



TRAUMA & EMERGENCY TEAMS



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Independence Day: A Tribute to Freedom and Nationhood



Every year, on the 15th of August, India celebrates its Independence Day — a momentous occasion that commemorates the nation’s liberation from British colonial rule in 1947. It is not merely a day marked by ceremonial events but a solemn reminder of the resilience, sacrifices, and unwavering spirit of those who fought to secure our freedom.

Independence Day stands as a defining chapter in Indian history. After nearly two centuries of subjugation, India finally broke the chains of imperial domination. The road to freedom was long and fraught with suffering. Countless freedom fighters — from Mahatma Gandhi’s philosophy of nonviolent resistance to Netaji Subhas Chandra Bose’s call for armed struggle — contributed to this collective effort. The Quit India Movement, the Dandi March, and the Indian National Army were emblematic of our people’s courage and unity.

On this day, the Tricolour flutters proudly across the nation, symbolizing unity, diversity, and sovereignty. The Prime Minister’s address from the Red Fort resonates with every Indian, reminding us of our democratic ideals and progress as a nation. Schools, colleges, and institutions organize flag hoisting ceremonies, cultural performances, and patriotic songs that instill a sense of pride and belonging.

Behind our freedom lies the supreme sacrifice of innumerable martyrs. From the gallows where Bhagat Singh embraced death with a smile, to the prisons where countless others endured torture. Their stories continue to inspire generations to stand up against injustice and defend the ideals of the Constitution.

With freedom comes responsibility. As citizens, it is our duty to uphold the values of democracy, protect the environment, foster harmony, and contribute to nation-building. Independence Day should ignite not only celebration but also reflection and resolve — to create an India that is not just free, but truly just.

As we chant “Jai Hind”, let it echo not just from our mouths but from the very core of our conscience.

Dr. A.P. Singh

Dean
SGRD University of Health Sciences
Sri Amritsar



**Official Voice of
Academic College of Emergency Experts
(ACEE)
&
Emergency Medicine Association (EMA)
An INDUSEM Undertaking**

The Hidden Curriculum in Emergency Rooms: Unseen Forces Shaping Patient Care

Dr Nisha Toteja



Introduction: In the high-pressure world of the emergency room (ER), where split-second decisions can mean the difference between life and death, medical professionals navigate a complex landscape of protocols, patient needs, and team dynamics. While formal medical training and clinical guidelines

provide the backbone of ER operations, an often-overlooked force—the hidden curriculum—profoundly influences how these environments function. The hidden curriculum refers to the unwritten rules, norms, and behaviours that healthcare professionals absorb through observation, socialisation, and experience, rather than through explicit instruction. In the ER, this invisible force shapes decision-making, patient interactions, and team dynamics, with far-reaching implications for care quality, staff well-being, and operational efficiency. This newsletter delves into the hidden curriculum in ERs, exploring its manifestations, impacts, and strategies for fostering a healthier, more equitable environment.

What Is the Hidden Curriculum?

The hidden curriculum encompasses the implicit lessons and cultural norms that medical professionals learn through their daily interactions in the ER. Unlike the formal curriculum—structured through medical school lectures, clinical guidelines, and training programs—the hidden curriculum is absorbed through osmosis. It manifests in the unspoken expectations, hierarchical dynamics, and informal practices that shape how staff operate under pressure.

For example, a new resident may be taught to follow evidence-based protocols for triaging patients but may observe senior colleagues prioritising certain cases based on perceived urgency or resource availability, even if it deviates from guidelines. These unwritten rules, learned through experience, can significantly influence how care is delivered and how teams function in the chaotic ER environment.

Key Manifestations of the Hidden Curriculum in ERs

☑ **Hierarchical Norms:** ERs often operate within rigid hierarchies, where senior physicians hold significant authority over decision-making. Junior staff may learn to defer to their superiors, even when they have valid concerns, to avoid conflict or perceived insubordination. This dynamic can stifle innovation, suppress ethical discussions, and, in some cases, lead to errors in patient care. For instance, a resident might hesitate to challenge a senior consultant's decision to forgo a procedure, even if they believe it's in the patient's best interest, due to fear of repercussions. In extreme cases, unchecked hierarchical norms can lead to dysfunction. For example, a resident physician who makes elective decisions without consulting the senior consultant or team members may set a dangerous precedent that junior staff emulate, potentially leading to the mismanagement of patient cases. Over time,

this behaviour can erode trust within the team and compromise patient outcomes.

