INDIAN ASSOCIATION FOR THE STUDY OF TRADITIONAL ASIAN MEDICINE
पारंपारिक आशियाई स्वास्थ्य परिषद - भारत

IASTAM
INDIA
NEWSLETTER

Communiqué

*Vol : V *Issue : 5 *April 2021 (Monthly) *Price: Rs. 6/- *Page 8 *Pune

Connecting Systems; Bridging Disciplines
Ayurved *Yoga* *Unani* *Siddha* ***Asian Medicine***

"The most important thing in life are the connections you make with others"
- Leadership Freak

completion of 40 Years

PRE NOTE

PRACTICING AYURVEDIC SURGERY, A REALITY CHECK

Dr. Narendra Bhatt

An unwarranted controversy has raised its ugly head following the decision of our policy makers to permit surgical interventions by Ayurvedic practitioners.[1] It seems obvious that the debate seems driven more by professional greed than any claimed public good. Arguments put forth have centred around the comparison of education and training – medical and AYUSH – in terms of basic knowledge, learning, skill development and specialization that lead to professional capabilities. Unfortunately, once again something that should have been resolved by professional bodies has gone to court. ***Therefore, A Reality Check Is Necessary.***

In the earlier days, there was a belief that there was no science in surgery and that, historically it was the area in which surgeons were not considered equal to doctors or internees. I have come across references to barber surgeons from Europe in the medieval days who used to perform minor surgical procedures such as bloodletting, cupping therapy and even the pulling out of teeth. Pare, the French physician, was one of those who, though he had no formal education, wrote several books on Anatomy and wound healing. He introduced contexts as varied as the implantation of teeth, the use of artificial limbs and artificial eyes made of gold and silver. It would be interesting to note what the claimants of monopoly on surgery would say about this?

This reference to barber surgeons reminded me of my own experience when I accidentally had a fall from the first floor of my home at my native village through a wooden set of stairs down to the ground level in 2009. The trauma was so severe that I was not able to move even a wee bit due to the sharp shooting pain that I experienced even with the slightest of movement. As a regular practice there however, the local village bone setter, who was a barber was called in. With assurance and skill, he helped to lift me onto the bed to be rested. Later his skilful ability to manoeuvre and wind the bandage on and around the affected part amused me, as it helped reduce the pain considerably. At this stage he brought me a set of pain killers and even steroidal tablets (!) that I however did not take. I was then flown to Mumbai and wheeled out straight for an x- ray and scan and onwards to an orthopaedic expert. Although upon investigation nothing serious was found, I continued to have noticeable pain and stiffness. As an extension to the same story, I experienced true relief only after a year or so later, when I underwent two; one-hour sessions with a chiro practitioner in Germany who could locate the affected part exactly and realign the structure. Skilful manoeuvring of the *marma sthan* – specific neuromuscular points was the key to these benefits, as experienced.

These examples of two barbers - one contributing

to pioneering surgery and the second providing the necessary primary healthcare - provide adequate reason to conclude the debate.

I also recall my father, a traditionally qualified and trained - *Ayurveda Visharad* - Vaidya regularly handling minor surgeries for deep wounds, ripe boils, inflammatory conditions of the eyes and ears and even occasional serious cases of a bone tuberculosis in his dispensary. Even at my own clinic I have successfully treated non-healing wounds, abscesses, varicose veins, gouty arthritis and bedsores with internal medications, topical applications and *jalaukavacharan* - bloodletting with leeches.

RICHNESS OF AYURVEDA

Shalya Shalakya Tantra; one of the eight branches of Ayurveda representing present day surgical practices – invasive interventions - has unravelled knowledge yet to be explored to derive new linkages in Ayurvedic diagnostics and prognostics as also to develop novel applications.

