Dear Members,

Hope this bulletin finds you in the best of your health and spirits.

Vacation and summer would be at its peak when it will come to your hand. But as you all are well aware that we doctors don't have any official vacation in their private set ups. Friends, recently there was one judgement, where it was clearly mentioned that Doctors are Human beings first & then doctors. They can’t be forced or expected to work without rest. We strongly believe that all doctors should have their planned vacation schedule, so their patients won’t suffer, at the same time their batteries get fully recharged.

Recently Delhi High court has given one judgement, which clearly states that any doctor other than allopathy can’t prescribe modern medicines legally. This Landmark judgement would certainly support our IMA’s demand to implement it all over country.

Long awaiting decision about implementation of NEET for UG & PG medical admission has also come recently. If it would be implemented, then process of examination would become much smoother. That was a long pending suggestion of our visionary leader DR KETAN DESAI. We have given some details about NEET & Crosspathy decision in this bulletin. Kindly go through it. We are ongoingly putting important information related to our fraternity in bulletin. So keep habit of going through all details.

IMA HQ is representing & negotiating with appropriate authorities at higher level regarding various issues our fraternity. We ongoingly print important & useful matter in our bulletin continuously to update our members with what is going on. So once again I reiterate that kindly spare some time from schedule to go through bulletin for your own sake.

As we all know that corporate hospitals are increasing day by day. Looking to present scenario, there will be all possibility of corporate era. So in recent CWC meeting at Agra, our own leader mentioned the concept of corporate hospitals run by IMA. Our request to all members to think & work on possibility of the same in future.

At the end, we seek your feedback constantly to improve the quality of our own bulletin.

Jay Hind, Jay IMA.

Dr. Atul D. Pandya  
(President, G.S.B., I.M.A.)

Dr. Jitendra N. Patel  
(Hon. State Secy., G.S.B., I.M.A.)
<table>
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<tr>
<th>OFFICE BEARERS</th>
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<tr>
<td><strong>PRESIDENT</strong></td>
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<tr>
<td>Dr. Atul D. Pandya</td>
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<tr>
<td>(M) 98242 84947</td>
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<tr>
<td><strong>IMM. PAST PRESIDENT</strong></td>
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<tr>
<td>Dr. Chetan N. Patel</td>
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<tr>
<td>(M) 94263 78078</td>
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<tr>
<td><strong>VICE PRESIDENTS</strong></td>
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<tr>
<td>Dr. Jignesh C. Shah</td>
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<td>Dr. Ghanshyam L. Patel</td>
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<td>Dr. Anil D. Patel</td>
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<td>Dr. Paresh P. Golwala</td>
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<td>Dr. Vinod S. Noticewala</td>
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<td>Dr. S. S. Vaishya</td>
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<td><strong>TREASURER</strong></td>
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<td>Dr. Devendra R. Patel</td>
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<tr>
<td><strong>GUJARAT MEDICAL JOURNAL</strong></td>
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<tr>
<td>Editor</td>
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<tr>
<td>Dr. K. R. Sanghavi</td>
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<td><strong>SOCIAL SECURITY SCHEME</strong></td>
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<tr>
<td>Hon. Secretary</td>
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<td>Dr. Jitendra B. Patel</td>
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<td><strong>PROFESSIONAL PROTECTION SCHEME</strong></td>
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<td>Managing Director</td>
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<td>Dr. Bipin M. Patel</td>
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<td><strong>HEALTH SCHEME</strong></td>
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<td>Chairman</td>
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<td>Dr. Navneet K. Patel</td>
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<td><strong>HON. STATE SECRETARY</strong></td>
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<td>Dr. Jitendra N. Patel</td>
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<td>(M) 98253 25200</td>
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<td><strong>HON. JOINT SECRETARY</strong></td>
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<td>Dr. Shailendra N. Vora</td>
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<td><strong>HON. ZONAL JT. SECRETARIES</strong></td>
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<td>Dr. Vishnu N. Patel</td>
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<td>Dr. Rashmi J. Upadhyay</td>
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<td>Dr. M. H. Dalwadi</td>
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<td>Dr. Bhaskar Mahajan</td>
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<td><strong>HON. ASST. SECRETARY</strong></td>
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<td>Dr. Bharat I. Patel</td>
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<td><strong>SCIENTIFIC COMMITTEE</strong></td>
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<td>Dr. Bhupendra M. Shah</td>
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<td><strong>COLLEGE OF G.P.</strong></td>
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<td>Director</td>
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<td>Dr. Kirit C. Gadhavi</td>
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<td><strong>ACADEMY OF MEDICAL SPECIALITY</strong></td>
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<tr>
<td>Chairman</td>
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<td>Dr. Vidyu J. Desai</td>
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</table>
Indian Medical Association, 215th Central Working Committee meeting was held on 2nd & 3rd April, 2016 at Hotel Clarkes Shiraz, Agra, U.P.

Following members from our State attended the meeting.

1. Dr. Ketan D. Desai Ahmedabad
2. Dr. Jitendra B. Patel Ahmedabad
3. Dr. Atul D. Pandya Rajkot
4. Dr. Jitendra N. Patel Ahmedabad
5. Dr. Chetan N. Patel Vadodara
6. Dr. Bipin M. Patel Ahmedabad
7. Dr. Mahendra B. Desai Ahmedabad
8. Dr. Dhanesh A. Patel Ahmedabad
9. Dr. Parimal M. Desai Ahmedabad
10. Dr. Mahesh B. Patel Ahmedabad
11. Dr. Ashok D. Kanodia Ahmedabad
12. Dr. Mahendra H. Chaudhary Bardoli
13. Dr. Bharat V. Trivedi Bhavnagar
14. Dr. M. R. Kanani Bhavnagar
15. Dr. Ghanshyam L. Patel Bhavnagar
16. Dr. M. M. Jadeja Bhavnagar
17. Dr. Jayesh K. Sheth Mahuva
18. Dr. Anil J. Nayak Mehsana
19. Dr. Jesang F. Chaudhary Mehsana
20. Dr. Praful R. Desai Navsari
21. Dr. Pragnesh C. Joshi Surat
22. Dr. Navin D. Patel Surat
23. Dr. Babubhai J. Patel Unjha
24. Dr. Mayank J. Bhatt Vadodara
25. Dr. Suresh P. Amin Vadodara

Dr. Govind Purohit, Ahmedabad.

For getting award prize in Back Stroke swimming competition in Khel Maha Kumbh, 2016 organized by Govt. of Gujarat held on 18th January to 18th February, 2016.

Dr. Surendra Gupta, Palanpur

For getting a prestigious International award by GAPIO (Global Association of Physician of Indian origin) by Apollo Hospital group. Dr. Surendra Gupta is the only doctor from Gujarat to received this honour.

He donated blood for 49th time in Blood Donation Camp organized with the co-operation of Banas Dairy, Palanpur by I.M.A.

Sahil Saisahmed Patel son of Dr. Raisamed M. Patel, Ahmedabad

For securing First rank in final M.B.B.S. in Gujarat University with 75.88 %


President : Dr. Geetendra Sharma
President (Elect) : Dr. Hemant Bhatt
Vice President : Dr. Jayprakash Shah
Hon. Secretary : Dr. Rajal Thaker
Hon. Jt. Secretary : Dr. Kalpesh Trivedi
Hon. Treasurer : Dr. Jignesh Deliwala

New Office Bearers
IMA LOCAL BRANCHES

Election Notice of I.M.A. G.S.B. for the post of State President (Ahmedabad Zone) and Six Vice Presidents (One from each zone) has been posted to the Local Branch Secretaries.

RULES AND BYE-LAWS OF THE LOCAL BRANCHES:

(A) A Local Branch shall make its own Constitution to govern itself taking the Constitution of I.M.A. H.Q. and of the State Branch as the guideline. The Constitution, Rules and Bye-Laws of a Local Branch shall not infringe or contravene the provisions of Memorandum of Association Rules and Bye-Laws of I.M.A. Headquarters and / or of the State Branch.

(B) The Constitution, Rules and Bye-Laws so framed by a Local Branch and submitted to the State Branch, shall be forwarded to the Headquarters for approval and ratification with the remarks of the State Branch thereon if any, and it should be implemented only when it has been approved and ratified by the Working Committee of the IMA H.Q.

(C) Till such time as the Constitution of a Local Branch has been approved by the Headquarters, the said Local Branch shall follow Model set of Rules and Bye-Laws and guidelines prescribed by the headquarters and the State Branch for a Local Branch.

(D) The Rules and Bye-Laws of the Indian Medical Association Headquarters shall apply in any matter not covered by the Rules and Bye-Laws of the State Branch or of a Local Branch already ratified by the Working Committee.

IMA MEMBERS

Election Notice of I.M.A. G.S.B. for the post of State President (Ahmedabad Zone) and Six Vice Presidents (One from each zone) has been posted to the Local Branch Secretaries.

ELIGIBILITY OF OFFICE BEARERS:

(A) State President shall be a Life Member of Association.

(B) Vice President shall be from the same zone for which they have been proposed.

(C) Hon. State Secretary, Hon. Jt. Secretary, Hon. Asst. Secretary and Hon. Treasurer candidates shall be from amongst the State H/Q.

(D) Candidates for Zonal Posts shall be from amongst the eligible members of Local Branches from the same zone for which they have been proposed.

(E) Eligibility of local branches for nominating the candidate for election of the State Branch.

1) The local branch shall be an active branch not suspended or defunct.

2) It shall have cleared it’s S.F.C. for the year by 15th April.

(F) 1) He/She must be a life member of I.M.A.

2) He/She must have seven years continuous membership of I.M.A.

3) He/She should have served G.S.B. I.M.A. as a Working Committee member for at least 3 years.

In case of non receipt of valid nomination, any other life member can be considered for that particular post.

For further information, please contact your Local Branch Secretary.
## NEW LIFE MEMBERS

**I.M.A. GUJARAT STATE BRANCH**

We welcome our new members

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<tr>
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<th>NAME</th>
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<tr>
<td>LM/25076</td>
<td>Dr. Patel Bhavesh Keshavlal</td>
<td>Himatnagar</td>
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<td>LM/25077</td>
<td>Dr. Dharaviya Bhavesh V.</td>
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<td>Dr. Kambaria Vejanand D.</td>
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<td>LM/25079</td>
<td>Dr. Chavda Rama Somatbhai</td>
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<td>LM/25080</td>
<td>Dr. Ravat Bhargav Nileshkumar</td>
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<td>LM/25081</td>
<td>Dr. Jariwala Pooja Bharatbhai</td>
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<td>LM/25082</td>
<td>Dr. Patel Nikunj Durlabhbhai</td>
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<td>Dr. Mehta Reema Shaleshbhai</td>
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<td>Dr. Ramani Narendra Rameshbhai</td>
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<td>Dr. Vikani Mehul Arvindbhai</td>
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<td>Dr. Parmar Amit Chhaganbhai</td>
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<td>Dr. Karmata Nirav Jethabhai</td>
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<td>Dr. Daudia Bhushan Jayendrabhai</td>
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<td>Dr. Basida Komal Dhirubhai</td>
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<td>Dr. Bhuva Abhishek P.</td>
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<td>Dr. Bhuva Kinjal A.</td>
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<td>Dr. Kathiria Atman Vallabhbhai</td>
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<td>LM/25104</td>
<td>Dr. Kotadia Ghatna Ramnikbhai</td>
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<td>LM/25105</td>
<td>Dr. Sheth Akash Kalpeshkumar</td>
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<tr>
<td>LM/25106</td>
<td>Dr. Bariya Bhavesh Rameshbhai</td>
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**I.M.A.G.S.B. NEWS BULLETIN**

APRIL-2016 / MONTHLY NEWS

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<td>LM/25107</td>
<td>Dr. Rathod Bhupendra Kaushik</td>
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<td>LM/25108</td>
<td>Dr. Patel Sagar Rohitbhai</td>
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<td>Dr. Patel Anand Bhikhabhai</td>
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<td>Dr. Gaikwad Rila Vijayra</td>
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<td>Dr. Sharma Sharadkumar S.</td>
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<td>Dr. Prasad Sunil Ramashray</td>
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<td>Dr. Rathva Anil Muljibhai</td>
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<td>Dr. Pathak Tapan Tusharbhai</td>
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<td>Dr. Morzaria Hardik Mohanlal</td>
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<td>Dr. Morzaria Avani Hardikbhai</td>
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<td>Dr. Maharaul Honeypalsinh</td>
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<td>Dr. Sohda Nitaba G.</td>
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<td>Dr. Vora Yusuf Hasanji</td>
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<td>Dr. Dahodwala Taseem S.</td>
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<td>Dr. Prajapati Sanjay Ashokbhai</td>
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<td>LM/25141</td>
<td>Dr. Shekh Mahmmd Ajaruddin</td>
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<td>LM/25142</td>
<td>Dr. Bhalodia Mihir Janyabhai</td>
<td>Ankleshwar</td>
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<td>LM/25143</td>
<td>Dr. Parekh Dipen Hitendarbhai</td>
<td>Jamnagar</td>
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</tbody>
</table>
**OBITUARY**

