I was struck by the number of people entering the premise. My family had told me that AIIMS was a town in itself -- "AIIMS-Nagar" was no stretch from reality. Passing through the entrance gate, a canteen was a few feet to my left. In the shade, people with hep-locked lines awaited their orders. Continuing towards the outpatient clinic, I noticed a cue that stretched several yards into an entrance. On the pavement, patients lay in stretchers as their close ones

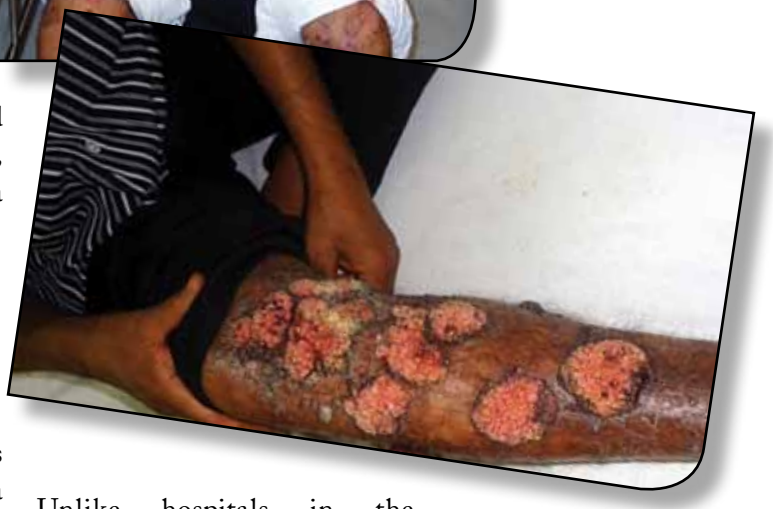
A boy with pustular psoriasis

stood under the full extent of the Indian sun, hoping to reserve a bed in the hospital. A few individuals, who may have travelled thousands of kilometers to reach AIIMS, had set up camp with gas-burning stoves, bedding, pots and vegetables.

Navigating through the many people, I made it to the outpatient clinic for the "skin" department. The senior resident ushered me into his room as he finished with the final patients of the day. The room was simple: a table surrounded by four chairs and a bench against the wall. Patients, in groups of five, were called into the room and waited on the bench. A resident sat at either side of table and patients were examined at the ends. Privacy and confidentiality were not highly guarded as conversations and diagnoses could be heard by all in the room. Yet, the volume of patients that needed to be seen demanded restructuring of the typical American patient-physician interview. People from all corners of India would arrive at AIIMS, seeking therapy for diseases that may have gone unseen or improperly treated for *(continued on next page)*

years. Each morning, a resident would examine 50 or more patients -- an incredible number, especially considering the severity of some of the presentations. Compared to the 15 minute dermatology visit at my medical school, visits at AIIMS would rarely last more than 5 minutes.

A usual encounter consisted of the resident calling for the patient to sit at the end of the table. The resident would then confirm the patient's identity and ask to see the rash. After quickly examining the skin, a few additional questions were asked as a brief note with the findings, diagnosis and treatment was written. The patient was handed his chart, a prescription and a follow-up appointment. Unlike our health care system, in which there is a constant concern regarding malpractice, the Indian system seems to be free of the trials and tribulations of lawsuits. Thus, more time is applied to providing the correct diagnosis and treatment than in practicing defensive medicine. Moreover, the Indian system allows the physician to see more patients, which is necessary in AIIMS and other government hospitals where treatment for thousands if not millions is provided. Though not much time could be invested in solidifying a physician-patient relationship, the large volume of people was adequately cared for in a cost-effective manner.



From top to bottom: Patients and families outside of the hospital, trying to get in.

Man with severy *pemphigus vulgaris*.

***Chromoblastomycosis* of the leg (result of chronic neglect!)**

The cases I saw in the outpatient clinics were phenomenal. From a port-wine stain that malformed most of the face to a neurodermatitis that spanned much of the leg, the diseases and their severity were shockingly memorable. Many patients had first ignored their symptoms to only then try homeopathic treatment. If that failed, a majority of these individuals would consult a doctor of Ayurvedic medicine. And, if Ayurveda had no effect, the patient would finally see a certified dermatologist. In going from one place to another, a person could spend nearly five years before actually seeing a medical doctor. Hence, fungal diseases that could have easily been diagnosed and treated in their early stages were allowed to grow into rampant conditions that covered large surfaces of the body. Fear, distrust and denial were common underlying reasons for delaying timely and appropriate care.

Unlike hospitals in the United States, AIIMS has a dedicated in-patient dermatology ward. The thirty-six beds in the ward were often filled with those with critical illnesses. Pemphigus vulgaris and severe drug reaction cases demanded constant supervision and well designed treatment plans. My first patient in the ward had several large fungating masses growing from his leg. The patient to his right was blinded from cicatricial pemphigoid, while the one on the left had post kala-azar dermal leishmaniasis. Often family members stayed next to the patient and *(continued on page 31)*

AAPI Hosts Successful 2011 Legislative Conference on Capitol Hill

Dino Teppara, JD, Esq*

On June 1, AAPI held its annual legislative conference and reception on Capitol Hill. The event was a great success, with members of Congress, think tank representatives and the AMA president joining us for the day's events.

We started off hearing from U.S. Congressman Phil Roe, MD (R-TN), an obstetrician and gynecologist who had delivered nearly 5,000 babies over a 31-year medical career prior to his election to Congress in 2008. Congressman Roe discussed the issue of medical malpractice insurance reform and his concerns with the health care reform law that was passed by Congress and signed into law by President Obama last year.

Those concerns were echoed by U.S. Congressman Bill Cassidy, MD (R-LA), who noted the paramount importance of maintaining the doctor-patient relationship. Dr. Cassidy's wife is also a physician and he has traveled to India with his family. Both Congressman Roe and Cassidy joined AAPI during our 2009 legislative conference and we were pleased to have them join us once again.

We then heard from U.S. Congresswoman Zoe Lofgren (D-CA) who provided us with an immigration update. The Congresswoman told us she would introduce legislation to make the J-1 visa permanent, which AAPI applauds to help increase access to health care in rural and medically underserved areas.

We heard from U.S. Congressman Joe Heck (R-NV), a physician experienced in emergency medicine; Dr. John O'Shea, Senior Health Policy Adviser to the Chairman of the House Energy & Commerce Committee and U.S. Congressman Frank Pallone (D-NJ), ranking member of the Health Subcommittee on the House Energy and Commerce Committee.

We finished the morning session of the conference with a panel of experts discussing the health care reform bill, which included: Neil Chatterjee, Legislative Assistant to U.S. Senator Mitch McConnell (R-KY); Dr. Robert Moffitt, Ph.D., Senior Fellow, Center for Policy Innovation, The Heritage Foundation; Vivek Murthy, MD, MBA, President and Co-Founder, Doctors for America; Cindy Brown, Vice President, Government Affairs, American Medical Association; Mike Stinson, Director of Government Relations, Physicians Insurers Association of America (PIAA); and Neera Tanden, Chief Operating Officer, Center for American Progress.

The panelists discussed various aspects of the

Congressman Frank Palone during his speech at AAPI's annual legislative conference on Capitol Hill.

Clockwise: Congressman Steny Hoyer addressing the audience.

Dr. Singhvi and Dr. Kanumury.

Congresswoman Zoe Lofgren with Drs. Ajeet and Mamta Singhvi.

legislation, which included positive factors that many AAPI members supported such as providing coverage for young adults up to the age of 26 and preventing insurance companies from denying claims based on preexisting conditions. Other areas of concern remain the lack of medical malpractice insurance reform within the bill, the failure to address the future physician shortage by creating residency positions and the failure to address the Medicare sustainable growth rate (SGR). These remain areas of ongoing concern to AAPI members and the nation's physicians.

During lunch, we heard from one of the co-chairs of the Congressional Caucus on India and Indian Americans, U.S. Congressman Joe Crowley (D-NY), who updated us on various health care issues and U.S.-India relations. Robert Popovian, a senior executive from Pfizer's New York City office, provided us with a state update before we heard the keynote address from Dr. Cecil Wilson, current president of the American Medical Association. We concluded the day with a successful evening reception attended by a dozen bipartisan members of Congress, followed by a dinner at the Embassy of India hosted by the Deputy Chief of Mission, Ambassador Arun K. Singh.

Many of the attendees noted this was their first legislative conference and they greatly appreciated the insights from all of the conference speakers. Our next step is to expand on this success by having AAPI members actually go to congressional offices to directly engage the staffers and members of Congress themselves. Stay tuned for more details on future legislative conferences!