The most common word used in Sushrut Samhita is *bhishak* which implies a physician having in-depth and practical knowledge in understanding the disease and therapeutics and performing it aptly. Sushruta (in about 600 B.C.) was a pioneer in presenting and practising anatomical and surgical principles, the real depths of which are being realized now. He was the earliest exponent of surgery as a part of medicine where pursuit of health is depicted with clarity and specificity. Surgical skills were essential and an integral part of healing the whole rather than a part of the body. Sushruta represents the highest level of clinical - observational, and integrated - skills with objectivity and applicability. Functional Anatomy as depicted by Sushrut in addition to precise descriptions of disease processes provides deeper understanding of otherwise invisible disease processes and conditions. With unparalleled explanation about the origin of life, Sushrut has elaborately described the entire nine-month foetal development including causes that lead to abnormal or still birth; and has prescribed pertinent therapeutics and non-surgical and surgical treatments. He has emphasized that the knowledge of internal medicine, among other skills, is an essential qualification of a surgeon.

Concepts related to *Shotha* – inflammation and detailed description of *Vrana* [ulcer], *Vravavastha* [stages of ulceration] and *upadrava* [sequel] as in Sushrut Samhita, if studied carefully will not only help understand the pathophysiology of inflammatory diseases but the biological variations of inflammation that forms the basis of such dysfunctions. The human body gets exposed to '*vrana*' in the very early period of life, at the time of birth when the umbilical cord gets separated. *Dhoopan* [fumigation with aromatics or bitter woods] is not relevant only to the new-born and mother but can be applied to disorders like piles, post-surgical or infected wounds, and these contexts are worth exploring for challenges of post-surgical infections and antibiotic resistance.

WHAT IS PRACTICED?

Ksharsutra, the treatment for piles and fistula with ***medicated threads*** is the most successful example of a single surgical procedure established for its scientific basis to gain national acceptance with hundreds of Ayurvedic practitioners contributing to treat a subset of surgical conditions. Pioneered by Prof. P. J. Deshpande, a scholar of Ayurveda and several others from B.H.U. and later supported by both the Central Council for Research in Ayurveda and Siddha and the Indian Council of Medical Research to examine different aspects of the procedure and documented with thousands of cases it has become part of regular Ayurveda practice. Yet a few of its aspects, mainly manufacture and variable applications need further research to develop its enhanced applicability. Industry has yet to play a dynamic role that I have stated time and again, in this endeavour. The further extension of the concept of *Ksharsutra* and various other non-surgical and surgical procedures from Ayurveda are required to be explored in the context of present needs.

Other such areas include **management of fractures** and dislocations. ***Agnikarma*** as practiced in several pockets in the country and several such documented surgical interventions are in need of exploration and acceptance. Another promising area is that of Ayurvedic surgery for eye conditions where it can definitely make a mark. While exploring the depth of science of ***Ayurvedic ophthalmology*** it is desirable that these procedures be developed for their optimal utilization to become part of the healthcare offering in every part of the country. Similarly, several skilled ***Dant vaidyas*** are known to offer beneficial interventions including painless tooth extraction.

ISSUES AND ARGUMENTS

Arguments put forth are about the skill development, training, use of equipment and requirements in terms of years of training, specialisations, and such. These are related to development of systems within which the practices must function. Historically the present institutionalization - academic structure of AYUSH was *initiated and imitated* because of similar demands at that time from the professional bodies of modern medicine only. Over the last five decades the present institutional structure of AYUSH has evolved and contributed to

medical care in the country and it will continue to do so. The present AYUSH structure is also driven by qualified specialization after three years of skill development and training only after the completion of the BAMS. Curricula of these courses have also undergone changes through assigned bodies to adapt to the needs of the times. Many AYUSH hospitals have a long history of success with integrated medical care where modern specialists also participate to offer medical care to hundreds of patients. It is unseemly to not accept an approved method of specialization. **No single system of medicine can prevent the other system from gaining its rightful place.**

Undoubtably the surgical practices in the areas of specialization and super-specialization acquired by undergoing respective learning and training under modern medicine must remain within the domain of modern surgery.

