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GUJARAT MEDICAL JOURNAL

INDIAN MEDICAL ASSOCIATION, GUJARAT STATE BRANCH

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STATE PRESIDENT'S MESSAGE



Dear IMA GSB Friends,

Seasons' Greetings. Wishing you Happy RathYatra in advance.

Increasing problems in medical field are becoming new challenges for all of us. Especially, large number of doctors graduating every year, low health budgets of governments, less and unfilled medical posts, unfilled

PG seats, extremely expensive medical education, unhealthy competition, violence against doctors leading to fearsome work environment, inadequate law & legal protection... now it is high time that we must bring these issues to hall governments. Although, we don't want to, but we are forced to go on strike by such unresolved issues.

Our medical system is world famous for ease of access and affordable healthcare. As a country and society, it is It is our collective responsibility to maintain the best aspects of Indian medical system.

Career options for young medical graduates ; should we worry about them?

Young medical graduates are the real pillars of our community, that will serve the nation in coming years. They will be the custodians of the nation's health. We have focussed on opening out more and more medical colleges in the country but without really worrying for these young medical graduates, especially those who decide to offer primary care to the society as family practitioners.

India produces approximately 67000 MBBS graduates every year. In addition, some 20000 Indian medical students after completing Foreign Medical education from Russia, China, Philippines and other countries return to India every year. Even if, only 15% clear the Foreign Medical Graduates exam, that still makes the number of qualified and licensed MBBS doctors produced yearly at over 70000. This is a huge number of medical talent pool available to us.



Government, which is the largest employer has 1750 vacancies every year for MBBS to work in Primary Health Centres. About similar number is also employed yearly by various Government agencies like railways, ESI, PSUs, army and other public institutions. This leaves over 65000 MBBS doctors looking for career opportunities every year. A very few could find options in research, teaching, hospital management, pharma companies and unconventional sectors such as information technology supporting back end medical work. A tiny number would also go abroad for a better future.

Many of these graduates would join post graduation, but even with the increased number of seats still about 35000 MBBS doctors yearly who remain searching for career options or unemployed. Since the number of PG seats was limited to about half the current strength upto 2 years ago there is a backlog of previous years which adds to this number which is evident as nearly 1 lac MBBS doctors appearing for NEET PG entrance exam every year. These 35000 doctors and of course the backlog (who do not clear NEET) have to join some small or large private hospitals as resident doctors for a few months to few years but this may not be a final career option for a MBBS who has put in hard work in completing MBBS education.

There is actually no permanent career, in being a resident doctor however good in clinical skills you may be. This is not a permanent job in a private sector with a regular pay scale and yearly increments and / or stock options as their colleagues in some other industry are lucky to get! Ultimately, after some time a resident doctor is expected to move on. This is where the problem arises. Those graduates who are left without a post-graduation , have tried multiple attempts to crack the NEET PG, done residents job for 3- 4 years or so and are not beneficiaries of any reservation so have not got any Government Job, are the ones who are most vulnerable. Having reached an age of about 28 – 30 years they are expected by their families and friends to have “settled” by that age but they are adrift with no sense of direction.

Setting up a private practice is easier said than done. To set up a GP practice in a city is no longer a financially viable option for them. Costs are prohibitive in cities and the GP space in suburbs, small towns and villages is firmly occupied



by entrenched Government approved quacks and crosspaths. To do in Rome as Romans do, the MBBS in small towns and villages would have to resort to the tricks and fraudulent actions of those around them to survive in the quagmire, but then that is not practice of medicine in true sense. Many youngsters leave the profession to join IT firms doing medical transcription, others join pharma industry, some try for civil services others opt for management career.

The super specialist culture deeply prevalent in India today encourages treatment of organs rather than the human body. The role of MBBS in clinical practice has been gradually but surely emasculated to the level that a catheterization is to be done by a urologist and an ECG by a cardiologist. We are moving from superspecialities to super super specialities. A DM Gastroenterology today needs a further fellowship to perform EUS and so also POEM and other specialized procedures. In this environment, the role of MBBS in clinical practice today is that of a glorified clerk and plebotomist. The turf war among specialists has led to a situation where despite being a graduate in medicine and surgery the MBBS can neither practice medicine nor surgery, obstetrics, ENT, Eye or any other field which today is defined as a speciality. Interestingly, our courts have contributed their might to creating this mess.

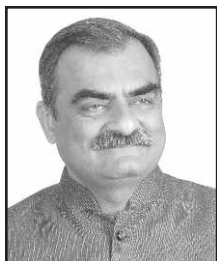
Unfortunately, this weakest segment of our profession is the one, which is least heard in the innumerable conferences and meetings of the professional associations. Is it not our responsibility as seniors to secure the professional needs of your youngsters? But then we are too busy trying to build and run our own practices, to be bothered about such mundane matters. Should we not have our first and foremost demand as creation of more regular posts for MBBS doctors to serve in our country? The government and the society continue to worry about the dearth of the doctors but are loathe to provide them a stable career option as doctors to the community.

Jay IMA, Jay Garvi Gujarat, Jay Hind.

Dr. Mahavirsinh M. Jadeja
President, G.S.B., I.M.A.



HON. STATE SECRETARY'S MESSAGE



Dear Members,

"Be the Hero Your Village Needs: Embrace the 'Aao Gao Chale' Movement and Transform Lives!"

We hope this message finds you in good health and high spirits. We are reaching out to you today to extend an invitation to be a part of a noble cause that aims to transform healthcare in rural India.

As you may be aware, the Indian Medical Association has initiated the **"Aao Gaon Chalen"** movement which seeks to **improve the health status of underserved communities in rural areas**. This community project focuses on providing essential healthcare services, promoting preventive medicine, and emphasizing mother and child health to ensure a healthier future for all.

“जनसेवा प्रभुसेवा है”

We believe that your esteemed association, with its dedicated members and expertise, can make a significant impact by adopting a village and actively participating in this movement. **By adopting a village, you will have the opportunity to directly contribute to the well-being of the community and bring about positive change.**

Here's how you can be a part of this transformative endeavor:

1. **Assess your Member Strength:** Evaluate the number of doctors and healthcare professionals within your association who are willing to volunteer their services for the **"Aao Gaon Chalen"** movement.
2. **Identify a Village:** Choose a village that is in need of healthcare support and aligns with the capabilities and resources of your association.
3. **Engage with the Local Community:** Establish connections with the villagers, community leaders, and local healthcare providers to understand their specific healthcare needs and challenges.



4. **Plan and Execute:** Develop a comprehensive plan that includes regular medical camps, health education programs, preventive care initiatives, and special focus on mother and child health.
5. **Mobilize Resources:** Collaborate with local stakeholders, organizations, to secure necessary resources, equipment, and infrastructure to support your adopted village.
6. **Monitor and Evaluate:** Continuously assess the impact of your initiatives, monitor health outcomes, and make necessary adjustments to maximize the effectiveness of your efforts.

By adopting a village, your association will not only provide much-needed medical services but also foster a sense of belonging and community empowerment. **Together, we can create a network of compassionate healthcare professionals working towards the betterment of rural India.**

Join us in this noble cause, and let's make a tangible difference in the lives of those who need it the most. **For more information and guidance on adopting a village, please reach out to us.**

Thank you for your consideration and dedication to the well-being of our nation's rural communities.

Another essential component that needs our attention is blood donation. A blood service that gives patients access to safe blood and blood products in sufficient quantity is a key component of an effective health system. This year the IMA plans to organise blood donation camps and awareness programs to make people aware of the need of blood especially at critical times.

The global theme of **"World Blood Donor Day"** changes each year in recognition of the selfless individuals who donate their blood for people unknown to them. The slogan this year is

"Give blood, give plasma, share life, share often."

Dr. Mehul J. Shah
Hon. State Secy., G.S.B., I.M.A.



INDIAN MEDICAL ASSOCIATION (HQs.)

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Ref. No.

3-5-2023

To,

All Local Branches Presidents & Secretaries,

All State Working Committee Members.

Dear Colleague,

Sub : Request to adopt atleast one village in your Branch under IMA Aao Gaon Chalen Project

Greetings from IMA, Gujarat State Branch.

As you know, our beloved leader and Chief Patron, Dr Ketan Desai launched "Aao Gaon Chalen" a dream Project of IMA in 2003 in Mehsana (Gujarat). To increase the Doctor-Patient Relationship and Doctor Community Services in good spirit. Now once again, this project is re-launched as the main theme with full enthusiasm and spirit.

It was emphasised upon Local Branches of IMA to adopt at least one village following their jurisdiction under this esteemed project and were requested to conduct various activities on regular basis like :- Public Awareness Camps on Anaemia, General diagnostic camps for screening of various diseases, side effects of Tobacco, various drugs and alcohol addiction, sexually transmitted diseases and emphasis of cleanliness etc. for organizing such camps. The information in this regard from the States / Local Branches are still awaited.

The Goal of the project is to bring about holistic improvement in the village health scenario using existing infrastructure and promoting inter-sectoral coordination & networking through active involvement of IMA, Public Sector health delivery system and the community. We have not received any information from your Local Branch so far as you have adopted any village or not. Kindly look into it and send us a reply through your State Branch at the earliest.

We are pleased to inform you that a mega launch of IMA Aao Gaon Chalen Project will be organized by IMA HQs. all over the country on 25th June, 2023. You are requested to kindly plan your activities to be done on the above date in the village being adopted by your Branch. Kindly also arrange for media coverage of your activities for the wider publicity of this dream project.

In this regard, a prompt communication from all the Local Branches of IMA is highly expected.

Thanking you and with kind regards,

Yours sincerely,

Dr. Sharad Kumar Agarwal
National President, IMA

Dr. Anilkumar J. Nayak
Hony. Secretary General, IMA

Dr. Mahavirsinh M. Jadeja
President, G.S.B., I.M.A.

Dr. Bipin M. Patel
Chairman, Aao Gaon Chalen
IMA, HQs

Dr. Mehul J. Shah
Hon. State Secy., G.S.B., I.M.A.



CONCEPT NOTE ON AAO GAON CHALEN

Aao Gaon Chalen has been an important initiative of IMA to reach the community with multiple healthcare and allied services, and launched by our leader Dr. Ketan Desai in 2004. Its purpose has been to increase our reach to the community, proper documentation of services that are being provided by us and their projection to the Govt. by quantifying the net total of our services for the last 19 years. Some States have performed very well over the years but other states did not do much activity in a proper way. IMA (HQs.) has taken up this project again in a big way and we are trying to reach atleast 1700 villages of the country through the State leadership so that each one of them can adopt one village and provide multiple healthcare activities on a regular basis.

How to adopt a village :-

- Select a village or cluster or urban slum near to the branch jurisdiction.
- Select an area where deficiency in the form of health services, water and sanitation services, family welfare, immunization are inadequate.
- Discuss with Local Administration, Municipal Health department about existing gaps in the area where IMA can pitch in.
- You will realize many villages have been adopted by various Members of Parliament under the Prime Minister monitored schemes which can be adopted by us.

Purpose :-

- IMA would be providing only complimentary support to help the local authorities to achieve health and other health related indicators.
- A brief health survey of the area should be taken up to understand their requirements.
- Organize a meeting with community levels stakeholders to understand their needs.
- Meet local Govt. officials and health authorities and coordinate with them.
- Work out an execution plan whereby we are providing a sustainable activity and not just a one time or one month activity.
- Identify team of dedicated, willing IMA workers who would be ready to work on a continuous basis.
- Regular review meetings should be held to fill the gap wherever there are.
- Monthly activity report should be sent to IMA (HQs.).

Suggested Activities :-

- Anemia control
- Immunization
- Pre Natal and Post Natal care



- Cancer awareness and screening
- Awareness about Hygiene, education and social welfare
- Capacity building of existing healthcare providers
- Health education
- Need of safe water Supply
- Develop a robust system for referral in all types of emergencies with the local health care institutions in and around the village

Depending upon the area and its requirements the above activities can be enlarged and many more initiatives can be taken.

Aao Gaon Chalen can be a game changer activity to change the perception of public, media and administration about Indian Medical Association and its members. It is our continued commitments that can bring change in the health care scenario of the country especially in rural area.

