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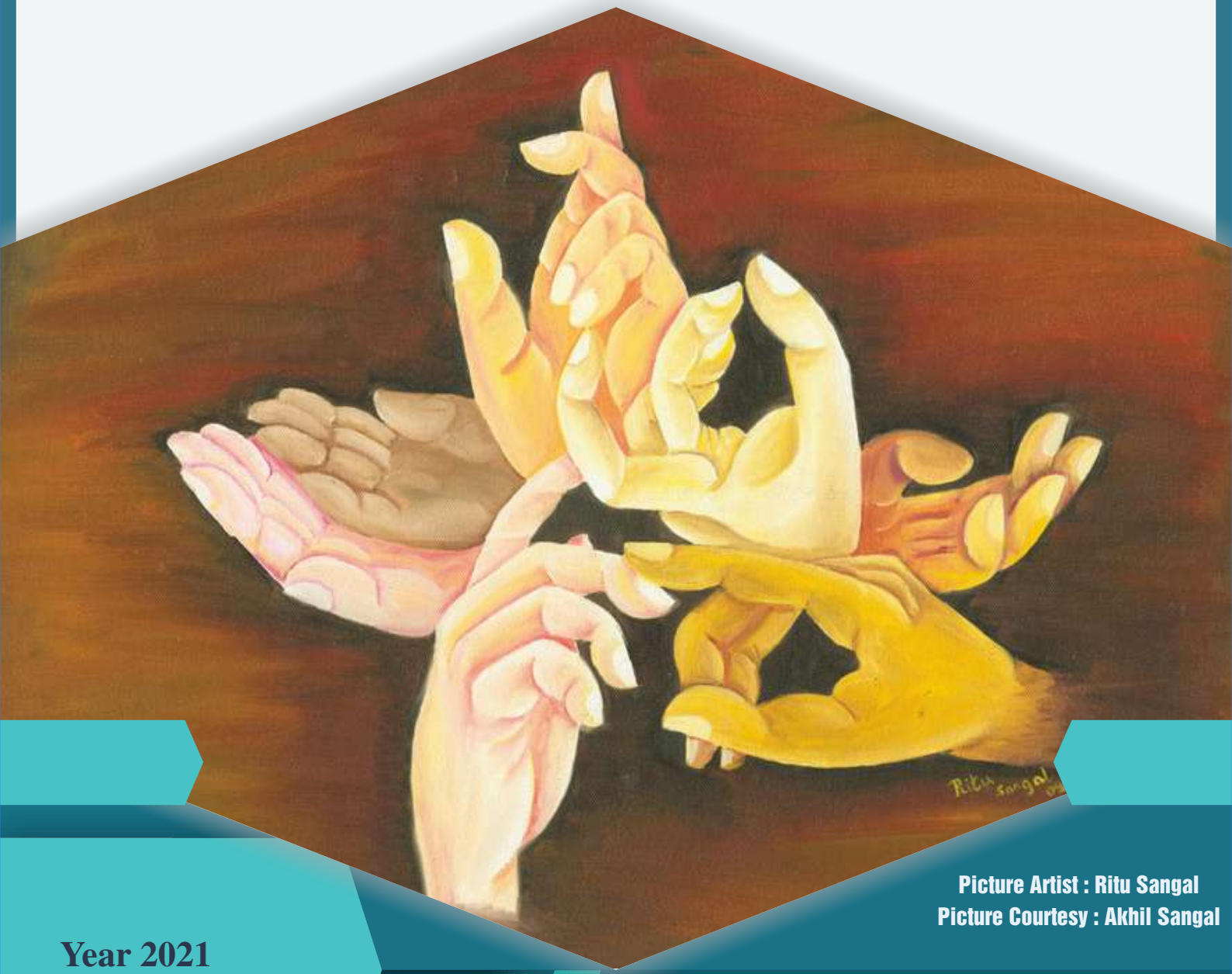

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Regd. Office:
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Pataudi House Road,
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info@icha.in
www.icha.in

Dr. Akhil K. Sangal
Honorary Director
Indian Confederation for Healthcare Accreditation

Collegiality

By A/Prof Chin Jing Jih

Sometime last year, I met a senior doctor who had practiced in both the public and private sectors before his retirement. He lamented to me that doctors these days, whether in private, public or academic practice, are more concerned with "staying ahead and winning, and see many of their fellow doctors as rivals and competitors, rather than colleagues. In their chase for the number one spot, they become selfish and reluctant to help, share and cooperate with one another." He ended off with a sigh, "This lack of collegiality is bad for the profession, and ultimately, for patients." Although he did not elaborate with specific examples, I found myself concurring with his sentiments somewhat.

Some may dismiss his views as overgeneralisation and exaggeration. And in a way, we tend to take for granted that the medical fraternity is a happy family, bound together by common ideals and professional goals. But when I polled a few fellow doctors, they all agreed that the "kampong spirit" of respect and close cooperation in the profession has undergone a subtle but definite decline over the last decade. Disputes and conflicts seem to be on the rise among doctors, who tend to see those in their way as "business competitors" or "academic rivals". Every now and then, we hear about disparaging remarks made by one doctor about another, and frequently, to a patient. All these are rather disconcerting, and I thought perhaps the start of 2013 is a good time for the medical fraternity to revisit one of our pillars of professional Medicine, collegiality.

Historically, the word *collegiality* was used in reference to the participation of bishops in the governance of the Roman Catholic Church, in collaboration with the pope. Today, it is commonly used to describe the cooperative relationship of colleagues – those who belong to the same body of members in a profession concerned with maintaining professional standards (a "college"). The various colleges of physicians and surgeons were formed to provide an organised environment for the collective pursuit of academic interests and technical excellence in the various fields of Medicine. At its most basic, collegial behaviour encompasses doctors treating one another with professional courtesy and respect.

But collegiality in the context of medical professionalism is more than just "being cordial" or "displaying gentlemanly behaviour" to another colleague. Described by the College of Physicians and Surgeons of Ontario as a "cooperative interaction between colleagues", collegiality is a special relationship among doctors based on a common pursuit for medical excellence and a desire to provide good patient care. It is also characterised by respect for one another's professional abilities, a genuine humility to accept constructive criticisms and learn from one another, and an eagerness to help and serve one another. The Singapore Medical Council's (SMC) Ethical Code and Ethical Guidelines sum it up comprehensively: "Doctors shall regard all fellow professionals as colleagues, treat them with dignity, accord them respect, readily share relevant information about patients in patients' best interests and manage those under their supervision with professionalism, care and nurturing."

Why should physicians be collegial in their dealings with one another? What is a collegial relationship that is truly consistent with medical professionalism?

