STATE PRESIDENT AND HON. STATE SECRETARY'S MESSAGE

Dear Members,

Wishing you all a very very happy & safe summer season.

As you all must be experiencing the peak of this summer while this bulletin is under process of printing. We have previously mentioned in one of our message that day by day all seasons are getting harder & harder. This year we have witnessed severe heat wave. It was never experienced in last few years to our knowledge. Temperature has almost touched 50*c this season in almost all parts of the state. Various corporations have declared red & orange alerts for the same. We have included details of guidelines to combat heat wave elsewhere in this issue. And let us reiterate that we the human beings are responsible by & large for such a drastic climatic change. Its high time to have collective actions from all the fronts. Its not a job of any single agency or authority. It's a global issue & critical impact of over ambitious developmental process of human race.

Last month, biggest hot topic other than heat wave was NEET examination ruling by supreme court. Medical aspirant

students & their parents have faced stressful period by sudden declaration of change of examination pattern. We always welcome NEET as it provides single window system for admission & also provides transparency. As government has cleared the confusion for current year students as of now, it seems now that NEET will be implemented from next year.

Medical fraternity is passing through turmoil scenario. It faces lots of different kind of issues from all the corners. Like govt policies, CEA, assault, PCPNDT, interpathy practice issues, issues related to pharma companies & commission, overall rising investment for establishment of private set ups, caping of charges, record keeping, corporatisation of medical practice 7 on & on & on. And hats off to our national leaders that they are powerfully dealing all the issues efficiently.

Our sincere request to all IMA members to support whole heartedly for call of IMA.

Jay Hind, Jay IMA.

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

Dr. Jitendra N. Patel
Hon. State Secy., G.S.B.,I.M.A.)

I.M.A.G.S.B. NEWS BULLETIN

GUJARAT MEDICAL JOURNAL

INDIAN MEDICAL ASSOCIATION, GUJARAT STATE BRANCH

Estd. On 2-3-1945

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GUJARAT MEDICAL JOURNAL

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STATE PRESIDENT-HONY. SECY. & OFFICE BEARERS TOURS/VISIT

17-04-2016 Dr Atul Pandya, President IMA GSB felicitated Dr. Sushil Karia senior urologist for his social services rendered at remote areas of Nagaland. (West zone urology society organized operative camp.)

19-04-2016 Dr Atul Pandya: Felicitated Dr Atul Badiyani for performing 224 free surgeries in one day at Ranchhoddas Bapu eye hospital.

21-04-2016 Dr Atul Pandya, President IMA GSB launched Anti malnourishment programme for Vidhansabha 69 and felicitated Dr. S. T. Hemani (senior surgeon) with life time achievement award at Rajkot IMA at the installation ceremony.

06-05-2015 Dr. Atul D. Pandya, President IMA GSB, Dr. Bharat Kakadia, Dr. Rajguru and Dr. V.B. Kasundra visited the Amreli Branch.

* * * * * *

DISCLAIMER

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

I.M.A. NATIONAL SOCIAL SECURITY SCHEME

DFC No.21 was circulated to all the members.

Those members who have not yet paid the same, send the DFC amount with penalty ₹ 100/-.

Last date of payment is 15/06/2016.

So please send your Cheque / Draft at Ahmedabad Office directly.

Dr. Kirti M. Patel — Chairman

Dr. Yogendra S. Modi — Hon. Secretary

* * * * * *

SOCIAL SECURITY SCHEME GSB-IMA

DFC (Death Fraternity Contribution) No.41 was circulated to all the members. **Last date of payment was 30/04/2016**.

Those members who have not yet paid the same, send the DFC amount with penalty ₹ 100/- **before 10/06/2016** by cheque to S.S.S. GSB-IMA office..

Dr. Jitendra B. Patel — Hon. Secretary

Dr. Kirit A. Gandhi — Hon. Jt. Secretary

Dr. Yogendra S. Modi — Hon. Treasurer

* * * * * *

CONGRATULATIONS

❖ **Satvik M. Mashkaria; son of Dr. Mehul & Dr. Hina Mashkaria, Ahmedabad**

Selected for International Mathematics Olympiad Training Camp (IMOTC) by Homi Bhabha Institute, Mumbai & Central Govt. of India.

NEW LIFE MEMBERS

I.M.A. GUJARAT STATE BRANCH

We welcome our new members

L_M_No.	NAME	BRANCH
LM/25191	Dr. Bhojani Magan Arjanbhai	Mahuva
LM/25192	Dr. Prajapati Ramesh Mangalbhai	Deesa
LM/25193	Dr. Shah Prachi Priyankbhai	Godhra
LM/25194	Dr. Agrawal Pritesh Omprakash	Mehsana
LM/25195	Dr. Suthar Dhrupal Chandrakant	Radhanpur
LM/25196	Dr. Patel Jignesh Babulal	Radhanpur
LM/25197	Dr. Lanukiya Bansal Jayantibhai	Radhanpur
LM/25198	Dr. Vadher Samir Hasmukhbhai	Surat
LM/25199	Dr. Khetani Seema Arvindbhai	Surat
LM/25200	Dr. Patel Neha Arvindbhai	Surat
LM/25201	Dr. Patel Ankit Baldevbhai	Surat
LM/25202	Dr. Patel Jigisha Ankitbhai	Surat
LM/25203	Dr. Morker Pinank Ravindrabhai	Surat
LM/25204	Dr. Vankar Thakor Vitthalbhai	Devgadh
LM/25205	Dr. Patel Swapnil Lavjibhai	Himatnagar
LM/25206	Dr. Gheewala Pratik Dilipkumar	Bhavnagar
LM/25207	Dr. Pipalawala Mohammed Imran	Sidhpur
LM/25208	Dr. Parikh Harsh Hemangbhai	Sidhpur
LM/25209	Dr. Patel Dipen Dineshbhai	Sidhpur
LM/25210	Dr. Prajapati Bhavesh Kantilal	Sidhpur
LM/25211	Dr. Patel Kashyap Govindbhai	Patan
LM/25212	Dr. Memon Ramiz Manzoorahmed	Surat
LM/25213	Dr. Meman Taslimabanu Ramiz	Surat
LM/25214	Dr. Viradiya Hitesh Manijibhai	Surat
LM/25215	Dr. Patel Amit Dahyabhai	Surat
LM/25216	Dr. Kapadiya Keyur Amarkumar	Surat
LM/25217	Dr. Kapadiya Parul Keyur	Surat
LM/25218	Dr. Shah Viral Kishorchandra	Surat
LM/25219	Dr. Jonwal Kamaxi Chhotelal	Gandhidham

LM/25220	Dr. Dhadhal Rakesh Mohanbhai	Gandhidham
LM/25221	Dr. Koradia Tejas Maganlal	Morbi
LM/25222	Dr. Dhudhwala Utkal Sureshbhai	Navsari
LM/25223	Dr. Kansara Darshan Upendra	Surat
LM/25224	Dr. Kansara Chandni Darshan	Surat
LM/25225	Dr. Bharmal Yusuf Asgar	Surat
LM/25226	Dr. Vansia Jay Natvarlal	Surat
LM/25227	Dr. Paneria Tejal Babulal	Surat
LM/25228	Dr. Pawara Chirag Laljibhai	Surendranagar
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LM/25331	Dr. Zala Girishbhai Danabhai	Mehsana
LM/25232	Dr. Patel Bhavik Chhotalal	Modasa
LM/25233	Dr. Upadhyay Sandeep Suresh	Modasa
LM/25234	Dr. Kania Shalini Vinodkumar	Surat
LM/25235	Dr. Patel Harshad Vasharambhai	Surat
LM/25236	Dr. Sharma Manish Anilkumar	Surat
LM/25237	Dr. Mehta Vishakha Ashokkumar	Surat
LM/25238	Dr. Patel Mittal Jayantilal	Surat
LM/25239	Dr. Jariwala Nainesh S.	Surat
LM/25240	Dr. Agarwal Dinesh	Bhavnagar
LM/25241	Dr. Gupta Parul	Bhavnagar
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LM/25243	Dr. Dave Mohit Janardan	Ahmedabad
LM/25244	Dr. Mori Jignesh Pratapbhai	Ahmedabad
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LM/25247	Dr. Gajjar Himani Mithilbhai	Ahmedabad
LM/25248	Dr. Panchal Karnav Bharatbhai	Ahmedabad
LM/25249	Dr. Desai Harita Munjal	Ahmedabad
LM/25250	Dr. Patel Sachin Jayantilal	Ahmedabad
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LM/25283	Dr. Gamit Mital Jivabhai	Rajkot
LM/25284	Dr. Chaudhari Kirtikumari K.	Rajkot
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LM/25286	Dr. Parmar Nisha Jayantlal	Rajkot
LM/25287	Dr. Rai Sunilkumar	Rajkot
LM/25288	Dr. Kakadiya Mahesh Raghavbhai	Rajkot

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LM/25290	Dr. Bhut Kruti Pradipbhai	Rajkot
LM/25291	Dr. Kotadiya Tushar Ramniklal	Rajkot
LM/25292	Dr. Patel Chirag Dayabhai	Rajkot
LM/25293	Dr. Bhojani Kaushal Rasiklal	Rajkot
LM/25294	Dr. Dalwadi Chintan C.	Rajkot
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LM/25298	Dr. Makwana Chandani Vasudev	Rajkot
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LM/25301	Dr. Damor Kamlesh Gendalbhai	Rajkot
LM/25302	Dr. Taviyad Shilpa Prakashbhai	Rajkot
LM/25303	Dr. Vaghasia Krunal Punalal	Rajkot
LM/25304	Dr. Dobariya Trushali K.	Rajkot
LM/25305	Dr. Patil Pankaj Shrishbhai	Rajkot
LM/25306	Dr. Chavda Amita Bharatbhai	Rajkot
LM/25307	Dr. Thakor Bhaumik Prabhatsinh	Rajkot
LM/25308	Dr. Desai Ruchi Dullabhbhai	Rajkot
LM/25309	Dr. Zinzala Vipul Kababhai	Talaja

* * * * *

OBITUARY

We send our sympathy & condolence to the bereaved family

Dr. Chandra Deo Chaubey	24-12-2015	Ahmedabad
Dr. Bhikhabhai S. Parmar	11-03-2016	Ahmedabad
Dr. Vipul R. Sanghani	12-03-2016	Ahmedabad
Dr. Y.R. Premlatha	20-03-2016	Vadodara
Dr. Ishwarlal M. Patel	29-03-2016	Sidhpur
Dr. Nitinkumar N. Patel	15-04-2016	Patan

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

BRANCH ACTIVITY

GANDHIDHAM

23-04-2016 "Sudden Cardiac death & new frontiers in Arrhythmias" by Cardiologist doctors of Sterling Hospital. Approx 30 members were present.