However, one must not forget that till the seventies even medical representatives having 10 years of experience of selling allopathic drugs could become Registered Medical Practitioners (RMPs) and that MIMS and CIMS were the bible for most practitioners in India. Recently the councils have equally been besieged with the extensive influences of pharma and medical equipment industry on medical and surgical practices.

Variety of issues about the quality and efficiency of these academic structures and professional misconduct are common to both the systems and should be dealt with separately for their capabilities to deliver the right medical care.

The concern about purity of systems or the issue of **mixopathy** as anticipated is an outcome of the prevalent excessive commercialization of medical care. It relates to professional responsibilities and ethical practices. There is a need to prevent unscrupulous or inappropriate use of these and other surgical procedures in the hands of unqualified, poorly qualified, or greedy professionals to avert accusations being levelled by either of the systems. Issues related to regulation should not be mixed with that of what to practice.

Another argument that 'Each system must grow by its own research, and not by a borrowed, easy pattern''. I believe that the ***"True Science Grows Being Inclusive in Nature and Closed Knowledge Becomes Redundant Without Application".***

Visa as a tool to enter a country to regulate territorial boundary has been cited as an example to advocate the limitation of surgical practices by AYUSH practitioners. This is totally irrelevant for healthcare when today medicine has developed and is practiced as in a global village, where medicine without boundaries is strongly propagated and where a USA passport is seen as a representative of global vision, reach and inclusiveness and is accepted by the majority. The future of healthcare, the future of medicine is driven by global perspectives and inclusive means.

'ONE NATION, ONE SYSTEM', THE NEW POLICY AND THE PEOPLE'S NEED

Since independence India has followed the earlier British Model for its healthcare delivery that has been variably adopted by countries the world over. Despite more than 95 % of the budget being spent on healthcare delivery models based on conventional medicine over the last 70 years, medical services have remained poorly attended to with the gap between the rich and the poor widening, as is the gap between the private and the public institutions. Whereas healthcare delivery in the country of origin as in the UK and other countries has been dynamic and responsive to the qualitative needs for the stated objective, the Indian system due to reasons of resources and administration has been dominated by socio-political factors thereby remaining stagnant or mostly dependent on ideas and means borrowed from the western model. Ideal healthcare has thus remained a dream. The fact is that limitations of modern medicine have been recognized even in advanced countries investing more GDP on healthcare and are in search of an alternate economic model.

The modern surgical procedures depend highly on technology which leads to substantial increase in costs. There have been serious concerns about modern surgery not only for economic reasons but also because of its complexities, over-dependence on technology, uncertainties about the outcome and monopolistic means. Research and development though necessary require careful analysis for their end-benefits.

The issues of unscrupulous practices are aplenty in overall medical care of the country and are required to be attended not only by regulatory mechanisms but by developing an environment for public good which should be the basis of medical care which unfortunately is missing altogether. Ethical norms prescribed by ancient sages or covered under Hippocratic oath will be relevant not through regulatory mechanisms but by developing an appreciative and rewarding system where people can play an important role. The challenge is to minimize professional greed if it is not possible to control it in a socio-political environment that suffers from similar virtues. ***The new system will have to be people centric.***

Every country in the world, overburdened with a technology based, costly medical care system is

searching for economic options. The challenge for India is greater as it has the second largest population in the world and limited funds which in turn demands optimal utilization of resources. India needs to evolve a model of its own based on its needs, its culture, its tradition, and its realistic capabilities. India must reduce the big gap in the quality of medical care being provided between the rich and the poor while satisfying the requirement of an increasingly vulnerable middle-class that is more dependent on private medical care.

NITI AAYOG has rightly taken a policy decision of "One Nation, One System" approach for medical care of the country to be achieved by 2030. All plans for macro or micro level infrastructure development and functional efficiency must be aimed to reach the farthest end of medical need.