It has been said that the medical problems and needs of today's patients have become so multifaceted and complex that Medicine has to be practised like a team sport. Instead of the rare geniuses, heroes and prima donnas, quality medical care is more dependent on well-integrated and efficient teamwork, and free sharing of knowledge, skills and experiences among physicians of different expertise. Mutual trust, respect, and knowledge of each other's expertise, skills and responsibilities are all important in establishing lasting collegial relationships. Collegiality can also affect the comprehensiveness and continuity of care that patients receive. Ultimately, collegiality is needed to achieve care integration and coordination, and is instrumental to good clinical outcomes, improved patient safety and the delivery of quality care. It is, for example, this collegial relationship that allows us, when faced with a diagnostic or therapeutic challenge in our clinics or ward rounds, to consult a colleague expeditiously and conveniently. These informal kerbside consults, when used appropriately, benefit both patients and doctors. Equally important is the power of collegiality in bringing together doctors as a collective and unified voice to advance patient welfare and public interest.

In addition to patient care, a collegial relationship is crucial to other domains of Medicine, such as medical education, research, administration and management, patient advocacy, and public education. While there is no denying that competition can be a driver of excellence and a catalyst to great achievements, the neglect of collegiality can be counterproductive. Uncontrolled and intense rivalries among doctors will likely lead to a retardation of progress and productivity, as a result of distrust, wasteful duplication of efforts and inefficient use of precious resources.

As doctors exchange professional opinions in their work, be it in patient care, research, education or administration, differences are inevitable. What is essential in any divergence of professional opinion is for the doctors involved to remain objective, honest and open-minded. The professional engagement can only be sustainable if everyone remains positively collegial, with the humility to accept criticism from colleagues, the courage to admit and assume personal responsibility for mistakes, and the willingness to acknowledge the contribution of others. Without these, meaningful and fruitful engagements become impossible.

Perhaps one of the most professionally damaging behaviours, as far as lack of collegiality is concerned, is when doctors deliberately make disparaging and negative comments about their colleagues in a surreptitious manner. Some of these covert stabbings include: "Wah! Why did you wait for so long (before coming to see me)… you could have died!"; "I'm afraid Dr X is very junior and inexperienced. But now that you're with me, you are safe."; "Outside doctors cannot be trusted. They only want to earn your money."; "Government doctors – they are only familiar with cheap and old drugs."; and "Dr Y is outdated – his method was the latest… ten years ago!" Many of such comments are commonly unsubstantiated, and whether deliberate or not, are extremely erosive to patient trust, not just for the doctor who was stabbed, but for the entire profession.

The concern with the toxicity of such "bad-mouthing" of fellow professionals is well recognised by medical councils. The UK General Medical Council makes it clear in its document, Good Medical Practice (equivalent to SMC's Ethical Code and Ethical Guidelines), that a doctor "must not make malicious and unfounded criticisms of colleagues that may undermine patients' trust in the care or treatment they receive, or in the judgement of those treating them". SMC makes a similar appeal in its Ethical Code and Ethical Guidelines for doctors to "refrain from making gratuitous and unsustainable comments which, whether expressly or by implication, set out to undermine the trust in a professional colleague's knowledge or skills". The guidelines further prohibit doctors from canvassing or touting for patients, improper advertising or deprecation of other practitioners, in order to advance their position or earnings.

However, we also need to be mindful of the flip side of the coin. While disparaging remarks are undesirable, doctors do have a professional obligation to make truthful disclosure or offer honest opinions to their patients when confronted with medical errors committed by their colleagues. The key is retaining one's objectivity and humility when evaluating colleagues' medical opinion and management. Medical collegiality has, in recent times, been perceived rather negatively by sceptics external to the profession, and not without good reasons. They felt that collegiality is commonly distorted and misused to mask ineffective or inappropriate medical practices, or to protect incompetent or incapacitated doctors. Doctors have been accused of being too ready to close ranks and negate their duty to report on their colleagues' professional shortcomings, or even actively providing cover-ups in formal inquiries and legal proceedings. Whether it is an attempt to protect the profession's reputation, or a case of too much "respect" for our fellow doctors, such "unhealthy collegiality" will, in the long term, undermine the trust of patients and society for the profession and its practitioners.

Collegial behaviour needs to be anchored by positive values and attitudes, and hence the need for an early introduction in the vocational training of a doctor. The need for adequate and early emphasis in our medical school curriculum becomes more obvious when we consider the academic background of our medical students – virtually all of them are individuals that have been super selected from among tens of thousands of highly diligent individuals who have been conditioned in our highly competitive education system and environment since a very young age.

It is therefore heartening to know that many medical schools are beginning to adopt and incorporate innovative pedagogies, such as team-based learning (TBL), in their curriculum. In TBL, instead of fostering competition that give undue emphasis to individual merit and egocentrism, the framework and method put students through a learning experience and environment that stress teamwork, communication, collaboration, sharing of knowledge and exchange of ideas, without sacrificing the importance of individual accountability. Positive experiences with TBL are growing rapidly, and more significantly, TBL helps to plant the early seeds of positive or healthy collegiality among the young and malleable students. I am hopeful that our future doctors, being adequately exposed to TBL, will be well rooted in collegial values and attitudes, and be better equipped with collaborative skills needed for team-based care and professional engagement.

It is therefore most fitting when doctors recite the SMC Physician's Pledge, a statutory requirement for professional registration, to make a promise to "respect my colleagues as my professional brothers and sisters." Collegiality, regardless of doctors' own personal beliefs and philosophy, is not a matter of choice, but a professional obligation to engage our colleagues in a way that benefits patient care. SMA

A/Prof Chin is President of the 53rd SMA Council. Like most doctors, he too has bills to pay and mouths to feed, and wrestles daily with materialistic desires that are beyond his humble salary. He, however, believes that a peaceful sleep at night is even more essential.

VIEWPOINT

Humanism Before Heroism in Medicine

Urmimala Sarkar, MD, MPH
Center for Vulnerable Populations, Division of General Internal Medicine, Zuckerberg San Francisco General Hospital, University of California, San Francisco; and Department of Medicine, University of California, San Francisco.

Christine Cassel, MD
Department of Medicine, University of California, San Francisco.

During the COVID-19 pandemic, heroic clinician narratives have been a prominent feature of media coverage. Health care professionals who worked ceaselessly in intensive care units, sacrificed time with their families to travel to severely affected areas to care for patients with COVID-19, and put themselves in harm's way have been acknowledged and rightly celebrated.[1] For example, New Yorkers had a nightly ritual of cheering and making noise in support of health care workers and offered public support in the form of signs, treats, and other measures of appreciation that referenced the heroism of the health care workforce. However, the pandemic has outlasted these public demonstrations, and heroic narratives ultimately do not serve clinicians or public health.

The concept of heroism suggests performing some exceptional feat, such as an individual who disregards his or her own well-being to benefit others. Heroes are glorified in art, literature, and history, and these heroic narratives serve an important purpose in demonstrating that individuals can accomplish more than seems possible in response to a challenge or threat. For instance, people such as Nelson Mandela, who faced his long imprisonment without complaint and dedicated his life to justice, embody the heroic ideal.