☑ **Efficiency Over Empathy:** The relentless pace of the ER often fosters an unspoken emphasis on speed over thoroughness. Staff may prioritise rapid patient turnover to manage high volumes, inadvertently reducing time for meaningful patient communication or emotional support. This can lead to desensitisation, particularly when handling emotionally charged situations like patient deaths. Consider the case of a patient brought to the ER in rigour mortis following an out-of-hospital cardiac arrest (OHCA). The team, recognising the late signs of death, decides not to attempt resuscitation. While the senior consultant counsels the patient's family, junior residents are responsible for completing the necessary documentation. In the rush to resume normal operations, staff may engage in casual banter shortly after delivering devastating news, which can appear insensitive to grieving families. Such behaviours, learned through observation, highlight the need for dedicated spaces and protocols for handling sensitive moments, ensuring empathy is not sacrificed for efficiency.

☑ **Informal Communication:** The ER's fast-paced environment relies heavily on rapid, informal exchanges rather than documented processes. Residents often pick up cues from tone, body language, or shorthand instructions, which can lead to miscommunication if not standardised. For example, a senior physician's abrupt tone might signal urgency, but without clear context, it can create confusion or anxiety among junior staff. Moreover, if the upper hierarchy is perceived as rigid or dismissive, it can tacitly endorse disrespectful behaviour among lower-level staff. For instance, a senior physician who publicly criticises team members for minor errors may foster a culture of blame and dysfunction. This was evident in a scenario where a junior surgeon, influenced by a senior colleague's aggressive and minimalist communication style, adopted similar behaviours, leading to staff avoidance, reduced cooperation, and a vicious cycle of disrespect that undermined patient care. Conversely, observing a level-headed senior leader navigate high-pressure situations can provide a roadmap for navigating challenges constructively, promoting harmony and teamwork.

☑ **Patient Prioritisation and Bias:** Unwritten rules about which patients receive priority—often based on perceived severity, social status, or familiarity—can perpetuate biases. In resource-constrained settings, such as busy ERs in India, patients with recommendation letters from influential figures like local politicians may receive faster attention, creating a culture of favouritism. This practice, observed by residents, risks becoming normalised, undermining equitable care. Additionally, biases may lead to the neglect of marginalised groups or “difficult” patients, exacerbating health disparities. Residents learn these patterns through peer interactions and senior behaviour, highlighting the need for mindfulness to ensure high-quality, unbiased care.

☑ **Team Dynamics and Behavioural Mimicry:** Humans naturally mimic socially acceptable behaviours to gain confidence or fit into a group. In the ER, junior staff may



- ☑ emulate the behaviours of senior colleagues, even when they are problematic. For example, a resident might observe a senior physician performing bare-hand (ungloved) procedures or shuttling patients to other areas without proper assessment, adopting these practices as standard despite the risks. Such behaviours, if unchecked, can infiltrate the ER's culture, leading to errors and compromised patient safety.

Impacts on ER Functioning: The hidden curriculum has a dual nature, with both positive and negative effects on ER operations. On the positive side, it enables rapid adaptation to the chaotic ER environment. New staff learn to navigate high-pressure situations by observing senior colleagues, fostering team cohesion and efficiency. For instance, a resident might adopt a senior physician's shorthand for prioritising trauma cases, allowing them to act swiftly in critical scenarios.

However, the negative impacts are significant. Hierarchical norms can discourage junior staff from questioning suboptimal decisions, increasing the risk of errors. The emphasis on efficiency over empathy can erode patient trust and satisfaction, as rushed interactions leave little room for emotional support. Research by Hafferty and Franks (1994) suggests that hidden curricula in medical settings can reinforce biases, such as prioritising articulate or socially privileged patients, which exacerbates health disparities. Additionally, the pressure to conform to unwritten norms—such as suppressing emotions to appear “professional”—contributes to burnout, with up to 60% of ER physicians reporting emotional exhaustion (Shanafelt et al., 2015).