30-04-2016 IMA Gandhidham Branch in collaboration with Taluka Health Office (THO) Gandhidham organized a free medical checkup camp. More than 200 patients of DM, HT and other diseases were benefited. Health education of various medical disorders and cancers including breast cancer, cervical cancer and oral cavity cancer was also given.

KALOL

29-04-2016 "Frequently ask questions of Cardiology" by Dr. Urmil Shah.

"Life Style modification A New Mantra" by Dr. Dhaval Naik.

MORBI

03-04-2016 "Teenage parenting" by Dr. Nishchal Bhatt.

"Problems in adolescent" by Dr. Ramesh Boda.

Total presence was 98 (48 doctors with spouse) persons.

15-04-2016 "Venous insufficiency and pulmonary embolism, medical management" by Dr. Satyam Udhreja.

"Venous insufficiency and pulmonary embolism, surgical management" by Dr. Madhav Upadhyay.

17-04-2016 Free diagnostic and therapeutic camp at Samakhiyari – Kutch.

Total 400 people took benefit of that camp.

24-04-2016 Pamphlet distribution on World Immunization week. Total 10,000 pamphlets were distributed about general information of vaccination and routine vaccination schedule as part of Celebration of World Immunization week.

MMR vaccination was done in needy patient at free of cost during this week from 24-4-2016. Total 20 patients were immunised during this week.

22-04-2016 "Rational use of blood components" by Dr. Falguni Jani.

"Updates in transfusion medicine" by Dr. Nishith Vachhani

29-04-2016 "Repeated pregnancy loss" by Dr. Amita Bhatt.

"Spirituality in pregnancy" by Dr. Panara Jayesh. Total 10 doctors were present.

NADIAD

03-04-2016 Fitness Cycling and walking events was organized

05-04-2016 "Valve surgery the way ahead" by Dr. Agrawal.

"Life style modification" by Dr. Anil Jain.

17-04-2016 "Approach to patients with Neuropathy" by Dr. Lomesh Bhirud.

"Diabetic Neuropathy" by Dr. Daxesh Shah.

"Role of intervention pain specialist in treating neuropathy pain" Dr. Kiran Jayswal.

Seminar on Cancer detection and its management.

"Childhood Cancer overview" by Dr. Anup A. Joshipura.

"Multiple myeloma How to diagnose and treat" by Dr. Priyanka Srivastava.

Special Nursing Staff seminar was also organized.

24-04-2016 Mega Medical diagnostic camp and blood donation jointly organized by Nadiad Medical Association with Shree Nadiad Akda Khdayta Pragati Mandad and with help of specialist and super specialist doctor's from Nadiad-Anand-Ahmedabad Vadodara. More than 550 patients benefited and 128 bottles were collected of blood and very good lectures by experts on various subjects for prevention of common diseases.

RAJKOT

27-03-2016 Installation Ceremony of IMA office Bearers for Year 2016-17

09-04-2016 Felicitation of Senior Medical Teachers - Seven Senior Medical Teachers (Ex. Professors of Medicine Department of M. P. Shah Medical College, Jamnagar, were felicitated at Hotel TGB, Rajkot, by Dr. Atul D. Pandya, President IMA GSB. Rajkot IMA President Dr. Dilip Patel and Rajkot IMA Secretary Dr. Amit Agravat as part of Vadil Vandana Programme.

10-04-2016 Diabetes Screening Camp followed by Diabetes Awareness Lecture at Police Headquarters Rajkot for the benefit of Policemen & their Family members.

17-04-2016 Multi Specialty CME held at Platinum Hotel.

24-04-2016 "Life Style Diseases Awareness & Prevention" Theme Paintings on Wall of Railway Hospital, Rajkot by Indian Medical Association, Rajkot with Western Railway & Chitranagri Rajkot.

SIDHPUR

13-04-2016 “Myths & Facts about angiography & angioplasty” by Dr. Gaurav Gandhi. Total 50 doctors attended the CME.

* * * * *

ATTENTION PLEASE !!

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

L_M_No.	NAME	BRANCH
LM/13595	Dr. Bhatnagar Poonamswaroop V.	Ahmedabad
LM/05889	Dr. Parikh Piyush J.	Ahmedabad
LM/24181	Dr. Patel Pankaj Vrajlal	Ahmedabad
LM/18460	Dr. Patel Srujal Mulchandbhai	Ahmedabad
LM/20747	Dr. Shah Gunjan Dhirenbhai	Ahmedabad
LM/18635	Dr. Shah Maulik Mahendrabhai	Ahmedabad
LM/09999	Dr. Shah Mehul Devendrabhai	Ahmedabad
LM/10000	Dr. Shah Shruti Mehulbhai	Ahmedabad
LM/10739	Dr. Talati Shailesh Shantilal	Ahmedabad
LM/10740	Dr. Talati Seema Shaileshbhai	Ahmedabad
LM/20780	Dr. Nath Basavdatta Bhabanda	Dhroljodhpur
LM/10346	Dr. Patel Shahil Arvindbhai	Gandhidham
LM/07009	Dr. Joshi Natwarlal D.	Mangrol
LM/21822	Dr. Sanghvi Vivek Dineshchandra	Morbi
LM/18430	Dr. Kamani Praful Manjibhai	Rajkot
LM/05553	Dr. Vaidya H D	Rajkot
LM/17080	Dr. Thakkar Kirankumar P.	Sidhpur
LM/14145	Dr. Desai Dhaval Dilipbhai	Surat
LM/23365	Dr. Hirapara Pushpendra H.	Surat
LM/23366	Dr. Hirapara Nancy Pushpendra	Surat
LM/25154	Dr. Patel Nilesh Parsottambhai	Surat
LM/25155	Dr. Patel Shilpa Nileshbhai	Surat
LM/14966	Dr. Patel Niraj Kashinathbhai	Surat
LM/19547	Dr. Patel Smita Nirajbhai	Surat
LM/17985	Dr. Rathwa Suresh G.	Surat
LM/24483	Dr. Patel Amit Thakorbhai	Vadodara
LM/00089	Dr. Patel Ramanlal D.	Vadodara
LM/14073	Dr. Rolekar Yogini Girdharlal	Valsad

COLLEGE OF GENERAL PRACTITIONERS, I.M.A.G.S.B.

To,
All Local Branch
Presidents / Hon. Secretaries.

Respected Sir,

You are invited to arrange the C.M.E. under I.M.A. C.G.P. for improvising. The medical – update – knowledge so that services to society will be in a better – mannerThe rule – condition and guide lines for arranging C.M.E. programme are as follow;

A. Financial Assistance of Rs. 50-00 per member attending the seminar maximum up to Rs. 5000-00 will be provided to the organizing local branch.

B. The C.M.E. shall be "C.G.P. G.S.B. I.M.A. & name of local branch.

Please arrange C.M.E. programme jointly with College of G.P. I.M.A. Gujarat State branch & when will you arrange, please inform to College of G.P. I.M.A. Gujarat State branch.

You are requested to encourage the C.M.E. activities. Looking for your cooperation.

You are requested to encourage the C.M.E. activities. Looking for your cooperation.

Thanking You,

Yours Sincerely,

Dr. Vasant Patel
Hon. Secretary

Dr. Kirit C. Gadhvi
Director

INDIAN MEDICAL ASSOCIATION

GUJARAT STATE BRANCH
A.M.A. House, Opp. H.K. College, Ashram Road, Ahmedabad -380009
PHONE & FAX: (079) 265 87 370 Email: imagsb@gmail.com

Dear Branch Secretary

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

ORDINARY MEMBERSHIP FEES

CATEGORY	HFC	GMJ	GSB	ADM.FEE	TOTAL TO BE SENT TO GSB.IMA
Annual Single:	391-00	25-00	10-00	20-00	446-00
Annual Couple:	586-00	38-00	20-00	30-00	674–00

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

LIFE MEMBERSHIP FEES

CATEGORY	TOTAL FEES	BR.SHAHRE	ADM.FEES INCLUDING GSB. IMA	TO BE SENT TO GSB. IMA
Single	8095-00	760-00	{ 20-00 }	Rs. 7335-00
Couple	12050-00	1200-00	{ 30.00 }	Rs. 10850–00

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

I.M.A. COLLEGE OF GENERAL PRACTITIONERS

College of G.P Rs. 2000-00
Life Membership
Membership Fees along with Life Subscription of Family Medicine DD in favour of "IMA CGP HQ"
Payable at Chennai and send to us

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

Yours Sincerely

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

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

Respected Members,

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

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

18-04-2016 to 19-04-2016 : Migratory Polio by the centers of Ahmedabad.

29-04-2016 : Maha Medical Camp, Khokhra : Total Patients : 539

Rander - Surat : Mothers - Iron : 750 tablets & Calcium : 1000 tablets were distributed & Vitamin A solution given to 16 children.

Nanpura - Surat : Mothers - Iron : 1500 tablets & Calcium : 500 tablets were distributed & Vitamin A solution given to 30 children.