The culture of medicine aligns with heroic narratives by extolling 3 traits: individual skill, willingness to sacrifice, and stoicism in the face of physical and emotional hardship. Medical training rewards individual achievement, whether it is identifying the correct diagnosis or performing a procedure skillfully. Medicine also extols the heroic attribute of sacrifice, recognizing those who go beyond already significant professional obligations. Narratives about medicine often celebrate clinicians giving time beyond their job requirements, as illustrated in a collection of articles on "the heroic work of doctors and health workers."[2] Medical training demands physical endurance; even after duty hour reforms, 80-hour work weeks and long shifts are the norm. In some clinical settings, such as operating rooms, physical demands persist throughout careers. Unspoken messaging in medical and surgical training programs can promote stoic responses to the wrenching emotions in medicine and, at times, can be accompanied by increased cynicism during residency training.[3]

These 3 heroic attributes of individualism, sacrifice, and stoic endurance can actually undermine the system transformation needed in health care. The individualism inherent in the heroic narrative runs counter to the team-based problem-solving approach to health care delivery that leads to better quality.[4] If physicians and other clinicians are willing to make personal sacrifices to circumvent system shortcomings, leaders are less likely to take necessary steps to correct broken systems. Although systematic data are lacking in this area, Ofri observed that physicians often step in to ensure seamless care on their own time and create "work-arounds" to get patients what they need in dysfunctional microsystems.[5] She contends that medical care in the US relies on this strong sense of professional obligation to function.[5] Similarly, if nurses are willing to work double shifts or routinely cover extra patients, chronic understaffing, which is known to be unsafe for patients, persists.

The stoicism that comes with being a hero is also a risk for burnout, defined by the National Academy of Medicine as emotional exhaustion and distress stemming from work.[6] Stoicism can lead clinicians to underrecognize their physical and emotional needs and to conceal perceived vulnerabilities. For example, an account of a physician concealing her cancer diagnosis while leading a pandemic response, and her description of the healing effect of sharing the experience of her own illness, highlight the importance of changing culture to support physicians as human beings.[7] Moreover, heroic actions and attitudes require an activated mental state that can allow people to perform at a high level for defined periods of time. Sustaining that emotional activation is physically, mentally, and emotionally exhausting. Occupationally related emotional exhaustion and distress, and, in extreme cases, depression, anxiety, and suicide, can result from striving to meet impossible expectations over time. Emergency department physician Dr Lorna Breen, who died by suicide in April 2020, is a recent casualty of this long-standing and deep-seated culture.[8] Even when these heroic expectations do not lead to tragic or career-ending consequences, they can contribute to a lack of engagement and satisfaction in work that is highly prevalent among clinicians.[9]

It is possible that the energy physicians and other clinicians are putting into maintaining stoicism in the face of challenges could be better turned in a positive direction. Clinicians' creativity and problem-solving skills are underutilized resources for transforming health care. As a hypothetical example, consider a specialist in the community with an idea for a novel digital health approach to support patient self-management for a disease she manages on a routine basis. Her daily work includes routine overbooking of patients, frequent absences among staff, and distracting requests to manage tasks others could do, and she is expected to soldier through without complaint. Imagine if the patient scheduling, on-call, and staffing systems all functioned as intended, and she was able to deliver patient care without contingency planning and unplanned work time. She could have the energy and focus to turn to her idea and serve patients even beyond her practice through her digital self-management tool.

The National Academy of Medicine's report on clinician well-being provides an approach for reframing the

Corresponding Author: Urmimala Sarkar, MD, MPH, Division of General Internal Medicine, San Francisco General Hospital, University of California, San Francisco, PO Box 1364, SFGH Bldg 10, Ward 13, San Francisco, CA 94143-1364 (Urmimala.Sarkar@ucsf.edu).

culture, emphasizing humanism instead of heroism. Rather than envisioning medicine as a province of brilliant individuals saving lives without a thought for their personal regard, the aim should be to achieve a culture of teamwork that acknowledges the human needs—both physical and emotional—of clinicians and does not ask them to sacrifice their well-being on a routine basis. Organizational solutions abound, such as information technology–enabled coverage systems, data-supported anticipatory staffing, and team members empowered to a high level of function.[6] These precepts extend to medical education, whereby educators can rightsize learners' workloads, teach and model teamwork and team culture, and, most importantly, demonstrate support for learners and faculty experiencing the stress of their studies or emotional challenges of patient care.

Moreover, it is imperative that health systems provide support for clinicians to prevent and mitigate emotional exhaustion and distress, without stigma for seeking help or time away from work.

The COVID-19 pandemic demonstrated that heroism has its place in medicine. After this pandemic year, it is past time for society to support health care professionals' capacity to respond to emergencies and for medicine and health care systems to encourage and support clinicians to embody teamwork, embrace vulnerability and humanity in the health care workforce, and ask for personal sacrifice only in exceptional rare circumstances. These approaches could transform health and health care and would enable capable professionals to have the fortitude and resilience to respond heroically in an emergency, because they would not have to do so every day.

ARTICLE INFORMATION

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Conflict of Interest Disclosures: Dr Cassel reported being the co-chair of the National Academy of Medicine report *Taking Action Against Clinician Burnout: A Systems Approach to Professional Well-Being*. No other disclosures were reported.

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Dr. Akhil K. Sangal
Honorary Director
Indian Confederation for Healthcare Accreditation

Oxygen Therapy and Mucormycosis during COVID-19 Pandemic

Dr. Naveen Malhotra
Editor-in-Chief
THE ICHA NEWS

During the second wave of COVID-19 Pandemic, a very large numbers of patients got infected in a very short span of time. The medical facilities were overburdened with patients leading to scarcity of Oxygen, COVID beds, intensive care unit (ICU) facilities, essential drugs and other resources. It proved to be extremely challenging for all. Besides taking care of COVID and non-COVID clinical work, the medical fraternity during this period was intensely focused on arranging more and more beds and oxygen for the COVID patients and delivering oxygen from liquid medical oxygen (LMO) tanks, medical gas cylinders, oxygen concentrators or splitting the central oxygen supply (only as dire emergency measures). The sudden increased demand of medical oxygen led to its extreme shortage. To overcome this shortage, 93% ± 3% medical oxygen can be used for COVID-19 pandemic patients through the use of medical oxygen generation plants. The use of industrial oxygen to augment the shortage of medical oxygen should be discouraged unless stringent parameters of decontamination and sterilization are followed strictly.

To ensure optimal utilization of oxygen, Indian Society of Anaesthesiologists put forth several recommendations in its advisory and position statement. All hospital staff should be trained to implement zero leaks at all oxygen ports. While utilizing different modes of oxygen delivery and ventilatory support for COVID-19 patients like nasal prongs, face masks, non-rebreathing bag masks, non-invasive ventilation, invasive ventilation, etc., the target oxygen saturation should be kept at 94%. The high-flow nasal oxygenation should be used very selectively. The measures specific to the practice of anaesthesia during the scarcity of oxygen include the use of regional anaesthesia techniques for the surgical procedure wherever feasible, use of low-flow anaesthesia for surgery under general anaesthesia technique and judicious use of oxygen in the post-operative period.