The hidden curriculum also shapes the next generation of ER professionals. Physicians have a responsibility not only to deliver high-stakes care but also to model behaviours that foster a positive, equitable culture. A senior physician's ability to remain calm and respectful in challenging situations can inspire residents to adopt similar traits, creating a ripple effect that enhances team dynamics and patient care.

Strategies for Addressing the Hidden Curriculum To mitigate the negative effects of the hidden curriculum and harness its positive aspects, ERs can adopt several strategies:

- ☑ **Promote Reflective Practice:** Encourage staff to reflect on their behaviours and the unwritten norms they observe. Regular debriefings can help identify problematic patterns, such as biases in patient prioritisation, and foster open dialogue about improving care.
- ☑ **Standardise Communication:** Implementing clear, standardised communication protocols can reduce reliance on informal cues and minimise miscommunication. Training programs should emphasise respectful, collaborative communication to counteract toxic hierarchical behaviours.
- ☑ **Prioritise Empathy Training:** Incorporate empathy and emotional intelligence into ER training programs. Dedicated spaces for sensitive interactions, such as delivering bad news, can help staff strike a balance between efficiency and compassion.
- ☑ **Address Bias and Inequity:** Actively discourage practices like prioritising patients based on external

influence. Leadership should model equitable care and implement policies to ensure fair treatment for all patients.

- ☑ **Foster Mentorship and Role Modelling:** Encourage senior physicians to serve as positive role models, demonstrating professionalism, empathy, and collaborative decision-making. Mentorship programs can help junior staff navigate the hidden curriculum constructively.
- ☑ **Combat Burnout:** Address the emotional toll of the hidden curriculum by providing mental health resources and fostering a supportive work environment. Regular check-ins and wellness programs can help staff cope with the stress of unwritten expectations.

Conclusion: The hidden curriculum in emergency rooms is a powerful, often invisible force that shapes how medical professionals deliver care and interact with one another. While it enables rapid adaptation to the ER's chaotic environment, it can also perpetuate harmful norms, such as hierarchical rigidity, efficiency-driven desensitisation, and biased patient prioritisation. By recognising and addressing the hidden curriculum, ERs can foster a culture of empathy, equity, and collaboration, ultimately improving patient outcomes and staff well-being. As healthcare leaders, educators, and practitioners, we have a responsibility to shine a light on these unseen influences, ensuring they align with the values of compassionate, high-quality care. It is a massive responsibility in nurturing a generation of residents and staff whose work speaks not in decibels but in deliverables. Through reflective practice, standardised communication, and positive role modelling, we can transform the hidden curriculum into a force for good in the high-stakes world of emergency medicine. To err is human, but so is to learn from our errors.

Levels Do Matter !!

Dr. Linu Sekhar

We received two cases of lithium overdoses in our department in the last month of May 2025, among which one of them had a history of ingestion of massive dose amounting to 300 mg. After the initial management and stabilization, both of them were admitted under critical care unit. As it was dialysable toxin and lithium has a very narrow therapeutic index, the team decided to initiate hemodialysis for the second case with history of massive ingestion. For therapeutic monitoring as well as medicolegal purposes and documentation, our team in conjunction with critical care decided to send blood levels for assessing lithium levels. As the levels were not measurable in our institutional lab, we planned to outsource the same. However, on enquiry we came to know that the facility was unavailable in the entire city where our institution is located.

There were no life-threatening dysrhythmias or decreased consciousness or seizures in the patient, however there were prominent electrolyte abnormalities and deranged renal function tests. Though the critical care team-initiated Hemodialysis based on these surrogate markers of lithium toxicity, the inability to assess pre dialysis as well post dialysis lithium levels placed the treating team in a very precarious situation especially with regards to medico legal implications. The test was available at the nearby poison control center, but turnaround time was 7 days. Finally, we requested a large highly networked private laboratory network who consented to do the same and give the report within 8 hours.