Specialization contributes to the development of a system by providing expertise based on advanced knowledge and trained skills. Skill, surgical or otherwise in medicine, is the ability to offer better and effective medical care. Also, specialization solely dependent on technology driven by greed and used without reason not only increases costs but harms the patient. Any system that practices specialization without true acquaintance of enhanced skills and without benefit to the patient must be restrained as it leads to confusion and the system becomes suspect. The proposed system must aim at providing an effective, economic, transparent medical system that people can opt for, considering their benefits rather than be challenged by confusing and at times chaotic situations as prevalent today.

There is an urgent need to examine the reasons for limitations of present Medicare and identify the areas that need repair to avoid waste of resources. The need is to take on present day medical challenges which are degenerative, metabolic and lifestyle related and jointly look for solutions that will benefit people and knowledge and practices of systems. The need is equally of reducing the unaffordable burden of inflated hospitalization and at times unjustified surgeries.

The government while revamping a new approach will have to consider the shifting dynamics of healthcare. In a competitive world driven by economic considerations and privatization - commercialization of medical education - reviving the social dimension of medical practice is not going to be easy. The only option is to totally overhaul the system to develop a creative ecosystem that thrives only for patient benefit. The focus of the new proposal must be on be the upcoming new generation, their aspirations, and societal needs. In medical education creating an environment of curiosity, learning, training, and application is more vital.

The possible modalities of integrated medical education while retaining the independent identity of the different systems with convergence as required for healthcare delivery has been dealt with in a separate PreNote[2] entitled *'Integration of Medical Education - Issues & Challenges'.*

INTEGRATION [3]

With an objective to support Indian Systems of Medicine India has followed medical pluralism for fifty years from 1971 to 2021. While countries exclusively dependent on biomedicine are forced to explore integrated modalities India with the learning of 50 years of medical pluralism has rightly decided to evolve its ***own model of integration*** to take on present day medical challenges. Optimum utilization of its resources – infrastructure, manpower, skills, and low-cost development – will obviously be aimed at. The Indian model of integration will have to necessarily be complementary and converging.

Prior to modern surgery as we know it today, not more than 150 years ago, there were wars, injuries, and survival against odds, that were served by the traditional systems of medicine. The cupping procedures used in traditional systems and the humoral systems were part of Greek medicine during the time of Hippocrates who is considered the Father of modern medicine.

The intricacy of embryology as described by Sushrut (1500 BC) makes the depth of knowledge in Ayurveda obviously clear, irrespective of means, surgical or otherwise. It is amazing to know the timings of occurrence of different yet specific features during the gestational - fetal development, some of which have been recognized by modern medicine comparatively later, only after the invention of equipment. If so, is it not desirable that the present medical care be benefitted with many such amazing details for their newer applications, clinical inferences, interrogation, diagnostic tools, means and methods, and such other?.

While claiming anesthesia only as a modern prerogative, the recent embrace for severe pains in cancer treatment to alkaloids from cannabis that has been traditionally prescribed and used in Ayurveda cannot be ignored. Knowledge, information, skill, and training could never be the exclusivity of a system.

It is interesting to observe that substances like arsenic and digitalis, strychnine and several others classified as *visha* – poisons in Ayurveda helped shape the early development of conventional medicine. While these few but sharp acting substances were taken up, the other aspects of pharmacopeia remained unattended to.

It took 50 years for modern medicine to recognize that diabetes is a group of diseases and not a single disease

which is clearly described in the Ayurvedic classics.

As observed in clinical practice including my own there are several instances when one can identify earlier surgery or surgeries as cause/s of chronic disease conditions and even cancers after many years. Inflammation forms a significant aspect of diagnosis covering a wide range of diseases. Inflammation, as described and explained by Sushruta provides a much deeper and comprehensive knowledge that is now better understood in the light of molecular pathways.