Amidst this crisis, another entity emerged as an epidemic. There was a sudden surge in the cases of mucormycosis. The symptoms appear during the recovery from COVID-19. An environment of low oxygen (hypoxia); high glucose (diabetes, new-onset hyperglycaemia, steroid-induced hyperglycaemia); acidic medium (metabolic acidosis, diabetic ketoacidosis); high-iron (ferritin) levels; lymphopenia, neutropenia; malnutrition; decreased phagocytic activity of white blood cells due to immunosuppression (SARS-CoV-2-mediated, steroid-mediated or background comorbidities) and contaminated oxygen therapy and delivery devices favours the growth of the fungus.

Management of mucormycosis aims at early diagnosis, reversal of underlying predisposing factors, early administration of systemic antifungal therapy (intravenous liposomal Amphotericin B) and broad surgical debridement of infected tissue. A patient scheduled for mucormycosis surgery poses considerable challenges due to the requirement of multi-disciplinary procedures, difficult airway anatomy, multi-organ effects of COVID and DM, and systemic effects of Amphotericin B like renal dysfunction and dyselectrolytemia.

Hence meticulous attention should be paid to maintaining strict glycaemic control, proper nutrition and regular cleaning and decontamination of the oxygen delivery devices during the management of COVID-19 patients to prevent fungal invasion.

The two waves of COVID-19 have exposed the gross deficiencies in our healthcare system. Future preparedness for COVID-19 pandemic includes up gradation of hospital oxygen supplies, alternative sources of oxygen generation, adequate number of good quality working ICU ventilators and monitors, sufficient quantity of drugs used in the ICU management of COVID-19 patients, setting up ECMO ICUs, ensuring 100% vaccination for the health care workers and training more and more doctors and nursing staff in the basics of intensive care and mechanical ventilation.

Dr. Naveen Malhotra
Director ICHA
Honorary Secretary
Indian Society of Anaesthesiologists

Senior Professor & Head,
Deptt. of Cardiac Anaesthesia &
Pain Management Center,
PGIMS, Rohtak, Haryana
E-mail : drnaveenmalhotra@yahoo.co.in

Dr. Sunil Kumar Sethi
Member
Technical Council ICHA
Consultant Anaesthesiologist
Karnal, Haryana

Dr. Amit
Assistant Editor
THE ICHA NEWS
Deptt. of Anaesthesiology
PGIMS, Rohtak, Haryana

Medical Careers and COVID-19 Pandemic

Dr. Disha Gupta
Assistant Editor
THE ICHA NEWS
Deptt of Anaesthesiology,
PGIMS, Rohtak, Haryana

Dr. Sukriti
Assistant Editor
THE ICHA NEWS
Deptt of Anaesthesiology,
PGIMS, Rohtak, Haryana

COVID-19 pandemic has had an enormous impact on all ranks and domains of our society. Its ramifications on the health care system and medical fraternity are clearly evident. The towering magnitude of this global medical emergency has led to the need for channeling all the available healthcare resources into the fight against pandemic. As a consequence, every healthcare worker around the world has been challenged to push all his limits – be it physical, mental or emotional. Specifically, it is the young and dynamic force of resident doctors which has risen up to the occasion and anchored the war against COVID-19.

Pursuing residency training amidst the pandemic has conferred unforeseen challenges upon the resident doctors. All the teaching hospitals had to defer their academic activities and many had to work as the dedicated COVID hospitals. This has taken a serious toll on the medical education and research activities. Lack of didactic teaching and training has created holes in learning. Inability to run elective medical facilities has given a serious blow to the doctors in training as they are directed to work in COVID facilities instead of their specialties. This has also caused discontinuity and undue prolongation of the thesis work. Even after somehow completing the studies, there are very few opportunities available to present the research work. The exchange of ideas and personal experiences which happens in the medical conferences is gravely missing and although there is a continuing effort at trying to bridge this gap through virtual platform, the young researchers are missing out on the live interactions with their older counterparts.

On the top of this, the medical boards and colleges have not been able to the conduct the entrance and the exit examinations. The intake of new batch of residents has been delayed and the training periods of outgoing batch of residents has been extended for three to six months. Preparing for the exit exams, while serving the extension period under these uncertain circumstances, has proved to be a daunting task. The PG aspirants are also sailing the same boat of uncertainty due to the delay in the conduct of the NEET-PG examination. The incongruence between the final examinations and the advertisement for the posts senior residents has led to the loss of job opportunities for the residents creating a distressful situation for them. Those wanting to pursue super-specialty courses also in similar turmoil as the super-specialty entrance examinations are also delayed.

It is because of all these reasons that the medical careers seem to have gone into an interim standstill. Doubts are plenty which are subject to continued speculation leading on to further indecision. Medical students and trainees continue to look for respite while the cloud of unpredictability looms around. The need of the hour is to find a way to continue teaching and training, advertisement of posts and early yet safe conduct of examination to get rid of the blockage in the medical learning and career opportunities. We ought to remember that the strength our future healthcare system depends upon how efficient and confident the trainee doctors are today. Hence, every effort should be made at trying to allay their anxiety and helping them realize their career goals.

Post-COVID Patient for Elective Surgery

Dr. S. S. Bajwa
Member
Technical Council ICHA

With the second wave of COVID-19 receding, numerous patients who have recovered from the disease are reporting for elective/emergency surgery either for primary ailment or for a complication arising from COVID-19, such as mucormycosis. SARS-CoV-2 infection primarily affects the pulmonary and cardiac systems but has the potential for involvement of multiple systems with both short-and long-term sequelae. Post-COVID syndrome can include symptoms related to residual inflammation, organ damage, impact on pre-existing health conditions, non-specific effects due to hospitalization or prolonged ventilation (post-intensive care syndrome). The patients can be on polypharmacy, including steroids and anticoagulants. All these factors can have significant implications, which make the perioperative management of post-COVID-19 patients challenging.

The Indian Society of Anaesthesiologists, in its advisory and position statement, has laid down various recommendations for perioperative management of COVID-19-recovered patients with an aim to curb the debatable aspects arising out of insufficient published literature, guidelines, or protocols.

The decision regarding the timing of elective surgery after recovery from acute illness depends upon the magnitude and duration of COVID symptoms, the disease severity, the presence of post-COVID-19 multiorgan dysfunction and drugs used for COVID-19 management that can affect perioperative outcomes. The American Society of Anesthesiologists (ASA) and the Anaesthesia Patient Safety Foundation (APSF) recommend a duration of four weeks for those who have recovered from mild, non-respiratory symptoms; six weeks for symptomatic (including cough and shortness of breath) patients who did not require hospitalization; 8–10 weeks for symptomatic patients who are diabetic, immune-compromised or hospitalized with COVID-19; and a minimum 12 weeks for patients who were admitted in an intensive care unit (ICU) with COVID-19.