Reporting :-

While sending a monthly report the branch should identify the few indicators of services in the area provided by IMA and report before 7th of next month. Few illustrations can be :-

- Number of children receiving Polio Vaccination, DPT Vaccination, Measles Vaccination or Penta valent Vaccination
- The number of pregnant women registered, counselling done. TT Doses given, regular ante natal visits, iron folic tablets distribution, motivation for institutional deliveries
- Number of awareness classes on Hygiene and sanitation held.
- Number of persons attending the programs
- Number of people attending the OPD services.
- Number of patients referred to other Govt. institutions. Number of IMA doctors/health care workers providing their services, their name and contact details
- We will share with you the link for reporting your activities on a monthly basis very soon.

LET US GET STARTED

Dr. Sharad Kumar Agarwal
National President, IMA

Dr. Anilkumar J. Nayak
Hony. Secretary General, IMA

Dr. Bipin Patel
Chairman

Dr. V.K. Monga
Convenor

IMA Standing Committee for Aao Gaon Chalen

IMA Standing Committee for Aao Gaon Chalen

Dr. Mahavirsinh M. Jadeja
President, G.S.B., I.M.A.

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Date: 19-5-2023

To,

IMA State Presidents and Hony. Secretaries

IMA Local Branch Presidents and Secretaries

Dear Sir,

Greetings from Indian Medical Association HQs.

The WORLD NO TOBACCO DAY will be observed on 31st May, 2023 all over the Country.

As you all are aware, Tobacco is the most preventable cause of mortality & morbidity due to many diseases it causes, including 13 different cancers, Cardiac & respiratory diseases with nearly 1.3 million (13 lakhs) Indian people dying every year from its use.

Globally Tobacco is smoked by 1.1 billion people, while another 0.2 billion people use other tobacco products. Tobacco kills 8.67 million people globally every year. Most deaths are attributable to smoking but 1.2 million are due to non-smokers being exposed to second-hand smoke.

As a health professional it is our duty, too, to enlighten public about tobacco menace. Although, a significant number of people have now, also become aware of the health hazards of Tobacco and many of the tobacco users are interested in quitting but they need proper guidance too. We need to strengthen the knowledge of our Doctors, Nurses, Medical, Dental students in Tobacco control & Tobacco Cessation. As following the WHO "5A", the quit rate definitely increases and available pharmacotherapy also helps in doubling the quit rate.

Although e-cigarettes/ENDS are banned in our country, as per the PECA2019 act, we continue to get reports in media, of its sale at many places, which should be stopped and we should enlighten the public about the harms of ENDS, specialty to the young children.

The theme of World No Tobacco Day 2023 is "We need food, not tobacco" to raise awareness about alternative crop production and marketing opportunities for tobacco farmers and encourage them to grow sustainable, nutritious crops.

PI do arrange some awareness program for public &/or training program for health professionals in this May month.

On WNTD, State & Local Branches are advised to organise awareness rally, arrange workshops/symposium/lectures for media/public/social groups/police, give talk show on Radio/TV, Print & Distribute pamphlets, stickers, arrange oral lesion/Cancer detection camps etc.

Kindly send the activities report along with photographs to HSG (hsg@ima-india.org) and a copy to dilipacharya@gmail.com.

With kind regards

Dr. Sharad Kumar Agarwal
National President, IMA

Dr. Anilkumar J. Nayak
Hony. Secretary General, IMA

Dr. Dilip Kumar Acharya
Chairman, IMA Cancer
Prevention & Tobacco Control

Dr. Mahavirsinh M. Jadeja
President, G.S.B., I.M.A.

Dr. Mehul J. Shah
Hon. State Secy., G.S.B., I.M.A.



INDIAN MEDICAL ASSOCIATION

GUJARAT STATE BRANCH

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Ref No. A-11/HFC/LM/2023-2024

Date: 16-5-2023

Subject:- Circular of Membership Fee.

Respected Doctor,

Greetings from IMA, Gujarat State Branch.

We have received email from IMA HQs. on 11-5-2023 regarding the HFC share of membership fee for IMA Life Members will be reduced by **25% between 1st June, 2023 to 5th July, 2023, as a special drive to increase the membership of IMA.**

The last date of receiving the form / application is **10th July 2023** but the amount should have received during above period **(1st June, 2023 to 5th July, 2023).**

We would like to inform you that the below are the important information, kindly go through the same and implement at the earliest:-

Particular	GST on membership fee to be taken by Local Branches.	If the Local Branch does not have GST number, then sent the following amount to IMA GSB.	If the Local Branch has GST number, then sent the challan copy of GST paid and following amount to IMA GSB.
For Single Life Member	9216 + 1659 (GST 18%) = Total Rs. 10875-00	9216 – 623-00 (Local Branch Share) = 8593-00 + 1659 (GST 18%) = Total Rs. 10252-00	Rs. 8593-00
For Couple Life Member	13621 + 2452 (GST 18%) = Total Rs. 16073-00	13621 – 953-00 (Local Branch Share) = 12668 + 2452 (GST 18%) = Total Rs. 15120-00	Rs. 12668-00

Please send Membership Fees by a Cheque / DD. drawn in favour of
"G.S.B. I.M.A."

Yours Sincerely

Dr. Mehul J. Shah
Hon. State Secretary



Patient Blood Management- A revolutionary approach to Transfusion Medicine

Introduction

Blood transfusions can be life saving but are also associated with risks and complications. There is increased attention by professional associations and healthcare organizations to the variations of transfusion practices and overuse of blood worldwide. Further, there have been efforts to lower health care costs, improve quality of care and patient safety, thereby increasing the focus on reducing unnecessary transfusions.

The term Patient Blood Management (PBM) was first used in 2005 by Professor James Isbister, an Australian haematologist, who realised that the focus of transfusion medicine should be changed from blood products to the patients. [PBM is an evidence based multidisciplinary approach aiming at minimising the use of blood products and improving patient outcomes. PBM encompasses all aspects of the transfusion decision-making process, beginning with the initial patient evaluation and continuing through clinical management. These techniques are designed to ensure optimal patient outcomes, while maintaining the blood supply to guarantee that blood components are available for patients when they are needed.

PBM has three main objectives: 1) improving red cell mass, including treatments such as erythropoiesis-stimulating agents and iron and vitamin supplements; 2) minimising blood loss, e.g., by optimising surgical and anaesthetic techniques, treatment with Tranexamic acid (TXA) and autologous blood salvage; and 3) harnessing and optimising the tolerance of anaemia by promoting maximum pulmonary and cardiac function and the use of a restrictive transfusion threshold.

Successful implementation of a PBM program requires planning, education, and teamwork. There has to be commitment from the top management to implement it at a hospital.

The rationale for patient blood management addresses evidence-based transfusion medicine practice to:

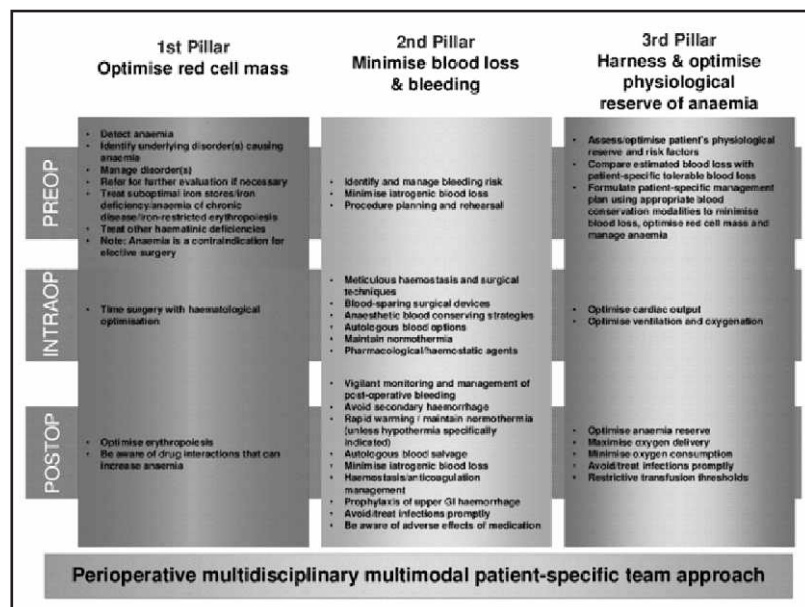
- view a patient's own blood as a valuable and unique natural resource that should be conserved and managed appropriately
- acknowledge that altruistically donated blood is a valuable, unique and costly resource that is held in trust, and that it will only be used as therapy when there is evidence for potential benefit and potential harm will be minimised
- consider transfusion alternatives



- ensure quality products are available in a timely and safe manner
- ensure potential hazards are considered and balanced against the benefits, and
- explain the benefits and risks to the patient/relatives.

The Three Pillars of PBM depicted below show how various practices can be initiated during pre-, intra- and post-operative stages of surgery.

Figure 1: The three pillars of PBM



Thresholds for transfusion

Several studies have established that hemoglobin or hematocrit should not be the sole clinical signal for transfusion. Nevertheless, hospital transfusion criteria often include laboratory values as thresholds and apply ambiguous language, such as “symptomatic anemia” or “failure of conservative measures.” The American Red Cross recommends RBC transfusion for patients with symptoms occurring from tissue hypoxia or lack of oxygen-carrying capacity caused by insufficient red cell mass, patients in need of an exchange transfusion, and acute blood loss not responsive to crystalloid volume replacement. RBC transfusions are contraindicated to treat anemia that can be managed with other therapies such as pharmaceuticals. RBCs should not be transfused as a means to increase blood volume, augment wound healing or make a patient feel better.



PBM in surgical settings

With the improvement of surgical techniques, a number of transfusion and non-transfusion measures have been implemented over the last decades to minimise perioperative blood loss⁴. Among PBM-related transfusion strategies, the issue of the most appropriate red blood cell (RBC) transfusion policy is particularly critical. A number of randomised controlled trials (RCTs) have been carried out on patients' outcomes by comparing restrictive (transfusing when the haemoglobin concentration is <7–8 g/dL) and more liberal (transfusing when the haemoglobin concentration is <9–10 g/dL) blood transfusion strategies in a variety of surgical settings. A critical literature review by Franchini et al, highlighted the fact that the great majority of experts are in favour of a restrictive transfusion policy, which appears to be associated with lower quantities of blood transfused and a higher level of patient safety than when a more liberal strategy is used.^[4] However, these recommendations apply mostly to haemodynamically stable surgical patients, while there is more uncertainty on the optimal transfusion policy in particular categories of patients such as those with acute coronary syndrome, myocardial infarction, neurological injury, acute neurological disorders, stroke, thrombocytopenia, cancer, haematologic malignancies, and bone marrow failure.

A prominent role in management of bleeding is played by Tranexamic Acid (TXA), which has been widely used to minimise bleeding in a variety of surgical procedures, particularly in major orthopaedic surgery. It has been called a “game changer”. Several large RCTs and meta-analyses have consistently confirmed that the intravenous administration of TXA can effectively and safely reduce perioperative blood loss and transfusion requirements in total hip and knee arthroplasty. Tranexamic acid is a synthetic analog of the amino acid lysine. It serves as an antifibrinolytic by reversibly binding four to five lysine receptor sites on plasminogen. This decreases the conversion of plasminogen to plasmin, preventing fibrin degradation and preserving the framework of fibrin's matrix structure.

Pharmacological correction of Perioperative Anemia

Another important target of a PBM-based approach is the pharmacological correction of perioperative anaemia, which has a negative effect on patients' health. It is usually associated with prolonged hospitalisation, an increased rate of post-operative complications (especially infections) and, finally, a lower survival rate. In particular, post-operative anaemia (PA) has a considerable impact on patients' outcomes. PA may be due to various factors, including pre-existing anaemia, perioperative blood loss, frequent blood sampling, and inadequate nutritional intake after surgery. As iron deficiency is a typical feature of the post-operative period, iron supplementation is the main target of a PBM-based approach. In this



context, administration of intravenous iron, with or without erythropoiesis-stimulating agents, has been found to be a safe and effective way of correcting anaemia in a variety of major surgical interventions. In a recent prospective randomised trial, Khalafallah et al. reported that a single post-operative intravenous infusion of ferric carboxymaltose (800–1,000 mg) after major orthopaedic, abdominal or genitourinary surgery, significantly improved haemoglobin and ferritin concentrations. It also reduced the number of transfusions and length of hospitalisation in treated patients compared with controls. Similar results were observed in a retrospective, single-centre study conducted by Laso-Morales et al. in 159 patients undergoing colorectal cancer surgery. Compared to standard oral iron therapy, the post-operative intravenous administration of iron sucrose (200 mg up to three times a week) to anaemic patients improved the recovery of haemoglobin levels without adverse events.