Objectivity as provided in Sushrut Samhita has a huge potential to integrate with biomedical advances. Simple concepts on bandages and ingredients and products used, can complement present day cosmetic and plastic surgery. As research approaches undergo change from the reductionist approach to the multidisciplinary science of complexity even Ayurveda has much more to offer.

The clash has had its impact and the time is now ripe to converge the two streams of knowledge and experiences for the benefit of the people. Rather science helps the applicability of any knowledge or experience and that must be utilized for the benefit of the people. No knowledge or system can grow without being contemporary, without the addition and acceptance of newer and newer applications. No knowledge or system has ever developed or grown without learning from other areas or subjects.

The proposed integrative modality must be driven by the single-minded pursuit of people's welfare where relevant scientific objectivity could be applied to management of knowledge and information as obtained over decades. Developing integrative modalities for institutionalization and privatization of academia, industry, research, and service activities will form part of the present-day healthcare delivery. Imposition or predominance of one system or a process has no place in a system driven by people's welfare.

The need for integration has been realized by the professional bodies representing different systems of medicine. The next step is to collectively help evolve the right means and methodologies to help ailing patients and help the administration to achieve the national goals for affordable medical care.

There is thus an urgent need to integrate medical and surgical procedures to provide the best care possible to the patient. Modern day Ayurvedic surgery has a productive role to play, both for expanding space for Ayurveda and to help patients.

AYUSH OPPORTUNITIES AND RESPONSIBILITY

Of course, the use of Ayurvedic products, medicines, and treatment modalities by the Ayurvedic profession must form the basis of its new development and growth. Here lies the opportunity for Ayurveda. Cost being the main factor, the challenge is to utilize the inherent strengths of Ayurveda and other systems to evolve a model by identifying all such areas that could be attended to, in a comprehensive manner.

The variety of surgical interventions as practiced today are required to be amplified for their wider use and applicability. Dietetic restrictions and specific nutritional support as followed in Ayurveda will help open a new understanding in preparatory surgery and post-surgical recovery. Surgical, invasive procedures should be performed with utmost care and clear understanding of the underlying disease process and keeping in mind the *Prakruti* [constitution] of the person.

Research and development have been the backbone of development. Novel surgical interventions based on Ayurvedic principles when appreciated by people, could be the only way to help create its own identity. The reach established with competencies within the gamut of AYUSH practices could be a game changer for the role of Ayurveda in healthcare delivery to provide economic, reliable, and effective solutions. There is a need for developing, institutionalizing and adhering to Standard Operating Procedures for these surgical processes thereby enabling the physicians of Ayurveda to increase the scope of practice with effective outcomes. These surgery specific tools and support products could be developed and standardized for ease of administration and compliance. Rather than leaving the subject of quality to the practicing profession it is desirable that the administration with the help of professional bodies – the medical councils – undertake strategic exercises and programs for ensuring skill and capabilities that will help achieve the intended objectives. This is vital to pursue the goal of 'One Nation, One System' by 2030.

CONCLUSIONS

1. Ayuredic practitioners have the wherewithal to take on the responsibilities of conducting certain surgical procedures.

2. No system, either singly or jointly, can develop or deliver health and medical care delivery goals without respect to principles, practices, experience, skills and capabilities of other systems or streams of knowledge and information.

3. Regulation alone cannot provide solution to all issues of health care. Developing an ecosystem to provide safe, economic, and effective health and medical services including surgical interventions to the people must be the primary goal of all systems and professionals involved with healthcare delivery.

4. Integration is unavoidable. It is pertinent that right methods are jointly evolved and adopted by the policy makers, the administrators, and the professions representing different systems by coming together to reduce friction and parallelism that otherwise will be time consuming, costly, and prohibitive of the purpose to serve people. Efficiency and reach to the farthest end user must be the only criteria to address the variety of issues on the way to integration.

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1. A debate by 'OMNICURIS' India's largest online platform of doctors, DEBATE on AYUSH & SURGERY (CCIM Notification) 4 March 2021 where Dr. Bhatt and Dr. Jayalal, President, IMA participated.