A thorough pre-operative evaluation of pulmonary function, cardiovascular and thrombotic complications, renal and hepatic impairment, hormonal and metabolic disturbances, neurological and psychiatric manifestations and other generalized symptom is an indispensable tool to improve surgical outcome in a post-COVID-19 patient. Prehabilitation and multidisciplinary optimization is always desirable prior to elective surgery. Another aspect of post-COVID period which needs specific attention is the guideline directed management of anticoagulant and anti platelet therapy.

Pre-operative anxiolysis and reassurance are important keeping in mind that the patients are very often anxious and stressed. As far as possible, regional anaesthesia (RA) is an important option. Optimal oxygenation by providing adequate inspired oxygen concentration should be ensured when administering general anaesthesia (GA). Heat and moisture exchange filters should be used to maintain mucociliary function. In patients with renal dysfunction, drugs that are normally excreted by the kidney are avoided because of altered drug pharmacokinetics. Use of renal replacement therapy, individualized fluid management to prevent congestive heart failure, avoidance of saline, use of haemodynamic monitoring, and careful selection of ventilatory strategies should be considered in those with AKI. In post COVID-19 patients

with cardiovascular manifestations, goals of management are optimization of preload, maximization of forward flow, maintenance of stable haemodynamics, avoidance of myocardial depressant drugs and prevention of complications such as arrhythmias and precipitation of heart failure.

Depending on the post-operative condition, presence of co-morbidities and degree of invasiveness of surgery, shifting of the patient to the ICU/ward followed by oxygen supplementation and ventilatory support is recommended. Post-operative analgesia should be provided using a multimodal approach.

The full scope of the long-term effects of COVID-19 and their clinical implications have not yet been fully understood. Similar to acute COVID-19, there is considerable variability in the presentation and severity of its sequelae. Knowledge of COVID-19-induced systemic effects is essential for better perioperative management of post-COVID-19 patients and new evidence should be incorporated in the practice guidelines as and when available.

Dr. S. S. Bajwa
Professor & Head
Deptt. Anaesthesiology & Critical Care
Gian Sagar Medical College &
Hospital, Patiala, Punjab

Dr. Rajiv Gupta
Member
Technical Council ICHA
Senior Consultant & Head
Deptt. of Anaesthesiology
& Interventional Pain Medicine
Maharaja Agrasen Hospital,
Delhi

Dr. Bharat Bhushan Bhardwaj
Member
Technical Council ICHA
Assistant Professor,
Deptt. of Emergency Medicine
AIIMS, Rishikesh

Dr. Poonam Rajput
CEO & Director ICHA

Medics.Academy and Indian Confederation for Healthcare Accreditation (ICHA) sign MoU to launch "Improving Healthcare Practices" training in India.

Date / location - Medics.Academy – a revolutionary UK company delivering global access to world-leading medical education – and the Indian Confederation for Healthcare Accreditation (ICHA), New Delhi India, have signed a Memorandum of Understanding (MoU) with the aim to jointly work to impart training in India on Rebuilding Trust in Healthcare by Improving Healthcare Practices.

The organisations will collaborate to develop and deliver a unique programme to accelerate the training of healthcare workers across India. This project has been mentored by Dr Rajan Madhok (UK) and Dr Akhil Sangal (Hony Director ICHA, India).

Medics. Academy will be acting as ICHA's European partner in this regard to help foster clinical leadership, furthering the mission to support the development of an additional 18 million healthcare workers needed globally to meet the United Nations and World Health Organisation (WHO) targets for 2030. The focus will be on delivering large scale, impactful education across India by pooling resources and expertise of both organisations.

Dr Johann Malawana, Chief Executive Officer at Medics. Academy, said *: "We are delighted to be chosen as ICHA's European partner in what is a major milestone for our company. It aligns with our objective of forming partnerships based on shared principles and a vision for equity in health. Our focus will be to deliver large scale, impactful education across India, in line with our mission to help solve the global workforce crisis through education and improve healthcare delivery."*

Dr Poonam Rajput-CEO & Director ICHA, added: *"Our mission is to establish validated excellence through collaborative efforts and hence we are delighted to partner with* Medics. Academy *to jointly deliver this programme. To achieve excellence we need to build trust by creating a culture, using Patient safety as one of the tools. We look forward to a long, sustainable relationship to further our vision in delivering quality improvement and making India the health destination of the world."*

Medics. Academy was founded to help solve the global workforce crisis through education. It's vision is to deliever healthcare education that is affordable and accessible to healthcare workers and students across the globe. Established in 2016, the organisation aims to empower health professionals globally through innovative education, delivered through their unique digital platform, as well as supporting continued professional development.

The vision of ICHA is to attain global leadership and make India the health destination of the world by providing continuously better-quality healthcare through actualisation of its tremendous expert resource potential.

Dr. Poonam Rajput
CEO & Director ICHA
Director, Morpheus Healthcare Pvt Ltd
Delhi

INDIAN CONFEDERATION FOR HEALTHCARE ACCREDITATION
(Incorporated as a not-for-profit Section 25 Company)
Regd. Office: Lal Kothi, 2nd Floor, 3830, Pataudi House Road, Daryaganj, New Delhi – 110 002, INDIA
CIN: U85110DL2004NPL129651 Website: www.icha.in

ICHA: Safe Healthcare for All

NOTICE OF THE 17th ANNUAL GENERAL MEETING

NOTICE is hereby given that the **17thAnnual General Meeting** of the members of **Indian Confederation For Healthcare Accreditation** will be held as under :-

DAY	:	**Sunday**
DATE	:	**26th September, 2021**
TIME	:	**11:00 AM to 1PM**
VENUE	:	**Online meeting on Zoom Platform** via the link as below

https://us02web.zoom.us/j/89533915962?pwd=U0duaUN1KzkwVE9idVkwdnRGaHRPQT09

Meeting ID: 895 3391 5962
Passcode: ICHA

to transact the following business:

ORDINARY BUSINESS

1. **To receive, consider and adopt the Audited Financial Statements for the Year ended 31st March, 2021 together with the Auditors' and Directors' Report thereon.**

SPECIAL BUSINESS

1. **Appointment of New Directors to the Company:** In the meeting held dated 5th Sep 2021 of the Directors, Technical Council Nominees, Office bearers of Constituent Associations and invitees, the nominations were recorded and approved and as per article 6.2 and 7 of AoA, the nominees were invited to volunteer their names as Nominee Directors under Section 161 (3) of the Companies Act 2013 of their respective Member Associations. The following volunteered to be appointed as Nominee Directors if approved in the AGM. They were briefed about the requirements viz. DIN allotment, Form DIR 2 or if already having DIN and holding Directorships to submit DIN and DIR 8:-

    i. Dr. Ajay Soni – Nominee ACBM

2. **To approve and record new nominations received from Members/Affiliate Members to the Technical Council in each category received after September 05th 2021 but before 24th September 2021.**

3. **To elect new Directors after briefing on new requirements/procedures and process in addition / modification of above in Item no. 1 for nominations received later as above.**

INDIAN CONFEDERATION FOR HEALTHCARE ACCREDITATION
(Incorporated as a not-for-profit Section 25 Company)
Regd. Office: Lal Kothi, 2nd Floor, 3830, Pataudi House Road, Daryaganj, New Delhi – 110 002, INDIA
CIN: U85110DL2004NPL129651 Website: www.icha.in

ICHA: Safe Healthcare for All

4. To consider and if thought fit, to pass the following resolution, with or without modification, as an ordinary resolution for any new nominations / applications received:-

"RESOLVED THAT pursuant to Articles of Association and Section 255 of Companies Act, 1956 and other applicable provisions, if any, the consent of members be and is hereby accorded to the Board of Directors of the Company for appointment of new nominees to the Board of the Company at duly convened Board Meeting, subject to completion of formal documentation of the nominees."