We send our sympathy & condolence to the bereaved family

**Dr. Karamshibhai K. Pipalia**  
(01/07/1930 - 27/01/2016)  
Age: 79 years  
Qualification: M.S.  
Name of Branch: Junagadh

**Dr. Ishwarbhai M. Patel**  
(01/05/1948 - 29/03/2016)  
Age: 68 years  
Qualification: M.B.B.S.  
Name of Branch: Siddhpur

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| LM/25144 | Dr. Shah Shail Hareshbhai | Vadodara |
| LM/25145 | Dr. Butala Mihir Vijendrabhai | Vadodara |
| LM/25146 | Dr. Ajitkumar Birendra Pratap | Vadodara |
| LM/25147 | Dr. Priti Lata Sinha | Vadodara |
| LM/25148 | Dr. Bumiya Raj Girishkumar | Vadodara |
| LM/25149 | Dr. Dabhi Pinalben Girishkumar | Vadodara |
| LM/25150 | Dr. Prajapati Vasant Ambaram | Kheralu |
| LM/25151 | Dr. Vagadiya Ajay Nanubhai | Surat |
| LM/25152 | Dr. Vekariya Shailesh G. | Surat |
| LM/25153 | Dr. Dudhat Mahesh Dhirubhai | Surat |
| LM/25154 | Dr. Patel Nilesh Parsottambhai | Surat |
| LM/25155 | Dr. Patel Shilpa Nilesbhi | Surat |
| LM/25156 | Dr. Khandelwal Mahipal | Rajkot |
| LM/25157 | Dr. Parmar Vishal Himatilal | Rajkot |
| LM/25158 | Dr. Asari Hasmukh Martabhai | Una(S) |
| LM/25159 | Dr. Rathod Santoshdev P. | Ahmedabad |
| LM/25160 | Dr. Rathod Archana S. | Ahmedabad |
| LM/25161 | Dr. Pawar Hardik Siddharajsingh | Ahmedabad |
| LM/25162 | Dr. Patel Naman Kamleshbhai | Ahmedabad |
| LM/25163 | Dr. Patel Shaishav Vasudev | Ahmedabad |
| LM/25164 | Dr. Vyas Sheetal Sharadbhai | Ahmedabad |
| LM/25165 | Dr. Patel Ghanshyam Chunilal | Ahmedabad |
| LM/25166 | Dr. Shah Ishan Hemantkumar | Ahmedabad |
| LM/25167 | Dr. Patel Samir Anandbhai | Ahmedabad |
| LM/25168 | Dr. Patel Maulik Sureshbhai | Ahmedabad |
| LM/25169 | Dr. Patel Mansi Maulikbhai | Ahmedabad |
| LM/25170 | Dr. Jani Kinjal Rameshbhai | Ahmedabad |
| LM/25171 | Dr. Jani Sheetal Kinjalbhai | Ahmedabad |
| LM/25172 | Dr. Ajith Narayankutty | Ahmedabad |
| LM/25173 | Dr. Arora Sneha R. | Ahmedabad |
| LM/25174 | Dr. Patel Rishit Vishnubhai | Ahmedabad |
| LM/25175 | Dr. Jhaveri Preeti Niravbhai | Ahmedabad |
| LM/25176 | Dr. Makadia Nirzar Shantilal | Ahmedabad |
| LM/25177 | Dr. Makadia Alpa Nirzarbhai | Ahmedabad |
| LM/25178 | Dr. Umrania Ravi Arvindbhai | Ahmedabad |
| LM/25179 | Dr. Shaikh Uzair Mohamedrafik | Ahmedabad |
| LM/25180 | Dr. Agrawal Madalsa Basanthbhai | Ahmedabad |

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| LM/25181 | Dr. Gupta Nikhil Brijkishor | Ahmedabad |
| LM/25182 | Dr. Shah Ruchita Mukeshbhai | Ahmedabad |
| LM/25183 | Dr. Sanol Rakesh Vasubhai | Ahmedabad |
| LM/25184 | Dr. Kapadia Maulita P. | Ahmedabad |
| LM/25185 | Dr. Agarwal Kunal Rameshchandra | Ahmedabad |
| LM/25186 | Dr. Solanki Ashok Narsinhbhai | Ahmedabad |
| LM/25187 | Dr. Solanki Parul Ashokbhai | Ahmedabad |
| LM/25188 | Dr. Patel Jigar Kaushikbhai | Ahmedabad |
| LM/25189 | Dr. Parikh Milap Pravinbhai | Ahmedabad |
| LM/25190 | Dr. Shah Kunjan Hiteshkumar | Ahmedabad |

We pray almighty God that their souls may rest in eternal peace.
AMRELI
19-03-2016  “Renal transplant Therapy” by Dr. Jigar Shrimali.

ANAND
01-03-2016  “Endoscopic management of G.I. Bleed” by Dr. Prashant Buch.
“Metabolic surgery” by Dr. Pankaj Khndelwal. Total 70 members enjoyed the great interactive session.
26-03-2016 & Dhruvpal Memorial cup Gujarat state inter IMA Cricket
27-03-2016  tournament. Total 18 IMA teams participated and IMA Anand stood winners.

BHAVNAGAR
12-01-2016  Women empowerment : Kite flying celebration for Female.
15-01-2016  Launching of Cardiac Screening Camp for IMA Members.
16-01-2016  Starting of project Yes I Can (training of non medical and paramedical for First Aid and CPR) till date trained 400 participants.
24-01-2016  Medicolegal update 2016 one day seminar by Dr. Hitesh Bhatt and Gitendra Sharma
30-01-2016  Gandhi Olympiad MCQ Exam on life of Father of Nation Mahatma Gandhiji.
03-02-2016  Action for your financial Well being.
04-02-2016  Really for awareness of Cancer.
07-02-2016  “Sarva Rog Nidan camp”.
09-02-2016  Haemophilia patient meet and starting of Bhavnagar Chapter of Haemophilia.
10-02-2016  Workshop on “Ma” and “Amrutam Ma” Yojana.
13-02-2016  Sensitization of 1000 adolescent girls for breast cancer awareness by doing street dram on breast cancer by trust “Ek Sangh” from Khambhat.

JAMNAGAR
06-12-2015  “Obstructive sleep Apnoea” by Dr. Chirag Gangajaliya.
“Obstructive sleep apnoea and its pathophysiology” by Dr. B. Goswami.
“Management of Obstructive sleep apnoea” by Dr. Arun Joy.
“Panel Discussion on Obstructive sleep apnoea” by Dr. Viral Chhaya, Dr. B. Goswami, Dr. Amit Oza, Dr. Chirag, Gangajaliya and Dr. Arun Joy.
“Workshop – Live demonstration of application of various appliances for management of OSA” by Dr. Subhash Patel.
03-01-2016  “Recent trends in financial management” amongst doctors.
07-01-2016  Lecture on Medical mistakes, Negligence, Legal Implication and Safeguards for doctors by Dr. Jayant Karania.
18-01-2016  IMA Jamnagar Picnic with Youth Club. The picnic was arranged in batches of 2 on 18-1-2016 & 31-1-2016 comprising of 30 members and their families.
07-02-2016  IMA Doctor's Premier League (Inter IMA Cricket Tournament).
14-02-2016  Junior Doctor's Cricket Tournament. The event was successful and enjoyed by all.
23-02-2016  Lecture on Zika Virus by Dr. Mehul Kalia.
28-02-2016  CME on Neurology. Endoscopic skull base surgery by Dr. Siddharth Shah. Achche Din – A neurologist’s perception of nutrition by Dr. Amit Udani.
28-02-2016  Mega Ophthalmology Camp. Total 163 patients out of which 30 patients were diagnosed to be suffering from retinal ailments.

JETPUJ
10/02/2016  “Explaining Unexplained Insight into Medically Unexplained Symptoms” by Dr. Milan Rokad.
17-02-2016  “Pulmonary Function Tests(Spirometry)” by Dr. Dhiren Tanna.
27-02-2016  “Common skin disorders and Cosmetic Dermatology” by Dr. Piyush Borkhatariya.
13-02-2016  “Update on Zika virus” by Dr. Kamlesh Upadhyay.
09-03-2016  “Interpretation of CBC and Hb Electrophoresis in routine clinical practice” by Dr. Njshant Dharsandia.
17-03-2016  “Indian scenario ; Metabolic state, A big brude” by Dr. Vidyut Shah
“Improving Metabolic state with Dapagliflozii” by Dr. Nilesh Detroja.
30-03-2016  “Revascularization strategies in STEMI” by Dr. Kapil Viraparia Kalol
29-03-2016  “Polyarthritis approach & management” by Dr. Vishnu Sharma.
“Chhoti Chhoti Baten - E.N.T.” by Dr. Vinod C. shah

MEHSANA
20-03-2016  IMA Mehsana, CIMS Hospital, Mehsana Nagar Palika & Mehsana Urban Charitable Trust has organized Cardiology & Cancer Sarva Rog Nidan Camp & Parisanvad.
24-03-2016  IMA Mehsana Holi Celebration with family members together with splashes of fun, masti, music & dance at Sneh Kutir Vrudh Ashram, Mehsana.
01-04-2016  IMA Mehsana & Samaran Medical group organized Medico-Spiritual Seminar. Topic:
1. Science & Spirituality
2. Why Doctors should mediate?
3. Health care for health care provides (Health Doctors Health Society)
Speakers: Dr. Jayesh Thakrar and Dr. Sakshi Thakrar.
08-04-2016  “3D & 4D Sonography overview” by Dr. B.I. Patel
“IVF overview (Gynecologist)” by Dr. Nisha S. Patel

MORBI
07-02-2016  Sports Day celebration for IMA member families.
14-02-2016  Adult and Adolescent vaccination programme. Total 30 vaccines given.
21-02-2016  Pulse polio mission. Free polio drops were given to child visited the booth on that day.
27-02-2016  Dermatology camp at Saumya Skin clinic. Total 87 patients were benefited.
27-02-2016  An awareness lecture on Rheumatology at Apple Hospital for general practitioners. Total 34 GPs were took part.
28-02-2016  Free Diagnostic camp at Aandarna village. Total 153 patients were benefited.
04-03-2016  “Dealing with difficult situation and relatives, humor in medicine” by Dr. Mehul Mitra.
“Newer vaccine” by Dr. Manish Sanariya. Toal 48 doctors were present.
25-03-2016 “Recent updates on rotavirus vaccination” by Dr. Jayesh Sonvani.
“Recent updates on pneumococcal vaccination “ by Dr. Dhruv Desai. Total 13 doctors were present.

06-03-2016 A free diagnostic and therapeutic camp was held at Juna Katariya village. Total 30 patients got benefit for that camp.

20-03-2016 A diagnostic and therapeutic camp with Blood donation camp at peripheral area school of Morbi.
Total 150 bottle of blood were collected in blood donation camp. Total 1000 patients got benefit of diagnostic and therapeutic camp.

24-03-2016 Pamphlet distribution on World TB Day. Total 5000 pamphlet regarding the general information about TB in gujarati language were distributed.

NAVSARI
20-03-2016 CME on Cosmetic Surgery by Dr. Ashutosh Shah. Total 70 doctors have attended the CME.
16-04-2016 CME on Rheumatology & Gastroenterology by Dr. Nishil Shah and Dr. Saumin Shah. Total 56 Doctors have attended the C.M.E.

PALANPUR
15-02-2016 Blood donation camp was organized with the Co-operation of Banas Dairy. Dr. Girdhar Patel, Dr. Sanket Patel, Dr. H.G. Bhavsar and Dr. Surendra Gupta were present.
21-02-2016 Blood Donation camp was organized with the Co-op. of Palanpur Nagar Seva Samiti. Total 38 bottles were collected by this camp.

PALITANA
16-03-2016 “IVF & Surogacy The role of stem cell in infertility” by Dr. Gaurav Chawada.