** AAPI Director of Legislative Affairs*

2011 Legislative Conference

2011 Legislative Conference












2011 Legislative Conference

2011 Legislative Conference

AAPI CME Accreditation Committee Report

Sri Iyengar, MD*

Dear Friends:

Getting the CME accreditation for AAPI from Accreditation Council for Continuing Medical Education (ACCME) was an important **goal**. AAPI, one of the largest Physician Organization with a membership of nearly twelve thousand and climbing, year after year for 28 years had to go to different providers to get the CME credit. Finally, in March of 2011 we accomplished this **goal**. My sincere thanks to Drs. P.K. Natarajan, P. Deedwania, Sanku Rao, Vinod Shah and Ajit Singhvi for helping me to accomplish this historic feat. I must also thank the Executive Committee for its support.

To summarize briefly, in November of 2008, Dr. Sanku Rao, AAPI President then, was the guest during the Indian Medical Association of Southern California (IMASC) Annual Convention. He witnessed the accomplishments of IMASC CME committee. IMASC in September 2008 had received four years of accreditation. Having known that the 26 year old AAPI did not have the CME accreditation I suggested to Dr. Sanku Rao that we should get the CME Accreditation for AAPI. He agreed and convinced the EC to establish a committee and sanction appropriate fund for the expenditure. The budget was sanctioned and placed in a separate account. I was then the AAPI Pacific Region Regional Director.

As Chair of the Accreditation Committee I prepared a project plan.

- Appointed Mrs. Judy Hyle as CME consultant to guide us to prepare the initial application to ACCME and the accreditation process

- Established a Planning Committee with Drs. Sanku Rao, P.K. Natarajan, Deedwania, Ajit Singhvi, Vinod Shah and Ms. Vijaya Kodali for her excellent secretarial help.

- The pre-application was submitted and approved.
- Had monthly committee meetings to establish a "track record" showing a working knowledge of each accreditation essentials and elements.

- Evaluated the past CME activities of AAPI hoping that we could submit them for credit. In our opinion they did not meet the requirements. Therefore, we decided to conduct two separate CME activities as per the rules and submit for survey.

- We prepared CME mission statement, goals, budget, by-law, policy manual, forms, etc.

The final application and all the documents were submitted for approval in July 2010. Our application was approved and a survey date was set for November 2010. After 27 months of dedicated hard work and with a very minimal expenditure, we got the Accreditation Certificate. We scored A+ in the ACCME evaluation. It is very important that we follow the rules and regulations in all future CME activities in order to maintain the certification.

Thank you for the privilege of serving you.

** B.Sc., M.D., FRCSC, FACS.*
Diplomat Am. Board of Surgery Thoracic Surgery
Chair, AAPI CME Accreditation.

MSRF President's Report

Mamta Singhvi, MD*

Welcome to New York City and the 29th Annual AAPI Convention! AAPI-MSRF has had a very productive year, and I'm excited to report on all that has transpired.

A primary goal during my tenure was to increase awareness and credibility in our group, and nothing speaks louder than numbers. I am proud to say that we have been able to add over 1,500 new lifetime members to our database in the past year, which is more than a 25% increase in membership than in the past 28 years combined. Of this number, a staggering 80% is comprised from the MSRF/YPS sector. We are a dynamic, vibrant organization and I urge each and every one of you to continue your involvement in defining the future role of Indian Americans in medicine.

Service and outreach was another aspect we concentrated heavily on this year. With the help of parent AAPI, we were able to strengthen our International Missions and Community Service program. By providing financial aid and logistical support, we sent dozens of ambitious medical trainees abroad to places like Egypt, China, Tanzania and Haiti. As a result our members were able to become more cognizant of the global scope of medicine and saw first hand how medicine is practiced with limited resources in developing nations. This has proved to be an extremely popular and gratifying initiative, and I hope that it will only continue to grow in years to come.

We launched a very well received Externship to India program, whereby several of our members received a $1,500 scholarship and traveled to the subcontinent for an enriching and unforgettable four week rotation. During my own trip to India for our 4th Indo-US Health Summit held in Rajasthan, I had an opportunity to interact with our Indian MSRF counterparts. I hope that the meaningful dialogue that we started will become a strong collaborative partnership with time. I also was able to meet with the Indian Health Minister, Honorable Azad, and on behalf of our organization apprised him of the pressing need to revitalize the Indian medical school curriculum, especially as it pertains to psychosocial and ethical issues.

Our work this year was prolific in the realm of leadership and policy as well. Seminars were hosted in California, New York, Texas, Illinois and Michigan to train our members in communication skills and to educate them on issues of advocacy. The recent Legislative Day on Capitol Hill proved to be an effective forum to explore topics ranging from affordability of higher education and loan forgiveness to elimination of residency caps and J1 visa waivers. We also introduced a one month Capitol Hill fellowship this year. I truly hope our members will take advantage of this scholarship, as it will undoubtedly be an unparalleled learning experience.

In addition, we unveiled the first ever AAPI Journal dedicated to the MSRF/YPS sectors. It successfully highlighted the humanistic talents of our membership, which are indeed impressive. Finally, we've put together a unique convention this year—the combination of a state of the art CME series featuring approximately 20% MSRF/YPS speakers, exclusive entertainment at world class venues, unique networking opportunities, and high profile personalities is incredible, and I hope you will avail every opportunity.

I'd like to end by thanking my father Dr. Ajeet Raj Singhvi, AAPI President and the rest of the AAPI Executive Team and AAPI Office Staff for their stalwart support and invaluable wisdom throughout the year. I also want to extend my gratitude to Dr. Priya Kundra, YPS President, for setting a fine example for us to follow. To my MSRF Board, I have truly enjoyed working with all of you and am grateful for your hard work and dedication to making this year a resounding success. Finally, I wish our incoming President, Dr. Avni Shah, all the very best as she takes over the reins.

AAPI-MSRF President
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YPS President's Report

Priya Kundra, MD*

A full year has almost ended since I started my presidency last June. While there was a lot accomplished this year, there is always more work ahead and I look forward to collaborating with Vinita Bhagia-Jethani and the YPS board into making our organization even stronger. As YPS president, I focused on the following key components:

- Expanding YPS membership through incentives that are tangible to young physicians
- Tapping into the "voice" of young physicians to educate members of Congress
- Community service involvement
- Developing an extensive network within YPS/ promoting professional and social events

There were numerous social networking events and leadership seminars in many different cities to grow YPS and to encourage young physicians to get involved with the healthcare policy agenda. We were also very focused on enhancing communication and fostering pertinent events that YPS members could gravitate towards. One of the key components in enhancing communication was an effort to organize the database to identify given members by their section (i.e., MSRF, YPS) and to identify inactive members. In addition, we were able to centralize and grow the YPS Facebook page so that the group can be passed on year to year to new officers.

As an organization, AAPI is committed to increasing your knowledge, enhancing your career, and empowering you to play a key role in healthcare advocacy and community service. AAPI has a range of activities from CME to practice management resources and community service opportunities that are geared towards young physicians.

I look forward to working with Vinita Bhagia-Jethani and the YPS board this year and the years ahead to make YPS a stronger, more cohesive section within AAPI. Please email any comments/suggestions to me at kundrapk@yahoo.com

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"A Night to Remember"

Rahul Wadke*

At 22, fresh out of medical school, I found my calling as a government medical officer at a rural hospital in Maharashtra. It was a perfect opportunity to serve rural community and to give back to society and the country. After a year and half at the job I was in love with the place, the people, and the job but disliked the system, and the bureaucracy just as much. Summer was brutal that year, with heat waves, water shortages, and power outages. Broken windows in doctor's quarters allowed cross ventilation but not enough to sleep inside. Sleeping on the terrace under the clear starry night was both a luxury and a necessity.

After one long busy day at the clinic and the hospital, I retired to bed early. My colleague had his trusty companion "McDowell Whisky" and was passed out for the night. That meant I was on call for three straight weeks by now. My good luck charm and wishes only lasted till 1 am, when a nurse woke me up. A 72 year old man and a 7 year old boy, both neighbors, clearly shaken, were sitting in the hospital with half of their face torn apart and dripping blood all over the floor. In the middle of the night while sleeping outside the house, a rabid wolf had bitten into their faces. I grabbed my precious pair of autoclaved gloves (had only two to work with), cleaned the wound with soap and water. I gave a tetanus shot in the arm and 5 cc anti rabies vaccine (ARV) on the abdomen.

Both families thanked me profusely for waking up in the middle of the night to take care of the patients. I carefully washed my gloves, left them to dry. In the morning I would start the autoclave again so I could have clean gloves to work. On their way out boy's father told me "The entire village is awake now; at least 20 people were bitten by the rabid wolf". Great! That's all I needed that night with a drunken colleague, only five more doses of ARV, and one clean pair of gloves left. I needed a new lucky charm for sure. There was no point in trying to get to bed for a quick nap. We got busy preparing for possibly 20 more rabid wolf bite patients.