Rajkot : 17-4-2016, Migratory Polio : 30-4-2016, Medical Camp : Patients : 150

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

APRIL-2016

No.	Name of Center	New Case	Old Case	Total Case
(1) Ambawadi	(Jamalpur Ward)	864	546	1410
(2) Behrampura	(Sardarnagar Ward)	1528	406	1934
(3) Bapunagar	(Potalia Ward)	1499	409	1908
(4) Dariyapur	(Isanpur Ward)	963	211	1174
(5) Gomtipur	(Saijpur Ward)	1723	630	2353
(6) Khokhra	(Amraiwadi Ward)	2071	411	2482
(7) New Mental	(Kubernagar Ward)	463	76	539
(8) Raikhad	(Stadium Ward)	347	351	698
(9) Wadaj	(Junawadaj Ward)	456	80	536
(10) Khambhat		—	—	—
(11) Junagadh		----	----	----
(12) Rander-Surat		----	----	----
(13) Nanpura-Surat		----	----	----
(14) Rajkot		940	402	1342

APRIL - 2016

No.	Name of Center	Female Sterilisation	Male Sterilisation	Copper-T	Condoms (PCS)	Ocpills
(1)	Ambawadi (Jamalpur Ward)	20	—	48	8490	280 P
(2)	Behrampura (Sardarnagar Ward)	07	04	33	4800	1316
(3)	Bapunagar (Potalia Ward)	24	—	24	13380	302 P
(4)	Dariyapur (Isanpur Ward)	20	—	35	26250	1050
(5)	Gomtipur (Saijpur Ward)	23	—	27	55925	1878
(6)	Khokhra (Amraiwadi Ward)	05	02	60	12750	228
(7)	New Mental (Kubernagar Ward)	21	---	17	16410	520
(8)	Raikhad (Stadium Ward)	22	---	42	5814	966
(9)	Wadaj (Junawadaj Ward)	07	—	35	12000	1860
(10)	Junagadh	13	02	42	3000	243
(11)	Rander-Surat	09	—	21	750	40 P
(12)	Nanpura-Surat	25	—	27	1920	80 P
(13)	Rajkot	21	01	32	230	150

MOLECULE OF THE MONTH
Almotriptan malate, a selective 5-hydroxytryptamine1B/1D (5-HT1B/1D) receptor agonist.

Mechanism of Action

Almotriptan binds with high affinity to 5-HT1D, 5-HT1B, and 5-HT1F receptors and have weak affinity for 5-HT1A and 5-HT7 receptors

Agonist effects of almotriptan at 5-HT1B/1D receptors on the extracerebral, intracranial blood vessels that become dilated during a migraine attack, and on nerve terminals in the trigeminal system. Activation of these receptors results in cranial vessel constriction, inhibition of neuropeptide release, and reduced transmission in trigeminal pain pathways.

Pharmacokinetics

Almotriptan is well absorbed after oral administration with absolute bioavailability of about 70% with peak plasma levels 1 to 3 hours after administration; food does not affect pharmacokinetics. Plasma protein bounding is approximately 35% and mean half-life of 3 to 4 hours. Almotriptan is metabolized by one minor and two major pathways. Monoamine oxidase (MAO)-mediated oxidative deamination (approximately 27%) and cytochrome P450-mediated oxidation (approximately 12% of the dose) are the major routes of metabolism while flavin monooxygenase is the minor route. About 75% of almotriptan is eliminated primarily by renal excretion. Approximately 13% of the administered dose is excreted via feces, both unchanged and metabolized.

Adverse effects:

The most common adverse events are nausea, somnolence, headache, paresthesia, and dry mouth. Vasodilation, palpitations, and tachycardia, hypertension and syncope may occur.

Other ADRs are myalgia and muscular weakness, arthralgia, arthritis, and myopathy.

Hyperglycemia and increased serum creatine phosphokinase, increased gamma glutamyl transpeptidase and hypercholesteremia

Serious cardiac events, including myocardial infarction and coronary artery vasospasm, have occurred following the use of almotriptan malate. These events are extremely rare and most have been reported in patients with risk factors predictive of CAD.

Postmarketing Experience

Coronary artery vasospasm, intermediate coronary syndrome,myocardial infarction, seizures have been reported spontaneously to various surveillance systems with almotriptan.

Precaution & contraindications

- Hypersensitive to almotriptan,
- Cardiovascular disease & uncontrolled hypertension (Because of the risk of (5-HT1B/1D agonists) coronary vasospasm), should not be administered within 24 hours of treatment with another 5-HT1 agonist, or an ergotamine-containing or ergot-type medication like dihydroergotamine or methysergide.
- It is recommended that patients who are intermittent long-term users of almotriptan and who have or acquire risk factors predictive of CAD, undergo periodic interval cardiovascular evaluation.
- Presence of risk factors (e.g., hypertension, hypercholesterolemia, smoker, obesity, diabetes, strong family history of CAD, female with surgical or physiological menopause, or male over 40 years of age)

- Almotriptan should also be administered with caution to patients with diseases that may alter the absorption, metabolism, or excretion of drugs, such as those with impaired hepatic or renal function

Pregnancy& lactation : There are no adequate and well-controlled studies in pregnant women; therefore, almotriptan should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Pediatric : Safety and effectiveness of almotriptan in pediatric patients have not been established; therefore, not recommended for use in patients under 18 years of age.

Drug Interactions

- Coadministration of moclobemide resulted in a 27% decrease in almotriptan clearance and an increase in Cmax of approximately 6%. No dose adjustment is necessary.
- Concomitant use of other 5-HT1B/1D agonists within 24 hours of treatment with almotriptan is contraindicated
- Life-threatening serotonin syndrome have been reported during combined use of selective serotonin reuptake inhibitors (SSRIs) or serotonin norepinephrine reuptake inhibitors (SNRIs) and triptans
- Coadministration of almotriptan and verapamil resulted in a 24% increase in plasma concentrations of almotriptan. No dose adjustment is necessary.
- Coadministration of almotriptan and the potent CYP3A4 inhibitor ketoconazole resulted in an approximately 60% increase in the area under the plasma concentration-time curve and maximal plasma concentrations of almotriptan. Although the interaction between almotriptan and other potent CYP3A4 inhibitors (e.g., itraconazole, ritonavir, and erythromycin) has not been studied.

- Serotonin Syndrome may occur with triptans, including almotriptan, particularly during combined use with selective serotonin reuptake inhibitors (SSRIs) or serotonin norepinephrine reuptake inhibitors (SNRIs).

Indications and usage

Almotriptan malate is indicated for the acute treatment of migraine with or without aura in adults.

It is not intended for the prophylactic therapy of migraine or for use in the management of hemiplegic or basilar migraine.

Dosage and administration

Almotriptan malate : single doses of 6.25 mg and 12.5 mg for the acute treatment of migraines in adults. If the headache returns, the dose may be repeated after 2 hours, but no more than two doses should be given within a 24-hour period.

Almotriptan malate tablets are available as : 6.25 mg, 12.5 mg

► Almotriptan 6.25mg/12.5mg for acute treatment of migraine attacks with a history of migraine with or without aura in adults was approved by CDSCO on 05.10.12 in India

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

Medical Error is Third Biggest Cause of Death in US: BMJ

To Err Is Human, for a Doctor to Apologize Is Uncommon

Medical error is 3rd leading cause of death in US after heart disease and cancer, according to findings published in BMJ.

But accurate, transparent information about errors is not captured on death certificates.

Death certificates depend on International Classification of Diseases (ICD) codes for cause of death, so causes such as human and system errors are not recorded on them. According to WHO 117 countries used ICD system

The report examined four studies that analyzed medical death rate data from 2000 to 2008. Then, using hospital admission rates from 2013, they extrapolated that, based on 35,416,020 hospitalizations, 251,454 deaths stemmed from a medical error. That number of deaths translates to 9.5% of all deaths each year in the US — and puts medical error above the previous third-leading cause, respiratory disease.

In 2013, 611,105 people died of heart disease, 584,881 died of cancer, and 149,205 died of chronic respiratory disease. The new estimates are considerably higher than those in the 1999 Institute of Medicine report "To Err Is Human."

The statistics of errors may be more if we include doctors' offices and ambulatory care centers.

IMA stand

1. Make errors more visible so their effects can be understood.
2. Hold discussions in open room rather than in closed door forums like department's morbidity and mortality conference.

3. Change death certificates to include not just the cause of death, but an extra field asking whether a preventable complication stemming from the patient's care contributed to the death.
4. All hospitals should carry out a rapid and efficient independent investigation into deaths to determine whether error played a role. A root cause analysis approach would help while offering the protection of anonymity, they say.
5. Standardized data collection and reporting
6. Human error is inevitable. But one can better design safer systems mitigating its frequency, visibility, and consequences.
7. Most errors aren't caused by bad doctors but by systemic failures and should 'not be addressed with punishment or legal action. Sensitisation of medical councils an consumer forum regarding this
8. No suspension of license or penal provisions for any error.

Dr K. K. Aggarwal
HSG, IMA (Hqs)

Is it Obligatory for Hospitals to Provide Copy of the Case Record to Patient or his Legal Representative?

OPINION

Yes, it is obligatory for doctors, hospitals to provide the copy of the case record or medical record to the patient or his legal representative.

The preamble to the Constitution of India coupled with the Directive Principles of State Policy strives to provide a welfare state with socialist patterns of society. It enjoins the State to make the "improvement of public health" a primary responsibility.

Furthermore, Articles 38, 42, 43 and 47 of the Constitution provide for promotion of health of individuals as well as healthcare. The Constitution of India also enumerates the separate and shared legislative powers of Parliament and State Legislatures in three separate lists: the Union List, the State List and the Concurrent List. The Parliament and State legislatures share authority over matters on the Concurrent List, which include criminal law and procedure.

Health service includes securing citizen from medical negligence by punishing concerned for crime of medical negligence and compensating the damage caused by doctor or hospital through negligence under tort action or securing the enforcement of contractual obligation under law of contract.

Consumer Protection Act is another legislation which is aimed at preventing negligence and deficient services besides assuring right to information about medical treatment given to the patient at the threat of imposing compensation.

The Medical Council of India has imposed an obligation on Hospitals as per the regulations notified on 11th March 2002, amended up to December 2010 to maintain the medical record and provide patient access to it. These regulations were made in exercise of the powers conferred under Section 20A read with Section 33(m) of the Indian Medical Council Act, 1956 (102 of 1956), by the Medical Council of India, with the previous approval of the Central Government, relating to

the Professional Conduct, Etiquette and Ethics for registered medical practitioners, namely:

MAINTENANCE OF MEDICAL RECORDS

1.3.1. Every physician shall maintain the medical records pertaining to his/her indoor patients for a period of 3 years from the date of commencement of the treatment in a standard proforma laid down by the Medical Council of India and attached as Appendix 3.

1.3.2. If any request is made for medical records either by the patients/ authorized attendant or legal authorities involved, the same may be duly acknowledged and documents shall be issued within the period of 72 hours.