Maximum Surgical Blood Order Schedule (MSBOS)

The concept of MSBOS is based on data driven protocols for determining which patients need preoperative blood orders. It could be institution based. The cross match -to - transfusion ratio (C:T ratio), which is the classic measure of blood ordering efficiency, can be improved (decreased) by using an accurate MSBOS.

PBM in nonsurgical settings

A PBM approach has also been tried in a number of medical conditions, with the aim of minimising patients' transfusion requirements and improving their clinical outcomes. An excellent example of a PBM policy applied to a non-surgical setting is provided by advanced liver disorders. Liver cirrhosis is ranked as the 13th most common cause of mortality worldwide. In 2010, it contributed an estimated 1.2% of the 31 million global disability-adjusted life years (DALYs). It is also well known that patients with end-stage liver disease have coagulation abnormalities (primarily thrombocytopenia and enhanced fibrinolysis) that predispose them to an increased bleeding risk (mainly acute upper gastrointestinal bleeding) requiring specific and closer evaluation by physicians. Anaemia is a frequent finding in patients with liver cirrhosis, with a reported prevalence of approximately 60% of cases with a multifactorial etiology; this includes iron/vitamin B12/folate deficiencies, hypersplenism, malnutrition, and complications related to underlying causes such as alcohol-induced marrow aplasia or anaemia related directly to viral liver disease or its treatment. Thus, within the framework of a PBM program, potentially reversible causes of anaemia should be diagnostically explored and corrected to reduce unnecessary transfusions. This consideration is particularly valid for patients undergoing liver transplantation, as blood transfusion is considered a valid predictor of post-transplant overall survival. Viscoelastic test-guided management would also



help to reduce the use of FFP and guide the use of coagulation factor concentrates such as prothrombin complex and fibrinogen concentrate.

PBM in Obstetrics

The PBM program has also shown benefits in the field of obstetrics. Anaemia is frequent during pregnancy and its treatment is mandatory in order to improve maternal and foetal outcomes. Intravenous iron has been found to be an effective and safe way to correct pregnancy-related anaemia in those patients with intolerance or unresponsiveness to oral iron formulations. High-dose intravenous iron has also proved to be effective in obstetric haemorrhage, in association with other surgical and medical therapies (e.g., TXA, fibrinogen, and viscoelastically-guided supplementation of coagulation factors), in reducing blood loss and the need for blood transfusions. With regards to PBM management during post-partum haemorrhage, Shaylor et al. performed a qualitative systematic review of published national and international guidelines. Interestingly, the authors observed significant differences between the various guidelines on the recommendations for transfusion and PBM management in this critical condition, highlighting the need for a standardised PBM approach.

Post operative Strategies

Post operative strategies like blood recovery by collecting and reinfusing blood from surgical drains and wounds can be done. It is mainly used in trauma, vascular, cardiac and complex orthopedic cases where shed volume is substantial (>500 ml).

Monitoring PBM

Auditing or monitoring physician practice is a useful intervention to establish a successful program. Blood utilization, overtransfusion, undertransfusion, clinical outcomes, length of hospital stay etc. can be monitored.

Conclusion

Patient Blood Management program is an extraordinary tool for the rational use of blood as well as improvement of patients' clinical outcomes. The need of each patient is different and hence each patient needs to be clinically evaluated to optimise the PBM approach in both surgical and non-surgical cases. It is an essential challenge to replace the long-standing, well-organized, product-centered culture of transfusion medicine by the patient-centered model of Patient Blood Management. For its success, all the diverse stakeholders need to communicate, collaborate and overcome the complexity of the Patient Blood Management implementation process.

Dr Nidhi Bhatnagar
Ahmedabad

Dr Ripal Shah
Ahmedabad



NATIONAL CONSUMER DISPUTES REDRESSAL COMMISSION

NEW DELHI

CONSUMER CASE NO. 785 OF 2017

1. MOHIT JAIN
HOUSE NO.5, 1ST FLOOR, SUKH VIHAR.
DELHI-110051Complainant(s)
- Versus
1. M/S. MAX SUPER SPECIALTY HOSPITAL & 4 ORS.
THROUGH ITS CHAIRMAN, MAX SUPER SPECIALITY HOSPITAL,
108 A, INDERPRASTHA EXTENSION, PATPARGANJ. DELHI-110092
.....Opp.Party(s)

1. Facts:

1.1 The facts narrated by the Complainant – Mr. Mohit Jain (for short, the 'patient') are that on 06.04.2015, in the morning, he consulted Dr. Sanjeev Kumar (OP-2) at Max Super Specialty Hospital, Patparganj, Delhi (OP-1) (for short, the 'Hospital') for the complaints of fever, fatigue / bony pains, visible blood spots/bruises on both his arms & legs and recently had vomited with blood clot. The OP-2 prescribed few lab investigations viz. CBC, PBS, Urine Analysis, Urine Culture, Dengue Serology and Malaria. Few reports were available in the evening and same were informed to OP-2 on mobile. It was alleged that the OP-2 enquired about Complainant's Insurance cover and upon determining it, he advised the Complainant to get admitted immediately through emergency and he shall visit hospital from 8pm to 8.30 pm. Accordingly, he got admitted in the hospital (OP-1) through emergency, where the provisional diagnosis of Viral Hemorrhagic Fever (VHF) was made. The platelet count was 10000 / cmm, which was critically low and other findings were suggestive of hemolytic anemia. The patient was also examined by the Hematologist – Dr. Rahul Nathani (OP-3) and Dr. Mansi Sachdev (OP-4). The doctors, on 08.04.2015, arrived at the final diagnosis of Immune Thrombocytopenic Purpura (ITP) and reconfirmed hemolytic anemia. It was alleged that though he was admitted in Medicine Dept. and his primary consultant was OP-2, but having diagnosed as blood disorder, he should have immediately transferred to Hematology Dept. The OP-2 kept the patient under medicine with intention to raise the hospital bills. The doctors at OP-1 had allegedly been playing with his life. He was forced to discharge on 13.04.2015, instead of transferring to Hematology. The patient's stool for occult blood was positive for three occasions, but no steps were taken to check the GI bleeding. On 17.04.2015, the nuclear scan to check GI bleed was done, but patient was not examined by Gastroenterologist. The patient was scheduled to undergo colonoscopy at 11.00 am on 20.04.2015 though his condition was deteriorating. Finally, he was transferred to Hematology Dept. on 20.04.2015. He suffered tonic seizures and became very critical. He was intubated and kept in ICU. It was alleged that Dr. Amit Batra (Neurologist) was not summoned in time and he came after 60 minutes to examine the patient. The Complainant suffered seizure before NCCT could be started.

1.2 The Complainant further alleged that during 13 critical days (from 8 - 20 April) doctors did not mention blood test reports in the progress sheet. The Peripheral Blood Smear (PBS) screening was negligently done and Schistocytes in PBS was not detected; therefore the diagnosis of life threatening Micro-Angiopathic Hemolytic Anemia (MAHA) was delayed. It was further alleged that during his 29 days of hospitalization, the OP-3 made only 8 scattered visits and he was absent from the critical stages of diagnosis and treatment, but the billing was done for 39 visits. He further alleged that the hospital did not provide treatment summary despite repeated requests, therefore his wife was not able to take second opinion. He was forced to stay in confinement of OPs at their mercy. He further alleged that the OPs fabricated the treatment record. From 20.04.2015, twelve plasma exchange (PEX) sessions were held and the doctors told that ITP was a lifelong disease, which may relapse at any time. He further alleged that before PEX, patient's HIV and Hepatitis-B & C viral markers were not done. He was discharged from the hospital on 04.05.2015 with follow-up advice for a month. He paid bill amount of around Rs. 16 lakh towards



the hospitalization. He further alleged that the discharge report was incorrect on facts, vague and misleading. It was sub-standard which lacks key details, does not give a clear and accurate progression of the patient condition and treatment. For a long time he was under follow-up of Neurologist - Dr. Amit Batra at OP-1, who put the Complainant on anti-epileptic drugs for 6 months and medication for anxiety regularly which he was consuming even as on date. He consulted several doctors about his treatment and they have commented adversely on the correctness of final diagnosis of Thrombocytopenic Thrombotic Purpura (TTP) and the delayed treatment. During follow-up OPD visits, he was subjected to humiliation. The Complainant's other allegations are that OPs were indulged in billing malpractices, double billing for doctor's visits, billing for tests which were not done and he did not get proper response from the OPs.

1.3 Thereafter, on 07.06.2015, he approached Chief Minister, Deputy CM and Health Minister of Delhi. He also approached various Govt. authorities like Director of Health Services (DHS) and Delhi Medical Council (DMC). He further alleged that the OPs did not co-operate with the Govt. authorities and not filed medical records there. The DGHS, in its report dated 07.11.2016, mentioned that the hospital and doctors were found indulged in unethical practices. The copy of report was sent to DMC on 20.12.2016, but the DMC passed non-speaking Order on medical negligence. The Complainant challenged the DMC Order by filing Appeal before the MCI. After huge delay, the hospital provided voluminous medical record about 657 pages to him on 25.02.2017. The records were alleged to be different from those placed before the Govt. authorities. Therefore, fabrication, manipulation, interpolation of the medical record by OPs cannot be ruled out. The OPs failed to make differential diagnosis of TTP. There was no family history of TTP, but doctors told about the risk of inheritance to their children, therefore he and his wife (couple) suffered severe mental anguish and trauma. The Complainant raised the allegations of administrative issues, functioning of hospital, billing and malpractices. Being aggrieved, the Complainant filed the instant Complaint before this Commission, seeking overall compensation to the tune of Rs. 20,33,44,867/-.

2. Defense:

2.1 The hospital filed the reply through Medical Suptd. (OP-5) and denied any negligence during diagnosis and treatment of the patient. It was submitted that OP-1 is a super specialty hospital and the doctors are qualified and experienced for more than a decade in their specialty of medicine and Hematology. The Complainant filed this complaint, which is devoid of the facts and it is based on assumptions and beliefs.

2.2 On 06.04.2015, the patient was admitted in night through Emergency under OP-2 in medicine dept. It was provisionally diagnosed as a case of Viral Hemorrhagic Fever (VHF). The laboratory investigations showed low Platelet count 10000/cmm and Hb was 12.3g%. The PBS did not show evidence of Schistocytes and hemolysis. The blood parameters were not deteriorated so fast as alleged by the Complainant. The OP-2 was a Senior Consultant in Department of Internal Medicine; he was competent to treat such cases. A reference was made to the hematologist Dr. Rahul Nathani (OP 3) who reviewed the case on 07.04.2015. The patient's Platelet count was 30,000/cmm and on 08.04.2015 Bone Marrow (BM) Biopsy was done. The differential diagnosis of Immune Thrombocytopenic Purpura (ITP) was made as ITP is a diagnosis by exclusion. The patient was treated on the line of UTI with secondary ITP. The differential diagnosis of VHF was also there. Hence steroids were not given. Therefore, in view of UTI with secondary ITP, it was the conscious decision of OP-2 to keep the patient in medicine dept. At that time there was no special need to transfer the patient to Hematologist. In the OP-1 hospital, the OP-3 was working as Consultant in Hematology & Bone Marrow Transplant with his team consists of Dr. Mansi Sachdev (OP 4) and Dr. Manoj who works on all days. All the in-patient are billed under the name of unit head (primary consultant), not for a single doctor. Therefore, the bill was shown under OP-3 as Consultant, though the OP-4 saw the patient.

2.3 On 09.04.2015 the patient suffered an episode of passing blood (occult) in stool; however it was denied that no Gastroenterologist (GI) saw the patient till 18.04.2015. The duty doctor has sent a referral request to GI dept. and on 10.04.2015 the patient was examined by GI team and ruled out frank bleeding. The team recommended Endoscopy in case of significant drop in Hb% or if there any frank GI Bleed.



2.4 On 17.04.2015, CBC picture was high TLC and the PBS showed myelocytes and metamyelocytes. Thus PBS was suggestive of leucoerythroblastic blood picture. The OP-3 suspected GI malignancy as all other common causes were ruled out by the investigation like ANA, CECT Chest & abdomen, Coombs test. The JAK2 test was ordered because of leucoerythroblastic blood picture. Patient's blood samples were sent regularly in the morning to OP-1 lab for various tests. For Fibrinogen level - one of the special test, the sample was sent to laboratory at Max Hospital, Saket, the sample receiving was acknowledged by that lab at 12:22pm, it was shown as time of collection in the report.