2. Bhatt, Narendra, Integration of Medical Education - Issues & Challenges, IASTAM Newsletter, Volume V, Issue 4, March 2021

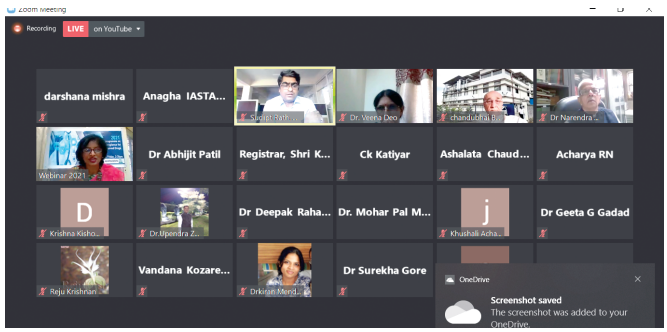
3. Bhatt, Narendra (2020) Significance of Demonstrated Outcomes in Shalya Shalakya to Integrate Ayurveda with Mainstream Medicare, In N. Bhatt [Ed.], Integrative Perspectives: Ayurveda, Phytopharmaceuticals and Natural Products, (IV/21, pp. 217-220), Continental Prakashan, Pune, India.

REPORT

NATIONAL WEBINAR - Awareness Programme on Pharmacovigilance for Ayurved Drugs, 26th March 2021

By Dr. Manasi Deshpande

National webinar on Pharmacovigilance for Ayurved drugs was jointly conducted by Bharati Vidyapeeth, Deemed to be University College of Ayurved and IASTAM India on 26th March 2021, from 2.30 pm to 5.00 pm on the subject of "Awareness Programme for Pharmacovigilance for Ayurved drugs" through ZOOM and was broadcasted live on YouTube.



For a long time, Ayurved, Siddha, Unani, and Homoeopathy (ASU & H) systems of medicine have been practiced in India. In this era of globalization, concerns have been raised in regards to their clinical safety. There is a widespread misconception that all drugs of "natural" origin are "safe". There is a common belief that long term use of medicine based on tradition, assures safety and efficacy. The field of Pharmacovigilance is growing rapidly and its development is making tremendous impacts in ASU Drugs and pharmaceuticals. This national webinar is aimed to understand the principles of Pharmacovigilance in Ayurved in view of ADR, misleading advertisements, product development, challenges and solutions.

Welcome Address

The programme commenced with Lord Dhanvantari prayer chanted by Dr. Vedika Sadhale.

Dr. Abhijit Patil, Dean/Principal in his welcome

speech briefed about the college activities along with the function of the peripheral Pharmacovigilance cell. This cell was started in September 2018 under the Ministry of AYUSH. From its inception, the cell has worked in four categories as monitoring and reporting of ADR, visiting various institutes & clinics, creating awareness to medical professionals and reporting misleading advertisements. To date the cell has reported 186 misleading advertisements, 624 health care providers involved in awareness, 128 clinical and institute visits and 5 ADR reports. We are agreeing that reporting of ADR is not appropriate, but awareness amongst health providers is increasing but still, we have a long way to go.

Dr. Manasi Deshpande, Secretary General,

IASTAM India highlighted the activities of IASTAM and its role in the development of Asian medicinal systems. The association is aimed to provide a catalytic platform with a theme 'Connecting Systems; Bridging Disciplines'. She also highlighted the initiation, purpose of various awards, organization of various activities and publications of the association.

Chairperson's Opening Remarks

Being connected with this industry for a long time, ***Dr. Narendra Bhatt***, feels that Pharmacovigilance is an important subject. We have adapted to institutionalization and industrialization that has happened over few decades. We are trying to be relevant in the present competitive environment. AYUSH systems need to have standards

and appropriate parameters relevant for the consumer. Pharmacovigilance has come into focus as there were some mistakes and bad apples in our basket.He expressed that AYUSH systems have played an important role, if not in curing but treatment approaches during CV 19 epidemic. He complemented the present ministry for making extensive efforts.