MCI ethics regulations 7.2 further clarifies that not giving records can amount to professional misconduct.

Misconduct: "7.2 If he/she does not maintain the medical records of his/her indoor patients for a period of 3 years as per regulation 1.3 and refuses to provide the same within 72 hours when the patient or his/her authorized representative makes a request for it as per the regulation 1.3.2."

With the enforcement of the MCI Regulations, 2002 it is made clear that the patient has a right to claim medical records pertaining to his treatment and the hospitals are under obligation to maintain them and provide them to the patient on request.

In Kanaiyalal Ramanlal Trivedi v Dr Satyanarayan Vishwakarma 1996; 3 CPR 24 (Guj); I (1997) CPJ 332 (Guj); 1998 CCJ 690 (Guj), The Hon'ble High Court of Gujrat has held that the hospital and doctor were held guilty of deficiency in service as case records were not produced before the court to refute the allegation of a lack of standard care.

In Raghunath Raheja v Maharashtra Medical Council, AIR 1996 Bom 198, Bombay High Court upheld the right of patient to medical record very emphatically. Judges M. Shah and A. Savanth stated:

"We are of the view that when a patient or his near relative demands from the Hospital or the doctor the copies of the case papers, it is

necessary for the Hospital authorities and the doctors concerned to furnish copies of such case papers to the patient or his near relative. In our view, it would be necessary for the Medical Council to ensure that necessary directions are given to all the Hospitals and the doctors calling upon them to furnish the copies of the case papers and all the relevant documents pertaining to the patient concerned. The hospitals and the doctors may be justified, in demanding necessary charges for supplying the copies of such documents to the patient or the near relative. We, therefore, direct the first respondent Maharashtra Medical Council to issue necessary circulars in this behalf to all the hospitals and doctors in the State of Maharashtra. We do not think that the hospitals or the doctors can claim any secrecy or any confidentiality in the matter of copies of the case papers relating to the patient. These must be made available to him on demand, subject to payment of usual charges. If necessary, the Medical Council may issue a press note in this behalf giving it wide publicity in all the media.

" In the matter titled as PP Ismail v KK Radha 1997 (2) CPR 171 (NC); 1(1998) CPJ 16 (NC); (1997) 5 CTJ 685 (CP) (NCRDC); 1999 CPJ 99 (NC), the Hon'ble National Commission for Consumer Dispute Redressal Forum has held the hospital vicariously liable for the negligent action of the doctor on the basis of the bill showing the professional fees of the doctor and the discharge certificate under the letterhead of the hospital signed by the doctor

In S. A. Quereshi v Padode memorial Hospital and Research Centre II 2000. CPJ 463 (Bhopal) it was held that the plea of destroying the case sheet as per the general practice of the hospitals appeared to the court as an attempt to suppress certain facts that are likely to be revealed from the case sheet. The opposite party was found negligent as he should have retained the case records until the disposal of the complaint.

In case of Dr Shyam Kumar v Rameshbhai, Harmanbhai Kachiya 2002;1 CPR 320, I (2006) CPJ 16 (NC), the Hon'ble National Commission of Consumer Dispute Redressal Forum has held that not producing medical records to the patient prevents the complainant from seeking an expert opinion and it is the duty of the person in possession

of the medical records to produce it in the court and adverse inference could be drawn for not producing the records.

The Hon'ble Kerala High Court in the matter titled as "Rajappan Vs. Sree Chitra Tirunal Institute for Medical Science and Technology [ILR 2004 (2) Kerala 150]" has held that:

It is also to be noticed that Regulations do not provide any immunity for any medical record to be retained by any medical practitioner of the hospital from being given to the patient. On the other hand it is expressly provided that a patient should be given medical records in Appendix 3 with supporting documents. Therefore in the absence of any immunity either under the Regulations or under any other law, the respondent Hospital is bound to give photocopies of the entire documents of the patient. Standing counsel for the respondent Hospital submitted that the documents once furnished will be used as evidence against the hospital and against the doctors concerned. I do not think this apprehension will justify for claiming immunity against furnishing the documents. If proper service was rendered in the course of treatment, I see no reason why the hospital, or staff, or doctors should be apprehensive of any litigation. A patient or victim's relative is entitled to know whether proper medical care was rendered to the patient entrusted with the hospital, which will be revealed from case sheet and medical records. There should be absolute transparency with regard to the treatment of a patient and a patient or victim's relative is entitled to get copies of medical records. This is recognized by the Medical Council Regulations and therefore petitioner is entitled to have copies of the entire medical records of his daughter which should be furnished in full.

The Hon'ble Central Information Commission has examined the issue of right of patient to have the medical records in the matter titled as Nisha Priya Bhatia v Institute of Human Behaviour and Allied Sciences GNCTD, bearing File No. CIC/AD/A/2013/001681SA vide order dated 23.07.2014 has held that:

"The Patient has a right to his/her medical record and. Respondent Hospital Authorities have a duty to provide the same under Right to Information Act, 2005, Consumer Protection Act, 1986, The Medical Council Act as per world medical ethics. The Commission recommended the Public Authority to develop a timeframe mechanism

of disclosure of medical records to patients or their relatives with safeguards for privacy and confidentiality of the patient".

In the matter titled as Shri Prabhat Kumar versus Directorate of Health Services, GNCTD, Delhi, the Hon'ble Central Information Commission vide order dated 07.04.2015 has held that:

"The Commission recommends the Government of India, states and Union Territories, besides the respondent authority in this case, to take necessary steps to enforce the right to information, i.e., forcing the private hospitals to give medical records of the patients on day to day basis, because this daily disclosure will prevent undesirable practices of altering records after damage caused to patient. Forcing the private hospitals to provide daily wise medical records will also act as a check on some hospitals from resorting to CIC/SA/A/2014/000004 Page 30 extortionist, inhuman and ruthless business of prescribing unnecessary diagnostic tests, unnecessary surgical operations, caesarean deliveries, unwarranted angioplasties, inserting stents, without need, or of substandard nature, or putting low quality stent while collecting price of high quality stent, and several such malpractices amounting to medical terrorism, etc. They should not be allowed to such malpractices with all impunity and get away without any legal consequences as if there is an absolute immunity. The Government, Medical Council of India and the health regulatory has to see that licence to practice medicine will not become licence to kill and extort and come to the rescue of helpless patients."

A Bombay High Court ruled against Ruby hall clinic and said that patient has a right over his record with the hospital and hospital should provide copy of it within a reasonable time (MMC says 3 days) and hospital is entitled to charge a reasonable amount for the same.

A hospital should provide a copy of the patient's medical record when requested by the patient. But the above right cannot be enforced under the MCI, 2002, Regulations. The patient's indoor medical case sheet is a property of the hospital and the patient has only a right to get a copy, not the original record.

How long records of patients should be maintained?

- As per the proposed/draft "Clinical Establishments (Registration and Regulation) Rules, 2010, "Copies of all records and statistics shall be kept with the clinical establishment concerned for at least 3 or 5 years or in accordance with any other relevant Act in force at the time."
- As per Regulation 1.3.1 of the Indian Medical Council (Professional conduct, Etiquette and Ethics) Regulations, 2002, "Every physician shall maintain the medical records pertaining to his/her indoor patients for a period of 3 years from the date of commencement of the treatment in a standard proforma laid down by the Medical Council of India and attached as Appendix 3."
- As per Rule 6F (3) of the Income Tax Rules, 1962, doctors in private practice are required to preserve the daily case register as per Form 3C for a period of 6 years from the end of the relevant assessment year. That would ordinarily mean for 7 years from the close of the accounting year.
- As per Punjab Medical Manual (1934), the medicolegal record is to be preserved for 12 years.
- As per the DGHS vide letter No. 10-3/68-MH dated 31-8-68, records should be maintained as follows:

  For inpatient medical records (case sheets)...10 years

  For medicolegal registers.... 10 years

  For outpatient records 5 years

  The above requirement can be found in the "Hospital Manual" published in 2002 by the Directorate General of Health Services, MOHFW, GOI, in Chapter 12 titled "Medical Record Services."

In summary medical records belong to the medical professionals /entities but patients generally have a right to review them, demand copies of them, and to demand their confidentiality as per the MCI ethics regulations.

Dr K K Aggarwal, Ira Gupta, Rahul Gupta

Courtesy : IMA NEWS

Clinical Establishments (Registration and Regulation) Act, 2010

IMA in principle, support the CEA Act but not in its present form. It should have amendments in the following points:

1. The district Appropriate Authority must be headed by a medical person.
2. At the District Level Committee, the Police person should be excluded from this Committee.
3. Single Doctor Establishment (Husband & Wife should be taken as one unit/OAE-Own Account Entrepreneur) should be excluded from the registration under the CEA.
4. Medical Establishment which has entry level accreditation or above under NABH, need only registration under the Act and should be automatically get registered under CEA without any other formalities.
5. The provision of action including prosecution against quacks should be included in the Act.
6. The standard treatment guidelines require updation on a regular basis and should not be under the provision of CEA. Standard treatment guidelines are laid down by professional bodies (IMA and other speciality organizations) and are periodically updated. The Act has no role in fixing the standard protocol.
7. The cost of treatment cannot be fixed by the Govt. or the State. Let it be decided by the market forces but it should be transparent and displayed.

8. In the District Level Committee, the number of members should be as per the strength of the doctor. Proportionate representation for stakeholders should be given at least, 40% by Modern System of Medicine.
9. Stabilization clause should be replaced by First AID.
10. The name of the Act include the Promotional word so that the name of the Act is Registration and Regulation and Promotion Act 2010.
11. All Emergency Services given by the medical practitioners to people from economically weaker sections of the society should be reimbursed by the State government, as per the standard State Charges.
12. Provision for Grievance Redressal should be deleted, since the facilities are already available in the State Medical Council and other forums.
13. CEA should have single Window Registration facility.
14. Para Medical staff currently working under qualified doctors for the last five years should be treated as trained healthcare personnel and be included in the category of qualified' staff.
15. Penalties due to contravention of the Registration or deficiency are very high, this to be made realistic.