2.5 On 20.04.2015 at around 9.30 AM, the patient developed neurological symptoms (irrelevant talking). The duty doctor and OP4 have seen the patient and noted the disorientation and hematuria. It was suspected as intracranial hemorrhage in view of low platelets with other bleeding manifestations like hematuria and GI bleeding. Immediate NCCT Head was advised and call was sent to Neurologist Dr. Amit Batra, who attended the patient immediately and arranged for NCCT. The patient, while shifting to the CT room, had an episode of seizure in triage.

2.6 The OPs denied that, at any point of time there was tampering with the records. On 20.04.2015, CBC was reported in morning and the Pathologist viewed the stained PBS slide at around 12.15 pm and noted presence of Schistocytes. The hematologist- OP-4 went to the lab and reviewed PBS and discussed the findings with OP-3. To confirm the RBC morphology, fresh blood sample was called again. There was no provision or category in billing for finger prick sample.

2.7 The patient was initially given IVIG 36g and transfusion of RBC and platelets. The OPs further submitted that the diagnosis of TTP was made on 20.04.2015. The duration of treatment for such patient depends upon the condition of the patient. Initially 5-6 sessions of PEX were planned but since the platelet count was gradually increasing, the treatment plan was revised and 12 PEX sessions were carried out as lifesaving measure. The patient was treated with standard protocol. The patient was discharged in good condition on 04.05.2015. The patient himself acknowledged that he did not suffer repeat episodes.

2.8 It was further submitted that the 'ADAMTS 13 Test' is diagnostic test for TTP. It was not available in India and expensive, costs around Rs 95000/- which needs about 45 days for reporting. However, its result does not change the line of treatment. The OPs discussed about the decision of not doing the test on financial ground with Complainant's wife, whom she duly agreed; it was recorded in the post discharge audio-visual recording.

2.9 The OPs further submitted that the Delhi Medical Council (DMC) observed that diagnosis seems to have been arrived in a reasonable period of time and managed the patient. DMC has already held that, no case of medical negligence was made out.

2.10 The parties on both the sides have filed their respective evidence by the way of affidavits. The Complainant in his support filed email communication and replies / opinions from Dr. H. P. Pati, Dr. Brig Ajay Sharma, Dr. Upender Srinivas.

3. Arguments:

3.1 I have heard the arguments at length. The Complainant was present in person; he was allowed to argue the matter with his Counsel. The Complainant filed voluminous written arguments, some medical literatures and legal citations. The learned Counsel for Complainant brought my attention to the email replies of the experts and the replies received from health authorities on his complaints.

3.2 The learned Counsel for the OPs argued the matter and reiterated their evidence. He further submitted that the DMC and MCI have already held no negligence on the part of hospital or the treating doctors. He relied upon the standard text books and the medical journals on the subject. Therefore, prayed for dismissal of the Complaint.

4. Observations and Reasons:

4.1 After the discharge from OP-1, the Complainant wrote emails to three experts in Hematology and sought clarification/opinion on his treatment. The sum and substance of those replies are as below:



4.1.1 **Dr. H.P. Pati**, Professor, Department of Hematology, AIIMS New Delhi has pointed out that PBS has to be done in low platelet counts. Indeed PBS was performed on hospital admission itself and it was found to be normal. On 18.04.2015 the PBS seen by OP 3 noted leucoerythroblastic blood picture. It was noted in the Patient's file. On 18.04.2015 the patient did not have TTP because of low Fibrinogen and high D-Dimer values. It is pertinent to note that Complainant has deliberately not submitted the lab findings of 20.04.2015 to Dr. H. P. Pati wherein the PS showed. Schistocytes and the PT, aPTT and Fibrinogen levels were normal and the Patient was diagnosed as TTP. The Patient has deliberately suppressed about high TLC and Myelocytes and Metamyelocytes in his PS and also evidence of Reticulin and Fibrosis in his bone marrow. Therefore to rule out the chronic myeloproliferative disorder JAK-2 test was performed.

4.1.2. Another expert **Dr. Brig. Ajay Sharma**, Professor and Head, Department of Hematology & Centre for Stem Cell Transplantation, Army Research and Referral Hospital, Delhi Cantonment has pointed out - that the Patient initially did not have TTP and it was brought and it was brought into the picture only at a later stage when the Patient had a seizure. Admittedly the patient suffered seizures on 20.4.2015

4.1.3 **Dr. Upendra Srinivas**, DM (Hematopathology) AIIMS has also ruled out TTP at the initial phase as discussed in the expert opinion and reply of Dr. H.P. Pati. With respect to JAK2 test, his opinion is similar to opinion of Dr. Brig. Ajay Sharma.

4.1.4 On careful perusal of the emails, it is pertinent to note that the Complainant made specific queries; he has not sent entire treatment record to the experts. In my view, those email replies (supra) were based on the information which ever provided by the Complainant. The possibility of half or incomplete information was given to the experts and/or suppression of material facts cannot be ruled out. The experts have, with good intention, replied to the emails of the Complainant. In my view, such email communications are not construed as expert opinions. The experts were not called by the Complainant to file affidavits or to adduce evidence. Thus, the email communications are not sufficient to hold the treating doctors for negligence or deficiency in service.

4.1.5 I have perused a printed (typed) prescription of Dr. Rahul Bhargava, the Hematologist from Artemis Health Institute, Gurgaon dated 02.06.2015. It is a printed prescription (assessment sheet), wherein, a hand written note was seen as an insertion. Its text is '**and delayed diagnosis and management of TTP from 6/4/15 - 20/4/15 & --illegible - Tonic clonic seizure - 9650373043**'. Such insertion creates more doubt, why Dr. Rahul Bhargava made such insertion in the specific area of prescription. It appears to be afterthought interpolation under emotional pressure of the patient. The said assessment sheet is not considered to be evidence.

4.1.6 The main allegation of Complainant that failure to detect presence of Schistocytes in PBS, which resulted in delayed diagnosis of MAHA and its treatment. The contention of the Complainant that OP-4 recorded the presence of 25 nRBC on PBS but it was totally ignored presence of Schistocytes. It was gross negligence and case of *Res Ipsa Loquitur* as not following the Standard operating procedures (SOP).

4.1.7 It is evident from the medical record that on 20.04.2015 numerous Schistocytes were seen in PBS, however the presumption of Complainant that such numerous Schistocytes would not have developed suddenly on 20.04.2015. In my view the OP-3 & 4 have ordered PBS along with CBC, from 21 to 25 April and same was billed. In CBC report for each of those dates, presence of Schistocytes was reported. There was no evidence that Schistocytes were present in the PBS before 20.04.2015, it was an imagination or presumption of the Complainant that the OPs-2, 3 & 4 failed to detect presence of Schistocytes on any date prior to 20.04.2015.

4.1.8 Another allegation of the Complainant is that though it was diagnosed as blood problem (hematology), the OP-2 should have immediately transferred him from Medicine to Hematology. It was not done in spite of his several verbal and written requests even marked as 'Urgent'. In my view, OP-2 was specialist in internal medicine, having experience and Hematology is an integral part of medicine, thus he can treat the patient of ITP. Thus, OP-2 was neither prohibited to treat nor it was mandatory for him to shift the instant patient to hematology. Moreover, if necessary,



there was always inter departmental consultation or referral was possible in the OP-1 hospital. Thus, the OP-2 has adopted a reasonable approach for the patient's care. This view dovetails from the case **Dr. Laxman Balkrishna Joshi v Dr. Trimbak Babu Godbole⁹¹**, it was held by Hon'ble Supreme Court that if a doctor adopted a practice that is considered "proper" by a reasonable body of medical professionals who are skilled in that particular field, he or she will not be held negligent only because something went wrong. Doctors must exercise an ordinary degree of skill.

4.1.9 Let us examine was there any delay in diagnosis of TTP? From the literature and text books, it is described that the course of TTP is rapid and fatal. Therefore proper diagnosis is important, because 90% mortality seen in untreated TTP patients, which can be reduced with prompt plasma exchange (PEX). About 50% deaths occur within 24 hrs of presentation^[4]. Early deaths (50%) still occur within 24 hrs of presentation. In the instant case, on 18.04.2015 the patient's clinical presentation and the blood reports were not suggestive of TTP. The OP 3 seen the PBS and documented leucoerythroblastic blood picture. No Schistocytes were seen. Thereafter, TTP was diagnosed on 20.04.2015 after the PBS findings of presence of Schistocytes, it was reconfirmed by the hematologist on calling fresh blood sample again. Then, the treatment for TTP was started with PEX. Thus, in my view there was neither delay nor failure in diagnosis of TTP.

4.1.10 It is pertinent to note that, the Complainant filed a complaints before various Government authorities DHS & DMC. He challenged the Order of DMC before Board of Governors of MCI by filing an appeal which was also dismissed. The Observations made by the Ethics Committee of the Board of Governors dated 25.09.2019 are more crucial in the instant case. The relevant paragraphs are reproduced as below:

7. The Ethics Sub Committee noted the appeal of the appellant that from 05.05.2015 to 06.06.2015, the period was eventful with follow ups, negligence, delayed diagnosis, medical malpractices. On 07.06.2015, after getting no positive response from the respondents the appellant approached the Chief Minister, Deputy Chief Minister and Health Minister Of Delhi: Directorate General of Health Services (DGHS) took the cognizance of the complaint and sought explanation from the respondent hospital and its doctors. After receiving a reply, the DGHS directed the appellant to file a rejoinder. On 11.12.2015, the appellant fled a rejoinder with annexures (1 set for DHS, 6 sets for DMC with a request to take up the complaint and 1 set to be sent to the respondent, MAX Hospital).
8. The Ethics Sub Committee noted that on 15.02.2016, the Delhi Medical Council directed the appellant to appear before them and asked to file a review of the complaint if not satisfied. On 06.04.2016 the appellant received a letter from Delhi Medical Council (DMC) informing that the representation dated 15.02.2016 of Sh. Mohit Jain does not constitute a complaint under Rule 32 of DMC Rules, 2003 and hence cannot be entertained. Thereafter, several other complaints and representations were made to the Delhi Medical Council by the appellant. The appellant stated that DMC did not pay much heed to their complaint and were not clear of their own rules.
12. Dr. Rahul Naithani appeared before the Ethics Sub Committee of the Medical Council of India and stated that he was the treating doctor of Sh. Mohit Jain with a low platelet count. He further stated that the patient was primarily the patient of Dr. Sanjeev Kumar as the initial working diagnosis was Viral Hemorrhagic Fever (VHF) which was revised to Idiopathic Thrombocytopenic Purpura (ITP) on 14.04.2015 and was subsequently transferred under the care of Dr. Rahul Naithani. The patient was duly attended by the Hematologist. The respondent denied all the allegations pointed out by the appellant.
13. It was further noted by the Ethics Sub Committee that Dr. Rahul Naithani stated that the patient used to message and call him stating that he has not cured him and was dying because of his treatment. He alleged that it was a mental harassment for him as



frequently on calls, e-mails and messages he used to harass him pointing out negligence. A complaint of this activity was also made to the Medical Superintendent of MAX Hospital, Patparganj New Delhi.

4.1.11 The Executive Committee observed the diagnosis and treatment at OP was reasonable. It also noted the conduct of the patient (Complainant), who used to harass Dr. Rahul Nathani due to frequent calls, e-mails and messages pointing out negligence. The Executive Committee held that prima facie no case of medical negligence was made out against the OPs. The doctors at OP-1 arrived at the diagnosis in a reasonable period and treated the patient. The Executive Committee observed that the TTP is a rare disorder of 0.000006%^[5]. The most common precipitating factor with ITP is viral fever which at times can result in prolonged thrombocytopenia. Such cases show spontaneous recovery as initially it is suspicious of ITP.

4.1.12 It is pertinent to note that the Directorate of Health also constituted a committee of three officers with the approval of Competent Authority to look-into the grievances of the complainant with specific concern to administrative and hospital related matters (other than medical negligence). The committee examined the case with specific reference to administrative issues related with the functioning of hospital and considered following points:

1. Double Billing and extra charges.
2. Visits of consultants.
3. Delay in providing case summary for second opinion.
4. Management issues like smoking in hospital.
5. Tests like HIV/Viral Markers not done but shown to have done on various occasions.
6. Discharge summary prepared despite deteriorating health parameters.

The Committee based on factual position in the instant case, opined that there was double billing and the patient paid cost for number of times for the services not provided but billed. There was lack of proper, adequate and timely co-operation by hospital authority in providing case summary to patient / attendant for second opinion, there was lack of transparency in Attendance records. Whereas, in the instant case, it is reflected that there is inadequacy of the hospital management in keeping proper checks and balances. There was absence of inherent preventive measures in the system on the above-mentioned accounts which was unbecoming of being a responsive hospital administration and management. The Committee finally, under the signature of DGHS, directed in the notice to the hospital to take corrective actions within one calendar month from the date of receipt of the notice, failing which, action may be initiated against the Hospital as per Delhi Nursing Home Registration Act and Rules.