Small wrong might make all right wrongs. Though 90-95% of the population is benefitted; as the 4-5% has had a wrong impact, it will affect the overall belief in the system. This is where Pharmacovigilance becomes very important

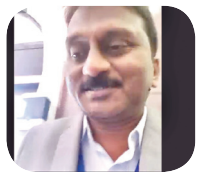
AYUSH products are based on different paradigms and their safety and efficacy require a different approach.He opined that the modern medicine has limitations because of the adverse side effects, including in countries like USA. If this is a fact with a strong scientific backing then we need to mould our sciences, our approaches, our requirements that are more appropriate.

Dr. Bhatt expressed his views about misleading advertisements. There should be a strong link between quality control, FDA regulations, manufacturers and selling methods. These cannot be treated in an isolated manner. It is our responsibility as professionals to ensure that we don't allow anything wrong to happen. He emphasized that the need for synergy and interlink between regulation and things to be executed, or else this will remain an isolated activity without purpose.

Dr. C. K. Katiyar, Vice President IASTAM India shared his experience of 45 years, ADRS of traditional medicine, Garbhapal rasa, and the inappropriate use of drugs. He also stated that there is a need to differentiate ADR and its side effects. The Ministry of AYUSH should come out with standards for mercurial preparations. The present model of Pharmacovigilance is copied as a modern system with some minor changes. Safety and efficacy data should be published from time to time.

Motivation Speeches from Special Invitee

Vaidya Jayant Deopujari, Chairman, Board of Governors, CCIM New Delhi was the special invitee for the webinar. He shared his many years of clinical experience. Medicines should be taken within specific time duration otherwise they may cause adverse reactions. For example, Aarogyavardhini cannot be used for more than 40 days, Tribhuvankirti not for more than 4 days, Mahayograj Guggulu not more than 90 days. Triphala powder stopped working after a few days, but with ghee it can be used longer. Kidneys are affected after long use of kumariasav whereas Ayushkwath is not suitable for Pitta Prakriti. It is need to document all these experiences for the safety of Ayurved drugs.



Dr. Galib R. Coordinator, National Pv Centre, AIIA, New Delhi expressed his views on how inappropriate traditional use of drugs can create ADR. Lack of awareness of ADR reporting among health workers is one of the causes of ADR. He also highlighted the functionality of the National Pharmacovigilance cell in the areas of refining clinical practice, refining traditional practice, and creating awareness about ADR and Misleading Ads.

Resource Person's Brainstorming Speeches

Dr. Sudipt Rath, Associate professor, Dravyguna & coordinator, IPvC National Institute of Jaipur explained in his presentation about the overview of functioning of Pharmacovigilance cell from the definition and mechanism of Pharmacovigilance at various levels. He also expressed importance of Pharmacovigilance, Risk-Benefit calculation, Mental Block for Pharmacovigilance, changing scenarios in AYUSH, WHO mandate and journey of Pharmacovigilance in the ministry of AYUSH. He also gave information about the Programme management, workfow of suspected Adverse Drug Reaction and Misleading Advertisements, Suspected ADRs, and importance of the National Pharmacovigilance Programme - ASU.

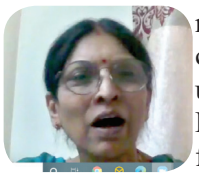
Dr. Rabinarayan Acharya, Dean, ITRA, Jamnagar & Coordinator IPvC delivered his talk on Monitoring and Reporting of Misleading Advertisements in the AYUSH sector with an excellent presentation. He highlighted what is advertising, the need for advertising for manufacturers and consumers, the history of mass media in India, the method and types of advertising, the sector wise percentage of advertisements and the legal framework for advertisements, prohibited and controlled advertising along with its impact on misleading advertisements and penalty - DMRA Amendment 2020. He shared the aims and objectives of Pharmacovigilance for AYUSH drugs, Food Safety and Standards Act, Effects of Adertisement on Consumer Behaviour, Drug and Magic Remedies Act. He has also explained the process of reporting misleading advertisements.