Indian Pharmacological Society Ahmedabad Branch
President : Dr. Supriya D. Malhotra
Secretary : Dr. Devang A. Rana

Executive Committee Members
Dr. Parth Desai Dr. Parloop Bhatt
Dr. Prakruti Patel Dr. Charu Gautam
Dr. Sumit Patel Dr. Bhoomika Goyal

* * * * *

Tobacco & Diabetes

- Tobacco users are more likely to develop type 2 diabetes than non-users. Both must be warned about the dangers of tobacco use.
- Tobacco users can face greater difficulty in controlling their diabetes. Warn your patients to stay away from tobacco.
- Smokers with diabetes can experience poor blood flow to body parts and amputations. Large warnings inform about health effects.
- Tell your patients with diabetes that quitting tobacco can help them to manage their diabetes better and benefit their health.
- Diabetes patients who use tobacco are at greater risk of developing blindness, nerve damage, heart disease & kidney failure.
ATTENTION PLEASE !!

The office has received back News bulletins of the following members from Postal department with note as "Left", "Insufficient address" etc. The concerned member / friends are requested to inform the office immediately with change of address, L.M. No. & Local Branch.

<table>
<thead>
<tr>
<th>L_M_No.</th>
<th>NAME</th>
<th>BRANCH</th>
</tr>
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<tr>
<td>LM/10764</td>
<td>Dr. Multani Sudha T.</td>
<td>Ahmedabad</td>
</tr>
<tr>
<td>LM/17318</td>
<td>Dr. Patel Kamini Vipulbhai</td>
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<td>LM/02997</td>
<td>Dr. Patel Madhusudan A</td>
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<tr>
<td>LM/06777</td>
<td>Dr. Tiwari Anjani S.</td>
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<tr>
<td>LM/00406</td>
<td>Dr. Raja M.P.</td>
<td>Amreli</td>
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<td>LM/12678</td>
<td>Dr. Patel Jitendra Virabhai</td>
<td>Bharuch</td>
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<td>LM/12679</td>
<td>Dr. Patel Geetaben Jitendra</td>
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<tr>
<td>LM/21399</td>
<td>Dr. Sagar Ameeta Prashantbhai</td>
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<tr>
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<td>Dr. Jhala Jitendra J.</td>
<td>Gandhidham</td>
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<td>LM/18523</td>
<td>Dr. Nathani Harish P</td>
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<td>Dr. Nathani Kalpana H</td>
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<tr>
<td>LM/14718</td>
<td>Dr. Sheth Rupesh G.</td>
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<tr>
<td>LM/01552</td>
<td>Dr. Chokshi Vinod R.</td>
<td>Godhra</td>
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<tr>
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<td>Dr. Gandhi Pramodbhai C.</td>
<td>Himatnagar</td>
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<tr>
<td>LM/05497</td>
<td>Dr. Shah Vinodrai D.</td>
<td>Jamnagar</td>
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<tr>
<td>LM/02873</td>
<td>Dr. Shah Ashok M.</td>
<td>Lunawada</td>
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<tr>
<td>LM/01848</td>
<td>Dr. Mehta H.P.</td>
<td>Mehsana</td>
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<tr>
<td>LM/19952</td>
<td>Dr. Prajapati Dipesh Govindbhai</td>
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<td>Dr. Raiyani Hinaben Babulal</td>
<td>Morbi</td>
</tr>
<tr>
<td>LM/02363</td>
<td>Dr. Shah B.K.</td>
<td>Nadiad</td>
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<td>LM/10113</td>
<td>Dr. Dafda Naresh Sajanbhai</td>
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<tr>
<td>LM/00401</td>
<td>Dr. Patel Bhanukant M</td>
<td>Porbandar</td>
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</table>

** * * * * *

Attention - I.M.A. Members; Essay Competition

**GIMACON-2016**

Subject: EVOLVING LIFESTYLE

“CHANGES AND CHALLENGES” TO MEDICAL FRATERNITY

The essay should be in three typed copies double spacing on one side of the full-scrap paper. The author should not print his/her name & address on the essay but put up on a separate piece of paper.

Last Date for Submission at the State Office is 31/08/2016
Family Planning Centre, I.M.A. Gujarat State Branch

Respected Members,

Indian Medical Association, Gujarat State Branch runs 9 Urban Health Centers in the different wards of Ahmedabad City.

These Centres performed various activities during the month of March-2016 in addition to their routine work. These are as under:

01-03-2016 to 31-03-2016: Intra domestic house to house survey by the centers of Ahmedabad.

Rander - Surat: Mothers - Iron: 7500 tablets & Calcium: 5000 tablets were distributed & Vitamin A solution given to 13 children.

Nanpura - Surat: Mothers - Iron: 4500 tablets & Calcium: 1500 tablets were distributed & Vitamin A solution given to 40 children.

The total number of patients registered in the OPD & Family planning activities of Various Centers are as follows:

<table>
<thead>
<tr>
<th>No.</th>
<th>Name of Center</th>
<th>New Case</th>
<th>Old Case</th>
<th>Total Case</th>
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<tr>
<td>(1)</td>
<td>Ambawadi (Jamalpur Ward)</td>
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<td>535</td>
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<tr>
<td>(2)</td>
<td>Behrampura (Sardarnagar Ward)</td>
<td>1963</td>
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<td>(3)</td>
<td>Bapunagar (Potalia Ward)</td>
<td>1904</td>
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<td>Dariyapur (Isanpur Ward)</td>
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<td>(5)</td>
<td>Gomtipur (Saijpur Ward)</td>
<td>2404</td>
<td>672</td>
<td>3076</td>
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<td>(6)</td>
<td>Khokhra (Amraiwadi Ward)</td>
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<td>(7)</td>
<td>New Mental (Kubernagar Ward)</td>
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<td>(8)</td>
<td>Raikhad (Stadium Ward)</td>
<td>489</td>
<td>264</td>
<td>753</td>
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<tr>
<td>(9)</td>
<td>Wadaj (Junawadaj Ward)</td>
<td>1152</td>
<td>280</td>
<td>1432</td>
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<tr>
<td>(10)</td>
<td>Kambhat</td>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>(11)</td>
<td>Junagadh</td>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>(12)</td>
<td>Rander-Surat</td>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>(13)</td>
<td>Nanpura-Surat</td>
<td>---</td>
<td>---</td>
<td>---</td>
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<tr>
<td>(14)</td>
<td>Rajkot</td>
<td>1128</td>
<td>753</td>
<td>1881</td>
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MARCH - 2016

<table>
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<tr>
<th>No.</th>
<th>Name of Center</th>
<th>Female Sterilisation</th>
<th>Male Sterilisation</th>
<th>Copper-T (PCS)</th>
<th>Condoms</th>
<th>Ocpills</th>
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<td>New Mental (Kubernagar Ward)</td>
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<td>Raikhad (Stadium Ward)</td>
<td>47</td>
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<td>64</td>
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<td>1249</td>
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<tr>
<td>(9)</td>
<td>Wadaj (Junawadaj Ward)</td>
<td>12</td>
<td>---</td>
<td>107</td>
<td>15000</td>
<td>1850</td>
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<tr>
<td>(10)</td>
<td>Kambhat</td>
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<tr>
<td>(11)</td>
<td>Junagadh</td>
<td>---</td>
<td>54</td>
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<tr>
<td>(12)</td>
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<td>54</td>
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<td>49</td>
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<td>121</td>
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<td>120P</td>
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<td>31</td>
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<td>142</td>
<td>530</td>
<td>255</td>
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(36) (37)
Pharmacovigilance in India – Taking the steps to success

Introduction

- Pharmacovigilance as defined by WHO is the science and activities relating to the detection, assessment, understanding and prevention of adverse effects or any other drug-related problem where an adverse drug reaction is a response which is noxious and unintended and occurs at doses normally used in man for the prophylaxis, diagnosis or therapy of disease. (1)

The magnitude of the problem

- During the last decades it has been demonstrated by a number of studies that medicine morbidity and mortality is one of the major health problems which is beginning to be recognized by health professionals and the public. It has been estimated that such adverse drug reactions (ADRs) are the 4th to 6th largest cause for mortality in the USA. (2) They result in the death of several thousands of patients each year. The percentage of hospital admission due to adverse drug reactions in some countries is about or more than 10%. (3) There is very limited information available on ADRs in developing countries and countries in transition. Another matter of concern is the lack of awareness about ADR among Indian healthcare professionals. Despite improvement of ADR reporting systems in India by launching PvPI (Pharmacovigilance Program of India), the improvement in ADR reporting rate is reported to have not been up to the mark. (4)

Why postmarketing surveillance and reporting ADR is needed?

- The information collected during the pre-marketing phase of drug development is inevitably incomplete with regard to possible ADRs. This is mainly because the tests in animals are insufficient to predict human safety; Patients used in clinical trials are selected and limited in number, the conditions of use differ from those in clinical practice and the duration of trials is limited; Information about rare but serious adverse reactions, chronic toxicity, use in special groups (such as children, the elderly or pregnant women) or drug interactions is often incomplete or not available; Thus, post-marketing surveillance is important to permit detection of less common, but sometimes very serious ADRs.

Why health professionals are in the best position to detect and report on ADRs?

- The effectiveness of a national postmarketing surveillance programme is directly dependent on the active participation of health professionals. Health professionals are in the best position to report on suspected ADRs observed in their every day patient care. All healthcare providers (physicians, pharmacists, nurses, dentists and others) should report ADRs as part of their professional responsibility, even if they are doubtful about the precise relationship with the given medication.

What should be reported?

- For “new” drugs - report all suspected reactions, including minor ones. (drugs are still considered “new” up to five years after marketing authorization)
- For established or well-known drugs - report all serious or unexpected (unusual) suspected ADRs;

How to report ADRs in our country?

- The reports generated by you are called “Spontaneous reports” so called because they arise during a clinician’s normal diagnostic appraisal of a patient, the clinician drawing the conclusion that a drug may be implicated. ADR Monitoring Centres (AMCs) under PvPI play a vital role of collection and follow up of ADR reports from the patients. They are set up across India to collect the adverse event information from patients. These AMCs are the MCI approved medical colleges and hospitals, medical/central/autonomous institutes and some corporate hospitals. They are responsible for collecting the adverse event information, performing follow up with them to check the completeness of the ADR reports, entering information in the prescribed software (VIGIFLOW) and sending them to NCC via the same software.

How to recognize ADRs?

- Since ADRs may act through the same physiological and pathological pathways as different diseases, they are difficult and sometimes impossible to distinguish. However, the following step-wise approach may be helpful in assessing possible drug-related ADRs:
1. Ensure that the medicine ordered is the medicine received and actually taken by the patient at the dose advised;

2. Verify that the onset of the suspected ADR was after the drug was taken, not before and discuss carefully the observation made by the patient;

3. Determine the time interval between the beginning of drug treatment and the onset of the event;

4. Evaluate the suspected ADR after discontinuing the drugs or reducing the dose and monitor the patient's status. If appropriate, restart the drug treatment and monitor recurrence of any adverse events.

5. Analyse the alternative causes (other than the drug) that could on their own have caused the reaction;

6. Use relevant up-to-date literature and personal experience as a health professional on drugs and their ADRs and verify if there are previous conclusive reports on this reaction. The National Pharmacovigilance Centre and Drug Information Centres are very important resources for obtaining information on ADR. The manufacturer of the drug can also be a resource to consult;

7. Report any suspected ADR to the person nominated for ADR reporting in the hospital or directly to the National ADR Centre

Experiences at our centre

We at the department of pharmacology, are striving hard to report all ADRs provided by the physicians to the national coordinating centre from where the reports are sent to WHO Uppsala monitoring centre at Sweden.

- Causality assessment of all reports is performed meticulously and physicians advised regarding management of the ADR.
- Rare and challenging ADRs to drugs reported, is disseminated via publications in peer reviewed journals
- Regular sensitization programmes are held for postgraduate residents, physicians to motivate them to report ADR

Let us start reporting ADR to help our patients: It makes a difference

- Regular updates from PvPI regarding drugs are forwarded to the physicians.
- Recently the centre came across rare reports in the form of (2015)
  1. Penicillin induced fatal anaphylactic shock after 18 years of therapy in a patient with history of Rheumatic fever
  2. Linezolid induced complete myelosuppression in a patient of cellulitis which improved on drug withdrawal.
  3. Treatment emergent Suicidal ideation with paroxetine and Escitalopram in adolescent and young population.
  4. Sodium valproate induced hyperammonemic encephalopathy in a patient of epilepsy which resolved on drug discontinuation.
  5. Amisulpride induced hyperprolactinemia and galactorrhoea in a young non pregnant lady which resolved on drug discontinuation.