5. Reference from some Medical Literature on TTP:

5.1 Thrombotic thrombocytopenic purpura (TTP) is a thrombotic microangiopathy relatively uncommon disorder characterized by the formation of platelet-rich thrombi in the microvasculature. This formation results in consumptive thrombocytopenia, organ ischemia, and increased shear stress with mechanical destruction of RBCs, resulting in Schistocytes. These platelet microthrombi are responsible for a mechanical hemolytic anemia, a thrombocytopenia and a multi-visceral ischemia. Although TTP often involves microangiopathic haemolytic anaemia, thrombocytopenia, fever, neurological symptoms, and renal impairment, many patients do not exhibit the full pentad of findings. Furthermore, this same combination of abnormalities can be present in other disorders such as classic haemolytic uremic syndrome (HUS), atypical HUS (aHUS), or disseminated intravascular coagulation (DIC). With high clinical suspicion of TTP is a rare but life-threatening disease in the absence of appropriate treatment (Plasma Therapy). Therefore, life-saving therapy must be started immediately.

5.2 Clinical prediction scores using readily available laboratory information (creatinine, platelet count, d-dimer, reticulocyte percentage, indirect bilirubin, etc.) have proven useful for acute decision-making. The TTP has been linked to a severe deficiency in ADAMTS13 (a disintegrin and metalloprotease with thrombospondin type 1 motif, member 13) activity. The



ADAMTS13 activity level of less than 10% supports the diagnosis of TTP in appropriate clinical contexts, but many centers do not offer testing in-house and must send out the test to a reference laboratory with a turnaround time of several days. Patients with acquired TTP receive plasma exchange (PEX) therapy. This kind of therapy removes proteins in the blood that damage the ADAMTS13 enzyme, then replaces the enzymes. The initial therapeutic regimen for acquired TTP involves immunosuppression and provides supplemental ADAMTS13. Although confirming severely decreased ADAMTS13 activity helps establish the TTP diagnosis, therapy must start even before test results are available.

5.3 Plasma exchange (PEX) is the most important for management of TTP and should be initiated without delay in all patients with suspected TTP. Delay in initiation of PEX is a major factor in adverse outcomes. PEX is associated with a reduced death rate and is superior to plasma infusion alone, which is the result of the additive effects of both removal of autoantibody by the exchange process (in the case of acquired TTP) as well as supplementing ADAMTS13 activity in the exchanged plasma^[6]. Steroids are used initially to achieve relatively rapid immunosuppression.

5.4 DIAGNOSTIC AND PROGNOSTIC VALUE OF ADAMTS13 MEASUREMENTS^[7]

In the era before effective treatment, TTP was defined by a pentad of clinical features, namely thrombocytopenia, microangiopathic hemolytic anemia, neurologic abnormalities, renal failure, and fever.^[8] ADAMTS13 measurements may not assist initial diagnosis and management decisions but are important for prognosis. Although most patients with severe ADAMTS13 deficiency have no renal insufficiency, causing initial reports to suggest that ADAMTS13 activity measurements may distinguish TTP from HUS, some patients with severe ADAMTS13 deficiency have acute renal failure. ADAMTS13 activity 5% appears to be specific for TTP but does not identify all patients who may relapse; ADAMTS13 activity 10% essentially identifies all patients who are at risk for relapse but is not specific; patients with sepsis, and liver cirrhosis may also have ADAMTS13 activity 10%.

6. Law on Medical Negligence:

6.1 Medical negligence is discussed in a catena of judgments from the Hon'ble Supreme Court and worldwide. In the cases of medical negligence, to bring a successful claim the victim or victim's family bringing the action must prove the "four D's" against the erring doctor/hospital. The 4 D's of medical negligence stand for 'Duty', 'Dereliction/Deviation', 'Direct (proximate) Cause' and 'Damages'.

6.2 What does not constitute medical negligence?^[9]

From the decisions of Hon'ble Supreme Court in the cases viz. Jacob Mathew's^[10], Malay Kumar Ganguly^[11] and Kusum Sharma^[12] cases (supra). Thus it was not negligence in case of any deviation from normal practice or any accident, any error of judgement through any professional or any patient does not favourably respond to the treatment. The doctor would not be held liable for negligence if his diagnosis is different from other fellow doctor or he treats patient from other method and taking any higher element of risk but could not save patient.

7. Conclusion:

7.1 On careful analysis of the facts and chronology of events in the instant case, admittedly the OP-2 to 4 are the subject specialists having experience. During the hospitalization, based on symptoms and signs, the patient was investigated and treated as per the standard of reasonable practice. On 20.04.2015, at the 1st time the diagnosis of TTP was made from the PBS and treatment with PEX was started. In my view, it was mere assumption of the Complainant that before 20.04.2015, the OP-3 failed to detect Schistocytes in PBS. The patient showed recovery after PEX and discharged on 13.04.2015. As discussed above there was no delay in diagnosis and treatment of TTP. The ADAMTS13 test was not available in India, and even as on today very few centers in India have such facility. The patient was informed about high tests expenses and long time for reporting. It is an admitted fact that, prior to starting PEX, the patient's HIV and Hepatitis-B & C viral markers were not done. It was an act of omission from OPs. However, because of such omission, the patient did not suffer any injury or loss; but in fact, the PEX Therapy was beneficial. Therefore, OPs are not liable for this act of omission.



7.2 I would like to rely upon the case - **Achutrao Haribhau Khodwa and others versus State of Maharashtra and others**^[13], wherein the Hon'ble Supreme Court held that:.....

7.2.1 In the recent judgment of the Hon'ble Supreme Court in the case of **Chanda Rani Akhouri vs M.S.Methusethupathi Mithupathi**^[14], it was held that:.....

7.3 In the instant case, I find, the standard medical protocol being followed by the OPs-2 to 4 to the best of their skill and with competence at their command. Thus, it is clear that out of '4 Ds' the Complainant has proved only the 'Duty' of hospital and doctors, but failed to prove the other ingredients of medical negligence

i.e. Dereliction/breach in duty of care and the Direct/proximate cause (causa causans).

7.4 Adverting to the administrative deficiencies, the Complainant approached DHS and the Committee of three members has noted some administrative defects like double billing, doctors' visits etc. I agree with the view taken by the DHS and the directions issued to OP-1 hospital. In my view, the complainant deserves refund of excess amount. Therefore, the hospital is directed to be careful and meticulously look for systemic improvement in their functioning.

7.5 In the instant case, the principle of 'res ipsa loquitur' would not be applicable, on considering the medical record. The Complainant has made several allegations on the presumptions. The Complaint runs in 48 pages, whereas the brief Written Submissions runs in 37 pages with 39 issues. In my view, mere averments/allegations cannot be taken as a gospel truth. The Complainant has not produced cogent evidence to prove his case. This view dovetails from the decision of the Hon'ble Supreme Court in **C.P. Sreekumar (Dr.), MS (Ortho) vs. S. Ramanujam**^[15], wherein it was held that the Commission ought not to presume that the allegations in the complaint are inviolable truth even though they remained unsupported by any evidence. It was held as under:.....

7.6 I endorse the observations and the view taken by the Board of Governors of MCI, which held no negligence of the OPs.

7.7 The Consumer Protection Act should not be a "halter round the neck" of the doctors to make them fearful and apprehensive of taking professional decisions at crucial moments to explore possibility of reviving patients hanging between life and death. Reliance is placed on **Kusum Sharma & Ors. v. Batra Hospital & Medical Research Centre & Ors.**^[16], wherein it was held:.....

7.8 In conclusion, based on the findings of MCI, DHS and various medical literatures on TTP and respectfully following the precedents of Hon'ble Apex court, in my view, medical negligence is not conclusively attributable to the hospital (OP-1) and the doctors (OP-2-4).

7.9 However, the findings of DGHS on the administrative lapses of the hospital can't be ignored. The hospital is liable to that limited extent of administrative lapses. The hospital is strictly cautioned and directed to take necessary steps for systemic improvement. The Complainant has not produced detailed calculation of alleged excessive charges, therefore in the ends of justice, lump sum amount of Rs. 1,00,000/- (One lakh) will be just and reasonable compensation in the instant case. Accordingly, the Hospital (OP-1) is directed to pay Rs. 1,00,000/- to the Complainant within 4 weeks from today, failing which the amount shall carry 9% interest per annum till its realisation.

With this direction, the Consumer Complaint is dismissed.

The parties shall bear their own costs.

The Registry is directed to send free copies of this Order to the Complainant and the Opposite Parties within one week from today.

DR. S.M. KANTIKAR
PRESIDING MEMBER



NEWS CLIP

PMના 'મન કી બાત'ના ૧૦૦મા એપિસોડની દેશભરમાં ઉજવણી થશે મેડિકલ અને પેરામેડિકલની ૧,૨૪૪ સંસ્થાઓમાં આજે 'મન કી બાત' કાર્યક્રમ

૧૦૦થી વધુ હોસ્પિટલો, મેડિકલ-પેરામેડિકલ સહિતની શાખાઓ ભાગ લેશે

વડાપ્રધાન નરેન્દ્ર મોદીના મન કી બાત કાર્યક્રમનો રવિવાર રોજ ૧૦૦માં એપિસોડ ઉજવાશે. રવિવાર સવારે ૧૧ થી ૧૧:૩૦ દરમિયાન યોજનાના આ કાર્યક્રમનું દેશભરમાં પ્રસારણ થશે. ઈન્ડિયન મેડિકલ એસોસિએશન દ્વારા રાજ્યની દરેક સ્થાનિક શાખા, હોસ્પિટલો, ક્લિનિકલ અને તમામ મેડિકલ કોલેજો અને અન્ય પેરામેડિકલ સંસ્થાઓ સાથે સંકલન કરવાની પહેલ કરી છે. જે અન્વયે ગુજરાતની મેડિકલની જુદી જુદી ૧,૨૪૪ સંસ્થાઓમાં આ કાર્યક્રમ ઉજવાશે. મહાન સંખ્યામાં સેક્ટરો, પેરામેડિકલ સ્ટાફ અને વિદ્યાર્થીઓ તેમની પોતાની સંસ્થાઓમાં આયોજન કરશે.

વડાપ્રધાન મોદીના 'મન કી બાત'નો કાર્યક્રમ ભાજપ ૭૮૭ બુથ પર યોજશે

કેન્દ્રીય મંત્રી દર્શના બીજી તરફ ભારત સરકારના રેલવે અને ટેલેગ્રાફલ રાજ્યમંત્રી ક્રીમી દર્શનાબેન જયદોજ દ્વારા વોર્ડ નં. ૧૦ અને કે. જાળન, હેલ્થીયમમાં શ્રીકૃષ્ણ સ્ટેડિયમમાં શ્રીકૃષ્ણ સિટીયલના નીતિશ ભારદવાર હાજર રહેશે આ ઐતિહાસિક પ્રસંગના સાક્ષી તરીકે સુરતના ગણમાલ્ય બ્લોકિઓ ઉત્ખિલિત થશે, જેમાં પત્થની કાર્ટીસ્ટોવલ હશેવિદ્યા, પત્થની મયુરભાઈ સાવાળી, પત્થની સવરુભાઈ ધોળકીયા, પત્થની કમુભાઈ ટેવર દીરા ઉદીયાના અગ્રણીઓ, સુરત શહેરના ઠિઠંગા બાગડો, તેમજ ૬૦૦૦ જેટલી વન સંખ્યામાં નામાંકિત નાગરીકો, સ્વતંત્રતા સોયે સુરતની સભ્ય સર્વ બાળી બાગડોવલ વિવેક ઉત્ખિલિત રહેશે. ઈન્ડોર સ્ટેડિયમમાં પણ આ અંગેનો કાર્યક્રમ થશે. જેમાં ભોળાના પૂર્વ વડાપ્રધાન જિમલેન્દ બિદીની સાથે સાથે પશ્ચીમ કિલ્લ સર્જેટ મનોજ મુલગિર તેમજ મહાભારત પ્રદેશ પ્રમુખ સી.અર.પટીલ, કેન્દ્રીય સેલો યુવા કાઉન્સિલર વસીમ અલીખાન પણ હાજર રહેશે. મન કી બાતના ૧૦૦મા એપિસોડને સફળ બનાવવા ઈન્ડિયન મેડિકલ એસો. સુરત દ્વારા ૮૦ હોસ્પિટલોમાં પ્રસારણની સજાડ કરવામાં આવી છે. ઈન્ડિયન મેડિકલ એસો. સુરતની સેલે આજે ગુજરાત સરકારના મુખ્ય મંત્રીને, દિવાળી બાગડો, મોડેરેટર મુખ્ય મંત્રી ડો. અમલકુમાર ભાગડે, પ્રમુખ ડો. મેહાલચરિષિલ જાડેજા, માનદ મંત્રી ડો.મહેશ શાહ દ્વારા સંકલન સાથે પ્રસારો કરાવા છે. આ કાર્યક્રમને સફળ બનાવવા માટે ડો. પાણલ વડાપ્રધાનને ભારે જલદત્ત ઉઠાવી છે.