5. To discuss and decide the future of ICHA and the course of action to be pursued: The various committees / projects discussed in the meeting of 05th September 21 and other ones received thereafter shall be taken up for ratification / approval / consideration as deemed fit.

NOTES:

1. The Explanatory Statement pursuant to Section 102 of the Companies Act, 2013, with regard to the special business mentioned above is enclosed.
2. Status of Statutory Auditors: M/S Agiwal & Associates, Chartered Accountants (FRN:000181N), Statutory Auditors of the Company hold office from the conclusion of 15th Annual General Meeting until the conclusion of the 20th Annual General Meeting of the Company to be held in 2024 as resolved in 15th AGM held on 28th September 2019. **This is for information and record.**
3. A member entitled to attend and vote at the meeting is entitled to appoint a proxy to attend and vote instead of himself and the proxy need not be a member. The proxies to be effective should be deposited at the registered office of the company not latter then 48 hours before the commencement of the meeting.
4. Members are requested to notify change of address, if any, immediately on receipt of this notice.

By Order of the Board of Directors

Place: New Delhi

Dr.Poonam Rajput
(CEO-& Director)

Dated: 10th September 2021

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Annexure to notice calling AGM on 26 Sep 2021.

Explanatory Statement pursuant to Section 102 of the Companies Act, 2013.

SPECIAL BUSINESS

ITEM No. 1: The nominees volunteering to be Nominee Directors (u/s 161(3) of Cos. Act 2013): The nominees at S. no. i. As per Section 160 of the Companies Act 2013 from aforesaid nominees proposing candidature for office of Nominee Director of the company.

The Board recommends the passing of the Ordinary Resolution for each of the approved candidature. None of the Directors and Key Managerial Personnel of the Company and their relatives is concerned or interested, financial or otherwise, in the resolution(s) to be passed for each candidature approved.

ITEM NO. 2: Expansion of Composition of Board: Your Company is on the lookout for opportunities for furtherance of its activities and in the view of same the Board has recommended to introduce new nominees to the Board of Directors in accordance with these Articles in addition to those in Item No. 1 above.

Further to the changes in the companies Act 2013, the members need to discuss and decide the revised governance structure and implement the same.

The nominee directors of the associations are to be elected by the Technical council nominees. Therefore based on the discussions and decision appropriate steps towards appointment / resignations shall be pursued with the Registrar of Companies.

None of the Directors is interested in the proposed resolution and recommend the resolution for your approval.

By Order of the Board of Directors

Place: New Delhi

Dated: 10th September, 2021

Dr. Poonam Rajput
(CEO-Ex-Officio Director)

Dr. Nirmal Surya
Chairman
ICHA Telemedicine Academy
MD, DNB(Neuro), FIAN
Director ICHA
Chairman Surya Neuro Center

ICHA: PAEDIATRIC TELEMEDICINE SEMINAR
(9 MAY 2021)

The healthcare ecosystem has become one of the most diversified and largest sectors in India. COVID-19 pandemic has caused significant disruptions in the healthcare value chain and has tremendously halted the routine access of patients to healthcare institutions. To keep up with the advancements it is important to resort to telemedicine practice which facilitates distant consulting of patients through digital mediums.The second virtual ICHA conference on Tele-medicine was conducted on 9th May 2021 after the first meeting that was successfully held on 14th March 2021.

The session was commenced at 11 am sharp by Dr. Nirmal Surya, TMA Chairman who greeted and welcomed all the speakers and participants. He briefly spoke on the last session conducted by ICHA and emphasized on the importance of tele medicine in the current scenarios

Dr. Nirmal Surya along with Dr. Poonam Rajput, CEO ICHA inaugurated the session by introducing ICHA, its scope of work and its focus on addressing doctors' concerns in the current scenario of managing tele-medicine. She spoke on the demand of tele-consults in the pandemic, how ICHA recognizes doctors needs to manage the patients in terms of their fears and treatment andproviding training and certification of doctors for the same. Dr. Poonam released the second edition of the e-newsletterand encouraged all to participate in the e-newsletter publication by sharing and circulating their best practices with all. She congratulated the Editor-in-Chief of ICHA, Dr. Naveen Malhotra for coming up with the second edition.

Dr. Nirmal Surya, TMA Chairman exhibited the previous 36-paged e-newsletter addressing patient safety, the current perspective of vaccines on COVID 19, Will Tele-medicine practice stay beyond pandemic? and much more. The link for this newsletter was shared in the chat box with all to get an access to it.

Dr. Anand Vasudev, conveyor of second ICHA edition gave a brief background of the Pediatric session and invited chair panel of the conference, Dr. Bakul Parekh, Secretary General of Indian Academy of Pediatrics (National) and Dr. G V Basavraj, Pediatrician with 20 years of experience followed by the speakers and their topics of discussion.

Dr. Anil Gulati was introduced by Dr.Anand Vasudev and started with the first topic with a brief on Telehealth and Telemedicine

- What is Tele-medicine?
- Why is it in demand today especially in the pandemic?
- Telemedicine vs Telehealth
- Advantages of Tele-medicine
- Legalization of Telemedicine in India since 25th March 2020

Dr. Anand Vasudev, presented his topic of discussion, Guidelines for Pediatric Teleconsultation and gave a brief on the following topics in brief to the participants.

- GOI guidelines for Tele-consultation
- Guiding principles: Rules that guide consent, introduction of the doctor before consultation
- History taking technique
- Difference between first and follow up consult
- What are the components of management? Importance of counselling patients
- Medical ethics with examples of misconduct in Tele-medicine
- Following documentation and digital trail
- Managing the fees of Tele-consultation
- Discussing a few practical tips for doctors and patients (Handling emergencies, accountability in case of misconducts)
- What is Out of scope of Telemedicine: From GOI

Dr. Anand Vasudev introduced Dr. Gunjan Baweja and her contribution. Dr Gunjan Baweja shared an approach to Various platforms available for tele-consultation and shared on the below points.

- Various modes available for tele-consultation with limitations of each (Video, audio, text, real time interaction)
- What is an emergency consult?
- Ideal characteristics of Tele-consultation
- Caution that doctors have to take care of while tele-consulting
- Recommended prescription format
- Added advantages of Tele-consultation
- IAP, E Sanjeevani, other private platforms used for tele-consulting

Dr. Nirmal Surya introduced WONDRx and its application for doctors. Mr. Pankaj Agrawal, co-founder of WONDRx gave a quick glance of the Consumer application, patient journey, its usage and benefits to the doctors. He addressed the importance of retrievability and reproduction of data for doctors while maintaining complete data security at WONDRx.