Under the IMA-PvPI initiative, Indian Medical Association (IMA) has become a nodal centre for reporting of Adverse Drug Reactions (ADR) / Adverse Events (AE) under the Pharmaco Vigilance Programme of India (PvPI). One can contact IMA-PvPI ADR/AE helpline and report any ADR/AE to Ms. Megha Joshi on Mobile No. +919717776514 from Monday till Friday from 9am to 5pm

- All ADR's can be reported to the nearest ADR monitoring center in our city (happens to be BJ Medical college and civil hospital or to NHL medical college and VS General hospital). For reporting ADRs you may please contact Dr. Supriya Malhotra:(M) : 9727760262,
  E-mail ID: supriyadmalhotra@gmail.com
- They can be directly reported by the prescribers and the patients to The PvPI helpline (toll free) at 1800-180-3024, Mon – Friday (9.00AM to 5 PM)
They can also be reported using the recently launched ADR application (ADR APP) which can be downloaded from Google play store. It is a mobile app for instant ADR reporting. 

References


(4) What is India doing to curb Adverse Drug Reactions. TNN | Sep 24, 2015,

(5) Newsletter published by the National coordination centre, IPC Gaziabad, JAN 2016

Dr. Parth Desai - Junior Lecturer, Department of Pharmacology
Dr. Supriya Malhotra - Professor and Head, Department of Pharmacology, Coordinator, ADR monitoring centre(AMC) under PvPI
Dr. Pankaj Patel - Dean, SMT NHL Municipal Medical College, Ahmedabad

* * * * *

DISCLAIMER

Opinions in the various articles are those of the authors and do not reflect the views of Indian Medical Association, Gujarat State Branch. The appearance of advertisement is not a guarantee or endorsement of the product or the claims made for the product by the manufacturer.

Insulin detemir is a long-acting insulin analogue indicated for use as basal insulin therapy in patients with type 1 or 2 diabetes mellitus.

Chemical structure:

Insulin detemira long-acting insulin analogue in which threonine is omitted from position B30 of the insulin β-chain and replaced by myristic acid, a C14 fatty acid chain. This fatty acid modification allows insulin detemir to reversibly bind to the long-chain fatty acid binding sites.

Mechanism of action:

- Regulates glucose metabolism.
- Binds insulin receptors to lower blood glucose by increasing cellular uptake of glucose into skeletal muscle and fat; inhibits hepatic glucose production, lipolysis and proteolysis and increases protein synthesis.
- Longer duration of action and less intra-patient variability in blood glucose concentrations than with isophane insulin human.

Pharmacokinetics:

Following sub-cutaneous injection, absorption is slower and more prolonged than isophane insulin human with less intra and inter individual variations.

Following sub-cutaneous injection, absolute bioavailability is 60%. It is more than 98% bound to albumin. Its half life is 5 to 7 hours.

Adverse effects:

Hypoglycemia, pruritus, rash, injection site reactions, weight gain, Headache, dizziness and hypoglycemic unconsciousness, Nausea, diarrhoea and vomiting

Pregnancy and lactation:

- It has not been studied in children with type 2 diabetes or in children with type 1 diabetes who are younger than 2 years of age.
The information about its use in pregnancy is lacking however it is not inferior in terms of efficacy and safety to human insulin. (Class B)

Contraindications and Cautions:

1. It is contraindicated in combination with TZDs as it can increase the risk of developing new or worsening heart failure.
2. Dose adjustment should be done with drugs that increase or decrease insulin requirement.
3. Dose adjustment is required in patients with hepatic and renal disease.
4. Contraindicated in patients hypersensitivity to insulin detemir.

Drug interactions:
Concomitant use of other drugs may decrease insulin requirements like Oral antidiabetic drugs, monoamine oxidase inhibitors (MAOI), beta-blockers, angiotensin converting enzyme (ACE) inhibitors, salicylates, anabolic steroids, sulphonamides and alcohol.

The substances may increase insulin requirements like Oral contraceptives, thiazides, glucocorticoids, thyroid hormones, sympathomimetics, growth hormone and danazol.

Therapeutic indications:

1. The treatment of type 1 diabetes mellitus in adults, adolescent and children 2 years and above.
2. The treatment of type 2 diabetes mellitus in adults when insulin is required for the control of hyperglycemia.
3. The treatment of type 2 diabetes mellitus in combination with oral anti-diabetic agents (OADs) in adults who are not in adequate metabolic control on OADs alone. For safety reasons, the use of insulin in combination with thiazolidinedione is not indicated.

Advantages:
Insulin detemir is a neutral, soluble, preparation which enables it to remain in a liquid form following subcutaneous injection, unlike NPH insulin and glargine. The solubility of insulin detemir may be a factor contributing to the reduced variability in glycemic control observed in recipients of this agent compared with NPH or glargine because precipitation and dissociation of a precipitate are unpredictable processes. There are less chances of weight gain and hypoglycemic episodes as compared to other insulin preparations.

Limitations of its use:
It is not recommended for the treatment of diabetic ketoacidosis. Intravenous rapid-acting or short-acting insulin is the preferred treatment for this condition.

Dosage schedule: Insulin detemir can be used as basal therapy in conjunction with short-acting bolus insulin in both patients with type 1 or type 2 diabetes. It can be injected in the subcutaneous tissue one or two times a day. Initially, it is recommended to inject insulin detemir in the evening (at dinner or bedtime). Nevertheless, it was shown that morning plus evening administration of insulin detemir (plus insulin aspart at mealtime) provided also less variable glucose levels.

Approved by CDSCO on 2015

Dr Prakruti Patel     Dr Anuradha Gandhi     Dr Chetna Desai
Coordinators, B. J. Medical College, Ahmedabad
**NEWS CLIP**

**Gujarat has 7th highest number of TB cases**

Disease Consumed More Than 14,000 People In 4 Years

The state has been recognized for its efforts in preventing TB. Experts believe that early detection and treatment are key to reducing the number of cases.

**INDUSTRIAL TIMES**

**Hakims, Vaidys can’t prescribe allopathic medicines: HC**

The court ruled that practitioners of Ayurveda and Unani medicine cannot prescribe allopathic medicines under the Indian Medicines Act.

**TIMES**

**‘Can’t expect docs to stay with patients all the time’**

Consumer Court says docs too need rest

Ahmedabad: A consumer court has ruled that doctors cannot be expected to stay with patients all the time. The court directed the hospital to provide rest to the doctors.

**INDUSTRIAL TIMES**

**No practitioner of Indian system of medicine has prescribed a patent medicine for a period exceeding 12 months:**

The court has ruled that practitioners of Ayurveda and Unani medicine cannot prescribe allopathic medicines under the Indian Medicines Act.
A DESIGNATED COURT in Amreli convicted sitting BJP MP from the region, Naran Kachhadiya, in a 2013 case of assaulting a doctor (SC ST) at a government hospital and committing atrocities against him and sentenced the politician to three years of imprisonment.

Even though the court stayed execution of the sentence for a month, Kachhadiya faces disqualification as a Member of Parliament due to his conviction in the criminal case under new rules.

The court pronounced Kachhadiya guilty under IPC Section 332 and sentenced him to three years of imprisonment and six months of imprisonment under IPC Section 143 read with the Atrocities Act.

The remaining five were found guilty under IPC Section 143 and sentenced to six months of imprisonment. The court also imposed a fine of Rs 35,000 on the MP.

IPC 332: Voluntarily causing hurt to deter public servant from his duty.
-Whoever voluntarily causes hurt to any person being a public servant in the discharge of his duty as such public servant, or with intent to prevent or deter that person or any other public servant from discharging his duty as such public servant, or in consequence of anything done or attempted to be done by that person in the lawful discharge of his duty as such public servant, shall be punished with imprisonment of either description for a term which may extend to three years, or with fine, or with both.

IPC 143: Whoever is a member of an unlawful assembly, shall be punished with imprisonment of either description for a term which may extend to six months, or with fine, or with both.

Atrocities act: ACT No. 33 of 1989: An Act to prevent the commission of offences of atrocities against the members of the Scheduled Castes and the Scheduled Tribes, to provide for Special Courts for the trial of such offences and for the relief and rehabilitation of the victims of such offences and for matters connected therewith or incidental thereto.
NATIONAL CONSUMER DISPUTES REDRESSAL COMMISSION, NEW DELHI, CONSUMER CASE NO. 366 OF 2014,
Shri MANISHBHAI KANTILAL JOSHI vs SHETH P. T. SURAT GENERAL HOSPITAL Surat

HON’BLE MR. JUSTICE V.K. JAIN, PRESIDING MEMBER and HON’BLE DR. B.C. GUPTA, MEMBER, Dated: 09 Feb 2016,
ORDER: JUSTICE V.K. JAIN, PRESIDING MEMBER (ORAL)

Late Shri Kanti Lal C. Joshi, aged about 86 years, father of the complainant was admitted in Sheth P.T Surat General Hospital (Opposite Party No.1) on 19.11.2012. He was admitted under another doctor, but later put under the treatment of Dr. Sameer Gami.

He expired at about 2.30 AM on 21.11.2012 while on ventilator. In the night of 20.11.2012, he was under the care of Dr. S.S. Indorwala after Dr. Sameer Gami had retired for the day. Alleging negligence in the treatment of his father, the complainant is before this Commission seeking compensation quantified at Rs.2 Crores along with cost of litigation quantified at Rs.50,000/-. When this complaint came up for consideration on 26.09.2014, the learned counsel for the complainant submitted that the main grievance of the complainant was that Dr. Sameer Gami had left for outstation on 20.11.2012 itself without giving proper instructions to Dr. S.S. Indorwala as regards the treatment of the patient and Dr. Indorwala not being a Chest Specialist was not qualified to treat the patient.

We however find no merit in the contention. It has come in the reply of Dr. Gami that he had last saw the patient at about 8.00 PM on 20.11.2012. The medical record clearly supports the stand taken by Dr Gami in this regard. There is absolutely no evidence of Dr Gami having left for outstation on 20.11.2012. Be that as it may, even if we proceed on the assumption that DR

He further stated in the reply that on account of critical sickness of his father in the evening of 20.11.2012, he planned to leave for out station and therefore he advised shifting the patient to ICU.

Dr Gami had treated the patient as per the standard protocol and practice but the patient succumbed to the chronic disease despite adequate treatment given to him. It is also stated in the said reply that Dr. S.S. Indorwala is a qualified doctor, who was employed on regular basis with the hospital.

We however find no merit in the contention. It has come in the reply of Dr Gami that he had last seen the patient at about 8 PM on 20.11.2012. The medical record clearly supports the stand taken by Dr Gami in this regard.

In their reply the hospital and Dr Indorwala have maintained the stand taken in the reply of Dr Gami and have stated that the patient was admitted with past history of Bilateral Centrilobular Emphysemotus in the form of Hyperinflated lung with flattening of lobes. Minimal subpleural opacity in the right upper lobe suggest fibrotic/old granulomatous lesion, Atherosioretic arotic changes and degenerative spinal changes along with Rounding of Trachea and filling defect in upper trachea.

It is however stated in the said reply that Dr Gami had treated the patient as per the standard protocol and practice but the patient succumbed to the chronic disease despite adequate treatment given to him. It is also stated in the said reply that Dr. S.S. Indorwala is a qualified doctor, who was employed on regular basis with the hospital. The learned counsel for the complainant has submitted during the course of arguments that Dr gami left for outstation on 20.11.2012 itself without giving proper instructions to Dr Indorwala as regards the treatment of the patient and Dr Indorwala not being a Chest Specialist was not qualified to treat the patient. We however find no merit in the contention.

The deceased had been taking nebulizer and home oxygen support for six months before his death. Lung transplant, which was only option available in such a case was not suitable for him, considering his advanced age and therefore he had been put on steroids.
Gami had taken leave and left for outstation on 20.11.2012 that by itself does not make out any negligence on his part in the treatment of the patient.

A Doctor, like any other professional can take leave if felt necessary by him on account of his personal reasons or otherwise.

If that happens it is for the hospital in which the patient is admitted to make alternative arrangement for the treatment of the patient in the hospital.

We have to keep in mind that the patient was admitted in a hospital and not in the clinic of Dr Gami.

Therefore, in the absence of Dr Gami the patient was to be treated by some other doctor available in the hospital or called by the hospital from outside. No case of negligence on the part of the Dr Gami is therefore made out even if we assume that he had left for outstation on 20.11.2012.

As far as briefing the other doctor who was to treat the patient in his absence, in our opinion, no such briefing would be necessary since the symptoms and diagnosis of the patient as well as the treatment being given to him in the hospital is recorded in the treatment record of the patient kept in the hospital and therefore any suitably qualified doctor attending the patient, in the absence of the previous doctor, would be in a position to advise appropriate treatment and medicines taking into consideration symptoms, conditions and illness of the patient along with the treatment given to him in the past.

So long as the doctor treating the patient in the absence of the previous doctor is a competent doctor he should have no difficulty in treating the patient on the basis of the record prepared in the hospital.

Therefore, Dr. S.S. Indorwala could have absolutely no difficulty in treating the patient in the absence of Dr. Sameed Gami.