Soon patients started trickling. The entire hospital was buzzing and felt more chaotic than during the busiest of days. I recruited volunteers from the crowd to line up patients. One volunteer went back to the village to look for more patients. A fast triage of all patients was set up and I was able pick out patients in immediate need of care. Everyone was happy that the doctor tended to their needs right away and I avoided getting to the sicker patient late.

Ten buckets with a small piece of soap were ready in front of every bed. I secretly patted myself for the preparation. After quick cleaning of the wounds, tetanus vaccine for everyone, and rabies vaccine for severe wounds for the patients, I was ready for my paperwork. My volunteer team from the village came back with 10 more patients. After pleading with a few good hearted pharmacists in nearby villages, I had enough supplies to finish round three. I was proud of everyone and myself. I thanked the nurse for a great job. It was 6 am; I decided to finish the paperwork.

As I sat down, my hands were covered with dried blood. I did what I could; scrubbed it long and hard with soap and water. I certainly didn't have any vaccines left even for myself. After a long sign out, I took the morning bus to the district hospital to gather supplies and vaccines. Multiple forms were filled and after speaking to the civil surgeon for half an hour, my order was approved. I carried precious vaccines on my lap the entire way while keeping a close eye on the thermometer. Now I was tired, barely awake, hungry, and frustrated. I sent both patients with facial injury to the district hospital for newer intramuscular ARV.

(continued on page 26)

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Morning brought another set of challenges, one for which I was neither trained nor prepared. A group of 5 reporters were waiting for me with the civil surgeon eager to know more about the events that night. Everyone including myself then posed for a picture with a fake smile for the local media. All I did that week was, talk to the health ministry or local politicians; people who didn't care about my patients, hospital, or staff members. Everyone grabbed as much credit, as much headlines as they could. I finally got my first ARV 5 days after the incident.

Two weeks later, I saw my 7 year old patient in the clinic. My heart sank seeing him drooling, aggressive, and trying to bite his parents. They couldn't afford to travel to the district hospital to receive ARV. Parents knew where this was heading, just wanted to hear it from me. His mother also needed treatment. I handed them money for their return journey. Two days later the kid died. His parents received 2000 rupees as a compensation for his death. The same week my 72 year old patient died a similar painful death, at the home he built himself. Two dead, 30 survivers sounded like a success story; but I failed them and the system failed them. For a mere 200 rupees in transportation cost, a kid and a grandfather lost their life.

How could I remain part of a system which was inherently morally corrupt? Will I become one of them if I stay any longer? I resigned exactly a month after that life changing experience. I left India the following month deciding never to return to clinical medicine again. I still vividly remember the faces of my patients. Moments of disappointment, frustrations have now turned into an inspiration. I was back in clinical medicine after a couple of research years. With more wisdom, patience and enthusiasm, I am embarking on a journey back home with a hope of different results this time.

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Patients as Teachers

Ripal Shah*

Likely unbeknownst to them, the varied identities of my patients have shaped the way I intend to practice medicine. They have become and continue to be my most prominent instructors. These interactions cannot easily be communicated, and certainly not replicated, but what I have captured from them is clear to me.

Patients teach us during their hospital stay and long after they leave. In the hospital, they provide valuable cases and hands-on experience to the future generation of physicians. After they leave, the treatment they received impacts future patients, and their cases contribute to an imaginary bookshelf in the minds of all health care professionals, later drawn upon to teach medical students and residents. The sum of these experiences becomes a well of questions that evolve into hypotheses for large clinical trials, designed to elevate anecdotal evidence from subjective experiences to objective fact. What those large trials do not teach, however, are the lessons of empathy that a variety of patient interactions will impart on physicians in training and their role in shaping a physician's identity. We draw on these lessons when conducting our profession's most dreaded tasks—where objective data is meaningless without empathy—from consoling a patient after reporting a fatal diagnosis, to explaining the limitations of science and medicine to those with chronic illnesses.

A memorable lesson as a young medical student came as a victim of the often-misunderstood role of trainees by patients. As I entered the operating room of a major hospital in India, I was informed I would assist throughout the surgery and help close the incision site at the end. The procedure went smoothly, and I triumphantly announced that I had taken part in my first cholecystectomy. A few weeks later, I recognized the same patient being wheeled in to the inpatient service, admitted with right-sided abdominal pain. I followed the gurney as a dozen thoughts raced through my mind. Did the knots I throw around the cystic duct not hold? Had I nicked a nearby structure? Did the incision site become infected? Moreover, did the patient even realize her entire body was exposed to me, and the entire operating room, during the procedure? I felt such a sense of remorse—even before examining the patient—that I explained to her the circumstances surrounding her procedure. She appeared disturbed and admitted she had no idea that medical students played an active role in even simple procedures, especially in light of her Informed Consent form that declares that only the attending would be performing the operation. Yet, she quite benevolently added that skilled, experienced surgeons are not born overnight and that she was glad she could contribute to my training as a future physician. After the exam and work-up we concluded the patient had cellulitis from a source completely unrelated to her procedure; I breathed a heavy sigh of relief.

Through my euphoria in the operating room and then intense guilt at the sight of this patient returning for more care, I learned an important lesson, not about pathophysiology or treatment regimens, but about the ethical responsibilities of clinical trainees and the great debt we owe to our patients. My experience highlighted the educational richness of just one patient encounter. From start to finish, I acquired skill in the O.R., gained the early confidence so important to a young surgeon, and grappled with the ethical implications of my involvement in the surgery—more volumes added to that imaginary library.

As much as we often want to amount physician training to technique – something objective, definable, and perhaps even teachable – a student's most career-changing moments take place in a patient's room, not in a dorm room with a suturing kit. I am fortunate to have observed a wide range of medical cases and patient concerns in my training so far: introducing a child into the world, consoling a family after the death of a loved one, and calming a foreign celebrity frustrated with American physicians' inability to cure his incurable diseases. After working in parts of Africa where AIDS is deemed fashionable – a disease only able to be contracted by the sought after, the elite – I learned of the challenges associated with providing medical care to patients with such disparate identities *(continued on page 28)*

and perceptions of disease. The exposure to illness and suffering in elite teaching hospitals contrasts greatly with clinical experiences in rural communities, both here and abroad. The patient populations, availability of medications and treatments, even the languages spoken all vastly differed. More volumes added to that library, now in different languages.

From my more difficult cases I have learned that as a physician I will be faced with issues that may conflict with my own set of beliefs. Whether it be explaining to a pregnant cancer patient what may be best for her body and health if she is pro-life and I am pro-choice, or in kindly stepping out of the room at the request of older patients who find it peculiar that a female be pursuing a career in medicine, I have found that the physician's identity is shaped just as much by these difficult patients as it is by patients like A.B. In the process of overcoming these obstacles with our patients, we enhance our ability to work empathetically with thousands of personalities during our medical careers. As physicians, we can and should consult, understand, and adapt to the religious, cultural, or personal needs of patients – from investigating alternatives to porcine valve surgery for an Orthodox Jewish or Muslim patient, to consulting family members about the acceptability of a blood transfusion for a struggling Jehovah's Witness. A few more volumes to that library—difficult to read but all the more rewarding when finished.

My role models are my patients; they collectively form my identity. They are my page-turners, long novels, and short stories that collectively form the library that will help me script my own biography as I move forward from medical student, to resident, and finally, to a full-fledged physician.

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MSRF/YPS Competition Poetry

"The Doctor"

Sonia Chopra, MD*

**Sonia Chopra*
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I am God
for two seconds
as I stand above you
with my head of privileged
knowledge;
it is a calculating
scalpel in my clutch.

And for two seconds,
I share consequences with a Criminal,
a latent Murderer, who
has your Life
—a colossal Sun on my heart, a raw
strawberry in my hand—
thick between her fingers.

Yes, the pressure
gets to me. And at times,
I think I need
a Doctor.

Thinking about Medical School:
"First Day of Orientation"

Teja Surapaneni*

Medical school is sort of a high school cafeteria with the jocks, nerds, drama queens and of course the "gunners" sitting at their respective tables. Despite the differences, we all have one thing in common, the pursuit of becoming a doctor. This unifying goal is not to be perceived as a right, but rather a privilege that can be stripped from you when you slip and spill your coffee.

So let's open our eyes to all the pitfalls to avoid and save those white coats from ever being stained. Everyone goes through a post college hangover. Let's face it. None of us have a clue what it means to auscultate heart sounds or touch and listen to patients. It's magical when you realize that this will be your gift one day. The best analogy for medical school is living in Darwin's Galapago's Island, where the survival of the fittest and natural selection is the law of the land. You should stay ahead of your competition.