Dr. S. S. Agarwal

Courtesy : IMA NEWS

IMA HBI Update

On 11th April 2016, IMA HBI Chairman, Dr RV Asokan & IMA HBI Insurance Cell Coordinator, Dr AK Ravi Kumar met the Chairman IRDA to discuss various problems faced by patients and healthcare providers with Insurance companies & TPAs.

The meeting was very fruitful and they have agreed to take part in the proposed national level insurance summit involving all stake holders. IRDA has also agreed to include IMA HBI in their health insurance forum.

Following points were discussed:

1. IMA HBI is the representing body of majority medium and smaller hospitals across the country.
2. Health insurance awareness is increasing and penetrating to rural areas and towns.
3. More than 70% of Healthcare is being given by small and medium hospitals.
4. Majority of policy holders are urban centred.
5. Awareness about health insurance, various policies, benefits etc.; is lacking with both policyholders and service provider.
6. Major part of insured amount out flow is to corporate hospitals who charge many times higher than a smaller hospital.
7. Criteria for empanelment of smaller healthcare units to be

relaxed and all willing hospitals to be empanelled and package rates as basic criteria to be redefined.

8. By empanelling more smaller and medium hospitals will help not only the patients to get immediate care during the golden hour it also helps the smaller healthcare units to upgrade themselves and quality healthcare can be established in all corners of the country.
9. Patients liberty to choose the Dr and Hospital gets curtailed in present scenario. 10. IMA HBI representation in Advisory Body/committees of IRDA/Insurance companies/TPAS
11. Jointly can work out strategies to shift health insurance of towards smaller towns and rural areas.
12. IRDA with IMA HBI can formulate guidelines for grading of hospitals.
13. Jointly can formulate Package rates
14. Jointly can have an Insurance cell/web group to clear doubts related to health insurance.
15. Like to have a national summit involving all stakeholders with the guidance of IRDA to know and discuss on various issues faced amongst each other to find out solution.

All are kindly requested to give their opinions, points, issues which can be included and discussed in the insurance summit

Dr Ravi Wankhedkar, Secretary, IMA HBI

Courtesy : IMA NEWS

Doctors of Indian System of Medicine Cannot Practice Modern Medicine (Allopathy)

IMA hails the decision of the Double Bench of Hon'ble Delhi High Court decision validating IMA's stand that Bhartiya Chikitsa Practitioners (practitioners of Indian System of Medicine) cannot practice modern medicine (Allopathy).

In a landmark Judgement, in a PIL, Delhi Medical Association Vs. Principal Secretary (Health), the Double Bench of Hon'ble Delhi High Court has upheld the following:

- "No practitioner of Indian System of Medicine can practice modern scientific system of medicine;
- No practitioner of Indian System of medicine holding a qualification as listed in the Schedule of the Indian Medicine Central Council Act 1970 is entitled to practice modern medicine;
- No practitioner registered under Integrated Medicine as defined under Section 2(h) of Delhi Bhartiya Chikitsa Parishad Act, is entitled to practice modern system of medicine".

Hon'ble High Court of Delhi also directed the Delhi Medical Council (DMC) and Medical Council of India (MCI) to take action against those medical practitioners of Indian system of medicine who are practicing modern medicine.

The Hon'ble High Court further directed the Indian Medicine Central Council and Delhi Bhartiya Chikitsa Parishad to see that they do not allow their doctors to practice modern medicine.

The Court further clarified that Section 2(h) of Delhi Bhartiya Chikitsa Parishad Act does not permit any person holding qualification in Indian System of Medicine to practice modern medicine.

The Hon'ble Court further said that notification dt. 10.2.61 of Delhi Govt. issued in pursuance to Rule 2(ee) of the Drugs & Cosmetics Act 1945 does not entitle those registered under Indian Medicine Central Council Act to practice modern medicine.

It further clarified that notification dt. 19.5.2004 of Central Council of Indian Medicine does not entitle practitioners of Indian System of Medicine to practice modern medicine.

The High Court also relied on various related Judgements by Hon'ble High Courts of Madras, Gujarat, Himachal Pradesh and Allahabad on this issue.

Commenting on the Judgement, National President, IMA, Dr SS Agarwal and Honorary Secretary General, IMA, Padma Shri Awardee, Dr KK Aggarwal who is also President, Heart Care Foundation of India said that IMA's stand on the issue has been validated by the Hon'ble Court. IMA has been contesting for over a decade that practice of modern system of medicine by practitioners of other systems of medicine is injurious to the health of the public.

IMA congratulated Registrar, Delhi Medical Council, Dr Girish Tyagi and Team DMA, Dr Rakesh K Gupta, President & Dr Ashwani Goyal, Honorary Secretary along with Dr Anil Bansal & Dr V N Sharma, Members, IMA Anti Quackery Cell in their persistent efforts on this issue in the interest of the society.

Recently an Inter-Ministerial Committee formed by the Govt. of India to look into the demands of medical profession raised by Indian Medical Association, also substantiated the stand of IMA and disapproved Crosspathy that violates the IMC Act.

DMC has recently filed FIRs against such practitioners registered with the Delhi Bhartiya Chikitsa Parishad. This historic Judgement by a double bench of the Hon'ble Delhi High Court will further strengthen the cause of IMA/DMA/ DMC, added Dr Tyagi.

Courtesy : IMA NEWS

Understanding the HEAT-WAVE

Heat wave: Heat-wave is a condition of atmospheric temperature that leads to physiological stress, which sometimes can claim human life. Heat-wave is defined as the condition where maximum temperature at a grid point is 3°C or more than the normal temperature, consecutively for 3 days or more. World Meteorological Organization defines a heat wave as five or more consecutive days during which the daily maximum temperature exceeds the average maximum temperature by five degrees Celsius. If the maximum temperature of any place continues to be more than 45° C consecutively for two days, it is called a heat wave condition.

There will be no harm to the human body if the environmental temperature remains at 37° C. Whenever the environmental temperature increases above 37° C, the human body starts gaining heat from the atmosphere. If humidity is high, a person can suffer from heat stress disorders even with the temperature at 37°C or 38°C. To calculate the effect of humidity we can use Heat Index Values. The Heat Index is a measure of how hot it really feels when relative humidity is factored in with the actual air temperature. As an example, if the air temperature is 34°C and the relative humidity is 75%, the heat index--how hot it feels--is 49°C. The same effect is reached at just 31°C when the relative humidity is 100 %.

Heat wave in India:

Extreme positive departures from the normal maximum temperature result in a heat wave during the summer season. The rising maximum temperature during the pre-monsoon months continues till June and in rare cases till July, over the northwestern parts of the country. In recent years, heat wave casualties have increased. Abnormally high temperatures were observed during April – June during 2010 to 2015 across the country. In India the heat wave took 3028 lives in 1998 and more than 2000 lives in 2002. In Odisha, heat wave caused 2042 deaths in 1998 and more than 1200 deaths in 2002 in southern India. In India heat-wave caused 22562

deaths since 1992 to 2015 at various states (Table 2).2 Heat wave also caused death of wildlife, birds, poultry in states and most of the zoos in India.

Rational for Heat wave Action Plan (HAP)

Many states are affected during the Heat wave season, such as State of Andhra Pradesh, Telangana, Odisha, Gujarat, Rajasthan, Madhya Pradesh, Uttar Pradesh, Vidarbha region of Maharashtra, Bihar, Jharkhand and Delhi. In 2015, daily maximum temperature exceeded the average maximum temperature by more than 6°C to 8°C, which resulted in death of 2422 people in India due to heat-wave. A comparative data of highest maximum temperature and daily maximum temperature is shown in Table 3.

Table 2

Year	No. of Deaths
1992	612
1993	631
1994	773
1995	1677
1996	434
1997	393
1998	1016
1999	628
2000	534
2001	505
2002	720
2003	807
2004	756
2005	1075
2006	754
2007	932
2008	616
2009	1071
2010	1274
2011	793
2012	1247
2013	1216
2014	1677
2015	2422

Table 3: In year 2015 reported heat wave (April to May)

State	Month	*Mean Daily Maximum Temperature (°C)	**Recorded Maximum Temperature (°C)
1	2	3	4
Andhra Pradesh	15 April to 30 May 15 Hyderabad,	39.9	46
Telangana	15 April to 30 May 15 Khammam	40.0	48
Odisha	21 May 15 Jharsuguda,	41.4	45.4
	10 June 15 Bhubaneswa,	37.2	44
Uttar Pradesh	24 May 15 Allahabad	41.8	47.7
	8 June 15 Allahabad,	39.8	47.8
Delhi	25 May 15 Delhi	40.5	46.4
Chattisgarh	25 May 15 Jashpur	41.9	44.5
West Bengal	28 May 15 Kolkata	35.5	44.5
Gujarat	29 May 15 Ahmadabad	41.4	43.2
Madhya Pradesh	29 May 15 Harda	39.7	43.5
Bihar	29 May Gaya	40.8	46.3
Maharashtra	30 May 15 Vidarbh	42.5	47.1
Karnataka	30 May 15 Kalburgi	32.4	44.1
Rajasthan	19 June 15 Churu	40.3	48
	Total		

*Source: Mean Daily Maximum Temperature from http://worldweather.wmo.int/en/city.html?
** Source: Recorded Maximum Temperature & Mean Total Rainfall from imdpune.gov.in

However, it is likely that the death figure is much higher as heat related illness is often recorded inaccurately and figures from rural areas are hard to attain. The combination of exceptional heat stress and a predominantly rural population makes India, vulnerable to heat waves. Vegetable vendors, auto repair mechanics, cab drivers, construction workers, police personnel, road side kiosk operators and mostly weaker sections of the society have to work in the extreme heat to make their ends meet and are extremely vulnerable to the adverse impacts of heat waves such as dehydration, heat and sun strokes. Therefore, it is not surprising that these workers, homeless people and the elderly constitute the majority of heat wave casualties in India. It is time to devise a national level strategy and plan to combat this disaster. A comprehensive heat preparedness and response requires involvement from not only government authorities but also non-governmental organizations and civil society. The local authorities should carry out a vulnerability assessment in order to identify these areas.