In any case, this is not the case of Dr Indorwala in his reply that he was handicapped in any manner in the treatment of the patient on account of having not been adequately briefed by Dr. Gami. Therefore it is difficult for us to accept the contention that the leave taken by the Dr. Gami was responsible for the father of the complainant succumbing to the illness from which he was suffering.

As far as qualification of Dr Indorwala is concerned, we are informed during the course of hearing that he is an M.D. Being a Doctor of Medicine, he was competent to treat the father of the complainant, who was suffering from long ailments. It is not as if only a super specialist in chest related disease can treat such a patient.

A doctor, who has done Post Graduation in Medicine, in our opinion, is fully competent to treat the patient. In fact, in almost all the hospitals, Senior Doctors normally retire for the day in the evening/night and it is only Junior Doctor such as Junior Residents and Senior Residents who remain on duty. The consultant is called if necessary, depending upon the condition of the patient. Therefore, we are unable to accept the contention that Dr. S.S. Indorwala was not qualified enough to treat the father of the complainant in the absence of Dr. Gami.

In any case, as stated in the reply of Dr Gami he had last seen the patient at about 8 PM on 20.11.2012. The patient died at about 2.30 AM on 21.11.2012 i.e. within a span of 6 ½ hours after Dr. Gami had left the hospital. Dr. Gami could not have been expected to remain with the patient or in the hospital 24 hours of the day. Like other normal human being he also needs to take rest and his meals and then get ready for the duty to be performed on the next day. Therefore, there was no negligence on the part of Dr. Gami in leaving the hospital and the patient being treated by Dr. S.S. Indorwala in his absence.

For the reasons stated hereinabove, we find no merit in the complaint and the same is accordingly dismissed with no order as to costs.
In the case of Goyal Hospital & Research Centre Pvt. Ltd., Jodhpur & ors, V/s. Kishan Shukla (R.P. No.4023/2011), the National Commission was dealing with the aforesaid question and the answer was in negative. A doctor must have valid and recognised specialised qualification.

Facts:

Allegations:

1) The deceased wife of the Complainant No.2 was diagnosed as valvular disease of the heart and was further directed to take treatment of a Cardiologist. Dr. Goyal, who claimed himself a Cardiologist, conducted tests pertaining to heart problems on the patient and diagnosed her as Mitral Stenosis with Mitral Regurgitation (MS with MR) and started treatment. In the meantime of her treatment, she became pregnant. As there was no improvement in her health, she was further referred to another Cardiologist, who advised urgent hospitalization and further undergo delivery operation at the earliest, as it was her 8th month of pregnancy. She delivered a baby boy, but her condition deteriorated and she was shifted to ICU, where she was declared as dead in next morning, but no relative was allowed to see her.

Defense:

1) Dr. Goyal never denied the fact that “Consultant Physician and Cardiologist” has been printed on his prescription. Nevertheless he gave best possible treatment to the deceased. Gynecologist and Anesthesiologist also claimed that they performed their duties well.

Held:

1. The National commission relied upon the observations of The State Commission which after perusing entire record and evidence rejected the appeal of the petitioners and observed that

Dr. Goyal was not a Cardiologist and it was the duty of Goyal Hospital to make available Cardiologist at the time of operation of patient suffering from such serious ailment. After the delivery option, not allowing relatives to go inside and meet also create doubts.

2. Dr. R. K. Vyas also admitted that Dr. Goyal was not a cardiologist and a simple M.D., cannot claim of being cardiologist i.e. Specialist in Heart Disease. As per IMC Regulations, 2002 Clause-B Sub-clause 1.1.3., “No person other than a doctor having qualification recognized by Medical Council of India and registered with Medical Council Of India/State Medical Council(s) is allowed to practice Modern System of Medicine or Surgery. Even otherwise, undergoing several trainings, attending workshops in Cardiology did not confer qualification of cardiologist. Hence it is not recognized by MCI or Rajasthan State Medical Council.

3. The Commission further relied upon the landmark judgment of Hon’ble Supreme Court in Jacob Mathew V State of Punjab & Anr, (2005) 6 SSC 1= III (2005) CPJ 9 (SC) where in it had concluded that, “ a professional may be held liable on one of two findings: either he was not possessed of requisite skill which he professed to have possessed, or, he did not exercise reasonable competence in given case, the skill which he did possess.”

It was risky that a doctor who is not qualified and competent to do so which amount to therapeutic misadventure

4. Thus the Commission not only directed to pay the petitioners a sum of Rs.6,82,000,, but also saddled punitive cost of Rs.1,00,000/ -.

So beware of what you have and what you pretend to have. Nowadays specialisation in Medical field is enhancing rapidly. Jokingly it is said that there will be separate Doctors for treatment of Left eye and Right eye. SO, Honesty is the Best policy, isn't it?

Can a M.D. Medicine Doctor practise as a Cardiologist?
Wrong Dose of Anesthesia and failure to follow Std. Guidelines in ERCP procedure + unethical siphoning of government funds = Rs. 47 lakcs of Compensation.

The commission observed, Michael Jackson and Joan Rivers both lost their lives secondary to the anesthetic agent, Propofol...!!

The National commission was dealing with the case of D. UMA DEVI V/s. Yashoda Hospital., A.P.

In the opening para of the judgment, commission has referred "Anaesthesiologist, are like aeroplane pilots, are essentially 99% of the time in a “watchful waiting mode”. It is when an untoward event occurs that they are called into action, their level of alertness, skill and response is critical. It is not the drug Propofol itself that is the culprit for it is an effective and fast acting anesthetic agent. It is the monitoring of the patient and the ability of an attentive physician to promptly act with the necessary staff and equipment that can make the difference between life and death."

Facts in nutshell:

1. This started in 2008. The patient, was suffering from Jaundice. and after he was admitted in the Hospital, he was advised ERCP (Endoscopic Retrograde Cholangio- Pancreatogrpahy) with CBD endoscopy.
   But during ERCP, after the administration of anesthesia, something went wrong and the Patient went in Coma and became brain dead.

2. Thereafter also the Hospital refused to discharge the patient and hence the wife of the patient, the complainant approached National Human Rights commission (NHRC) which directed the Hospital to continue with the treatment alongwith case to be filed in Consumer court. ultimately, after a long struggle of 2.5 yrs, the patient succumbed to death in the year 2010, at the age of 42 years. The State commission granted Rs.10 laks of Compensation. But both the parties feeling aggrieved, approached National Commission.

3. The Doctors denied all the chargers. They attributed the initial complications to sudden cardiac arrest during ERCP.

Held:

It narrated the State commission observations

1. The principle of Res Ipsa Loquitur (the act speaks for itself) aptly applies in this case for the reason that; firstly it seems the doctors who have attended on the patient did not conduct necessary exercise before administering “Propofol”. Secondly, the patient was not admitted with complications. Mishandling or negligence for a spur of moment would adversely affect the life of a patient.

2. Further it was really shocking that the Hospital siphoned of government funds (as the deceased was a police personnel) to the tune of Rs. 12 lakhs and after exhausting the outer limit, started demanding more money from the patient for discharging him and then the NHRC intervened.

3. The cardiac arrest was not managed properly, therefore patient suffered coma. Thus, it is the case of medical negligence. If the hospital is having super specialty facilities, higher level of treatment facilities and cost of treatment; there will be higher expectations of treatment and care.

4. The National Commission took in to account, the dependant person of the family of the deceased and hence enhanced the compensation to Rs.47 lacks Plus 9% p.a. interest.

This case is a mixture of Medical Negligence and unethical practices. We must learn what not to do than what to do, from the mistakes of others.
Games Corner
Dr. Chandresh Jardosh Surat
Chhota Sudoku

"Place the numbers 1 to 9 in the spaces so that the number in each circle is equal to the sum of the four surrounding spaces."

KEN KEN PUZZLE

1. Write down 1 to 6 in each row and each column in such a way they come only once, in each row and column.
2. The heavily-outlined groups of squares in each grid are called "cages." In the upper-left corner of each cage, there is a "target number" and maths operation (+, −, ×, ÷).
3. Fill in each square of a cage with a number. The numbers in a cage must combine—in any order, using only that cage's maths operation—to form that cage's target number.
4. The number written in the cage of one square, will be the answer for the cage.
5. Important: You may not repeat a number in any row or column. You can repeat a number within a cage, as long as those repeated numbers are not in the same row or column.

** Answer Page No. 66 **

7 BR OK EN Words
By using following keys, join the broken words & find out the 7 different words related to Bank.

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Sudoku

The objective of sudoku is to enter a digit from 1 through 9 in each cell, in such a way that: Each horizontal row contains each digit exactly once. Each vertical column contains each digit exactly once. Each 3 by 3 square contains each digit exactly once.

** Attention Advertisers **

* You are requested to send your matter for advertisement in I.M.A.G.S.B. New Bulletin before **15th of Every month.**

* Your advertisement matter has to be **ready to print format or at least matter** has to be in printed form.

* In case of handwritten matter, publisher will not be responsible for any kind of printing error.
Dear IMA members,

You are aware that India has achieved a historic landmark by eradicating polio from the country. The last case of polio was reported from the country on 13th January 2011 and thereafter India was certified polio free by the World Health Organization (WHO) on 27th March 2014.

The last case of polio in Gujarat was reported 8 years ago and the state received the “Polio Free Gujarat” award from United Nations and WHO on 11th January 2015. The victory over polio in Gujarat is your victory and a result of your tireless efforts and commitment. Congratulations to all!!

As you know, the Trivalent oral polio vaccine (tOPV) currently being used in routine immunization and polio campaigns contains all three types of polioviruses – type 1, 2 and 3.

The last case of type 2 wild polio virus in India was detected in October 1999. Since the wild poliovirus type 2 has been eradicated from the world and because it is responsible for more than 90% cases of Vaccine Derived Polio Virus (VDPVs), there is no need to continue giving tOPV containing polioviruses – type 1, 2 and 3.

As part of the next stage for global eradication of polio, Bivalent oral polio vaccine (bOPV) which contains only type 1 and 3 will totally replace tOPV in all countries across the world including India.

The globally coordinated switch from tOPV to bOPV will occur in April 2016. In India, the National Switch Day will be 25th April 2016, when tOPV will be completely withdrawn and replaced by bOPV in both private and public sectors. Only bOPV will be used after this switch in both routine immunization and polio campaigns.

Your active involvement in all aspects of tOPV to bOPV switch will be very important to successfully implement the switch in Gujarat. The Department of Health and Family Welfare, Government of Gujarat requests you to undertake the following simple steps to support the switch.

Before the Switch:
- Be aware of the SWITCH date i.e. 25th April 2016 is the National Switch Day.
- STOP using tOPV & START using bOPV.
- Inform all your para-medical staff about the SWITCH so that they can support you during the SWITCH.
- Ensure that there is no excess tOPV stock in your clinic because the stock will be wasted as it cannot be used after the SWITCH date of 25th April 2016.
- Ensure that you return this excess tOPV stock to the Chief District Health Officer (CDHO) or Medical Officer of Health (MOH) for disposal.
- Check that your clinic does not have any tOPV stock remaining.

As the world gears up for eradication of this dreaded disease polio, we are relying on your help to ensure that this important milestone in the Polio Endgame is achieved in our country.

Remember, using tOPV after the SWITCH date will jeopardize polio eradication program.

In case you would like more information about the SWITCH, contact your Chief District Health Officer (CDHO) or Medical Officer of Health (MOH).

Yours Truly,

[Signature]

Additional Director (FW)
Gandhinagar
What is NEET supreme court order and what next??

On April 11, 2016 a Constitution bench of the Supreme Court recalled a controversial 2013 judgment passed by it striking down a common entrance examination for all medical colleges in India. The case, Medical Council of India vs Christian Medical College, will now be heard afresh in the Supreme Court.

Advocate Karan Seth, appearing on behalf of Union of India, explains the legalities and sheds light on irregularities and questionable practices followed by Indian medical colleges.

1. What is NEET?
   The National Eligibility-cum-Entrance Test (NEET) was notified by the Medical Council of India (MCI) for admission to MBBS and postgraduate medical courses. Aspirants can, through NEET, appear for a single examination, and apply for admission to any college of their choosing across the country except in the states of Andhra Pradesh and Jammu and Kashmir. NEET also specified that admission is to be conducted on basis of the examination scores alone and no extraneous factors would come into play.

   The NEET has been held only once in 2013, pursuant to which it was struck down by the Supreme Court.

   The purpose/merits of NEET are as follows:
   a) To reduce the mental and financial burden on medical aspirants who have to appear in a number of entrance examinations across the country.
   b) To prevent any form of malpractice such as donations, profiteering and capitation fees.
   c) To place the emphasis on merit as the only criteria for admission.