Post WONDRx platform brief, the session was taken ahead by Dr. L N Taneja with his expertise on clinical examinationduring pediatric tele-consulting and shared case studies based on the below points

- Understanding remote clinical consultation
- Importance and aim of history taking
- Completing history by recording all other details: birth/immunization/treatment/developmental history
- Reconstruction of all gathered facts (initial impression of a child is very crutial)
- Conducting remote physical examination, head and neck examination followed by respiratory system examination, abdomen examination, locomotor examination, throat examination at the end
- Displayed a few images sent by the patients to doctors to help patrticpants learn on how clinical examination is possible during teleconsultation

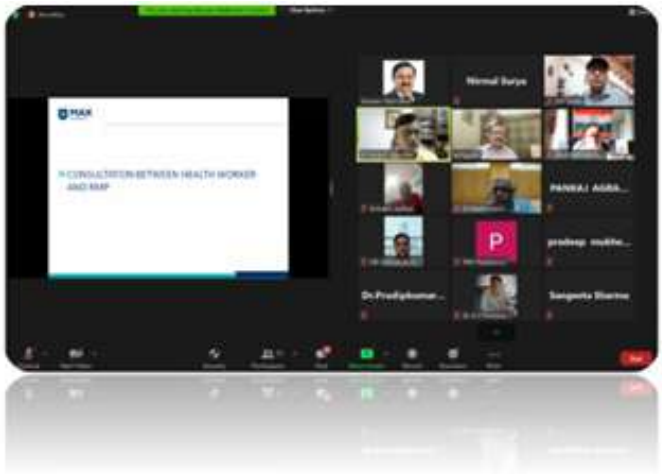
The concluding sessionwas taken up by Dr. Anil Gulati sharing on Teleconsultation for Doctor to doctor covering remote areas and covered

- Consultation between Healthcare worker and RMP

- Tele-consultation process: Patient identification, consent, Exchange of information for patient evaluation, patient management
- Role of a healthcare worker in Telemedicine
- Practicing Tele-radiology, tele-pathology and tele-ophthalmology as means of exchanging information

Throughout the session, participants kept posting their questions/queries on the chat box. Few of these were addressed immediately while a few questions were answered by the speakers at the end of the session.

After a round of question-answer session, MCQ, and certification Dr. KenshukMarwah, delivered the vote of thanks. The symposium proved to be of great value and thought-provoking guidance that can be leveraged by doctors across the country to adapt to the constantly evolving digital needs in the healthcare sectors. The insights shared and thoroughly discussed will definitely help doctors and all healthcare providers to bridge the gap and flourish in the era of healthcare digitization.



Dr. Virendra Sharma
Director ICHA
Chairman Membership Committee

Dear Office Bearers of Subscribing Member Associations of ICHA,

You are requested to please spread awareness about ICHA, its work being done like ICHA Mitra project and other ongoing projects amongst members of your association. Please promote them to join ICHA and contribute actively.

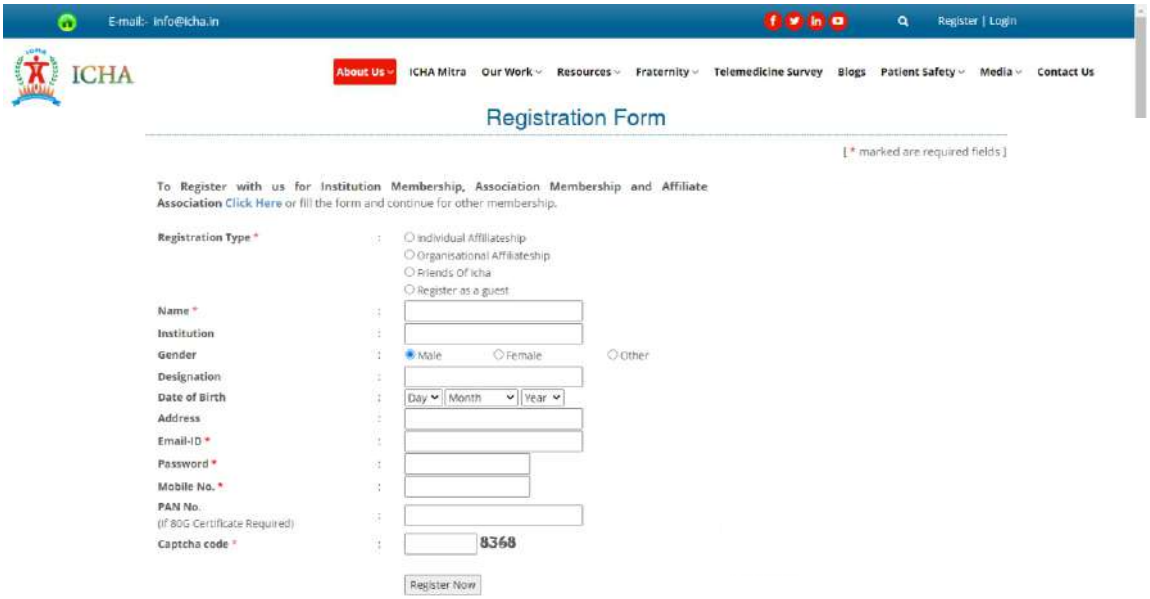
The ways to join forces together:
1. Organizational Affiliates
2. Individual Affiliates
3. Friends of ICHA
4. National Associations as Subscribing Members.

Unity is strength. COVID-19 Pandemic has highlighted the need even more starkly.

To join please visit our website www.icha.in

Thank You.

Dr. Virendra Sharma
Director ICHA
Chairman Membership Committee
Consultant Anaesthesiologist
Vivekananda Polyclinic & Institute of Medical Sciences, Lucknow
Treasurer ISA National



CONSTITUENT ASSOCIATIONS / INSTITUTIONS

List of ICHA's Constituent Associations / Institutions recognized as apex bodies in their respective fields.