Such instances depict the lack of adequate testing resources for rare toxins in at least some parts of our country. The fact that most modern psychiatrists don't prescribe lithium, have made lithium an even more rare toxin. In most laboratory set ups, the cost of maintenance of reagents and other components of the testing kits for such rare toxins in itself prohibitive. Unless there is some sort of support from the government or a plan for developing regional hubs for poison control centers who may partly bear the expenses of these laboratory equipment infrastructure, clinicians who treat such rare toxin ingestions can face similar situations in the future. When testing is available, the sample must be sent in an appropriate lithium-free tube because use of lithiated-heparin tubes will lead to false-positive results, up to an additional 4 mEq/L.

Doctor Helicopters, STRAUMA Codes & Biomarkers: What's New in Emergency Medicine?

The latest issue of JETS (Vol. 18, Issue 2) dives deep into innovative emergency care strategies, highlighting ground breaking research, smarter protocols, and a global collaboration of experts in trauma, shock, and acute care.

Feature Focus: Doctor Helicopters and Brain Trauma Survival: This edition's editorial zooms in on Japan's pioneering Doctor Helicopter system, a physician-staffed emergency medical service. Studies from the Japan Doctor Helicopter Registry System (JDRS) revealed how this system significantly improves outcomes in traumatic brain injury (TBI) cases. Even mild head injuries (GCS 14–15) can turn fatal, especially in elderly patients or those with rapid breathing at the scene. One key finding? Patients aged over 78 with a respiratory rate over 21 breaths/min had notably higher death rates—even with mild trauma. Early helicopter evacuation, AI-based triage, and future use of blood biomarkers like GFAP and Tau are poised to revolutionize how we handle brain trauma in the golden hour.

STRAUMA Code: A Lifeline for Dual Diagnosis Cases: A highlight of this issue is the introduction of the STRAUMA Code—a structured, checklist-based protocol for managing patients presenting simultaneously with stroke and trauma. This dual-hit scenario is more common than we think (e.g., a stroke causing a fall or trauma triggering a stroke). Tested in emergency departments across Singapore and Florida, the framework boosts confidence, ensures rapid assessment, and minimizes diagnostic errors. The STRAUMA Code adds a vital chain of survival for these high-risk patients with steps like Rapid Recognition, Rapid Dispatch, and Rapid Diagnosis, aiming to standardize care globally.

Triage Clues: Predicting ICU Admissions and 72-hour Mortality: Another original article investigates how a patient's first complaint at triage can predict serious outcomes. Data from AIIMS Delhi shows that certain presenting symptoms—like altered mental status or respiratory distress—are strong indicators of 72-hour mortality or ICU need. Recognizing these red flags at the door can dramatically improve triage accuracy in busy ERs.

Biomarkers in Concussion: Closer to Bedside Testing:

In a timely review, experts summarize the most promising blood-based biomarkers for diagnosing concussion and TBI. Glial fibrillary acidic protein (GFAP), neurofilament light chain, and S100B could help clinicians quickly assess the severity and prognosis of head injuries—even in the field. Portable biosensors and AI integration are on the horizon, promising faster, more personalized treatment decisions.

Odd Cases, Sharp Lessons: Larvae & Tattoos: Two striking case reports remind us why emergency medicine is anything but predictable. One involves a fly larva lodged in a patient's eye following a bizarre injury, while another details tattoo-associated uveitis that mimicked infection. These cases highlight the importance of detailed history-taking and high clinical suspicion.

Snapshot Highlights:

- ☑ **Convulsion management** improves when helicopter dispatch is triggered by keyword recognition.
- ☑ **Japan's new simulation-based HEMS training** improves team readiness.
- ☑ Checklist culture in the ED is reinforced with the STRAUMA approach—boosting safety in complex dual-diagnosis cases.