2. On what grounds was NEET struck down in 2013?
   Close to 178 petitions challenged NEET on the following grounds:
   a) The triple test laid down in the PA Inamdar case that the admission procedure must be fair, transparent and non exploitative was being followed by institutions and there was no violation.
   b) MCI has no power to conduct examinations.
   c) NEET is violative of the rights of private medical colleges under Article 19(1)(g), that is, freedom to practise any profession, or to carry on any occupation, trade or business
   d) NEET violates the rights of religious and linguistic minorities to establish and administer educational institutions as guaranteed under Article 30 of the Constitution.
   e) Regulations, flowing from a power given under a statute, cannot have an overriding effect over the fundamental right guaranteed under Articles 25, 26, 29(1) and 30 which protect religious practices and the rights of minorities to establish and administer educational institutions.
   f) Furnishing of regulations to the state government for consideration under Section 19A(2) of the Indian Medical Council Act (IMC ACT) was mandatory and had not been done. Section 19A(2) essentially states that all regulations that the MCI wants to notify must be first sent to the State Government to provide their opinion.

3. Can you give us a brief timeline of the case?
   Before the NEET regulations came about, the necessity of a common entrance test was considered and approved by the Supreme Court in a catena of judgments.

   Partly on the basis of these judgments, the MCI introduced NEET regulations in 2010.

   Further, the MCI was ordered by the Supreme Court to take such steps as are necessary to implement NEET in another case, known popularly as the Simran Jain case.

   These regulations were challenged by several organisations, institutions and the state governments of Tamil Nadu and Andhra Pradesh in various courts across the country. The cases were eventually transferred to the Supreme Court. Close to 178 writ petitions were filed and heard in the matter.

   On July 18, 2013, the Supreme Court, in a majority judgment, set aside NEET and upheld the above mentioned grounds.

   On October 23, 2013, a review petition challenging the judgment was filed by the MCI and the Supreme Court issued notice.
A belated objection was raised by the respondents on the maintainability of the review petition.

On April 7, 2016, the Supreme Court carefully considered submissions made by the advocates of the parties and reserved the judgment.

On April 11, 2016, Justice Anil Dave pronounced the judgment in open court holding that prima facie there were enough grounds to recall the judgment and hear the case afresh.

As on date, the NEET regulations stand restored and MCI can hold the NEET examination pending the judgment in the review.

4. There was a debate on how the test would affect minority rights. Can you explain why/why not?

Minority institutions (such as Christian Medical College, Vellore) are contending that NEET is interfering with the autonomy granted to them by the TMA Pai judgment. The judgment essentially states that minorities should be allowed autonomy to establish and administer their educational institutions and the government should not interfere and can only impose minimal regulations.

I do not think that the position taken is correct. The TMA Pai judgment gave minorities the ability to establish and administer educational institutions, but it does not bestow them with an absolute right to conduct their own entrance examinations.

However, the Centre does have an absolute right to prescribe minimum standards of education under the Constitution. NEET is an eligibility test setting minimum standards for admission. The right of minority institutions to admit students was not being denied. The institutes can admit students from their own community, but from the list of successful candidates who appear for the NEET.

Article 19(6) of the Indian Constitution provides for exceptions to Article 19(1)(g) and one of the exceptions is that the State can make any laws imposing reasonable restrictions on the right available under 19(1)(g) as long as the law relates to the professional or technical qualifications necessary for practising any profession or carrying on any occupation, trade or business. In my opinion, NEET is squarely covered by this exception.

This stand has also been taken by Justice Anil Dave in his dissenting opinion in 2013.

5. The order states that the 2013 judgment did not consider certain binding precedents. Can you elaborate on what these precedents were? A few of them are:

Veterinary Council of India vs Indian Council of Agricultural Research which held that prescribing standards of education includes the power to conduct Common Entrance test.

Dr Preeti Srivastava vs State of MP which stated that merit should be the only criterion for admission in medical colleges and that there is a requirement of excellence in medical education.

The judgment in review goes against this by holding: While the country certainly needs world class doctors, surgeons, specialists and others connected with health care, the country also needs committed “barefoot doctors”, who are committed and are available to provide medical services and health care facilities in different areas as part of their mission in becoming doctors.

That the judgment has considered ground realities in this aspect but has forgotten the ground realities of the economically backward students who have to travel from state to state on short notice to take entrance examinations for different colleges causing their families huge financial burden, is incongruous.

It has also not considered the fact that a patient who is receiving medical care from the doctor has a right to life and health under Article 21 and this would entail receiving care from highly competent and qualified doctors.

It is not enough that the doctors have a desire to provide medical services, they must also be competent enough to provide them. In the Atlas Cycle Industries case it was held that if there is no penalty imposed for not complying with the section then it would be directory/optional.

In the present case, neither Section 19A (2) nor the IMC Act provides as to what shall happen in the event of non-compliance with Section 19A (2).

6. What now and what’s next?

Although the judgment holding NEET unconstitutional has been recalled and
the examination is (for the time being) valid, it is unlikely that it will be conducted this year as deadlines are looming.

There is a need for an overhaul of the entire system. This can be initiated by introducing a clear cut legislation that lays down procedural guidelines and the Supreme Court can further aid the process through decisions that do not leave room for ambiguity.

During one of the hearings, senior advocate Vikas Singh, appearing for MCI, made the submission that it was high time colleges were allowed to become businesses and make profit from education. This would create natural competition in the market and drive away people who misused subsidies the government had provided to them. I agree with these submissions.

There is no reason that charitable educational institutions and educational institutions which run as businesses for profit cannot function in harmony with each other. This is a concept that is followed globally.

From
Public Health Champion Awards 2016: Dr. Paresh V. Dave
(Add. Director-Public Health, Health & Family Welfare Govt. of Gujarat)
Cricket Tournament | Anand Branch

Diagnosic Camp | Mehsana Branch

Hemophilia Patient meet | Bhavnagar Branch

Diagnosic Camp | Morbi Branch
In terms of the provisions of the Delhi Medical Council Act, 1997 and in light of the judgement dated 8th April, 2016 in W.P.(C) No.7865/2010 of the Hon'ble High Court of Delhi, it is informed that only persons who possess any of the recognized medical qualification as per First, Second or Third Schedule to the Indian Medical Council Act, 1956 and registered with the Delhi Medical Council is entitled to practice in modern scientific system of medicine (allopathy) in the NCT of Delhi.

It is further informed that qualifications of BAMS, BIMS, BUMS, Ayurvedic/ Unani / Siddha or Homeopathy are not recognized medical qualifications as per the Indian Medical Council Act, 1956, hence, holder of such qualifications are not entitled to practice modern scientific system of medicine (allopathy).

Any person practicing modern scientific system of medicine (Allopathy) in contravention of the above will render himself liable to punitive action, inter-alia, under Section 27 of The Delhi Medical Council Act, 1997, which is reproduced as under.-

Section 27. False assumption of Medical Practitioner or Practitioner under this Act to be an offence: Any person who falsely assumes that he is a medical practitioner or practitioner as defined in Clause (7) of Section 2 and practices the modern scientific system of medicine, shall be punishable with rigorous imprisonment which may extend up to three years or with fine which may extend up to Rs. 20,000/- or with both.

Dr. Arun Gupta
(President)

Dr. Girish Tyagi
(Registrar)
Medical Council of India Notification

New Delhi, the 28th January, 2016 No. MCI-211(1)/2010(Ethics)/163013:— In exercise of the powers conferred by Section 33 of the Indian Medical Council Act, 1956 (102 of 1956), the Medical Council of India with the previous sanction of the Central Government, hereby makes the following Regulations to amend the "Indian Medical Council (Professional Conduct, Etiquette and Ethics) Regulations, 2002:-

1. (i) These Regulations may be called the "Indian Medical Council (Professional Conduct, Etiquette and Ethics) (Amendment) Regulations, 2015." (ii) They shall come into force from the date of their publication in the Official Gazette.

2. In the "Indian Medical Council (Professional Conduct, Etiquette and Ethics) Regulations, 2002", the following additions/modification/deletions/substitutions, shall be, as indicated therein:-

3. (i) The title of Section 6.8, as amended vide notification dated 10/12/2009, shall be further amended by deleting the words "and professional association of doctors" as under:-

"6.8 Code of Conduct for doctors in their relationship with pharmaceutical and allied health sector industry"

(ii) Section 6.8.1. (b), as amended vide notification dated 10/12/2009, shall be substituted as under:—

(b) Travel Facilities: A medical practitioner shall not accept any travel facility inside the country or outside, including rail, road, air, ship, cruise tickets, paid vacations etc. from any pharmaceutical or allied healthcare industry or their representatives for self and family members for vacation or for attending conferences, seminars, workshops, CME programme etc. as a delegate.

(iii) Action to be taken by the Council for violation of Section 6.8, as amended vide notification dated 10/12/2009, shall be prescribed by further amending the Section 6.8.1 as under:-

6.8.1 In dealing with Pharmaceutical and allied health sector industry, a medical practitioner shall follow and adhere to the stipulations given below:-

a) Gifts: A medical practitioner shall not receive any gift from any pharmaceutical or allied healthcare industry and their sales people or representatives.

Action: Gifts more than Rs. 1,000/- up to Rs. 5,000/- : Censure
Gifts more than Rs. 5,000/- up to Rs. 10,000/: Removal from Indian Medical Register or State Medical Register for 3 (three) months.
Gifts more than Rs. 10,000/- to Rs. 50,000/- : Removal from Indian Medical Register or State Medical Register for 6 (six) months.
Gifts more than Rs. 50,000/- to Rs. 1,00,000/-: Removal from Indian Medical Register or State Medical Register for 1 (one) year.
Gifts more than Rs.1, 00,000/-: Removal for a period of more than 1 (one) year from Indian Medical Register or State Medical Register.

b) Travel facilities: A medical practitioner shall not accept any travel facility inside the country or outside, including rail, road, air, ship, cruise tickets, paid vacations etc. from any pharmaceutical or allied healthcare industry or their representatives for self and family members for vacation or for attending conferences, seminars, workshops, CME programme etc. as a delegate.

Action: Expenses for travel facilities more than Rs. 1,000/- up to Rs. 5,000/- : Censure
Expenses for travel facilities more than Rs. 5,000/- up to Rs. 10,000/-: Removal from Indian Medical Register or State Medical Register for 3 (three) months.
Expenses for travel facilities more than Rs. 10,000/- to Rs. 50,000/-: Removal from Indian Medical Register or State Medical Register for 6 (six) months.
Expenses for travel facilities more than Rs. 50,000/- to Rs. 1,00,000/-: Removal from Indian Medical Register or State Medical Register for 1 (one) year.
Expenses for travel facilities more than Rs. 1, 00,000/: Removal for a period of more than 1 (one) year from Indian Medical Register or State Medical Register.

c) Hospitality: A medical practitioner shall not accept individually any hospitality like hotel accommodation for self and family members under any pretext.
Action: Expenses for Hospitality more than Rs. 1,000/- up to Rs. 5,000/-: Censure

Expenses for Hospitality more than Rs. 5,000/- up to Rs. 10,000/-: Removal from Indian Medical Register or State Medical Register for 3 (three) months.

Expenses for Hospitality more than Rs. 10,000/- to Rs. 50,000/-: Removal from Indian Medical Register or State Medical Register for 6 (six) months.

Expenses for Hospitality more than more than Rs. 50,000/- to Rs. 1,00,000/-: Removal from Indian Medical Register or State Medical Register for 1 (one) year.

Expenses for Hospitality more than Rs. 1,00,000/-: Removal for a period of more than 1 (one) year from Indian Medical Register or State Medical Register.

d) Cash or monetary grants: A medical practitioner shall not receive any cash or monetary grants from any pharmaceutical and allied healthcare industry for individual purpose in individual capacity under any pretext. Funding for medical research, study etc. can only be received through approved institutions by modalities laid down by law/rules/guidelines adopted by such approved institutions, in a transparent manner. It shall always be fully disclosed.

Action: Cash or monetary grants more than Rs. 1,000/- up to Rs. 5,000/-: Censure

Cash or monetary grants more than Rs. 5,000/- up to Rs. 10,000/-: Removal from Indian Medical Register or State Medical Register for 3 (three) months.

Cash or monetary grants more than Rs. 10,000/- to Rs. 50,000/-: Removal from Indian Medical Register or State Medical Register for 6 (six) months.

Cash or monetary grants more than Rs. 50,000/- to Rs. 1,00,000/-: Removal from Indian Medical Register or State Medical Register for 1 (one) year.