- Association of Surgeons of India (ASI)
- Association of Physicians of India (API)
- The Federation of Obstetric & Gynecological Societies of India (FOGSI)
- Indian Society of Anaesthesiologists (ISA)
- All India Ophthalmological Society (AIOS)
- Academy of Hospital Administration (AHA)
- Indian Association of Physical Medicine and Rehabilitation (IAPMR)
- Paediatric Orthopaedic Society of India (POSI)
- Indian Cooperative Oncology Network (ICON)
- Indian Academy of Neurology (IAN)
- The Indian Association of Gastrointestinal Endosurgeons (IAGES)
- Indian Association of Dermatologists, Venereologists and Leprologists (IADVL)
- IAMI Indian Association of Medical Informatics
- Indian College of Pathologists (ICP)
- Association of Clinical Biochemists of India (ACBI)
- The Trained Nurses Association of India (TNAI)
- Nursing Research Society of India (NRSI)
- Indian Society of Psychiatric Nurses (ISPN)
- Indian Pharmaceutical Association (IPA)
- The Indian Hospital Pharmacist's Association (IHPA)
- Indian Pharmacy Graduates' Association (IPGA)
- All India Occupational Therapists' Association (AIOTA)
- The Indian Institute of Architects (IIA)
- Consumer Coordination Council (CCC)
- All India Management Association (AIMA)
- All India Institute of Local Self-Government (AIILSG)
- The Brain & Spine Foundation (BSF)
- Jansankhya Sthirta Kosh - JSK NPSF
- GVK EMRI (Emergency Management and Research Institute)
- IMA - College of General Practitioners (IMACGP)
- National Neonatology Forum (NNF)
- Consumer Association of India (CAI)
- IMA Hospital Board of India (IMAHBI)
- Indian Academy of Pediatrics (IAP)
- Association of Minimal Access Surgeons of India (AMASI)
- Association of Health and Hospital Administrators (AHHA)
- Indian Association of Surgical Oncology (IASO)
- Association of Medical Consultants (AMC)
- HEALTH EDUCATION LIBRARY FOR PEOPLE (HELP)
- Indian Society of Hospital Waste Management (ISHWM)
- ACBM Association of Clinical Biochemists and Microbiologists
- Delhi Society for Promotion of Rational Use of Drugs(DSPRUD)
- Indian Federation for Neurorehabilitation(IFNR)
- Indian Society for Health Care Risk Management (ISHCRM)
- Research Society of Anaesthesiology Clinical Pharmacology(RSACP)

Indian Confederation for Healthcare Accreditation is a professionally owned and driven Not-for-Profit organisation incorporated as a Section 25 Company. The basic aim of ICHA is to strengthen our health system using modified accreditation as a tool. Addressing the complexities of healthcare system comprehensively requires a collaborative team effort by all stakeholders.

ICHA is the National multi-stakeholder Confederation of National Associations/ Institutions for establishing validated excellence in healthcare in India in line with similar bodies in all developed countries. ICHA comprises all stakeholder groups across the health sector, viz. Providers, Receivers and users, Payers and funders, Educators and regulators.

Currently, all the major National Associations/Institutions of Medical Sciences and practitioners (Clinical, Lab, Admin), Nursing, Pharmacy, Therapy, Consumers, Management and Architects are our subscribers. All the Associations/Institutions are well established and are recognized as apex bodies in their respective fields.

ICHA logo depicts its mission of Patient Centred Healthcare. We seek to address Patient Safety concerns by placing patient safety at the top of all stakeholders' agenda- be it the healthcare receiver, the provider and every stakeholder groups across the health sector. Patient Safety is the hallmark of excellence and our chosen path to achieve excellence.

Board of Directors

Sl No.	Name	Association
1.	Dr. Akhil Sangal	Hony Director ICHA
2.	Dr. Poonam Rajput	CEO & Director ICHA
3.	Dr. Nirmal Surya	Director ICHA
4.	Dr. Sangeeta Sharma	Director ICHA
5.	Dr. Naveen Malhotra	Director ICHA
6.	Dr. Virender Sharma	Director ICHA
7.	Dr. Harshavardhan Singh	Director ICHA
8.	Pritpal Kaur Bamra	Director ICHA

Advisory Board Members

Sl No	NAME
1.	Dr. Arun Goel
2.	Mr. S L Nasa
3.	Dr. S V Bole
4.	Dr. Rajesh Upadhyay
5.	Ar. Vijay Garg
6.	Dr. Rajan Madhok (Overseas Advisor)

Technical Councillors

S. No	Names	Association Name (In alphabetical Order)
1.	Dr. LM Srivastava	Nominee ACBI
2.	Dr. Seema Bhargava	Alternate nominee ACBI
3.	Dr. Ajay Soni	Nominee ACBM
4.	Dr. Rishabh Rajput	Alternate Nominee ACBM
5.	Mr. Rajeev Gupta	Alternate Nominee ACBM
6.	Prof Mohd Masood Ahmed	Nominee AHHA
7.	Dr. Anil K. Srivastava	Nominee AIOTA
8.	Dr. R. K. Sharma	Alternate Nominee AIOTA
9.	Dr. Neeraj Mishra	Alternate Nominee AIOTA
10.	Dr. Nilima Vaidya Bhamare	Nominee AMC
11.	Dr. Arulrhaj Sundaram	Nominee API
12.	Dr. KK. Pareek	Alternate Nominee API
13.	Dr. Rajesh Upadhyay	Alternate Nominee API

14.	Dr. Anupam Prakash	Alternate Nominee API
15.	Dr. Renu Gupta	Nominee DSPURD
16.	Dr. Ragini Agrawal	Nominee FOGSI
17.	Dr. GV Ramana Rao	Nominee GVK EMRI
18.	Dr. Rajanarsing Rao	Alternate Nominee GVK EMRI
19.	Prof N G Rao	Nominee IAMI
20.	Dr. D Lavanian	Alternate IAMI
21.	Dr. Z. Zayapragassarazan	Alternate IAMI
22.	Prof. Pramod Pal	Nominee IAN
23.	Dr. Vinay Goyal	Alternate Nominee IAN
24.	Sh SL Nasa	Nominee IHPA
25.	Mr. Pankaj Bector	Alternate Nominee IHPA
26.	Dr. AK Adhikari	Alternate Nominee IHPA
27.	Dr. Mymoona Akhtar	Nominee IPA
28.	Dr. Naresh Sharma	Alternate Nominee IPA
29.	Mr. Kalhan Bazaz	Alternate Nominee IPA
30.	Atul Kumar Nasa	Nominee IPGA
31.	Prof(Dr)Arun Garg	Alternate Nominee IPGA
32.	Prof(Dr) Vijay Bhalla	Alternate Nominee IPGA
33.	Dr. Rajiv Gupta	Nominee ISA
34.	Dr. Bharat Bhushan Bhardwaj	Alternate Nominee ISA
35.	Dr. Sunil Kumar Sethi	Nominee RSACP
36.	Dr. S.S. Bajwa	Alternate Nominee RSACP
37.	Swapna S Joshi	Nominee TNAI
38.	Jaeny Kemp	Alternate Nominee TNAI

Committees of ICHA

COMMITTEE	Chairperson	Co-Chair
ICHA Mitra	Dr. Sangeeta Sharma	Dr. Poonam Rajput
Improving Clinical Practice	Dr. Akhil Sangal	Dr. Poonam Rajput
Tele Medicine Academy	Dr. Nirmal Surya	Dr. Kenshuk Marwah
News Events & Communications	Dr. Naveen Malhotra	
Membership Committee	Dr. Virendra Sharma	
Website	Dr. Neeraj Mishra Ar. Kapil Mehta	
Social Media Handling	Dr. Harshvardhan Singh	
Liaison and Fundraising	Dr Nirmal Surya	
Plasmapheresis	Dr. Nilima V. Bhamare	Dr. Kenshuk Marwah