Final Thought: A Global Effort Toward Safer, Smarter Emergency Care: This issue of JETS is a call for smarter systems, structured protocols, and continuous training. Whether it's a helicopter landing on a rural highway or a resident checking a STRAUMA checklist, the goal remains the same—**better outcomes, faster.**

Likelihood Ratios in Emergency Medicine: Enhancing Rapid and Accurate Decision-Making

Dr Ankit Kumar Sahu

Diagnostic tests are essential for clinical decision-making, guiding emergency physicians (EP) in confirming or ruling out diseases. Traditional measures such as sensitivity, specificity, and predictive values provide insights into a test's performance but often fail to translate directly into bedside application. Sensitivity and specificity describe how a test performs under controlled conditions but do not directly indicate how much a given result changes disease probability in a real patient. Positive and negative predictive values depend heavily on disease prevalence, making them variable across different populations. Furthermore, commonly used mnemonics like **SNout** (a highly **S**ensitive test that rules **N**egative patients **out**) and **SPin** (a highly **S**pecific test that rules **P**ositive patients **in**) oversimplify test interpretation. They fail to account for pre-test probability and the real-world performance of diagnostic tools. To overcome these limitations, likelihood ratios offer a more practical and reliable approach by integrating pre-test and post-test probabilities, making them highly useful in emergency medicine and inpatient settings.

Likelihood ratios (LRs) quantify how much a test result increases or decreases the probability of a disease, making them superior to traditional measures in real-world decision-making. A **positive likelihood ratio (LR+)** indicates how much a positive test result increases the odds of disease, while a **negative likelihood ratio (LR-)** indicates how much a negative result decreases the odds. Unlike predictive values, LRs remain stable across different disease prevalence rates



and can be applied directly to individual patients. By using LR_s, emergency and bedside physicians can refine diagnostic certainty based on test results, helping them decide whether to initiate treatment, order further testing, or safely rule out conditions.

A simple rule of thumb for interpreting likelihood ratios is that a positive likelihood ratio (LR₊) greater than 10 significantly increases the probability of disease, making a positive test highly confirmatory, whereas an LR₊ between 5 and 10 provides moderate evidence, requiring further clinical judgment. An LR₊ between 2 and 5 offers weak evidence in favour of disease but may still be useful when combined with other clinical findings, while an LR₊ between 1 and 2 has minimal impact and is generally not diagnostically significant. Conversely, a negative likelihood ratio (LR₋) less than 0.1 strongly decreases the probability of disease, making a negative test highly reliable for ruling out a condition. An LR₋ between 0.1 and 0.2 provides moderate evidence against disease, while an LR₋ between 0.2 and 0.5 weakly reduces disease likelihood. Finally, an LR₋ between 0.5 and 1.0 has minimal impact, meaning a negative result does not reliably exclude disease.

The key advantage of likelihood ratios is their immediate bedside utility. In the emergency department (ED), where time-sensitive decisions are critical, LR_s provide a structured way to interpret test results dynamically. For example, in minor head trauma, a depressed skull fracture on clinical examination has an LR₊ of 16 [3.1–59], meaning it strongly suggests an underlying intracranial injury. In suspected pulmonary embolism (PE), the Pulmonary Embolism Rule-out Criteria (PERC) has an LR₋ of 0.17 [0.11–0.25], reducing post-test probability to below 2% in low-risk patients, effectively ruling out PE without the need for further testing. However, in patients with intermediate risk (e.g., Wells score of 4.5), a negative D-dimer test (LR₋ = 0.1) can still reduce post-test probability sufficiently to avoid CT pulmonary angiography, whereas a positive test (LR₊ = 2) increases probability and necessitates further imaging. In stroke evaluation, the BEFAST mnemonic for recognition have an LR₊ of 8.0, substantially increasing suspicion, though an LR₋ of 0.2 means imaging is still required in high-risk cases. Additionally, bedside ultrasound via Extended Focused Assessment with Sonography for Trauma (EFAST) has an LR₊ of 30 when lung sliding is absent, confirming pneumothorax, while an LR₋ of 0.1 almost excludes it when lung sliding is present. These examples highlight how LR_s refine diagnostic probability, allowing emergency physicians to adjust probability estimates in real time, reduce unnecessary investigations, and prioritize life-saving interventions.

Despite their advantages, likelihood ratios have some limitations. Their usefulness depends on an accurate estimation of pre-test probability, which varies between clinicians and settings. Some tests have variable LR_s at different cutoff values, making interpretation more complex, especially for graded results like troponin or D-dimer levels. Additionally, likelihood ratios are underutilized in clinical practice, as many clinicians are more familiar with sensitivity,

specificity, and predictive values. The lack of widespread integration into medical training and decision-support tools also limits their application. Another challenge is the misconception that LR_s require complex mathematical calculations. While manual calculations using Bayesian methods can be cumbersome, tools like Fagan's nomogram simplify the process by providing a visual representation of pre-test probability, LR_s, and post-test probability.