Cash or monetary grants more than Rs. 1,00,000/-: Removal for a period of more than 1 (one) year from Indian Medical Register or State Medical Register.

e) Medical Research: A medical practitioner may carry out, participate in, work in research projects funded by pharmaceutical and allied healthcare industries. A medical practitioner is obliged to know that the fulfilment of the following items (i) to (vii) will be an imperative for undertaking any research assignment/project funded by industry-for being proper and ethical. Thus, in accepting such a position a medical practitioner shall:

(i) Ensure that the particular research proposal(s) has the due permission from the competent concerned authorities.

(ii) Ensure that such a research project(s) has the clearance of national/state/institutional ethics committees/bodies.

(iii) Ensure that it fulfils all the legal requirements prescribed for medical research.

(iv) Ensure that the source and amount of funding is publicly disclosed at the beginning itself.

(v) Ensure that proper care and facilities are provided to human volunteers, if they are necessary for the research project(s).

(vi) Ensure that undue animal experimentations are not done and when these are necessary they are done in a scientific and a humane way.

(vii) Ensure that while accepting such an assignment a medical practitioner shall have the freedom to publish the results of the research in the greater interest of the society by inserting such a clause in the MoU or any other documents/agreement for any such assignment.

Action: First time censure, and thereafter removal of name from Indian Medical Register or State Medical Register for a period depending upon the violation of the clause.

f) Maintaining Professional Autonomy: In dealing with pharmaceutical and allied healthcare industry a medical practitioner shall always ensure that there shall never be any compromise either with his/her own professional autonomy and/or with the autonomy and freedom of the medical institution.

Action: First time censure, and thereafter removal of name from Indian Medical Register or State Medical Register.
g) Affiliation: A medical practitioner may work for pharmaceutical and allied healthcare industries in advisory capacities, as consultants, as researchers, as treating doctors or in any other professional capacity. In doing so, a medical practitioner shall always:

i. Ensure that his professional integrity and freedom are maintained.
ii. Ensure that patients' interests are not compromised in any way.
iii. Ensure that such affiliations are within the law.
iv. Ensure that such affiliations/employments are fully transparent and disclosed.

Action: First time censure, and thereafter removal of name from Indian Medical Register or State Medical Register for a period depending upon the violation of the clause.

h) Endorsement: A medical practitioner shall not endorse any drug or product of the industry publicly. Any study conducted on the efficacy or otherwise of such products shall be presented to and/or through appropriate scientific bodies or published in appropriate scientific journals in a proper way.

Action: First time censure, and thereafter removal of name from Indian Medical Register or State Medical Register.

Dr. Reena Nayyar, Secy. I/c.

(ADV.-III/4/Exty./100/347)

The Principal Regulations namely, "Indian Medical Council (Professional Conduct, Etiquette and Ethics) Regulations, 2002" were published in Part - III, Section (4) of the Gazette of India on the 6th April, 2002, and amended vide MCI notification dated 22/02/2003, 26/05/2004 & 10/12/2009.

IMA Brings Relief to Medical Profession Under PNDT Act

Brief note on the judgment dated 17.02.16 passed by Hon'ble High Court, Delhi, in the matter of "Indian Medical Association vs Union of India: WP (C) NO. 2721/2014"

On 09.01.14, the Union of India amended the PNDT Rule, vide Notification No. DL 33004/99 whereby under the amended Rules, the Qualified Doctor/MBBS/ Sonologist/Imaging Specialist desirous of setting up a Genetic Clinic/Ultrasound Clin/Imaging Centre is to undergo 6 months training imparted in the manner prescribed in the Six Months Training Rules 2014.

As the amendment in the PNDT Rules, would take away the vested rights of Qualified Doctor/MBBS/ Sonologist/Imaging Specialist to operate Genetic Clinic/Ultrasound Clinic/Imaging Centre and would not serve any purpose as far as scope of the PNDT Act is concerned and the same is also not in the interest of doctors around the country, therefore, IMA took up the said issue of National Importance and challenged the same before the Hon'ble High Court of Delhi at New Delhi, vide WP (C) No. 2721/2014.

As the issue raised by the 1MA was of great importance, National Issue and there was no chance for any margin of error, therefore IMA engaged Mr. Jayant Shushan, Senior Advocate (well renowned advocate of the Country) to contest the matter.

IMA on person level of the office bearer took part in the proceedings of the said case before the Hon'ble Court and also provided help to the legal team in issue related to the medical field and were practically present in each and every hearing.

The matter was argued for 6-7 hearings and Mr Jayant Bhushan, Sr Adv raised the following legal issues:

i. That prior to coming into force of the PNDT Act, even a person having a degree of MBBS, not necessarily of MD (Radiology) operate a ultrasound machine;

ii. That Section 2(p) of the Act also includes in the definition of sonologist or imaging specialist, every such person who holds a medical qualification recognized by the MCI, again recognizing persons holding the MBBS qualification as sonologist and imaging specialist;
iii. That there is no post-graduate qualification in ultrasonography or in imaging techniques;

iv. That under Section 32 of the Act the power of the Central Government to make Rules extends only to make rules for minimum qualifications of persons employed at the registered genetic counseling centre, genetic laboratory or genetic clinic and not to make rules for persons employed at ultrasound clinics;

v. That the technique of ultrasound is used for diagnostic purpose qua various organs and not only for sex determination and thus all clinics using ultrasound machines would not qualify as genetic clinics;

vi. Instance is given of specialist hospitals/clinics dealing with specific organs, say heart, lung or liver and it was contended that they also use ultrasound machine but can by no stretch of imagination be called a genetic clinic;

vii. That the requirement, in Rule 3(3)(1)(b) as amended with effect from 9th January, 2014, of 6 months training can only be qua registered medical practitioners as defined in Rule 2(ee) of the Drugs and Cosmetics Rules, 1945 and cannot possibly be qua those who qualify as sonologist within the meaning of Section 2(p) of the Act;

viii. Alternatively, Rule 3(3)(1)(b) has to be confined to the genetic clinics only and cannot be extended to ultrasound clinics; all ultrasound clinics are not genetic clinics; those who have been practising as a radiologist or have been using ultrasound for 10 of years cannot be asked to undergo 6 months training or take any test, as the same cannot take the place of their experience of decades;

ix. The issue raised by amending the PNDT Act, are of moral issues and not legal, therefore amendment is itself bad.

x. That the amendment of Rule 3(3)(1)(b) w.e.f. 9th January, 2014 takes away the 1 year experience in sonography or image scanning as existed earlier and thus Rule 6(2) of the Six Months Training Rules is bad; and

xi. That under Rule 8 there was/is a right of renewal of registration; the amendment w.e.f. 9th January, 2014 takes away the said right; reliance is placed on GP Singh's Interpretation of Statutes to urge that interpretation rendering certain words otiose, cannot be adopted and on Dr Indramani Pyarelal Gupta Vs. WR Nathu AIR 1963 SC 274

laying down that the Central Government as a delegate of the legislature, without being specifically empowered can only make Rules having prospective operation and not with retrospective effect.

It is relevant to point out that Indian Radiological and Imaging Association (IRIA) petitioner in the WP (C) No. 6968/2011 argued against IMA and contended that the petition filed on behalf of IMA should be dismissed.

On the other hand, Sonologist Society of India, petitioner in the WP (C) No. 3184/2014 adopted the arguments of the IMA.

After considering the issue raised by IMA in the WP (C) No. 2721/2014 the Hon'ble High Court came to the conclusion that the PNDT Act, raised a moral issue rather than a legal issue in relation to sex determination by the doctors and any further qualification to already Sonologist/ Imaging Specialist in relation to same may not serve any purpose. The relevant para from the judgment delivered by the Hon'ble High Court is reproducing as under:-

"We are of the opinion that for the purposes of prevention of sex determination through ultrasound machines or other radiological techniques, it matters not whether the ultrasound machine is in the hands of an MBBS or an MBBS with six months training or an MBBS with one year experience who has cleared the competency test or in the hands of MD radiologist/ obstetrics. The qualification of MBBS itself is a highly sought after qualification, to secure which one has to first appear in a competitive examination for admission to a medical college and thereafter has to undergo the rigours of passing the MBBS examination. By no stretch of imagination can it be said that an MBBS qualified person lacks education or understanding to be not able to comprehend the fatal consequence of female foeticide as a result of sex determination or the morality behind the same. In our opinion, to understand the said aspects, the 1 year experience or passing the competency test or undergoing the 6 months training or acquiring the post-graduate qualification, add no further to the person. To make an as educated a person as a "Doctor" understand the ill effects of sex determination and that use thereof for the purposes of female foeticide is a crime, there is no need to require him either to undergo post-graduation or a 6 months training or gain a 1 year experience or pass a competency test. By doing so, he will not be less likely to break the said law than he would be without the same. It is not as if holding a medical qualification recognized by
MCI does not have any concern with the conduct/behavior of the holder thereof. The holder thereof is required to abide by the standards of professional conduct and etiquette and code of ethics prescribed by MCI in exercise of power under Section 20A of the MCI Act. Moreover, when the holder of medical qualification is capable of being sensitized with the code of conduct/etiquette/ethics, he/she can certainly be sensitized to the issue of PNDT without being required to undergo any training/experience.

Further, after detailed discussion before the Hon'ble High Court of the issued raised by the IMA, the Hon'ble High Court allowed/disposed off the Writ Petition of IMA with the following declarations/directions:-

i. That Section 2(p) of the PNDT Act defining a Sonologist or Imaging Specialist, is bad to the extent it includes persons possessing a postgraduate qualification in ultrasonography or imaging techniques — because there is no such qualification recognized by MCI and the PNDT Act does not empower the statutory bodies constituted thereunder or the Central Government to devise and coin new qualification; Meaning thereby as per the definition Under Section 2(p) of the PNDT Act a MBBS is a sonologist or Imaging Specialists.

ii. The PNDT Act/Rules does not apply to the MBBS doctor who gives a declaration that they will not be using the ultrasound machine for sex determination or prenatal diagnostic procedure.

iii. Rule 3(3)(1)(b) of the PNDT Rules (as it stands after the amendment with effect from 9th January, 2014) is ultravirus to the PNDT Act to the extent it requires a person desirous of setting up a Genetic Clinic/Ultrasound Clinic/Imaging Centre to undergo 6 months training imparted in the manner prescribed in the Six Months Training Rules.

The relevant paras from the judgment are reproduced herein under for ready reference:

"98. We accordingly dispose of these petitions with the following declarations/directions:

i. That Section 2(p) of the PNDT Act defining a Sonologist or Imaging Specialist, is bad to the extent it includes persons possessing a postgraduate qualification in ultrasonography or imaging techniques — because there is no such qualification recognized by MCI and the PNDT Act does not empower the statutory bodies constituted thereunder or the Central Government to devise and coin new qualification;

ii. We hold that all places including vehicles where ultrasound machine or imaging machine or scanner or other equipment capable of determining sex of the foetus or has the potential of detection of sex during pregnancy or selection of sex before conception, require registration under the Act;

iii. However, if the person seeking registration (a) makes a declaration in the form to be prescribed by the Central Supervisory Board to the effect that the said machine or equipment is not intended for conducting prenatal diagnostic procedures; (b) gives an undertaking to not use or allow the use of the same for prenatal diagnostic procedures; and, (c) has a "silent observer" or any other equipment installed on the ultrasound machines, as may be prescribed by the Central Supervisory Board, capable of storing images of each sonography tests done therewith, such person would be exempt from complying with the provisions of the Act and the Rules with respect to Genetic Clinics, Genetic Laboratory or Genetic Counseling Centre;

iv. If however for any technical reasons, the Central Supervisory Board is of the view that such "silent observer" cannot be installed or would not serve the purpose, then the Central Supervisory Board would prescribe other conditions which such registrant would require to fulfill, to remain exempt as aforesaid;

v. However such registrants would otherwise remain bound by the prohibitory and penal provisions of the Act and would further remain liable to give inspection of the "silent observer" or other such equipment and their places, from the time to time and in such manner as may be prescribed by the Central Supervisory Board; and,

vi. Rule 3(3)(1)(b) of the PNDT Rules (as it stands after the amendment with effect from 9th January, 2014) is ultravirus the PNDT Act to the extent it requires a person desirous of setting up a Genetic Clinic/Ultrasound Clinic/Imaging Centre to undergo 6 months training imparted in the manner prescribed in the Six Months Training Rules."

With the above finding, the is disposed off in favor of IMA.

IMA hereby congrats all members of IMA for great success.