Also be prepared to give up those days when you took classes that let you sleep until lunch and stay up until breakfast to beat your buddy in a game of halo. It's imminent to arrive to your first day of orientation at your school of choice with full intent to succeed and contribute to a life-long mission of service and sacrifice.

Your basic science years in medical school can be over in a blink of an eye through hard work, punctuality and a tad bit of enthusiasm. We all question our choice to be a part of this noble, yet painstakingly slow and lengthy, training pathway that may not result in instant gratification. However, self-doubt only reinforces the human in us, contrary to the popular belief.

You should always embrace your limitations while taking the initiative to overcome any preconceived notions. Tune your mind to tap into that locked in creativity and imagination that is so unique to all of us. Your inherent qualities will help you change someone's life for the better.

Your great grandfather who went to medical school could not have imagined the medical technology and pharmacological interventions that are at your fingertips, but he did foresee your enslavement to the materialistic world. The resources available in medical school and on the internet should just be an adjunct and never replace your arsenal: judgment, intuition, and humility. Please take a moment to realize that you are just about to swim in the same ocean that has harbored some of the greatest minds in medicine.

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There is More to Healthcare Than Healthcare

Anand Bhat*

Research indicates that modern medicine accounts for 10% of a person's life expectancy. This means that everything the formal health care sector does, from vaccines to trauma centers to the latest imaging technology, plays a role in only one-tenth to one-third of a person's health. We physicians are only the tip of the iceberg in improving health across the globe. If we want to undertake a realistic appraisal of what we are doing to improve Indian and American health, we need to look at something called the social determinants of health.

In 2008, Sir Michael Marmot revealed the final report of the WHO Commission on Social Determinants of Health. Social inequality, the commission argued, was killing millions of people a year. Education, poor living standards, poor working conditions, and unjust societies are directly responsible for disempowering people of all classes and increasing their burden of cardiovascular disease through increased stress levels. What does this mean for India?

In India, the problems creating poor health have been largely ignored. Despite what the media says, eight Indian states have more poor people than all of Africa combined (421 million versus 410 million). UNICEF reports that India has a higher percentage of malnourished children than Africa. This even applies to the richest families; one-third of the top 20% of children are malnourished. Both the illiteracy rates and malnutrition rates are above what is expected for India's GDP per capita. And despite all the economic growth in the last twenty years, the malnutrition rates have not improved. Can this be changed?

The Primary Health Care movement began at a 1978 WHO convention in Alma Ata in the Soviet Union. The conference unanimously declared health to be a human right and for nations to take an interdisciplinary role in reducing health inequalities. One Indian state, Kerala, had taken the lead even before Alma Ata.

Kerala is a great example of an Indian state that has addressed the social determinants of health. Life expectancy is high and infant mortality is low. How? Active community participation leads to an active and mobilized citizenry of all castes and both genders. Keralites demanded their rights to education and food. Unlike the rest of India, active citizen committees oversee the public distribution of rations and ration cards, eliminating corruption in distribution. Parents actively seek to get the children into school which has eliminated illiteracy in young people. All of this has made Kerala the most socially developed state despite having the highest unemployment rate in India. The per capita income is actually lower than the Indian average, and the per student spending on education is actually the same as other states such as Uttar Pradesh. In fact, the Rockefeller Center hosted Kerala along with China, Costa Rica and Sri Lanka as having good health at low cost. A more recent conference on the topic featured Tamil Nadu and Bangladesh among others.

But what does this mean for us as physicians? I feel that physicians carry a moral obligation to the community. For example, when sponsoring development work in India, Indians living abroad should visit local villages and neighborhood schools to find out whether the mid-day meal for children is actually being delivered rather than donating to a big urban hospital. A locally organized committee (like a PTA) of parents and concerned citizens should be empowered to audit the quality, quantity, and nutritional value of school food on a weekly basis.

A simple project would be to introduce the lentil-chapati used by Indians in Trinidad into schools. Trinidadian roti, fortified with more protein, could become a more filling and nutritious staple that would improve children's health. Once organized, the community can assess the quality of food, and if it is not *(continued on page 28)*

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up to par, then can demand their human right to food as guaranteed by Indian law. These parent groups can also then focus on other important issues such as absentee children (who may want to come but need a good meal), clean water, pollution, or making trade schools to teach practical skilled labor to those who will not go to college. Empowering the poor can be part of the solution to improving health within these impoverished states.

Through increased literacy and reduced malnutrition, more Indians will attain better health in India than through high tech American medicine. And this is the debate we need to be having as physicians wanting to improve India's health.

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University of Texas Medical Branch

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would respectfully stand and answer questions during rounds. As I spent my mornings mostly in the clinics and afternoons in the wards and on consults, I was exposed to numerous rare, tropical dermatoses. Dermatology is primarily a visual field; thus, seeing the disease instead of reading about it truly impacts one's ability to diagnose and understand.

My month at AIIMS taught me much in terms of tropical dermatology and the Indian healthcare system. Witnessing the struggle and suffering some of the patients experienced while waiting for treatment, I have become more cognizant of my role as a caregiver. My four weeks in India provided me with some of the most educational and changing experiences in medical school. It was Osler who once said, "A good physician treats the disease; the great physician treats the patient who has the disease." To accomplish the latter, it is essential for one to not only know the person, but also appreciate his or her culture and heritage.

By partaking in the International Externship Program, I gained insight into the intricate elements of care provided in India. Thus, I feel more comfortable in attending to the needs of my future patient population. I would like to thank AAPI for providing support in the form of a Scholarship for International Externship. Furthermore, I am grateful to Drs. Neena Khanna and V.K. Sharma for making my stay so memorable and providing me with seemingly unlimited learning opportunities.

Editor's note: Amit recently graduated from New Jersey Medical School as part of the BA/MD program. He will be continuing his medical training at Harvard University with a preliminary medicine year at Brigham and Women's Hospital and then a dermatology residency at Massachusetts General Hospital

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"If you want to leave your foot prints
On the sands of time
Do not drag your feet"

Hon'ble Adbul Kalam
Past President of India

Essential Technology for the Young Professional

Maneesh Kumar, MD*

As the webmaster for AAPI-MSRF, I thought this might be a good forum to introduce some technology that I use on a daily basis. I think these are two tips that can benefit anyone in today's digital driven world. They are mostly free services, available online, and not Mac or PC specific. So let's jump right in and start with email.

EMAIL

You may be thinking, "Who doesn't know how to use email?" And you'd be right to ask that question. In today's world everyone uses email. But here's the catch. Not all email services are created equal. Yahoo, Hotmail, and AOL are your parent's e-mail; Gmail is for the young professional. Here's a top 10 list for why to use Gmail: http://mail.google.com/mail/help/intl/en/about.html.

From that list, I'm going to focus on number 6 - lots of space. With Google's mail service you get over 7 Gb of storage space, and it's always increasing. This is important for a number of reasons, the first being that you never have to delete a message. To put that 7 Gb in perspective, I've been using Gmail as my primary address for about 7 years and have used only about half of that allotted space. Since more and more business is transacted over email, it's becoming more important to have the ability to keep those important messages.

Specific to physicians, as telemedicine grows and physicians begin communicating with patients via e-mail, it's going to be more and more important to keep those communications accessible. With Gmail, you just click "archive" and the message is removed from your inbox (so it's out of sight) but remains in your account and is easily accessible. Just as a quick note, it's easily accessible because your entire Gmail account is entirely searchable, using Google's powerful search technology.

That's great you might say for email sent directly to your Gmail account, but we also have university email addresses, or old Hotmail and Yahoo addresses we don't want to give up. We've given that address to family, friends, and colleagues for years. Gmail has a solution for that as well, mail fetcher, giving you all the power of Gmail without having to tell people your new e-mail address. You can use Gmail to retrieve all the messages from any email address that has POP access. Rather than get in to the technical details of POP access, I'll direct you to Gmail's help section on the topic: http://mail.google.com/support/bin/answer.py?hl=en&ctx=mail&answer=21288.

But, may be, you really like the way you access your current email and don't want to use the Gmail interface. That's fair, I do something similar; I like to keep my personal and university email separate. Work emails get sent from my .edu address and personal emails from my Gmail address (Gmail actually has a way of doing this within the Gmail interface, but let's save that for the next issue). I created a second Gmail account (it's free, make as many as you like!) and, using POP, set it so that my new Gmail account fetches all the mail that comes in to my university account.

It just makes a copy of the message, doesn't move or delete it from my university account, so I can continue using my university email as normal. The advantage, again, is utilizing Gmail storage capacity. Most university email services only give a few hundred megabytes of space, meaning you have to always manage your inbox, printing important emails or saving them some other way. With a Gmail backup, there's no need to manually save or print emails, delete them from your university email, and the backup copy remains in Gmail.