Likelihood ratios provide a structured, quantitative way to interpret test results, making them highly valuable in emergency and inpatient settings. Their ability to adjust disease probability based on real-time findings helps physicians make informed decisions, avoid unnecessary testing, and prioritize critical interventions. By incorporating simple rules of thumb and increasing awareness of their benefits, LR_s can become a more integral part of clinical reasoning, leading to improved diagnostic accuracy and better patient outcomes. Expanding medical education on LR_s, integrating them into clinical decision-support tools, and encouraging their routine use in emergency medicine can significantly enhance their practical utility, ultimately reducing diagnostic errors and optimizing patient care.

The Prakash Method: Revolutionizing Anterior Shoulder Dislocation Reduction in Emergency Medicine

Dr. Rajiv Singhal

Anterior shoulder dislocations make up 97% of all shoulder dislocations, commonly presenting in emergency departments. Traditional techniques - Kocher's, Hippocrates', and Stimson's - often demand **sedation, assistance, and carry risks** like humeral fractures or nerve injury.

Biomechanical Brilliance

The method works by leveraging shoulder **rotation** rather than traction:

- ✦ Gentle **external rotation** unlocks the dislocated humeral head.
- ✦ Holding this position fatigues the **subscapularis**, the main resisting muscle.
- ✦ Controlled **adduction and internal rotation** guide the head back silently into the glenoid.

No forceful pulling, no assistants—just biomechanical finesse.

Step-by-Step Technique: Mastery in 4 Minutes

The Prakash method's simplicity enables single-operator execution:

- ✦ **Positioning:** Seat patient upright with back against chair/wall to stabilize scapula. Standing is permitted if tolerated.
- ✦ **Counseling:** Demonstrate steps on the unaffected shoulder to reduce apprehension—critical for muscle relaxation.
- ✦ **External Rotation:** Hold elbow flexed 90° and wrist neutral. Gently externally rotate the arm to maximal range (coronal plane). Maintain for 2–3 minutes while distracting the patient verbally.
- ✦ **Adduction:** Slowly adduct the externally rotated arm across the body until the elbow passes midline.

- ✦ **Internal Rotation:** Internally rotate the forearm until the hand touches the opposite shoulder. Reduction occurs silently without audible "clunk" in most cases.

Clinical Results: Evidence Speaks

Study	Success Rate	Avg Time
Cureus (2023)	97.06%	<5 min
Orthopaedics J (2023)	98.4%	3-4 min
Yaqoob et al. (2025)	95.5%	~2 min

Why It's Better

- ☑ **No sedation** → Safer for all ages
- ☑ **No assistant** → Perfect for rural/solo settings
- ☑ **No traction** → Protects vessels and nerves
- ☑ **Fast ED discharge** → Cuts crowding and costs
- ☑ **Effective in complex cases** → Including greater tuberosity fractures

When to Avoid

- ☒ **Polytrauma or spinal injury** – upright position not possible
- ☒ **elayed dislocations >72 hrs** – muscle contractures
- ☒ **Uncooperative patients** – dementia, severe anxiety
- ☒ **Non-anterior dislocations** – not validated

Final Word

This method isn't just a technique—it's a **paradigm shift**. With a near-zero complication rate and ease of use, the **Prakash Method deserves a place as the first-line approach** to anterior shoulder dislocations worldwide.

Doctors Day – Wellness Activity

Dr. Murtuza Ghiya



An online event for organized to commemorate Doctors day on 6th July (as it was the first weekend after Doctors Day). Participants were not limited to EM doctors only, and not limited to India as we had participants for UK and USA.



Unique features:

- ✦ Actual stretching done by all participants.
- ✦ Real reflections on how all participants will be changing their routines to accommodate "me time".
- ✦ Laughter and stand up comedy.