Courtesy: IMA NEWS
ABSTRACT

The changing face of the doctor-patient relationship has once again brought forth the importance of consent in medical practice. At present, the written informed consent from patient admitted in the hospital is taken as per the format prescribed by the Indian Council of Medical Research (ICMR). Due to the phenomenal increase in the number of negligence suits against the medical personnel as a result of partial or lack of consent, it has once again become imperative to understand the legal issues and their implications along with the remedies to safeguard the medical man. The impetus in the present scenario is on informed consent and greater stress is being paid on the patient autonomy in making decisions regarding the treatment options available. It is important to take a valid consent, considering the competence, understanding and voluntariness of the patient and disclosing all information that will help the patient in judging the facts and coming to a reasonable conclusion. Failure of obtaining express written consent can lead to various legal issues like lawsuits for physical assault, indecent assault and negligence. The suits of negligence were being judged against the prescribed standards of care of the medical profession by taking evidence of medical men of repute. The judgments, recently have not considered the doctors’ opinion in deciding certain cases of negligence emphasizing on the changing trend in the judiciary and the increasing need of the doctors to protect them legally. This paper emphasizes and elaborates upon the role of written informed consent from the patient admitted in hospital vis-a-vis recent interpretation by the Indian legal system.

Keywords: Consent, Indian legal system

CASE REPORT

A 52-year-old male was operated for cholecystectomy on 03/12/2010 in Muzaffarnagar. The patient did not recover from the surgery, was transfused 2 units of blood and when the condition kept on deteriorating the relatives were advised to bring the patient to Delhi. He was admitted in Safdarjung Hospital on 07/12/2010 with complaints of abdominal distension and no passage of feces and flatus for 5 days. He died during the course of treatment. The relatives alleged that no written informed consent was obtained from them and the operating surgeon performed the surgery in their absence, while they had gone to arrange for money. They filed a complaint against the surgeon and a medicolegal case was recorded against the doctor (Fig. 1). The importance of informed express written consent is highlighted, especially since only that could have disproved the allegations. An understanding of consent and its ethical and legal implications is very important if the medical personnel want to develop a healthy doctor-patient relationship and also to safeguard against legal actions. The two most important issues to be considered while studying consent are, clinical and legal.

Figure 1. The allegation made by the relatives.

Clinical issues

The clinical issues deal with obtaining the trust and confidence of the patient. This is a “fiduciary relationship” and it becomes imperative for the doctors to uphold the faith held by their patients in them. It assists the sufferer in discussing his condition with the doctor and aids the doctor in treating the patient in the best possible way. The thrust in the present scenario is on informed consent. Consent is termed as informed when it is given after full understanding of the situation in hand and after due consideration of all available options by the patient. Whether the patient is competent enough to give consent is an integral part of informed consent. A mentally challenged individual or a child who does not have sufficient maturity of understanding cannot give a valid consent. The doctor is to disclose all the information known by him to the patient, who then chooses the alternative which appeals best to him.
However, there are limitations in the quantity of information that can be disclosed and is best understood by the following example. Suppose an inguinal hernia repair surgery is to be undertaken; it can be done under a spinal anesthesia as well as general anesthesia. If spinal anesthesia is opted for, then what drugs would be used and what are the side effects of the drugs? If it is converted to general anesthesia during the surgery, then what should be the course taken? Whether mask ventilation or incubation will be done? etc.

It is nearly impossible to discuss all the conditions that may arise during a procedure and therefore almost impossible to attain full disclosure and full understanding. However, the greater the harm involved, the more is the information that should be disclosed and greater the discussion should be there between the doctor and the patient. A number of suits have been brought against the medical professional as they have not disclosed adequate information.

In another case of Sidaway v. Bethlehem Royal Hospital Governors (1985), the plaintiff sued the hospital as the risk of spinal damage during spinal decompression procedure was not disclosed to her. The patient developed paraplegia after the decompression procedure. However, the case was dismissed by the court specifying that the doctor need not disclose the information, which he supposes a normal person usually knows.

Any misconception that the patient may have with regards to treatment should be resolved by the treating consultant. The doctor should not be dogmatic about his beliefs and treatment, and should not impose them on the patient. Information manipulation is one of the ways by which doctors impose their wishes on patients. They do not reveal whole information or reveal it in such a way that the patient is bound to think that this is the best approach. Many authors name this approach as ‘ paternalism.’ Consent obtained in such a manner is not valid as it may be due to misrepresentation of facts or due to influence.

More recently, various novel judgments and cases have led to a wider approach regarding the issue of influence by the doctors towards consent of the patients. In Chappel v. Hart (1998), though the surgery was performed as per standards prescribed and there was no evidence of negligence, still the claim of not delaying the surgery as desired by the complainant till a more experienced surgeon was available led to the decision being made in favor of complainant.

In Chester v. Afshar (2004), the complainant only had to satisfy court that though she would have undergone surgery it would not have been at that time and that she would have sought another opinion regarding the surgery, was enough to convince the court to favor the complainant. There are other models of consent that are also becoming prevalent in various countries. One of them is the consumerist model and the other is the cooperative model. Now, what is the role of patients in deciding the treatment to be instituted to them? As per the author's opinion, undue stress is placed on the concept and principle of patient autonomy (consumerist model).

This principle presently is being taken as the ace principle and all other principles of patient care have been sidelined. It is important to understand that the patient may not fully understand the medical issues inspire of the doctor's efforts and may decline a treatment, which would have been in his best interest. There may be situations in which the patient's relatives due to their inherent ulterior motives may deny definitive life-saving treatment to the patient. What is the role of the doctor then? Can he forcefully administer treatment or not? As per the authors' opinion, the best model of approach is the collaborative model. The patient-doctor relationship plays an important role in convincing the patient and their attendees to take the treatment in the interest of the patient. This forms the basis of collaborative model in which the doctor and the patient make a combined effort to reach the desired result.

Legal Issues

There are legal issues concerning written informed consent. It is a punishable act if medical personnel touch the patient without written informed consent except in cases of emergency when the act is done in good faith (Sec 92 Indian Penal Code [IPC]). The patient may charge the doctor for assault, indecent assault or negligence. Many surgeons take what may be referred to as blanket consent for a particular operative or surgical procedure. The written informed consent obtained does not specify a particular instance, which would be done or followed. Of course, the medical man is free to use his discretion during the emergency but in an elective setting, this is what a surgeon should refrain from doing.

If a doctor performs a surgery for appendix and finds a diseased uterus, for which the female may require to undergo hysterectomy in future and thinking that an operation can be avoided in the best interest of the patient, removes the uterus, may be charged with assault, if either the written informed consent is not taken from the patient or her attendees for removal of uterus or even if a blanket consent is taken and the procedure, which is going to be done is not specified in the written informed consent. It is labeled as negligence and the patient may claim damages in a civil suit if no harm has been done to him and in a criminal court if he has suffered some harm. Sections 87-92 of IPC deal with the issues of written informed consent. They give the age for written informed consent to be 12 years for general examination of the individual and give the age for written informed consent as 18 years for any procedure, which may endanger life. Consent for performing any surgical procedure is held as null and void as per Section 91 IPC, for example, if the written informed consent is taken to cause criminal abortion of the person, the consent will be invalid.

DISCUSSION

As described earlier the consent should preferably be express written informed consent. The express consent works in favor of the doctor. If the consent is not there; however, the courts decide the case on the basis of merit. This is especially seen in a recent case of Nizam's Institute of Medical Sciences Vs Prasanth S Dhananka. Prasanth was an aspirant engineer who was operated for a tumor of vertebral body in Nizam's Institute of Medical Sciences. Due to surgery, the patient suffered from paraplegia of both lower limbs. The complainant (Prasanth S Dhananka) 2009, first filed the case in the National Commission with his grievances being the complications of the surgery were not explained to him. The commission decided that it was not possible for the father to give consent for the procedure unknowingly and he would have known the duration of the procedure and hence the associated complications.
The complainant was given a nominal amount as compensation. Prasanth subsequently appealed in the Supreme Court. The court in its judgment noted that the hospital did not file the requisite papers in the court on time and also that the consent taken was not express. It, therefore, decided the point on its merit and came to the conclusion that the consent obtained was not informed. It finally awarded a compensation of Rs 1 crore to the complainant. The case clearly outlines the fact that to safeguard their interests, the medical personnel should take express and informed consent in each and every procedure and refrain from taking blanket consent.

Recent Outlook of Judiciary Towards Medical Negligence

Until recently, the Supreme Court of India framed guidelines regarding the arrest of doctors in a suit of negligence, in which it was specifically said that a panel of doctors or another doctor of repute will decide on the case of omission or omission to be labeled as negligence. In 2009, Justice Markandey Katju, in the case of Martin E D'Souza v. Mohd. Ishfaq, directed that the opinion of doctors is to be taken before filing a case of negligence against the doctor - "We, therefore, direct that whenever a complaint is received against a doctor or hospital by the Consumer Fora (whether District, State or National) or by the Criminal Court then before issuing notice to the doctor or hospital against whom the complaint was made the Consumer Forum or Criminal Court should first refer the matter to a competent doctor or committee of doctors, specialized in the field relating to which the medical negligence is attributed, and only after that doctor or committee reports that there is a prima facie case of medical negligence should notice be then issued to the concerned doctor/hospital. We further warn the police officials not to arrest or harass doctors unless the facts clearly come within the parameters laid down in Jacob Mathew's case (supra), otherwise the policemen will themselves have to face legal action."

However, in V. Kishan Rao v. Nikhil Super Speciality Hospital & others, 2010,7 a higher bench of the Supreme Court itself noted that the fora is not bound to accept the opinion of the doctors or to refer the case to the doctors for opinion - "This Court however makes it clear that before the Consumer Fora if any of the parties wants to adduce expert evidence, the members of the Fora by applying their mind to the facts and circumstances of the case and the materials on record can allow the parties to adduce such evidence if it is appropriate to do so in the facts of the case. The discretion in this matter is left to the members of Fora these questions are to be judged on the facts of each case and there cannot be a mechanical or strait jacket approach that each and every case must be referred to experts for evidence. In most of the cases, the question whether a medical practitioner or the hospital is negligent or not is a mixed question of fact and law and the Fora is not bound in every case to accept the opinion of the expert witness."

CONCLUSION

These instance thereby show that the judiciary is increasingly taking an independent view in the matters of negligence and also broadening their horizons. Thus, the medical fraternity is in for tough times if they do not take up the issues of consent seriously, especially in taking express written informed consent.

REFERENCES

Dear Branch Secretary

I hope that this circular finds you in the best of health and spirit. In continuation of my circular A-11/HFC/LM/2016-2017, further tabulated information is given below for the revision of fees effective from 1/4/2016. Herewith I am sending the copy of I.M.A. H/Q fee schedule regarding revised fees.

<table>
<thead>
<tr>
<th>CATEGORY</th>
<th>HFC</th>
<th>GMJ</th>
<th>GSB</th>
<th>ADM.FEE</th>
<th>TOTAL TO BE SENT TO GSB.IMA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual Single:</td>
<td>391-00</td>
<td>25-00</td>
<td>10-00</td>
<td>20-00</td>
<td>446-00</td>
</tr>
<tr>
<td>Annual Couple:</td>
<td>586-00</td>
<td>38-00</td>
<td>20-00</td>
<td>30-00</td>
<td>674-00</td>
</tr>
</tbody>
</table>

Local branch share to be collected extra as per individual branch decision/resolution. Kindly note that fees at old Rates will be accepted up to 31/03/2015 only at State Office. Thereafter the new revised rates will be applicable.

<table>
<thead>
<tr>
<th>CATEGORY</th>
<th>TOTAL FEES</th>
<th>BR.SHAHRE</th>
<th>ADM.FEES INCLUDING GSB.IMA</th>
<th>TO BE SENT TO GSB.IMA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Single</td>
<td>8095-00</td>
<td>760-00</td>
<td>[ 20-00 ]</td>
<td>Rs. 7335-00</td>
</tr>
<tr>
<td>Couple</td>
<td>12050-00</td>
<td>1200-00</td>
<td>[ 30-00 ]</td>
<td>Rs. 10850-00</td>
</tr>
</tbody>
</table>

Kindly send fees of old annual member, which should reach this office before 30/4/2016. Membership Fees by a D.D. drawn in favour of G.S.B. I.M.A.

<table>
<thead>
<tr>
<th>I.M.A. COLLEGE OF GENERAL PRACTITIONERS</th>
</tr>
</thead>
<tbody>
<tr>
<td>College of G.P</td>
</tr>
<tr>
<td>Life Membership</td>
</tr>
<tr>
<td>Payable at Chennai and send to us</td>
</tr>
</tbody>
</table>

Kindly send annual membership fees before 30/4/2016 so as to avoid deletion. The above increase of fee Rs. 50.00 in Life Member every year is computed as per the resolution passed in 41st State Council at Nadiad on 12/05/1989.

Yours Sincerely

(Dr. Jitendra N. Patel)
Hon. State Secretary