DROPBOX

Gmail is great because of the space, but unfortunately there's no easy way to store files (unless you email them to yourself). Fortunately, there's another solution, Dropbox. Dropbox is software that syncs your files online and across computers. You may have heard of "cloud computing" and that's where Dropbox is king. If you haven't heard of cloud

computing, don't worry, Dropbox is extremely easy to use. There's a lot of different online storage solutions out there- Amazon just unveiled cloud drive, Apple has MobileMe, and there are rumors that Google might release something soon. I personally use both MobileMe and Dropbox. Unfortunately MobileMe has a yearly fee, but we'll focus on Dropbox, which is free.

As far as storage goes, Dropbox offers 2 Gb of free storage, with the ability to expand your storage up to 8 GB with referrals (http://db.tt/Sdvp4dU, sign up with this link and we'll both get a 250 MB bonus). You can also purchase additional space, up to 100 GB. But the strength of Dropbox is not in the space. Dropbox's real strength is in its ease of use. After signing up online and installing a small program, Dropbox creates a folder on your desktop that you can treat just like your "My Documents" folder, dragging and dropping files. It automatically syncs with the Dropbox website and any other computers you have with Dropbox installed. It's all seamless, and after the initial setup, takes no more effort from you to put your files online.

Before installing Dropbox, I had a folder on my computer called "Research" that kept all my research data. Of course, as you should be doing too, I backed up that folder regularly, but it was always such a pain. And if I ever needed to work on something from home I had to transfer those files to a flash drive and then take them home and remember to transfer them back after making changes, corrects, etc. After installing Dropbox, I literally just moved that research folder in to the Dropbox folder. I then installed Dropbox on my computer at home. Now, my files are automatically backed up online and then automatically synced to my computer at home. Everything stays up to date, seemingly by magic.

But really, online storage is just the beginning of Dropbox. Dropbox also offers access to your files from mobile devices, 30 days of undo history, easy file sharing, and more. Use the referral link for an extra bump in storage (http://db.tt/Sdvp4dU) and take some time to explore everything Dropbox has to offer.

Have an idea for a tech story? Want to hear more about some software you've heard of? Let Maneesh know at website@aapimsr.org. The next article will discuss remote access, and how you can set up secure access to your computer from anywhere in the world.

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Big Apple to Bhavnagar

Veeral Mehta*

When I decided to sign up to volunteer for a medical camp in Gujarat, I did not realize what an impact this trip would have on my thinking. I never expected that a poor seven- year old Gujarati boy from a small farming village would teach me something that even the best college education could not. As the boy and I talked about sports and school, he taught me to value what I had. The boy described the difficulties his family had faced after his father had lost his leg in an accident. As I waited with him while a doctor fitted his father with a Jaipur foot, he described to me how much the camp meant to his family. I distinctly remember the smiles on the faces of both father and son while I taught them how to properly care for the appliance. Those smiles and their overwhelming joy introduced me to the rewards of medicine and volunteerism.

During my one-month stay in Palitana, Gujarat, I saw hundreds of young people my age with torn clothing, dragging their bodies on the ground because they suffered from polio and had received no medical care. The camp helped to provide calipers, Jaipur Foots, hearing aids, and tricycles to twenty five thousand people. More importantly from interactions with patients I learned that the camp provided people with hope and an improved quality of life. The people were thankful for the camp and had been awaiting it for several months. The camp was able to give a new lease on life to the poorest of the poor for whom this was one of the few times they had access to health care. The mobility camp was a huge success and became the largest such project.

After returning home, I was happy about the work that I had done, but still very disturbed by the fact that the people I had met did not have the ability to go see a doctor. I decided to look for opportunities to help provide basic health care to the children of Gujarat. At the camp I had learned that children could be immunized for as little as seventy cents. For less than the cost of a Kit- Kat, a young child could be saved from devastating disability. Once I reached New York, I started gathering more information about how I could raise money to help children in rural villages across India. I came across Shots for Shots, a non-profit organization which helps to administer vaccinations to young children across India. I decided to start a fundraising campaign to have five- thousand children immunized.

Giving instructions to patients in medical camp, Gurajat.

Despite what I had thought, hospitals and other local organizations were unwilling to allow a 16-year-old boy to undertake such a project. I had approached twenty-six organizations and been told "NO" all twenty- six times. In spite of the rejections and obstacles I faced because of my age, I was sure I would achieve my goal. At the village I had seen people who struggled each and every day just to provide a basic meal for themselves. I felt that no matter how difficult the task, the ability to give these villagers better lives for their children was the least that I could do. With the help of friends and family, my fundraising goal of helping five-thousand children is well on its way and I hope to achieve my goal before my trip to Baroda this August to help administer vaccinations to children in neighboring villages.

** Editor's Note: It is truly commendable that Veeral Metha, although only a high school student, is already involved in charitable activities and has embarked on the lofty mission of fund raising for helping poor children in India.*

** The Kew- Forest School Class of 2012 - Forest Hills, NY*

Painting Memories

Monita Soni, MD*

Our dad inspired us to value scientific innovation while mom inculcated the passion for arts. On every family trip my sister and I took a sketch pad and crayons. We drew a humming bird in flight, a green tree frog or train winding through the Darjeeling tea estates. Our paintings served as reminiscence-boards of shared happy times. This started a family tradition of **painting memories.**

Today this fascination for the play of light on a blade of grass, a scruffy weed, a baby's smile or a murmuring viola is an obsession that spills into my day job as a pathologist. Painting is in our genes now. Last summer we took a family trip to the Ranthambore Tiger Sanctuary. To commemorate this trip my daughter and I made large 4 feet by 3 feet paintings. We lavished our love for miniature Indian art, travel to exotic locales and penchant for beautiful ethnic clothes on canvas. We used bold acrylic paints topped with an oil glaze.

The girl in the two paintings is a stylized version of my daughter, the deer are from the wild life sanctuary and the mood reflects sunrise and sunset. A lot of research, planning, sketching and fun-filled conversations initiated this project. Poring over art books and photos, selecting a pose from one and a background from another was a wonderful exercise. Brimming with excitement we gathered in the studio with our papers, tool, and paints. Once we sketched the figures on the canvas, there was no turning back. We put the music on and start applying paint. The paintings came to life; we were compelled to follow the directions of our own creations. We lost control. A meditative calm suffused our souls. Even the dogs *"Doodey-bug"* and *"Bozzer"* did not bother us. We worked in harmony like *"three musketeers"*! While I stamped gold- sliver paint on the trim, Debbie decided to add a neon orange sun and my daughter traced delicate jasmine blooms on the transparent green *dupatta*.

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Sunrise

Sunset

(continued from page 31)

These paintings are the center-piece of our home art gallery. They remind us of the quality time we shared last summer, painting them together. My gaze lingers on the floating lily-pads to the doe nuzzling my daughter's hand; I feel a certain lightness of being. It is expansive like a breath of fresh air on a cool morning, talking to mum on the phone or re-reading "Alice in Wonderland" to my children. Our next project is to capture the ever-changing expressions on my grandson's face. **Viva Life!**

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More from APPI Member Artists...

"Attraction" — in pastels by
Adul Karim, MD, FACC
Cardiologist, Merritt Island, NY

"Dry Beauty" — Photo by S. Sivasankaran, MD

"Two Storks" — Photo by S. Sivasankaran, MD
Hudson, FL

Doctors! Doctors!

Chakrapani Prakash, MD

Every day I get letters or phone calls from 'top' money managers advising me how to manage my money. I found out a good way to handle these unwanted calls and letters. I tell them:

'You are obviously very smart and know all about investing, I will give you my money since you do this full-time; give me just 8% every year and you keep the rest'.

Fair deal isn't it? See them disappear under the radar and they will never call you again.

I have a lot of respect for doctors, the hours of sleepless nights we spent studying for exam after exam, a constant level of stress as a companion in our lives, and of course after graduation and residency, the need to deal with insurance companies, Medicare and the ever present lawyers. It is like watching Serengeti on National Geographic!

We are also constantly playing Tango with the hospital administration, committees and departments.

The business community has a very bleak view of us. They think we are not financially savvy and we do not mingle with other business owners in the community. But then, we are doctors and not businessmen.

The financial community thinks that we are naive, do not know how to manage our money and are easy targets for the Madoffs of this world.

I have a different perspective. A doctor can be an attorney, many of my friends are JDs. Some are money managers, others get an MBA and are administrators. A doctor has sound knowledge of basic sciences, can interpret studies, read graphs; and has sufficient knowledge of biological sciences to understand DNA and RNA, and how anti-viral drugs work. An attorney, money manager or an administrator can never be a doctor.