Raksha Bandhan – A Timeless Thread of Devotion and Protection

Dr. Pooja Abbi



Some festivals decorate our homes, but Raksha Bandhan adorns our hearts. Rooted in rich tradition and cultural warmth, Raksha Bandhan—commonly known as Rakhi—is not merely a ritual, but a heartfelt celebration of enduring sibling affection, unwavering protection, and familial devotion.

Celebrated on the auspicious full moon day of Shraavan (July–August) in the Hindu calendar, Raksha Bandhan marks the sacred bond between brothers and sisters. On this day, a sister ties a beautifully crafted rakhi—a thread symbolic of love and guardianship—around her brother's wrist. In return, the brother pledges to safeguard her against all adversities and showers her with blessings and tokens of appreciation.

Yet, Rakhi transcends the simple gesture of tying a thread. It is a soulful affirmation of loyalty, trust, and shared history—woven with laughter, childhood memories, and even sibling quarrels that only deepen the kinship.

Traditionally between biological siblings, Raksha Bandhan today embraces a broader definition of kinship. Rakhis are tied to cousins, close friends, and even to members of the armed forces as a gesture of gratitude and solidarity. In doing so, Rakhi becomes a celebration of human connection, mutual respect, and emotional security—a reminder that love knows no bounds.

The day is infused with vibrant customs. Sisters adorn their brothers with tilak (vermilion), aarti (prayer), and sweets, while brothers respond with gifts, heartfelt words, and protective vows. The home brims with laughter, the aroma of festive delicacies, and the warmth of togetherness.

Families reunite. Memories are relived. New moments are created. Rakhi is not just a tradition—it is a celebration of presence, protection, and promise.

In a rapidly changing world where digital interactions often replace personal connections, Raksha Bandhan serves as a gentle pause—an opportunity to cherish the irreplaceable value of family bonds. It reinforces the beauty of shared roots, emotional security, and unconditional support.

Raksha Bandhan is more than a ritual—it is a timeless expression of emotional intimacy and moral responsibility. A single rakhi thread binds not only wrists, but souls. It reminds us that no matter where life takes us, there is someone who will always stand by us, believe in us, and protect us.

In every loop of the rakhi lies a silent promise:
"I am with you—always."

Cheesy Baked Vegetable & Potato Cake

Ingredients:

- ✦ 4 medium **potatoes**, peeled and grated
- ✦ 1 medium **carrot**, grated
- ✦ 1 small **red bell pepper**, finely chopped
- ✦ 3 **eggs**
- ✦ 200 ml **milk**
- ✦ 200 g **all-purpose flour**
- ✦ 1 tsp **baking soda**
- ✦ 1 tsp **salt** (adjust to taste)
- ✦ ½ tsp **black pepper**
- ✦ Optional: ½ tsp **chili flakes**, ½ tsp **dried herbs** (oregano/thyme)
- ✦ ½–1 cup **mozzarella cheese**, shredded

Instructions

Preheat Oven:

- Preheat Oven

Prepare Vegetables:

- Grate the potatoes and carrot.
- Finely chop the red bell pepper.
- Squeeze excess water from the grated potatoes and carrot using a clean towel or cheesecloth.

Make the Batter:

- In a large mixing bowl, beat the eggs and add the milk.
- Mix in the flour and baking soda until a smooth batter forms.
- Season with salt, pepper, and optional herbs or chili flakes.

Combine:

- Fold in the grated vegetables and chopped bell pepper.
- Mix well to coat everything evenly.

Bake – Part 1:

- Pour the mixture into a greased or parchment-lined baking dish (8x8 inch or similar).
- Bake at 180°C (350°F) for 20 minutes, or until it starts to set and the top is slightly golden.

Add Cheese & Final Bake:

- Remove from oven, sprinkle with mozzarella cheese.
- Return to the oven and bake for 10–15 minutes more, until cheese is melted and golden.

Cool & Serve:

- Let it cool slightly, then cut into squares and serve warm.

Serving Suggestions:

- Great as a snack, breakfast, or light lunch.
- Serve with yogurt dip, green chutney, or tomato ketchup.

Cheesy Baked Vegetable & Potato Cake





XIth World Academic Congress of Emergency Medicine (WACEM25)

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See you all soon!