બોટાદ ઈન્ડિયન મેડિકલ એસો. દ્વારા મન કી બાત કાર્યક્રમ નિહાળવામાં આવ્યો



બોટાદ ભારતર / બોટાદ ઈન્ડિયન મેડિકલ એસોસિએશન દ્વારા વડાપ્રધાન નરેન્દ્ર મોદીનો ૧૦૦મો એપિસોડ મન કી બાત કાર્યક્રમ નિહાળવામાં આવ્યો હતો.

દમણ મેડિકલ એસો. ને સુના પીઆમ મોદી કેમન કી બાત કા ૧૦૦વાં એપિસોડ



અસલી આનંદી નૂપર ટેલરકે, જોસમી કે નિરેશ પા દમણ કૃષ્ના યમીયા, ડૉ. ચિત્તલ વેપમ એવે કે વર કો આ

Advertisement for Sanj Samachar LATEST NEWS. Features text like 'સાંજ સમાચાર LATEST NEWS SANJ SAMACHAR RAJKOT Date 25-4-2023 SATURDAY' and a photo of the news anchor team. Below it, there is another news item: 'કાલે વડાપ્રધાનના 'મન કી બાત'ના ૧૦૦મા એપિસોડમાં IMA-ગુજરાતના ૧૦ હજારથી વધુ તબીબો જોડાશે' followed by a list of names: ગુજરાતમાં ૫૦૦થી વધુ સ્થળે આયોજન રાજકોટના હેમુગઢી હોલમાં સામાજિક સંસ્થાઓ સાથે શહેરના નામાંકિત મંત્રીઓ રહેશે ઉપસ્થિત



Advertisement for Aajkaal newspaper. Features the title 'દેશ-પરદેશની આજકાલ', website 'www.aajkaaldaily.com', and date 'Dt. 29-04-2023'. The main headline is 'વડાપ્રધાનના 'મન કી બાત'ના ૧૦૦મા કાર્યક્રમમાં ગુજરાત આઈએમએના ૧૦ હજારથી વધુ તબીબો જોડાશે'. The text describes the event and lists participants: ડૉ. મહેશ શાહ, ડૉ. અનિલ નાયક, ડૉ. ડી. બી. ગણુપત્તી, ડૉ. ચેતન લાલસેતા, ડૉ. વિદ્યમ કોરાડી, ડૉ. વી. બી. ગણુપત્તી. It also mentions that the event is being held across 1000 medical centers in Gujarat. Below the text is a photo of several men in suits speaking at a podium.

Advertisement for Aajkaal newspaper. Features the headline 'વડાપ્રધાનની 'મન કી બાત'ના ૧૦૦માં એપિસોડમાં ગુજરાત આઈ.એમ.એ.ના ૧૦ હજારથી વધુ તબીબો જોડાશે' and 'ઈન્ડિયન મેડિકલ એસોસિએશન દ્વારા ડો.અનિલ નાયકના માર્ગદર્શનમાં ગુજરાતમાં ૫૦૦થી વધુ જગ્યા પર આયોજન'. It lists participants: ડૉ. મહેશ શાહ, ડૉ. અનિલ નાયક, ડૉ. ડી. બી. ગણુપત્તી, ડૉ. ચેતન લાલસેતા, ડૉ. વિદ્યમ કોરાડી, ડૉ. વી. બી. ગણુપત્તી. Below the text is a photo of several men in suits speaking at a podium.



સુરત આજે 'મન કી બાત' મય બની જશે, ઠેરઠેર કાર્યક્રમો

સુરત, તા. ૨૯ શહેર ભાજપ દ્વારા વેસુના વીઆઈપીરોડ ખાતે આયોજાવાના એપિસોડ પાસે વડાપ્રધાન નરેન્દ્ર મોદીના મન કી બાત કાર્યક્રમના ૧૦૦માં એપિસોડના કાર્યક્રમનું આયોજન કરવામાં આવ્યું છે. ભાજપ પ્રેક્ષક પ્રમુખ સી.આર.પાટીલના અધ્યક્ષ સ્થાને યોજનાવાર આ કાર્યક્રમ દરમિયાન અંદાજે ૫૦૦ ઉજારથી વધુ લોકો મન કી બાત કાર્યક્રમનું જીવન પ્રસારણ નિહાળશે. પુર્વ સેનિટ્રે, ટીબીઆઇ તેમજ આશા વર્કસ સહીતના કર્મચારીઓ આ કાર્યક્રમમાં ભાગ લેશે. શહેરના ધારાસભ્યોના અધ્યક્ષ સાથે મનપાના ઓડી ટીક મન કી બાત કાર્યક્રમનું આયોજન કરવામાં આવ્યું છે. ભાજપ દ્વારા શહેરના ૨૦૭૪ જુઓ પેલી ઓટલ સ્થળો પર 'મન કી બાત' કાર્યક્રમનું આયોજન કરવામાં આવ્યું છે. શહેર ભાજપ પ્રમુખ નરિન્દ્ર જાડવેરાએ જણાવ્યું હતું કે, વર્ષ ૨૦૧૪માં પ્રધાનમંત્રી જન્મ નરેન્દ્ર મોદી દ્વારા 'મન કી બાત' કાર્યક્રમની



શરૂઆત કરવામાં આવી હતી. આ કાર્યક્રમમાં રાજનીતિથી પરે સ્તરી દેશભરમાં બનતી યાતનાની યત્નવાઓનું પ્રધાનમંત્રી દ્વારા વિશ્વવ્યાપી કરવામાં આવે છે. દેશના અનિરિપાળ વાગોમાં બનતા વિકિરત બનાવો તથા બંધિતલો દ્વારા મેળવેલી સિપિયોનોનું વર્ણન પણ

અનુસંધાન પાતા પાંચ ઉપર

વેસુના વીઆઈપી રોડ ખાતે ભાજપ અધ્યક્ષ સી.આર. પાટીલની આગેવાનીમાં પાંચ ઉજારથી વધુ લોકો એકત્રિત થશે: ઈન્ડિયન મેડિકલ એસો.ના ઉપકમે ૮૦ જેટલી હોસ્પિ.માં કાર્યક્રમ: ઈન્ડોર સ્ટેડિયમમાં લગભગ ૧૦ ઉજાર લોકો એકઠા થશે

ઈન્ડિયન મેડિકલ એસોશિએશન દ્વારા સુરતની ૮૦ જેટલી હોસ્પિટલોમાં મન કી બાતના કાર્યક્રમનું જીવન પ્રસારણ કરવામાં આવશે

સુરત સમીક્ષા એમ.એ.ના પ્રમુખ ડો. ચોગેશકુમાર દેસાઈ અને મંત્રી ડો. વિનોદ શાહે જણાવ્યું હતું કે, સમીક્ષા એમ.એ. ના સુરતના રાજ્ય શાખાના માર્ગદર્શન હેઠળ સાવકીકાલે ૩૦મી મે સુધિવાર સવારે ૧૧:૦૦ કલાકે વડાપ્રધાન નરેન્દ્ર મોદીના મન કી બાતના ૧૦૦માં એપિસોડનું જીવન પ્રસારણ કરવામાં આવવાનું છે. સમીક્ષા એમ.એ. સુરતના ડાહ્યમેસાએ જણાવ્યું હતું કે, વર્ષ ૨૦૧૪માં પ્રધાનમંત્રી જન્મ નરેન્દ્ર મોદી દ્વારા 'મન કી બાત' કાર્યક્રમની

સુરતની ૭૫થી ૮૦ જેટલી હોસ્પિટલોમાં 'મન કી બાત'ના ૧૦૦માં એપિસોડનું પ્રસારણ કરાશે

ધબકાર પ્રતિનિધિ,સુરત,તા. ૨૯ સુરત આઈએમએના પ્રમુખ ડો. યોગેશકુમાર દેસાઈ અને માનદમંત્રી ડો. વિનોદ શાહ એક આખબારી યાદીમાં જણાવે છે કે આઈએમએ ગુજરાત રાજ્ય શાખાના માર્ગદર્શન મુજબ હેડક્વાર્ટસના માનદમંત્રી ડો. અનિલકુમાર નાયક, પ્રમુખ ડો. મહાવીરસિંહ જાડવેરા અને માનદમંત્રી ડો. મેહુલ શાહ, તારીખ ૩૦મી મે રવિવાર સવારે ૧૧ કલાકે માનનીય

વડાપ્રધાન નરેન્દ્ર મોદીનું આકાશવાણી દ્વારા પ્રસારિત થનાર ૧૦૦માં એપિસોડ નિમિત્તે આઈએમએ સુરતના તબીબો સફળ બનાવવા માટે હોસ્પિટલો તેમજ કલીનીકમાં પેરા મેડિકલ સ્ટાફ અને સગા સંબંધી સાંભળી શકે તે માટે ૭૫થી ૮૦ જેટલી હોસ્પિટલોએ સગવડ કરી છે. આ કાર્યક્રમને સફળ બનાવવા માટે પાણલ વડગામા તથા ડો. વિનોદ સી. શાહએ જહેમત ઉઠાવી છે.

મેડિકલ-પેરામેડિકલ કોલેજોમાં PMની 'મન કી બાત'નો ૧૦૦મો એપિસોડ પ્રસારિત કરાશે

અમદાવાદ, શનિવાર વડાપ્રધાન નરેન્દ્ર મોદી દ્વારા શરૂ કરાયેલ મન કી બાત સીરિઝનો ૧૦૦મો એપિસોડ આવૃત્તીકાલે પ્રસારિત થનાર છે ત્યારે આ ૧૦૦મા એપિસોડની ઉજવણી રાજ્યની તમામ મેડિકલ-પેરામેડિકલ કોલેજોમાં કરાશે અને હોસ્પિટલોના ડોક્ટરો આ ઉજવણીમાં જાડાશે. આવૃત્તીકાલે સવારે ૧૧થી ૧૧:૩૦ દરમિયાન આ ૧૦૦માં એપિસોડ

વિવિધ મેડિકલ, ડેન્ટલ, નર્સિંગ અને ફીઝિયોથેરાપી કોલેજોમાં પ્રસારિત કરાશે અને જેને નિહાળવા-સાંભળવા તમામ વ્યવસ્થા કરાશે. દેશમાં બે સ્થલેથી પીએમ સાથે સંવાદ થશે. જેમાં ગુજરાતમાં રાજકોટ ખાતેથી સંવાદ થશે. ઈન્ડિયન મેડિકલ એસોસિએશનની કુલ ૧૧૧ સ્થાનિક શાખાઓ તેમના વિસ્તારમાં બે અલગ અલગ કેન્દ્રો પર આયોજન કરશે. રાજ્યના ગ્રહ ઝોનમાં વિવિધ જિલ્લાની ૧૦૦ હોસ્પિટલો પણ ભાગ લેશે.

બોટાદ ઈન્ડિયન મેડિકલ એસોસિએશન દ્વારા સમરકેમ્પનું આયોજન કરાયું ભાર વિનાના ભણતર વિશેનું માર્ગદર્શન આપવામાં આવ્યું

બોટાદ શહેરના ખસ રોડ સ્થિત જિલ્લા પોલીસ વડાની કચેરી ખાતેના કોન્ફરન્સ હોલમાં ઈન્ડિયન મેડિકલ એસોસિએશન બોટાદ અને જિલ્લા પોલીસ દ્વારા મ્યુઝિકલ કાર્યક્રમ અને સમર્થ કેમ્પનું આયોજન કરવામાં આવ્યું હતું. જેમાં અધિક કલેક્ટર મુકેશ પરમાર દ્વારા સુંદર ગીતો રજૂ કરવામાં આવેલ

હતા. આ કાર્યક્રમમાં જિલ્લા પોલીસ વડા કે.એફ.ભલોલીયા, ડી.વા.પ. એસ.પી. ઈન્ડિયન મેડિકલ એસોસિએશનના પ્રમુખ તુષાર રોજસરા સહિત તબીબો ઉપસ્થિત રહ્યા હતા. સાથોસાથ સમર કેમ્પમાં ઉપસ્થિત બાળકોને ભાર વિનાના ભણતર વિશેનું માર્ગદર્શન આપવામાં આવ્યું હતું. તેમજ ૨૫૦ નોટબુકનું વિતરણ કરવામાં આવ્યું હતું.