It takes 8 years to make a doctor. Let us be proud of that and assert our standing in society.

Twenty years ago, after my conversation with a 'financial advisor,' I decided to manage my money myself. It was intimidating at first, but then, so is the deep end of a swimming pool if you do not know how to swim. Yahoo Finance has leveled the ground for the average investor. Insider trading laws have been tightened and so no one individual or institution has an advantage over you. Online trading has become extremely easy and trades are executed within a few seconds.

I feel that doctors have a tremendous advantage in this field. We are the ones seeing patients who are asking for Viagra, or write prescriptions for Herceptin. The patients call us with the side-effects, we know first- hand which drugs work and which ones are suspect. Drugs that get approved after phase lll trials, only to be withdrawn two-three years after, have been tested by us. We knew it coming. We are the ones who evaluate the 'robotic surgery' equipments when we sit on OR committees, approve or disapprove a drug when we sit on P&T Committees. We are the ones evaluating the different EMRs in the market.

We are the ultimate insiders! How many of us use that knowledge to invest in stocks? About ten years ago, I read in one of the financial magazines that the average doctors' portfolio had the maximum number of tech stocks! Many lost their savings, some are still trying to recover after the tech meltdown ten years ago.

Take charge of your financial future, learn the art and science of investing. You will make mistakes, but then, you do not have to pay someone else to lose your money.

Happy investing.

Mummy Knows Best... Or Does She?

Himani Singh Shishodia, MD*

"Ma, are you taking your blood pressure medicines?"

She said, yes… – except for when she forgot or if she didn't feel that her pressure was high. My mood instantly went from pleasant to annoyed. How many times have I had this frustrating conversation before?!

"Ma, you know you can't feel your pressure, right? Ma, they call it the silent killer for a reason. Ma, why can't you just take your medicine every day?"

It was my usual Thursday afternoon call. I dialed Mummy's number as I drove home from the office. When we moved to Baltimore soon after our son was born, Mummy enjoyed getting weekly updates about her 3 year old grandson and her now 9 month old grand-daughter. It was also our time to chit-chat and for me to check in to see how my parents were doing. Somehow one topic led to the next and Mummy was telling me about her health issues and the hundred and one reasons for her not taking her medicine.

*"Maybe it is these **chemicals** that I am allergic to; Meenu, do these blood pressure medicines cause allergic* reactions?" she asked. She asked in a calm and assertive way, but I knew better-- there was no real room for debate. These conversations were never simple. Mummy would debate and argue until I was blue in the face or I just had to hang up because she came up with her own theory of why her blood pressure was high or normal at any given moment.

She began telling me that she was having allergies and that she thought maybe it was due to her medicine. She was trying to figure out why she was breaking out into hives in the evening. She was trying to avoid fruits and sugars. I was listening but I already knew her actions and decisions were based on a logic that only made sense to her. I know that Mummy has multiple types of allergies. Every year growing up, I knew when springtime had arrived because Mummy would be in the kitchen sneezing ferociously because of her seasonal allergies. Cooking oil and smoke was an irritant causing her to sneeze and cough. I remember opening all the windows in the house as she cooked us paranthas or puris for breakfast. It made me wonder what would happen if I told her what she wanted to hear—that any medication can cause an idiopathic allergic reaction. I feared that five years of persistence to persuade her to continue to take her medicine would be negated in an instant.

I wished that I could give her an absolute "no." *"No, these medicines would not cause any allergic reactions; no, they never caused problems in patients; no, they are not associated with hives, ever, ever, ever."* But I knew that would be a lie – in the imperfect world of internal medicine, there are no absolutes. Wasn't I taught to always listen to the patient, to validate a patient's perspective and to try to envision the patient's reality to come up with a practical and more patient-centered approach when developing a treatment plan?

I thought of my own patients with "refractory hypertension". I never screamed at them and always patiently listened. I documented phrases such as "non-compliant", "patient re-educated" or "medication regimen changed" and had them schedule three month follow-up appointments. It now all sounded like mumbo-jumbo when speaking to Mummy. The art of medicine was lost on my mother, whose musings and oral debate could drive any human to the verge of surrender.

With Mummy, I had no patience. I had already tried using logic and giving her statistics, reminding her how Nanaji likely had hypertensive dementia and how her Buaji suffered an incapacitating stroke due to hypertension. My mother had been diagnosed with hypertension years ago. Somehow, she never held on to these *(continued on page 40)*

Breathless in Bolivia

Udita Jahagirdar, MD*

We were a foursome group of fifty something doctors adventuring in the Bolivian Altiplano. Our destination was the Sun Island of Moon Virgins in Lake Titicaca, the mythical birthplace of Inca civilization. Legend has it that Viracocha, the Creator God, rose from the depths of Lake Titicaca, journeyed to these islands and created the sun, moon, stars and the first people.

Well versed in the hazards of altitude sickness, the dreaded *"soroche"* as it is called in Bolivia, we had taken the necessary precautions. Coming from the sea level of Orlando, Florida, we had acclimatized over a few days. Use of Diamox was a little controversial and though three of us took the medicine ahead of time, the fourth member of our party was somewhat reluctant since he was already on a diuretic for hypertension, We had fortified ourselves with quarts of the ubiquitous coca tea and faithfully avoided alcoholic beverages.

We were after all a group of four physicians, with more than 25 years of medical practice under our belts. What could possibly go wrong?

Traveling through the pristine, cobalt blue waters of Lake Titicaca, in the company of flying fish and soaring condors we arrived at the shores of Sun Island. We were met by an excited bunch of teenage locals who quickly grabbed our suitcases and proceeded along the steep Inca steps. Our route would be a three to four mile hike over a hilly ridge offering us majestic views of the lake and the towering snow clad Andes, to our hotel, the Posada del Incas. The terrain was moderately rough, at an altitude of about 13,000 feet. We were met by a local guide with a mule that was to take one of the members of our party who had slightly sprained her ankle. Another person accompanying us was a small wizened person with an ageless weather lined Inca face, his barrel chest reflecting the compensatory lung capacity of the dwellers of this high altitude. He carried a flask of coca tea and much to our reassurance a small tank of oxygen in a satchel.

So we set out at moderate pace. The mule trotted off and soon our friend became a small speck in the distance,

Halfway up the hill, our friend who had avoided Diamox, started feeling nauseous and complained of a headache. We slowed down our pace while he took several swigs of coca tea and we tried to admire the view. Few more paces and he complained of faintness and shortness of breath. His face had taken on a grayish hue. Slightly alarmed but trying not to appear over concerned we nonchalantly felt his pulse. We tried to phone the hotel on our cell phones but there was no reception. The mule had disappeared into the horizon. *(continued on page 40)*

View of Lake Titicaca and Andes mountains, Bolivia

(continued from page 39)

Suddenly our friend threw up. The little man began gesticulating towards his first aid bag. Of course, we had a portable oxygen canister! Why did we not think of it before? What a relief! He came over and attached a facemask to a clear tubing. With infinite care he wiped the mask with an alcohol swab. Then with a flourish he attached it to the oxygen tank and with a practiced twist of his wrist opened the oxygen valve and carefully placed the mask over our friend's face. A minute passed and we waited with bated breath for our friend to respond. But what was this? Our friend tore off the mask, coughed and glared at the man, sputtering in rage. The oxygen tank was EMPTY. We four doctors with a combined 100 years of experience, veterans of travel into third world countries, had failed to do an elementary check of our equipment. Our guide was furious and roundly berated the attendant.

Somehow our friend got up and staggered the rest of the way, which was now thankfully downhill and reached the hotel A tank of oxygen awaited him and after a half hour inhalation of the life sustaining gas he emerged as good as new.

Over dinner we rued the fact that we could never get too complacent or let our guard down. "Time out" pause whether in the operating room or in the realm of adventure remains of critical importance. Rest of the trip passed without any untoward happening. The spirit of Viracocha smiled once again.