Dr. Veena Deo, Consultant for Product development from Nagpur has vast experience in product development.

Registered

IASTAM NEWSLETTER – Regd. Periodical RNI No. MAHENG/2016/72373; Decl. No. SDO/Haveli/SR/297/2016 dtd. 22.11.2016
Postal Registration No.: PCW / 196/2020-2022 (Posting at BPC, Vishrambagwada Post, Pune 411 030);
Date of Publication – 20.4.2021 Posting Date – 22.4.2021 For April 2021 Issue

Dr. Veena Deo pointed out the necessity of raw material testing, species variations, and collection period. She opined that well understanding and awareness about Pharmacovigilance should be initiated from the UG and PG level. There is a necessity for Standard operative procedures and digitalization for product development. To maintain quality and efficacy, clinical research should be done scientifically.



Chairperson's Concluding Remarks

In the concluding remarks, ***Dr. C. K. Katiyar*** pointed out that an appropriate guideline for use of drugs is necessary because inappropriate use of drugs can't be taken as ADR. Control of misleading advertisements is an additional responsibility of the Pharmacovigilance cell.

Dr. Narendra Bhatt expressed significance of Pharmacovigilance and need of appropriate parameters for Indian medicine to monitor drug effects and ensure for safety of users.

He suggested the following-

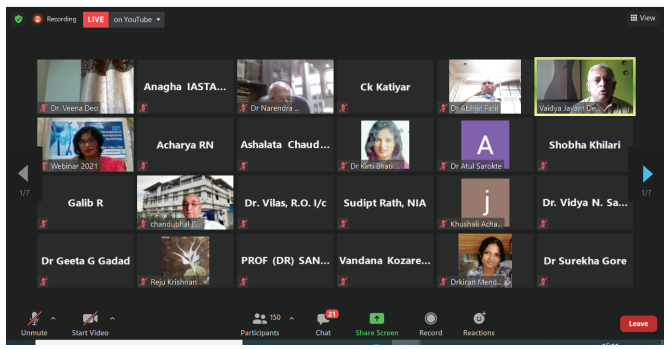
1. Pharmacovigilance and Advertising regulation are ongoing processes. Can we create a structure which takes cognizance of the changes from time to time? We have to create a dynamic system which is more open and sensitive.

2. A noteworthy infrastructure has been created. Now we created need functional efficiency. We need processes and an ecosystem which is progressive and pragmatic.

3. We need to focus on the approvals by the medical councils and FDA. These need to be sensitive to the professional requirement for the regulations. We need to have harmony and unanimity in our different approach. One wing of the government cannot be independent from the other wing of the government.

4. Regulations and administrations can give directions. It can monitor to an extent. In a country like India, we don't have the ability to reach all and punish the guilty. The main objective should be self-regulation. A motivation to industries, to profession, to whoever is involved, to be a part of, will benefit all. Efforts for self Regulation are must.

Dr. Manasi Deshpande, coordinator of the Webinar delivered the Vote of thanks. Anchoring of the event was done by Dr. Kirti Bhati. Overall, 184 online delegates participated in the event.



By adopting Pharmacovigilance in the AYUSH system, we make the system safer.

Views and opinions expressed in different articles are entirely of the writers and authors

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IASTAM NEWSLETTER, Monthly is owned by Indian Association for the Study of Traditional Asian Medicine, Printed & Published by Dr. Vandana Kozarekar, Printed at Ekvira Publicity, Sinhgad Road, Pune, Published at Bharati Vidyapeeth University, College of Ayurved, Dhankawadi, Pune - 411 043. **Editor** - Dr. Manasi Deshpande

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To,