Early Warning and Indicators of heat-wave

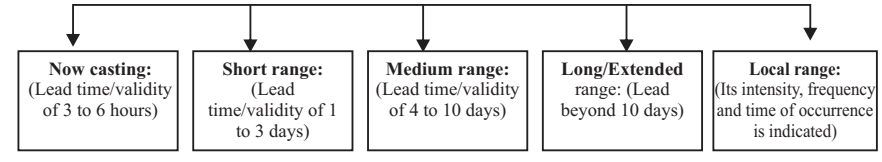
Early warning systems can enhance the preparedness of decision-makers and their readiness to harness favorable weather conditions. Early warning systems for natural hazards is based both on sound scientific and technical knowledge. In response to the devastating mortality and morbidity of recent heat-wave events, many countries have introduced heat-wave early warning systems. Heat-wave early warnings are designed to reduce the avoidable human health consequences from heat-waves through timely notification of prevention measures to vulnerable populations.

Forecast and Issuance of Heat Alert or Heat Warning

India Meteorological Department (IMD): The IMD is mandated to meteorological observations and provides current and forecast meteorological information for optimum operation of weather-sensitive activities. It provides warning against severe weather phenomena like

tropical cyclones, dust storms, heavy rains and snow, cold and heat waves etc. It also provide real time data and weather prediction of maximum temperature, Heat-wave warning, Heat-alert for the vulnerable cities/rural area of the severity and frequency. IMD provides following range and validity of time forecast:

Temperature Forecast: Specific Range, Time duration and area



Identification of Color Signals for Heat Alert :

Red Alert (Severe Condition)	**Extreme Heat Alert for the Day**	**Normal Maximum Temp increase 6º C to more**
Orange Alert (Moderate Condition)	**Heat Alert Day**	**Normal Maximum Temp increase 4º C to 5º C**
Yellow Alert (Heat-wave Warning)	**Hot Day**	**Nearby Normal Maximum Temp.**
White (Normal)	**Normal Day**	**Below Normal Maximum Temp.**

Identification of Heat-Wave illness and recordings of casualties:

In the past, when the Government declared ex-gratia compensation for heat-wave affected families, it was observed that some people who were aware of the provision of direct cash relief reported natural deaths as the heat wave deaths. In the event of false reporting, the following procedures can be used for verifying and ascertaining the real cause of death.

- Recorded maximum temperature on the particular time periods and place.
- Recording incidents, panchnama or others witnesses, evidence or verbal – autopsy.
- Postmortem/medical checkup report with causes.
- Local authority or Local body enquiry/verification report.

Prevention of Heat Related Illness:

Heat-related illness is largely avoidable. The most crucial point of intervention concerns the use of appropriate prevention strategies by susceptible individuals. Knowledge of effective prevention and first-aid treatment, besides an awareness of potential side-effects of prescription drugs during hot weather is crucial for physicians and pharmacists.

Acclimatization:

People at risk are those who have come from a cooler climate to a hot climate. When such visitors arrive during the heat wave season, they should be advised not to move out in open for a period of one week till the body is acclimatized to heat and should drink plenty of water. Acclimatization is achieved by gradual exposure to the hot environment during heat wave.

Table 4: Symptoms and First Aid for various Heat Disorders

Heat Disorder	Symptoms	First Aid
Sunburn	Skin redness and pain, possible swelling, blisters, fever, headaches	Take a shower, using soap, to remove oils that may block pores preventing the body from cooling naturally. If blisters occur, apply dry, sterile dressings and get medical attention.
Heat Cramps	Painful spasms usually in leg and abdominal muscles or extremities. Heavy sweating.	Move to cool or shaded place. Apply firm pressure on cramping muscles or gentle massage to relieve spasm. Give sips of water. If nausea occurs, discontinue.
Heat Exhaustion	Heat Exhaustion Heavy sweating, weakness, skin cold, pale, headache and clammy. Weak pulse. Normal temperature possible. Fainting, vomiting.	Get victim to lie down in a cool place. Loosen clothing. Apply cool, wet cloth. Fan or move victim to air-conditioned place. Give sips of water slowly and If nausea occurs, discontinue. If vomiting occurs, seek immediate medical attention. Or call 108 and 102 for Ambulance

Heat Disorder	Symptoms	First Aid
Heat Stroke (Sun Stroke)	High body temperature (106+F). Hot, dry skin. Rapid, strong pulse. Possible unconsciousness. Victim will likely not sweat.	Heat stroke is a severe medical emergency. Call 108 and 102 for Ambulance for emergency medical services or take the victim to a hospital immediately. Delay can be fatal. Move victim to a cooler environment. Try a cool bath or sponging to reduce body temperature. Use extreme caution. Remove clothing. Use fans and/or air conditioners. **DO NOT GIVE FLUIDS.**

Do's and Dont's

Heat Wave conditions can result in physiological strain, which could even result in death. To minimize the impact during the heat wave and to prevent serious ailment or death because of heat stroke, the following measures are useful:

DO's

- Listen to Radio, watch TV, read News paper for local weather forecast to know if a heat wave is on the way
- Drink sufficient water and as often as possible, even if not thirsty
- Wear lightweight, light-coloured, loose, and porous cotton clothes. Use protective goggles, umbrella/hat, shoes or chappals while going out in sun.
- While travelling, carry water with you.
- If you work outside, use a hat or an umbrella and also use a damp cloth on your head, neck, face and limbs.
- Use ORS, homemade drinks like lassi, torani (rice water), lemon water, buttermilk, etc. which help to re-hydrate the body.
- Recognize the signs of heat stroke, heat rash or heat cramps such as weakness, dizziness, headache, nausea, sweating and seizures. If you feel faint or ill, see a doctor immediately.

- Keep animals in shade and give them plenty of water to drink.
- Keep your home cool, use curtains, shutters or sunshade and open windows at night.
- Use fans, damp clothing and take bath in cold water frequently.
- Provide cool drinking water near work place.
- Caution workers to avoid direct sunlight.
- Schedule strenuous jobs to cooler times of the day.
- Increasing the frequency and length of rest breaks for outdoor activities.
- Pregnant workers and workers with a medical condition should be given additional attention.

DON'T's

- Do not leave children or pets in parked vehicles.
- Avoid going out in the sun, especially between 12.00 noon and 3.00 p.m.
- Avoid wearing dark, heavy or tight clothing.
- Avoid strenuous activities when the outside temperature is high. Avoid working outside between 12 noon and 3 p.m.
- Avoid cooking during peak hours. Open doors and windows to ventilate cooking area adequately.
- Avoid alcohol, tea, coffee and carbonated soft drinks, which dehydrates the body.
- Avoid high-protein food and do not eat stale food.

Courtesy :
National Disaster Management Authority,
Government of India.

World Medical Association Meeting at Argentina

* * * * *

Wall Paintings Rajkot Branch

Cricket Tournament Ahmedabad Branch

* * * * *

Felicitation of Senior Medical teachers Rajkot Branch

* * * * *

Diabetes Screening Camp and Talk on Diabetes Awareness Rajkot Branch

Diagnostic Camp Gandhidham Branch

* * * * *

Free MMR Vaccination Morbi Branch

SCIENTIFIC UPDATE

Step towards Thalassemia free India !
Let's start with Gujarat, Tips for action.

All Medical practitioner should know regarding below mention few facts of Thalassemia:

12000 new birth annual born in India with this disorder.3 million Indian trait & careers with this disorders while 240 million worldwide. More than one lakh fifty thousand people lives with this disorder in our country. It can be prevented but awareness play key role for successful prevention. Around 40-45 support groups & NGO work for awareness of this problems in our country.

1) Thalassemia is autosomal recessive problems; means chance wise 75% normal & 25% affected in next pregnancy. Approximately>200 mutations are known to cause, thalassemia all over the world. Of them five common thalassemia mutations in "INDIA" are–
   - (IVS) 1-S (G ->C)
   - IVS 1 -1 (G->T)
   - 619 by DELETION
   - +1 Codon 8/9(+G)
   - -Codon 41/42(-CTTT)
2) Thalassemia child requires regular 3-4 weekly filtrated RBC transfusion
3) Why Iron chelation therapy require? Repeated BT causes iron load.

   Desferoxamine is given S.C. for 8 hours every day for 5-6 days a week so as to chelate iron load.
4) Physical Suffering: In 15 years of life span: Thalassemia child requires:-
   - 250 unit of pack cells.
   - 4000 inj of desferroxamine
   - Needle in his body for 40,000 hours in his life.
5) Financial burden: Regular Iron Chelation therapy, Regular blood transfusion Vaccinations for prevention of infections;

   Cost 80,000/- to 1.2 lakh rupees annually per child.

6) The only curative treatment is bone marrow or stem cell Transplantation which cost around 10-15 lakh.

7) Do we want our child to be a victim of our ignorance & instead of feeding would you leave him/her on Blood transmission?

8) We need to investigate all reproductive age group patients.

Young boys & girls, those who are going to start their marriage life.

All above group of people should know their Thalassemia status.

Don't forget, if you forget it is crime. !!

9) What is the solution? Preventing the birth of a "Thalassaemia" child is the only answer to this worldwide problem.

10) How does the birth of a Thalassemia child occur? When both partners are carrier, there is 25% chance of child to be affected with Thalessaemia in each pregnancy.

11) But when only one partner is carrier then no child will be affected with Thalassemia.

12) Carriers are Asymptomatic-They are silent culprit: how to identify the carrier, needs to investigate all target populations as mention above.

13) How to detect a carrier?

See the baseline screening: in CBC routine examination:

MCV < 75 & MCH < 25

Ratio of MCV/TRBC = Mentzer index < 13: This magic figure should be kept in mind to suspecting person is Thalassemia carrier.

14) **Second level screening :** High performance liquid chromatography (HPLC) is the Gold standard test to estimate the HbA2 level for detecting carrier state: HBA2 > 3.5% is suggestive of thalassemia carrier.

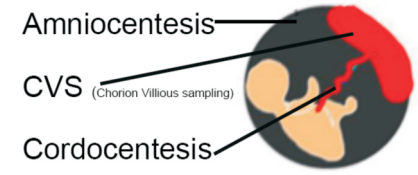
15) **Third level Confirmatory test :** DNA analysis of the carrier for the detection of thalassemia gene mutation is essential.

16) **Genetic Counseling :** Carrier should not marry with a carrier.

If marriage is unavoidable due to cultural & social reasons or diagnosed as carriers after marriage or after conception.)

17) Then what is the option?