બોટાદ ઈન્ડિયન મેડિકલ એસો. દ્વારા સમરકેમ્પમાં માર્ગદર્શન આપવામાં આવ્યું



બોટાદ ભાસ્કર | બોટાદ ખાતે યોજાયેલ સમર કેમ્પમાં જિલ્લા પોલીસ દ્વારા મ્યુઝિકલ કાર્યક્રમ અને સમર્થ કેમ્પનું આયોજન કરવામાં આવ્યું હતું. જેમાં અધિક કલેક્ટર મુકેશ પરમાર દ્વારા સુંદર ગીતો રજૂ કરવામાં આવ્યા હતા. તેમજ આ કાર્યક્રમમાં ઉપસ્થિત બોટાદ ઈન્ડિયન મેડિકલ એસોસિએશનના ડો. તુષાર રોજસરા દ્વારા બાળકોને ભાર વિનાના ભણતર વિશે માર્ગદર્શન આપવામાં આવ્યું હતું. સાથે જ ભાર વિનાના ભણતરની ૨૫૦ કોપીનું બાળકોમાં વિતરણ કરવામાં આવ્યું હતું.



229th Central Working Committee Meeting-2023 at SOU





229th Central Working Committee Meeting-2023 at SOU



229th Central Working Committee Meeting-2023 at SOU





229th Central Working Committee Meeting-2023 at SOU



Felicitation of Dr. Anil Nayak, IMA Siddhpur Branch



* * * * *

Felicitation of Dr. Anil Nayak, IMA Unja Branch



* * * * *

Stargazing Workshop IMA WDW Hitmatnagar Branch





100th episode of Prime minister Shri Narendra Modiji's Mann ki Baat Mehsana Branch



* * * * *

100th episode of Prime minister Shri Narendra Modiji's Mann ki Baat Kalol Branch



* * * * *

CME IMA Palanpur Branch



(40)



National IMA President, Dr. Sharad Kumar Agarwal visit to IMA Rajkot Branch



* * * * *

CME IMA Kapadwanj Branch



* * * * *

CME IMA Mehsana Branch



(41)



1st Announcement
28th, 29th October 2023
 Venue : ISCON CLUB & RESORT, BHAVNAGAR.



Solidarity for Dignity
GIMACON 2023

: Hosted by :
IMA BHAVNAGAR

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Dr. Mahavirsinh Jadeja

Secretary - IMA GSB
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IMA BHAVNAGAR

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GIMACON 2023

75th Annual Conference of IMA Gujarat State Branch
 Hosted by IMA Bhavnagar Branch
 28th & 29th October 2023



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 Qualification : _____
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 GMC/MCI Registration No. : _____
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 E-mail : _____ Mobile : _____

PARTICULARS

REGISTRATION FEES

Registration Status (Tick Appropriate)	Up to 31-7-2023	1-8-2023 to 31-9-2023	1-10-2023 to 26-10-2023	From 27-10-2023 (Spot Registration)
Patron	10,000/-	10,000/-	-	-
Reception Committee	5,000/-	5,000/-	-	-
Delegate (IMA Member)	3,000/-	3,500/-	4,000/-	4,500/-
Delegate (Non IMA)	3,500/-	4,000/-	4,500/-	5,000/-
Accompanying Person*	2,500/-	3,000/-	3,500/-	4,000/-
Medical Student**(UG & PG)	2,000/-	2,500/-	3,000/-	3,500/-

PAYMENT DETAILS

* 6 years & Above

** Letter from Head of the Department/Dean will be must.



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Hotel Accommodation Required : Yes No

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Details of DD/Cheque/NEFT : _____

DD/Cheque at par payable at Bhavnagar in favour of IMA, BHAVNAGAR

Correspondence Address :

Dr. Devang Pawar
E.N.T. Care Hospital,
 302, Carlton Square,
 Nr. Madhavdeep, Kalanala,
 Bhavnagar-364002. M. 9426704404

Bank Details :
 STATE BANK OF INDIA
 INDIAN MEDICAL ASSOCIATION
 Kalanala Branch
 A/c. No. 56008039116
 IFSC Code : SBIN0060008

Receipt No.:

Date :

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* * * * *

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Dr. Kirti M. Patel

Hon. Secretary

Dr. Shailendra Vora

Hon. Jt. Secretary

Dr. Yogendra S. Modi

Hon. Finance Secretary

* * * * *

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NEW LIFE MEMBERS

I.M.A. GUJARAT STATE BRANCH

We welcome our new members

L_M_No.	NAME	BRANCH
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LM/33995	Dr. Murarkar Chetana Wamanrao	Amreli
LM/33996	Dr. Gurjar Yash Manojkumar	Modasa
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LM/34001	Dr. Shah Chandni Rutween	Ahmedabad
LM/34002	Dr. Amin Parth Jigishbhai	Ahmedabad
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LM/34004	Dr. Barot Chirag Harshadkumar	Ahmedabad
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LM/34006	Dr. Unadkat Anjali Vinaykant	Junagadh
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LM/34009	Dr. Khanderia Ridham Ashokbhai	Morbi
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LM/34012	Dr. Khan Kais Hashim	Valsad
LM/34013	Dr. Khan Deba Ali	Valsad
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LM/34015	Dr. Chaudhary Jitendra Kalubhai	Palanpur
LM/34016	Dr. Dhuliya Sandeep Kesharbhai	Palanpur
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LM/34018	Dr. Agrawal Jitesh P.	Palanpur
LM/34019	Dr. Nangalia Priyanka	Palanpur
LM/34020	Dr. Gelot Ravindra Ishvarlal	Palanpur
LM/34021	Dr. Solanki Arati Maganlal	Palanpur



LM/34022	Dr. Motaka Mayur Dhaneshkumar	Surendranagar-Wadhwan
LM/34023	Dr. Maniya Surbhi Gordhanbhai	Dahod
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LM/34025	Dr. Narang Vinay Jawahar	Dakor
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LM/34027	Dr. Chaudhary Satish Babubhai	Patan
LM/34028	Dr. Baraiya Nimesh Devshankarbhai	Bhavnagar
LM/34029	Dr. Pandya Malhar Himanshubhai	Bhavnagar
LM/34030	Dr. Baldania Vasurbhai Bhupatbhai	Bhavnagar
LM/34031	Dr. Maniar Kush Nitinbhai	Bhavnagar
LM/34032	Dr. Patel Dhruv Jitendrakumar	Patan
LM/34033	Dr. Memon Sohilmahmad Ikbahusen	Himatnagar
LM/34034	Dr. Patel Zankhana Rajeshbhai	Himatnagar
LM/34035	Dr. Solanki Vishal Pratapbhai	Amreli
LM/34036	Dr. Barad Neha Raghuvirsinh	Amreli
LM/34037	Dr. Patel Naitik Rameshchandra	Vapi
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* * * * *

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Hon. Treasurer	:	Dr. Shashwat Jani



OBITUARY

We send our sympathy & condolence to the bereaved family

Dr. Tattitali Totappa	06-02-2023	Surat
Dr. Dave Devendrakumar N.	20-02-2023	Visnagar
Dr. Munshi Haroonrashid	23-02-2023	Bharuch
Dr. Sauda Savita K.	27-02-2023	Palanpur
Dr. Chag Sanjiv C.	02-03-2023	Jamnagar
Dr. Shah Jayshree V.	03-03-2023	Bhavnagar
Dr. Balar Seema N.	07-03-2023	Bhavnagar
Dr. Gandhi Harivadan C.	12-03-2023	Navsari
Dr. Parikh Kantiprasad B.	25-03-2023	Ahmedabad
Dr. Mehta Dineshchandra R.	26-03-2023	Ahmedabad
Dr. Patel Jayantilal S.	26-03-2023	Surat
Dr. Upadhyay Haresh N.	27-03-2023	Unjha

We pray almighty God that their souls rest in eternal peace.

* * * * *

BRANCH ACTIVITY

AMRELI

13-05-2023 CME on Dengue and its management" by Dr. Manoj Sida.
"Prevention cardiology (statin Therapy)" by Dr. Denish Rajivadia

DEESA

16-04-2023 COLS seminar. More than 250 members of Police Department.
17-04-2023 COLS seminar for Palanpur Police. More than 250 members of Police Department.
25-04-2023 COLS with Hands on training for Forest Department.
30-04-2023 CPR Medical camp. More than 150 members including children joined to learn with hands.



17-05-2023 World Hypertension day. Blood Pressure check up camp.

GANDHIDHAM

01-04 to

28-04-2023 Blood donation Camp. Total 865 Units were collected.

KALOL

12-04-2023 CME on "SGLT 2 Inhibitors and Kidney" by Dr. Mayank Shah.
"Recent advance in joint replacement" by Dr. Viral Gondaliya.
"Newer imaging in CAD" by Dr. Parth Thakkar.
19-04-2023 "Basic and advance in IVF" by Dr. Rakesh Patel.

KAPADWANJ

13-04-2023 CME on "Osteoporosis medication and friendship with agains" by Dr. Bharat Dave.
02-05-2023 "Antiplatelet therapy and heart failure management" by Dr. Himanshu Meghnathi and Dr. Pruthviraj Cuwar.
12-05-2023 "Lung Cancer Overview" by Dr. Bhavesh Parikh.
"Primary Angioplasty in Myocardial Infarction" by Dr. Jit Brahmhatt.

MEHSANA

19-04-2023 CME on "Optimizing stroke prevention in AF management" by Dr. Kamlesh Thakkar.
"Transplanting the evidence into clinical practice & NOAC in pulmonary embolism" by Dr. Nihar Patel.
26-04-2023 CME on "How AI can change landscape of acute neurological & neurosurgical decisions" by Dr. Kalpesh Shah.
"How can we contribute in adding value to your territory" by Dr. Dinesh Saini.

MORBI

02-04-2023 Basic life support CPR training. Total 120 staff trained.
06-04-2023 Skin Care Seminar by Dr. Jayesh Sanariya. Total 80 students presented.



- 08-04-2023 CME on "Paediatric cardiology" by Dr. Sudhir Rughani.
"Clinical updates on Hep A and MCV vaccination" by Dr. Khandeparkar.
Free student check up camp. Total 300 students were benefitted.
- 12-04-2023 Free eye check up camp. Total 100 students were benefitted.
Menstrual hygiene awareness seminar by Dr. Bhavnaben Jani. Total 76 students were benefitted.
- 13-04-2023 Menopause seminar by Dr. Hemaben Aghera. Total 300 females were benefitted.
- 18-04-2023 "Recent advance in radiation oncology" by Dr. Samir Batham.
"Head and neck ocosurgery videos presentation" by Dr. Parin Patel.
"Immunotherapy" by Dr. Kshitij Domadiya.
- 19-04-2023 CPR training programme for general public. Total 46 persons were trained.
- 21-04-2023 "Pre and Pro biotics role in OBGY" by Dr. Hetal Modha.
- 25-04-2023 "Recent updates in liver surgery" by Dr. Hitesh Chavda.
"Prognosis of liver cirrhosis" by Dr. Chirag shah
- 28-04-2023 "Emergency management in acute appendicitis" by Dr. Mayur Jadvani.
- 30-04-2023 Free neurosurgery department camp. Total 34 patients were benefitted.
Free orthopaedic camp. Total 120 patients were benefitted.

RAJKOT

- 9-05-2023 CME on "Recent updates in Hemato-Oncology with special focus on CAR-T Cell Therapy in recent times" by Dr. Babita Hapani and Dr. Niketa Shah. Total 200 members were present.