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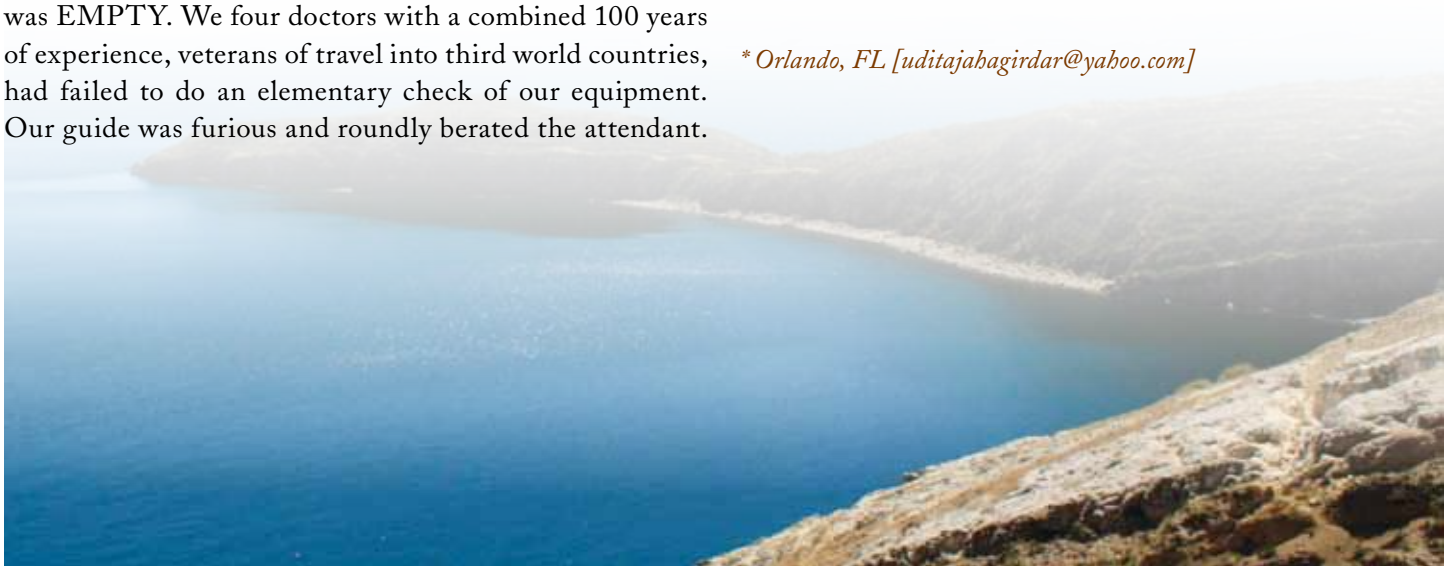

(continued from page 38)

facts. It would make sense to me that she has essential hypertension, similar to Naniji, Nanaji and both Mamajis. A strong family history, being post-menopausal and having no regular aerobic exercise– it was a simple diagnosis and with what I thought, would be an equally simple treatment plan. A three month follow-up may be fine for a patient but it just seemed inadequate when it came to my own mother. She made her own dietary changes and she had yet to start any formal type of aerobic exercise. In fact, I harbored a bit of resentment towards her internist for not being more aggressive and more adamant with treatment compliance and screening recommendations.

"Ma, have you had your mammogram this year?" She told me that she had one done three years ago and thought that was enough for now. She would think about calling her doctor about this – maybe she could discuss it when she had her routine follow-up visit in a few months. *"Ma, how about a colonoscopy - you have never been screened for colon cancer and you are now 63."* She was very quick to tell me that she would never have such a test – the mere mention and thought of it seemed repulsive to her. *"You know Ma, Indian people get cancer too."* I thought of the aunty that was diagnosed with metastatic breast cancer who recently passed away and another aunty who had accidentally palpated a mass and was also diagnosed with cancer.

As I drove home and turned into my driveway, Mummy told me that she was feeling well and that she was looking forward to coming to visit us at the end of the month. She told me that I should check her blood pressure and review her blood test results with her. *"It is always good to have a doctor in the family"*, she told me. Yes, I thought, I suppose it is good because I think an internist in the office may have given up long ago. At least I can keep talking and sometimes yelling and always trying to do my best to convince her and remind her to take her blood pressure pills. Maybe in a few years, I'll be able to convince her to have some cancer screening tests. That is my hope, anyway.

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Little Masters

Satish "Siva" (Sivasankaran), MD*

As busy practitioners of medicine we don't find enough time for anything else. We are busy with our patients, day in and day out. We think medicine, talk medicine and even dream medicine! Our long years of training to be a physician, the rigorous curriculum, the days and nights of training during residency, our relentless pursuit to excel in our field do not leave time for anything else. We push our own interests, hobbies and the right side of our cerebrum to sideline. And often do not pay enough attention to our own family!

I was one such physician, once upon a time. As a busy Interventional cardiologist, I was also caught in this web of life. That was until my son was born. He changed me completely as an individual. My train of thoughts took a different direction. I started to see a new meaning in my life and existence.

Children are true gifts of god. But, we have to open the gift wrapper to see the gift inside! We have to open our eyes and look. Otherwise, life will just move on and we would have lost the golden opportunity. We take children for granted. But, there must be a reason why the supreme power decided humans must have children.

The arrival of my little son created a new reason to live for. Now it was no longer the coronary stents, carotid interventions, angina or heart failure. It was him, his toys and his games. My world changed, changed for the good. It was not about me and my goals anymore. I had to sublime myself to understand him. I started thinking in his terms and looking through his eyes to understand him. I had to be extremely patient with him as our thought processes were different. This was a personality development class that god had set up for me. In the form of my son Advait!

Advait taught me love and innocence. These are qualities we are all born with but in the long process of growing up we lose them. Children are embodiment of love and innocence. Wouldn't it be nice if we can get back those qualities? Let's learn those from our children.

Children also reverse our biological age. They have abundant energy and can do a lot of things in a day without ever being tired. All this energy in a small body! If you spent a day with a five year old, you would know. They will drag you into playing with them quickly. Irrespective of our age, it is very important to feel young mentally. This will make us healthy. Children help train us that way.

Have you ever felt life is déjà-vu again? Have you heard parents saying "He is doing the same things that I did as a child"? The roles are reversed. We were dependent on our parents once upon a time. We needed them to feed us and even stay with us when we went to bed. We gradually outgrow this and no longer are dependent. We also forget to think of the important role parents played in our development. Our children will remind us of the same. When we play the reversed role, we will realize how our parents raised us.

Children play an important role in marriage, whether we realize it or not. They are the crux of the marriage. They are like the axle of the care or like the basement of the building called marriage. In a marriage there is still the presence of 'me and mine'. With a child, that disappears. The self dissolves and the goal becomes common, the child. This plays an important role in strengthening the relationship called marriage.

I wish my son Advait who has taught me all this in the first few years of his life stays young forever. But I know he will grow up and become a man. And no longer the child I want him to be! Even more saddening is the fact that he will not be mine any more. He will have a world of his own, a life of his own and family of his own. I am going to be just watching him from a distance. This is sadly a fact of life. But there is pleasure and enjoyment in that too and I am happy to be a part of it!

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Adapted from his forthcoming book, "Message from my child"

"Moral Resuscitation"

Morarji Peesay, MD*

Standing at the railway station
waiting restively for the delayed train
heavy rain pouring all the way
staring eyes with backlash memories
retracing heavy painful human atrocities
memories of reptilian cold blooded monsters
stirring people lives with re pungent, repulsive acts
those acts instantly changing meaning of Pain
onto painful emotional train
deep restlessness surfacing into revenge
revengeful genes losing all the meaning of life
meaningless power of uncertainty in life
drenching all our lives
adding 'certainty' of more emotional rain
listening to my thunderous roar of survival instincts
I look at the warmth of Sun
balancing the my train of thoughts
The thought of challenging the 'change'
Inching towards overwhelming burden of 'Truth'
With my helpless nature of restless mind
I recharge my Consciousness
Waiting, waiting, waiting to happen
What's life got to do with it????????