The answer is PRENATAL DIAGNOSIS.



18) Non Invasive:Free fetal DNA in maternal blood

19) Non invasive : Maternal blood is collected for isolation of fetal DNA fetal DNA is then tested for Paternal mutant gene :

20) Paternal mutant gene absent :Fetus is normal or carrier continue pregnancy .

21) Paternal mutant gene present:Fetus has 50% chance being Thalassaemia major : Massively parallel DNA sequencing done.

22) Prenatal Diagnosis : INVASIVE PROCEDURE :earlier detection is better so CVS is better than amniocentesis.

Chorionic villous sampling (CVS): under USG Guidance by 18gauge needle :exclusive Trans abdominal specific procedure invented by DR B I Patel at 11-14wks of pregnancy.

every years we perform > 500 procedures & prevent > 100 thalassemia major fetuses to be borne but this is a drop in the ocean.

23) **AMNIOCENTESIS :** Trans abdominal -Ultrasound guided after 17-18 weeks 22g needle ;Initial- 2-3ml is discarded usually 20cc amnioticfluid results –2 to 3 wks.

24) Gene mutation in DNA obtained from FETUS is matched with family gene mutation : If fetus is normal or carrier for thalassaemia :continue pregnancy: Gene mutation study should be done among all carrier for future family planning after birth.

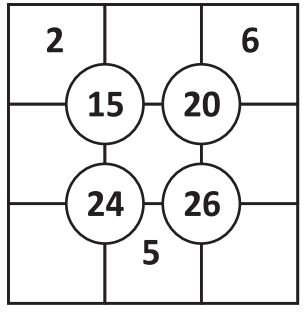
25) If fetus is thalassaemia major:After genetic counseling couple should be given option for termination of pregnancy.

- Dr. B. I. Patel, M.D., D.G.O. (Gynaec)
(Ahmedabad)

Games Corner

Dr. Chandresh Jardosh
Surat

Chhota Sudoku



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

7 BR OK EN Words

By using following keys, join the broken words & find out the 7 different words with 'MM'

Key	Words
5 Letters	1
6 Letters	2
7 Letters	3
8 Letters	1

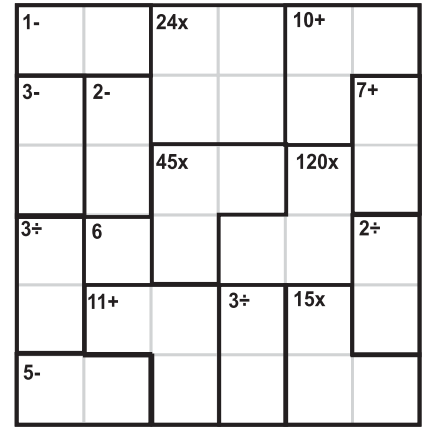
MA	RU	IM	MM	IM	SW
SH	MM	OTH	IM	SU	
NG	MA	MMY	MER	ER	
MM	SK	MER	MI	AL	

Sudoku

		6			2	5		9
					5	6		
	9				1	8	4	3
7					3			
		1				9		
			8					2
2	1	3	4				9	
		7	1					
6		8	7			4		

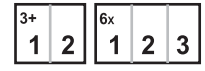
The objective of sudoku is to enter a digit from 1 through 9 in each cell, in such a way that:
Each horizontal row contains each digit exactly once
Each vertical column contains each digit exactly once
Each 3 by 3 square contains each digit exactly once

KEN KEN PUZZLE



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

FOR EXAMPLE



Answer Page No. 95

NATIONAL CONSUMER DISPUTES REDRESSAL COMMISSION

NEW DELHI

CONSUMER CASE NO. 119 OF 2007

1. MASTER RISHABH SHARMA & ORS.
   THROUGH FATHER & NATURAL GUARDIAN, SH.
   KULDEEP SHARMA, R/O H - 25, SHAKTINAGAR, DESU COLONY, DELHI - 110007
2. Smt. Pooja Sharma
   Wd/ of Late sh. Kuldeep Sharma, Through mother and natural guardian,
   H-25, Shakti Nagar DESU Colony, Delhi - 10 007.
3. Master Aman Sharma
   Through Mother And Natural Guardian Smt. Pooja Sharma,
   H-25, Shakti Nagar, DESU Colony,Delhi - 110 007.

.....Complainant(s)

Versus

1. DR. RAMA SHARMA & ORS.
   GYNAECOLOGIST & OBSTETRICIAN, SHARMA MEDICAL CENTRE,
   B - 112, SUBHADRA COLONY, DELHI - 110035
2. MAHARAJA AGARSEN HOSPITAL
   THROUGH DR. ANAND BANSAL, THE MEDICAL SUPERINTENDENT
   PUNJABI BAGH,NEW DELHI - 26
3. DR. G. S. KOCHHAR
   CONSULTANT PEDIATRICIAN/NEONATOLOGIST
   MAHARAJA AGARSEN HOSPITAL
   PUNJABI BAGH NEW DELHI - 26
4. DR. NAVEEN JAIN
   CONSULTANT PEDIATRICIAN/NEONATOLOGIST
   MAHARAJA AGARSEN HOSPITAL PUNJABI BAGH NEW DELHI - 26
5. DR. S. N. JHA
   SENIOR CONSULTANT OPTHALMOLOGIST OPTHALMOLOGY
   UNIT, MAHARAJA AGARSEN HOSPITAL , PUNJABI BAGH NEW DELHI - 26

.....Opp.Party(s)

BEFORE:

HON'BLE MR. JUSTICE J.M. MALIK, PRESIDING MEMBER

HON'BLE DR. S.M. KANTIKAR, MEMBER

For the Complainant : Mr. Anoop K. Kaushal, Advocate

For the Opp.Party : For the Opp. Party No.l : Mr. A.K. Sharma, Adv.
For the Opp. Parties 2 to 5 : Mr. R.K. Gupta,
Adv. with Opposite parties Nos.3&4 in person

Dated : 10 Mav 2016

ORDER

DR. S.M. KANTIKAR. MEMBER

1. This complaint is filed by three complainants namely Master Rishabh Sharma (1) Smt. Pooja Sharma (mother of complainant -1) and Master Aman Sharma (brother as complainant-3) against opposite party Dr. Rama Sharma (OP-1) and four other opposite parties.
2. Pooja Sharma, the complainant No.2 (for the convenience referred as "Patient"), during her pregnancy, was under antenatal care of OP1 from September 2005. Her expected date of delivery (EDD) was 13.06.2006. It was a case of Placenta Prevea, OP-1 assured, that she can handle such cases. The premature delivery took place on 02.04.2006; baby was delivered by Caesarean Section (LSCS). It was a premature baby about 32 week's age. There was no Paediatrician at the time of delivery, and no neonatal unit was in the hospital. It was alleged that, without proper facilities, the OP1 carried out delivery at her nursing home despite, there was no neonatal care.
3. Thereafter, on. 02.04.2005 baby was shifted to Maharaja Agrasen Hospital (OP2). It was kept under observation of consultant Paediatricians, Dr. G.S. Kochar (OP 3), Dr. Naveen Jain (OP 4) and a Senior Consultant Ophthalmologist- Dr. S.N. Jha (OP 5). The baby was in OP-2 hospital till 29.04.2005, but no test for ROP (Retinopathy of prematurity) was conducted within 4 to 5 weeks of birth. The OP-1 never cautioned the patient about such risk of ROP before or after the delivery. The patient attended the OPD as follow up visits at OP-2 on 04.05.2005 and 13.07.2005, but OP 3 and 4 did not advise anything about ROP. In the last week of November 2005, the mother noticed child's abnormal visual response , therefore on 23.11.2005 eye examination and ultrasound were conducted at Nayantara Eye Clinic,Delhi, Thereafter, on 3.12.2005, it was finally diagnosed as a case of total retinal detachment- ROP Stage 5 at Shroffs Charity Eye Hospital, Delhi. Then, the child was referred to Dr.Azad at AIIMS.
4. The mother/Complainant 2 approached OP-1 for explanation, but she shifted blame on OPs 2 to 4. Thereafter, OP-5 was consulted, who tried to avoid to comment, but later on, he referred the child/patient to Shankar Nethralaya, Chennai. The referral note was devoid of previous hospitalisation/treatment details. Thus, OPs failed to explain, why the test, within four to five weeks, was not conducted when the patient was under their custody? The OP falsely mentioned in the discharge summary dated 13.06.2005 that, test for ROP was done on 26.04.2005. The OPs attitude was not cooperative, complete treatment record was not given to the complainants, hence complainants initiated proceedings under Delhi Medical Council (DMC) to produce the medical record. The DMC vide order dated 14.12.2007 warned the OPs regarding supply of medical records.

5. Therefore, the complainants alleged that, it was the failure and negligence of OP-3 to 5 to treat the premature baby. OPs did not take proper NICU care for timely detection of ROP at stage I, during hospitalisation period of 4 weeks. The OP-2 could have prevented the development of ROP to stage 5 i.e. permanent blindness to the child. Hence, filed this complaint under Section 12 of the Consumer Protection Act on 19-11-2007 and prayed for total compensation of Rs. 1,30,25,000/-, under different heads.

Defense:

6. The OP1 resisted the complaint and denied all allegations of negligence. OP1 admitted that, from 16.02.2005 the patient was under her antenatal care, also took treatment for bleeding per vagina, at Sucheta Kriplani Hospital on 12.03.2005. The OP 1 denied that, the delivery was conducted in haste. On 02.04.2005 the patient came with profuse bleeding, therefore to avoid complications and to save her, life OP-1 performed LSCS, as per prescribed standard medical norms. It was performed in the presence of senior Pediatrician, Dr. Kapil Gupta who took proper care of the baby after delivery. The patient was shifted with proper reference letter and explaining the attendants about condition of baby. Therefore, there was no negligence on the part of the OP 1.