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**Revised rates of advertisement in
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(INCLUSIVE OF G.S.T.)**

POSITION OF ADVT.	JOURNAL		BULLETIN	
	For Members ₹.	For Non-Members ₹.	For Members ₹.	For Non-Members ₹.
A Inside Full Page (Multi Colour)	19000-00	24000-00	13000-00	18000-00
	+ 3420-00	+ 4320-00	+ 2340-00	+ 3240-00
	₹.22420-00	₹.28320-00	₹.15340-00	₹.21240-00
B Inside Full Page (B/W)	10000-00	14000-00	8000-00	12000-00
	+ 1800-00	+ 2520-00	+ 1440-00	+ 2160-00
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IMA/HSG/F-22/155

20-5-23

To
Dr Sandhya Bhullar
Secretary
National Medical Commission

Sub: Draft Report on the “Registration of Medical Practitioners and License to practice Medicine Regulations, 2023”

Dear Madam,

The NMC has notified Registration of Medical Practitioners and License to practice Medicine Regulations, 2023”. IMA is constrained to make the following critical observations. IMA demands appropriate actions from your end.

1. It is pertinent to note that the NMC had placed the Draft Regulation on License to Practice Medicine 2022 and Registration of additional medical qualifications and temporary Registration of the Foreign Practitioner to Practice Medicine in India -2022 in the public domain and had sought comments thereon.
2. IMA had sent its observations to the NMC and other competent authorities enclosing to the covering letter dt. 25th April, 2022 bringing out the gross inconsistencies, inadequacies, contradictions and also the grounds pertaining to its unsustainability in the eyes of law and also its testing on the legal and constitutional grounds.
3. It is a matter of concern that inspite of the detailed observations having been known by the IMA to the National Medical Council the final regulations that has been put into operations continues to be plagued by inconsistencies, inadequacies and contradictions including wanting whereby it turns out to be questionable in the eyes of law in a gross and substantial manner.
4. The Regulation is now titled as “Registration of Medical Practitioners and License to Practice Medicine Regulations, 2023” which is a deviation from the original nomenclature that was put into public domain in the form of draft regulations.

In the preamble it is categorically brought out that the operational regulation is notified in exercise of powers conferred by Clause (Z j), (Z k) and (Zl) of Sub-Section 2 of Section 57 of the NMC Act 2019. However, in operation it brings within its fold the grant of limited license to practice medicine provided for under Sub-Section 1 of Section 32 of the NMC Act 2019 which is squarely provided for coverage for issuance of a regulation under Section (Zn) of Sub Section 2 of Section of 57 of NMC Act 2019 which is not mentioned in the preamble, which by itself is a palpable fallacy.

5. Further, the ambit in terms of issuance of regulation in regard to the manner of regulating professional conduct and promoting medical ethics under clause b of Sub Section 1 of Section 27 of the NMC Act as provided for under Sub section (Zd) of Subsection 2 of Section 57 of NMC Act and the question of prescribing the manner of taking disciplinary action by the State Medical Council for professional or ethical misconduct of registered medical practitioners of professional or procedure for receiving complaints and grievances by Ethics and Medical Registration Board under Sub Section 2 of Section 30 of the NMC Act 2019 for which regulation is to be notified in terms of (Zh) of Sub Section 2 of Section 57 of the NMC Act is not covered in the ambit of present notified



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regulation meaning thereby that it would be regulated through issuance of a separate regulation to give an operational effect to the same.

6. Under Section 2 Definitions are brought out and vide a proviso it is brought out that “words and expressions used in these regulations and not defined herein but defined in the NMC Act shall have the same meaning assigned to them in the Act”. However, the word ‘Registered Medical Practitioner’ for whom the entire regulations is brought out is not defined under Section 2 of the Regulation and is also not defined under Section 2 of the NMC Act 2019 as well whereby the vary purpose for which the regulation is brought out is missing in terms of as defined definition which can be said to be nothing more or less than an apology in terms of the grossest possible omission in the Regulation.
7. The IMA in its communication dt. 25th April, 2022 enclosing thereto its Observations has brought out that the inconsistencies, infirmities and the inadequacies in the Draft Regulation were not only in consist with the provisions of the parent NMC Act 2019 but also violative of the Constitutional provisions and also prejudicial the principles incorporated therein specially with reference to Federalism and the doctrine of centre-state relationship. (Annexure A).
The same is not reproduced so as to avoid repetition but is annexed for reiteration.
8. In section 4 (I) read with Sub Section (iii), it is brought out in the Regulation that the NMC will be the primary registering authority for the persons who qualify NEXT and would be included in the NMC Register. However, this by itself is violative of the governing principle on the basis of which the State Medical Councils are created through State Legislative Enactments with original authority for registration of the Registered Medical Practitioners in the given States is not open for any trespass, prejudice, marginalization of any type by a regulation which in its very nature is a subordinate legislation. As such, the dichotomy renders the regulation questionable on this very count itself.

Section 4(iii) of the Regulation stipulates that a Registered Medical Practitioner primarily registered with NMC finding a place in National Medical Register can practice anywhere in India and therefore in terms of the same, the need for their registration in State Medical Council turns out to be redundant. In the teeth of this very clause, the entire operational mechanism incorporated in the regulation for transfer of registration turns out to be inconsistent by its nature and intended operation.

Section 4 (iv) stipulates that a processing fee of generation of UID shall be payable in favour of Secretary, NMC and Sub-Section (iii) entitling him/her to practice anywhere in India, then not only in the authority and jurisdiction of State Medical Council stands mauled but also the lone source of revenue receipt is pocketed by the NMC making them lifelong redundant and bankrupt as well.

9. In terms of Section 6 (a) of the Regulation, an application is to be made through a web portal of the Ethic and Registration Board, however no such web portal is notified as of now.

In terms of Section 6 (b) of the Regulation, it is provided that eligible persons may opt any State/States to practice medicine implying that an applicant can seek registration in more than 1 State through one application without the Regulation providing for any mechanism of any type for the purposes of providing the same. Nonetheless, in case Registration is awardable in more than 1 State through a common application, the modality of transfer of registration of such an applicant existingly registered in more than 1 State originally is not provided for.



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In terms of Section 6 (c), the State Medical Councils are to consider the application for registration within 30 days with due verification as warranted is much lesser a time limit for all the desired dispensation specially with reference to checking the authentication of all the documents including certificates, specially internship completion certificates and confirmations in regard to the vetting of the documents from the respective Embassies in case of Foreign Medical Graduates including confirmation of the documents submitted by them from the Foreign Universities.

- In terms of provisions included in Section 7 (iv) of the Regulation, the Registered Medical Practitioner with additional qualification is entitled to practice anywhere in India and not limited to the State where he or she is primarily registered with the State Medical Council which is hugely paradoxical and is plagued by an absolute contradiction.
- In terms of provision included in Section 8 of the Regulation, under the title "Renewal of License to Practice Medicine" provisions are made for renewal of registration in every 5 years without any prescription for the mandatory requirement stipulated credit hours. In absence of the same, it would amount to a blind renewal of registration which would be inconsistent with the provisions on this count in the international parlance and thereby is not only a retrograde step but also would make India a laughing stock in the comity of the nations. As such, renewal of registration in terms of its inseparable linkage with prescribed credit hours is a must to be provided even in terms of legal pronouncements as well made by the judicial forums where the same is upheld in unequivocal terms.

In Section 8(iii), there is no provision provided for reinvestment of "Inactive Registration" in the Regulation which would mean that Registration declared inactive due to minor inadvertence would end up in permanent removal of the name from the register. As such, a procedure for reinstatement for Inactive Registration needs to be provided for to avoid the consequent malady of ending up in invocation of an irreparable inter-alia lifelong damage.

- As provided for in Section 9 (ii), there is a mechanism for transfer of License to Practice in another State which is at the cost of losing the Right to Practice by the practitioner by the transferring State. This is inconsistent with the provision included in Section 6(b) of the Regulation, where the Registration is provided for the Registered Medical Practitioners in State/States. Upon harmonious reading of the 2 provisions in the Regulation, a mechanism for automatic registration between the transferring and transferee State/States needs to be worked out with right vested in the Registered Medical Practitioners to practice in such State/States.

In Section 9 (iv), the UID in case of a transfer of the Registration No. shall remain the same and the "Prefixed" code of the concerned State shall be substituted with the "Suffixed" code of the new State which is contradictory because in terms of Section 6 (d), the State Code is to be "Suffixed" whereas in terms of Section 9 (iv) the word used is "Prefixed" State Code which anomaly is beyond the scope of correction. As such, the contradiction mandates prompt correction.

- Section 10 of the Regulation provides for the removal and Restoration of Registration. However, it does not provide for any mode and manner for Restoration of Registration which makes the clause not only half baked but also half cooked.
- Section 11 of the Registration, under the title of transitory provisions, the period provided for is 3 months from the publishing and notification of the said Regulation. However, in the absence of non-existent web portal, the said proviso is meaningless. Further, there are State Medical Councils in the country which have their State



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Medical Councils in a digital format. The entire information of such State Medical Registers in one go can be transferred to the National Medical Register without compelling the individual Registered Medical Practitioners included in such electronic format to prefer individual applications for inclusion of their names in the National Medical Register.

It is stipulated therein under Section 11 of the Regulation that the Registration upon the inclusion in the name of National Medical Register shall be valid for 5 years for the date of such inclusion which also would be perilous for the State Medical Councils, specially from the point of view of their receipt revenue for the purposes of Renewal of Registration which would be causing a heavy prejudice to the financial receipts of the State Medical Councils.

The aforesaid contradictions, inadequacies, inconsistencies and infirmities have rendered the entire Regulations in an utterly confusing and dis-figured form which does not augur well for a subordination legislation in the official legislation of the Gazette of India by the National Medical Council as a Parliamentary Enacted Body, specially in the context of its resultant legal invalidity.

IMA would like to discuss the above matter with your goodself and put forward suggestions. Hope you will be open for remedial measures.

Thanking you,

Yours sincerely,

Dr. Sharad Kumar Agarwal
National President, IMA

Dr. Anilkumar J Nayak
Honorary Secretary General, IMA

Annexure: IMA's Observations sent on 25th April 2022 on Draft Regulation

Copy to :

- Shri Mansukh Mandaviya Ji, Honourable Health Minister, Government of India
- Dr. Suresh Chandra Sharma, Chairman, National Medical Commission
- All Office Bearers of IMA
- All State Presidents and Hony. State Secretaries of IMA



Family Planning Centre, I.M.A. Gujarat State Branch

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 April-2023 in addition to their routine work. These are as under :

01-04-2023 to 30-04-2023 : Intra domestic house to house survey
by the centers of Ahmedabad

Nanpur - Surat : Mothers : 2000 Iron Tablet

Children 40 Vitamin A solution were distributed

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

APRIL 2023

No.	Name of Center	New Case	Old Case	Total Case
(1)	Ambawadi (Jamalpur Ward)	771	201	972
(2)	Behrampura (Sardarnagar Ward)	1274	680	1954
(3)	Bapunagar (Potalia Ward)	1493	261	1754
(4)	Dariyapur (Isanpur Ward)	1368	352	1720
(5)	Gomtipur (Saijpur Ward)	2368	364	2732
(6)	Khokhra (Amraiwadi Ward)	1855	244	2099
(7)	New Mental (Kubernagar Ward)	1558	182	1741
(8)	Raikhad (Stadium Ward)	661	196	857
(9)	Wadaj (Junawadaj Ward)	1100	106	1206
(10)	Junagadh	-	-	-
(11)	Rander-Surat	-	-	-
(12)	Nanpura-Surat	-	-	-
(13)	Rajkot	814	838	1652



APRIL 2023

No.	Name of Center	Female Sterilisation	Male Sterilisation	Copper-T	Condoms (PCS)	Ocpills
(1)	Ambawadi (Jamalpur Ward)	15	—	33	4920	223
(2)	Behrampura (Sardarnagar Ward)	03	—	20	6750	600
(3)	Bapunagar (Potalia Ward)	18	02	28	11238	253
(4)	Dariyapur (Isanpur Ward)	20	—	24	12875 Nos.	710 Pkt.
(5)	Gomtipur (Saijpur Ward)	07	—	29	4860 Nos.	174 Pkt.
(6)	Khokhra (Amraiwadi Ward)	29	—	50	3760	262 Pkt.
(7)	New Mental (Kubernagar Ward)	11	—	50	22720	757
(8)	Raikhad (Stadium Ward)	33	—	40	8940	722 Pkt.
(9)	Wadaj (Junawadaj Ward)	05	—	32	7500	3100
(10)	Junagadh	13	—	33	5500	233
(11)	Rander-Surat	03	—	03	878 Nos.	17 Pkt.
(12)	Nanpura-Surat	11	—	27	960 Nos.	77 Pkt.
(13)	Rajkot	02	—	24	3700	200



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