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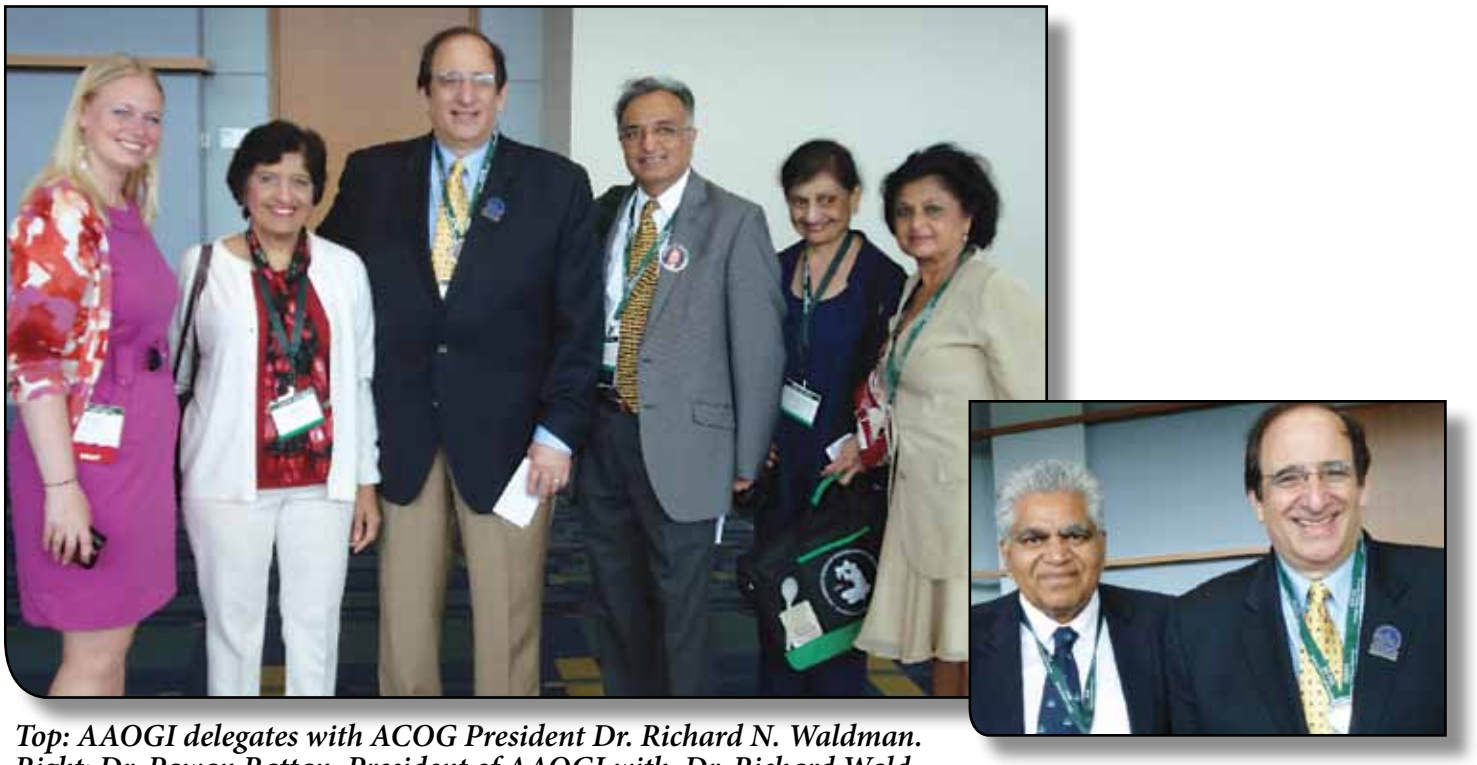
American Association of Obstetricians & Gynecologists of Indian Origin (AAOGI)



Top: AAOGI delegates with ACOG President Dr. Richard N. Waldman. Right: Dr. Pawan Rattan, President of AAOGI with Dr. Richard Waldman, ACOG president, at the recent Annual Clinical meeting in Washington, D.C.

Responding to a long felt need, members of AAPI have recently formed the above mentioned specialty chapter also to be known as AAOGI. Established as a 501(c) non-profit corporation, Tax ID 90-0671595, incorporated in the State of Florida (website www.aaogi.org), AAOGI hopes to be the voice of OB-GYNs of Indian origin and will serve as a bridge between AAPI, ACOG and counterparts in India. The primary purpose is to provide camaraderie, enhance knowledge and enable charitable endeavors both here in USA and abroad.

Founding President:	Dr. Pawan Rattan	Dr.Rattan@gmail.com
Vice President:	Dr. Udita Jahagirdar	uditajahagirdar@yahoo.com
Secretary:	Dr. Shakti (Ava) Mahapatra	samahapatra@yahoo.com
Treasurer:	Dr. Gita Mehta	gita.mehtamd@gmail.com
Co- Treasurer:	Dr. Trivedi	
Regional Advisors:	Dr. Ulhas Bala, Dr. Aditi Gupta, Dr. Yoshadhara Mishra, Dr. Veena Gandhi, Dr. Vimal Goyle.	

Chair CME Dr. Pravin Gaud, Chair India Liason Dr. Ulhas Bala, Chair ACOG Liason Dr. Mahapatra.

Dues established as $50.00 for Active Members, applicable to first 100 members and $500.00 for executive committee and officers, check to be payable to AAOGI, mail to Dr. Pawan K. Rattan M.D., 612 E. Davis Blvd. Tampa Fl 33606. By-laws have been proposed and will be discussed at the Annual AAPI Convention in June at New York where Dr. Rattan will also present a talk on "Reducing Maternal Mortality Rate in India: A Proposal." Response to AAOGI has been encouraging and enthusiastic.

BIMDA rising fast as a Leading AAPI Chapter in Florida

Mr. Glad Kurian and Dr. Prakash Reddy during the Medical Expo Gala in April.

AAPI's vision for strength in all places big and small, is evidenced with BIMDA's meteoric rise in a small town called Melbourne, FL. The 1997 AAPI Convention in Orlando was the motivation to form this Chapter, to uphold AAPI values and to grow the member base of a strong Indian Physician population.

BIMDA is the vision of two unique individuals: Dr. Mahesh Soni, Pediatrician and Glad Kurian, Senior Consultant with Morgan Stanley. Since the past 17 years, the two have built up an organization that has flourished each year with changing leadership of new Presidents and Committee Members. Dr. Prakash Reddy, current President of BIMDA, manages the group with help from Glad Kurian, Honorary Executive Director.

At the recent Medical Expo Gala held on April 30, Dr. Ravi Jahagirdar [AAPI Treasurer] along with Dr. MPR Nathan [AAPI Journal Editor-in-Chief], attended the dinner as special guests. In attendance was the Florida leadership: Dr. Sanjiv Kapil, President of CAPI, Orlando; Dr. Vraj Panara and Dr. Mahendra Shah, Past Presidents, CAPI; Dr. Humayun Shareef, President of TIPS of Florida; Dr. Asha Gupta, President, IPOF; and Dr. Aravind Pillai, National President, AKMG.

The daytime CME conference hosted diverse speakers on topics related to: Cancer Research, Radiology, Domestic Violence, Vascular Disease, COPD, ACO and Healthcare Reform. Keynote Speaker for the evening was Dr. Nagi Kumar, Senior Research Professor with USF and Moffitt Cancer Center.

A good part of the evening was devoted to introducing several charitable organizations on stage and awarding them each a generous check on behalf of BIMDA. Recipients included a dozen worthy organizations from diverse segments of society.

BIMDA holds AAPI as its national affiliate and has partnered with all major healthcare players.

There is no place in this town where an Indian Physician is not recognized as a member of the prestigious "BIMDA" group. Dr. Glen Bryan, renowned State Leader and former President of the FMA, chimes "BIMDA is a fabulous group! They are doing all the right things to stay relevant in a field that is fast diminishing the role of the physician as an independent provider of healthcare. We need more groups like BIMDA to bring us together as physicians, to have one voice in medicine! We need BIMDA and all similar groups to protect our profession as Doctors of Medicine!"

For more information on BIMDA, please visit www.bimda.com

Dr. George Thomas elected Chairman, Florida Board of Medicine

AAPI congratulates Dr. George Thomas on this distinguished honor to serve the Physicians and the Patients of The State of Florida. Dr. Thomas is a renowned Cardiologist, Humanitarian and National Leader in Medicine, having also served as the National President of AAPI [1993-94].

George Thomas, MD, FACC is a board certified practicing cardiologist and is co-founder of Bradenton Cardiology Center, a comprehensive cardiology center with twelve-physicians providing cardiac care to patients in the Manatee-Sarasota area. Active in medical staff and organized medicine, Dr. Thomas served as Chief of Staff, Chief of Medicine and member of the Board of Directors of Manatee Memorial Hospital. He was also chair of the Cardiology Committee, Open Heart Committee at the hospital and co-Director of the Manatee Heart Center. He was the president of the Manatee County Medical Society, member of its Board of Directors, delegate to the Florida Medical Association, and member of the Board of Directors of FMA and FLAMPAC.

At the national level, he has served as the chair of the International Medical Graduates section of AMA, a member of the IMG section council, and AMA delegate, and co-Vice Chair of the FMA delegation to the AMA. He is involved in several ethnic professional societies, and has served as the president and trustee of the American Association of Physicians of Indian Origin [AAPI].

We wish him all the best as he continues with his glorious career.

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*If Criminal Investigation Dept make a referral to Dept. of Justice for Felony indictment, the Criminal Sanctions can be as much as 5 years in Prison. That's why it is not in the account holder's best interest to wait for the IRS to approach them. IRS is becoming successful in obtaining Depositor lists.

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AAPI 30th Annual Convention
Long Beach, CA
June 28-July 1, 2012

AAPI 31st Annual Convention
Chicago, IL
May 23-27, 2013

AAPI 32nd Annual Convention
San Antonio, TX
June 25-29, 2014