7. The OPs 2 to 5 filed a written version and contended that the OP 2, Maharaja Agrasen Hospital is being run by a charitable trust. The complainant was admitted as a general patient in semi-private category on 02.04.2005. The complainant concealed the fact about free treatment of Rs.50000/- provided to the baby by OP2 from 04.04.2005 to 29.04.2005. The baby was extremely critical at the time of admission with little chance of survival having multiple problems; it was admitted in NICU (Neonatal ICU) in critical condition. It was cyanosed with features of respiratory failure. Baby was put on mechanical ventilator immediately after admission. It was diagnosed as a case of Hyaline Membrane Disease (HMD). Therefore, surfactant therapy and mechanical ventilation was started. During the hospital stay the child developed pneumothorax, therefore, tube thoracotomy was done by the paediatric surgeon. Blood component therapy was given. The baby was kept on ventilator for 10 days. As per standard protocol, nursing and ophthalmic care was properly given to rule out ROP. Eye examination was conducted by senior ophthalmologist and retina specialist, Dr. S.N. Jha (OP5) on 26.04.2005 and found no ROP at the age of four weeks. Hence, the mother was advised to attend for child's follow up in special OPD on Wednesday and Saturday, wherein high risk babies are followed up for neuro developmental assessment, visual and hearing screening. The OP3 constantly advised the complainant to attend the specialty clinic.

Arguments:

On behalf of complainants:

8. The learned counsel for complainant Mr.Anup Kaushal, submitted that, the principle of resipsa loquitor" should be applied in this case, because the OPs failed to produce medical record, same was observed by DMC also. Counsel took strong objection to the AIIMS report dated 11-05-2012, because it was a biased one, it has simply adopted the written versions filed by the OPs without going into the details of negligence about alleged no ROP examination done on 26.04.2005 and no follow up instructions were given by OP3 . It is further submitted that, AIIMS has supported the virtual plea of contributory negligence taken by the OPs without any material on record before it.

9. The Counsel for the Complainant relied upon the recent Judgment of the Hon'ble Supreme Court in the case of **V. Krishnakumar vs. State of Tamilnadu & Ors.,** JT 2015 (6) SC 503 in which the facts are similar and the child suffered ROP. The Hon'ble Court observed negligence on the part of the Opposite Parties, who failed to screen and manage the ROP during the advancing stage. It has made observation on the medical records like:

9. It must, however, be noted that the discharge summary shows that the above writing was in the nature of a scrawl in the corner of the discharge summary and we are in agreement with the finding of the NCDRC that the said remarks are only a hastily written general warning and nothing more. After a stay of 25 days in the hospital, it was for the hospital to give a clear indication as to what was to be done regarding all possible dangers which a baby in these circumstances faces. It is obvious that it did not occur to the respondents to advise the appellant that the baby is required to be seen by a paediatric ophthalmologist since there was a possibility of occurrence of ROP to avert permanent blindness. This discharge summary neither discloses a warning to the infants parents that the infant might develop ROP against which certain precautions must be taken, nor any signs that the Doctors were themselves cautious of the dangers of development of ROP

   He also relied upon the Judgment of this Commission in the matter of Akhilesh Jain vs. Nobel Hearing and Speech Therapy Clinic & Anr. Ill (2014) CPJ 61 (NC).

ARGUMENTS ON BEHALF OF OP1. DR. RAMA SHARMA

10. The learned counsel Mr. A. K. Sharma, for OP-1 submitted that the complaint is based on wrong and manipulated facts. The OP1 acted in accordance with the practice accepted as per the norms. The patient conceived in September 2009 whereas she approached OP1 on 16.02.2005. The patient was advised routine ultrasound (USG) which was done by Dr. Manish Gupta on 21.02.2005. The USG revealed risk factors to the child and the mother; therefore, it is false to state that the OP1 assured normal delivery. On 11.03.2005, the patient came with bleeding PV, she was treated conservatively and was referred to Sucheta Kriplani Hospital on 12.03.2005. The counsel denied that the delivery was conducted in haste. In fact as per USG report, it was a case of Palcenta Succenturiate (Asymmetric Placenta Previa), hence elective caesarean (LSCS) operation was unavoidable. Unfortunately the complainant No.2 went into pre-term labour, as placenta got

separated, therefore, on 2.04.2005 at 5.35 PM, LSCS was performed after informed consent and with standard care. One unit blood was also transfused. A senior pediatrician, Dr. Kapil Gupta, was also present, who received the baby immediately after delivery. The baby was preterm (32 weeks) with signs of HMD, condition of baby was informed to relatives and thereafter was shifted to Maharaja Agrasen Hospital (OP-2) under care of Dr.G.S.Kochar. Hence, there was no negligence on the part of the OP1.

ARGUMENTS ON BEHALF OF OPs 2 TO 5

11. The learned counsel Mr. R. K. Gupta argued on behalf of OP-2 to 5. The OP3 and 4 are also present in person. The counsel vehemently argued that, the OP2-hospital is run by a charitable trust. On 2.4.2005, the child and mother were admitted in the hospital as general patient in semi-private category, but they were shifted to general ward with effect from 04.04.2005 to 29.04.2005 at their request. OP1 has given Rs.50,000/- approximately worth free treatment to the patient in ICU with ventilators. Therefore, the complainants concealed this free treatment from the Commission. The baby was admitted in the neonatal ICU in critical condition. It was diagnosed as a case of HMD, started conservative therapy and mechanical ventilation. The baby developed pneumothorax for which tube thoracotomy was performed by the pediatric surgeon. As per standard protocol, regular investigations and Arterial Blood Gas (ABG) analysis were performed. Blood component therapy was given. The baby was kept on ventilator for 10 days. Regularly, the parents were informed about the critical condition of the baby and possible neuro development, visual and hearing sequel. As per protocol, ophthalmic examination was advised on 25.04.2005 to rule out Retinopathy of Prematurity (ROP). Dr. S.N. Jha (OP5), the senior ophthalmologist and retina specialist conducted examination for ROP on 26.04.2005 which showed no evidence of ROP. Since, there was no ROP at four weeks after birth, complainant 2 was advised to attend follow up and review in the special OPD on Wednesday or Saturday between 4 to 6 P.M. It was clearly explained to the parents about all the problems which premature babies may develop ROP. The patient was extremely critical at the time of admission with little chance of survival.

12. The counsel for the OPs placed reliance upon several medical textbooks and medical literature on Pediatrics and Neonatology. He further submitted that the child was given due care at every point of time. Hence, the hospital or doctor should not be condemned as negligent with just only a misadventure. The AIIMS medical board report is supportive of the case of OPs and it categorically stated that the OPs provided treatment as per standard medical protocol and there was no negligence The counsel also referred various judgments of Hon'ble Supreme Court and this Commission as follows:-

(i) Dr. Laxman Balakrishnan Joshi Vs. Dr. Trimbak Bapu Godbole & Ors., AIR 1969 SC 128.

(ii) Jacob Mathews Vs. State of Punjab and Anr., (2005) SCC (Crl.)1369

(iii) The Bolam's case, (1957) 1 WLR 582

(iv) Kusum Sharma Vs. Batra Hospital & Medical Research Centre, AIR 2010 SC 1050

(v) Indian Medical Association Vs. V.P. Shantha & Ors., (1995) 6 SCC 651

(vi) Sh. Ajay Gupta Vs. Dr. Pradeep Aggarwal & Ors., 2007 (3) CPR 117 (NC)

(vii) Samira Kohli Vs. Prabha Manchanda (Dr.), 1(2008) CPJ 56 SC.

Findings:

13. We have perused the medical record of Sharma Medical Centre of OP1. The Antenatal Medical Record clearly revealed that, proper ANC care was taken by OP-1. The USG report and Discharge -Summary sheet from Sharma Medical Centre showed that, it was the case of Placenta Previa (Placenta-Succenturiate posterior Lobes). Patient/complainant 2 was operated under spinal anaesthesia for an emergency LSCS on 2.4.2005. The baby was diagnosed as Preterm (32 weeks) with signs of HMD, therefore, after due information to the relatives, the child was shifted to Maharaja Agrasen Hospital (OP-2) under care of Dr. G. S. Kochar. Therefore, we are of considered view that, OP-1 conducted delivery with due care and referred the child and mother to higher centre for neonatal care. There is no negligence on the part of the OP1.

14. Further it is relevant to note that the Delhi Medical Counsel(DMC)'s order which has opined about lapses on the part of Dr. Rama Sharma(OP-1) in providing medical records in accordance with Regulation 1.3.2 of Indian Medical Council (Professional Conduct, Equity and Ethics) Regulation 2002, has not observed any negligence on the part of OP 1.

15. We have perused the entire medical record of OP-2 hospital, the prescriptions of different eye clinics where the patient visited. Accordingly, at the time of admission in OP-2 on 2.4.2005, the general condition of baby was poor, it was diagnosed as "32 weeks pre term AGA with HMD". (Appropriate for Gestational Age) Therefore, baby was treated in NICU with ventilator support, injection Surfactant was given gradually. The child was discharged on 29.4.2005 from OP-2, thereafter; the baby visited the OPD on 4.5.2005 and on 13.07.2005, Dr.Kochhar OP-2 advised BERA scan. On 23.11.2005, the child was taken to Nayantara Eye Clinic, B. Scan of eyes was performed. Thereafter, on 3.12.2005 the child was taken to Dr.Shroff's Charity Eye Hospital, USG (B scan) was performed. It revealed Total Retinal detachment (ROP stage 5). The prescription of OP-2 revealed that, on 7.12.2005, child was brought to OP-2 again, but it was referred to Shankara Netralaya for opinion of Dr. Lingem Gopal at Chennai. But, on 13.12.2005, the patient took OPD consultation at Dr. Rajendra Prasad Centre for Ophthalmic Sciences, New Delhi. The OPD card clearly revealed it was a case of ROP stage 5. in the month of December, 2005.

16. Our observations on the two letters on the file:-

I) One the complainants wrote on 04-08-2007 to the Medical Superintendent of OP2. The relevant part of the said letter is reproduced as below:

Under the above enclosure we have received photocopies of some Medical Record

(uncertified) along with a case summary dated 13-06-2007.

The said summary states that on 26-04-2007 ROP examination on our baby was conducted in the Ophthalmological unit of your hospital and review examination after two weeks was also advised.

We are rather intrigued by this observation as it does not_ find mention anywhere in the Discharge Summary nor is there any_ follow up advise.

Since both o f us do not recollect any such examination conducted in our presence or review advise and the said medical record is also totally silent about it, kindly provide us with the entire record of the Ophthalmological unit, name of the Paediatric Ophthalmologist who had conducted the ROP examination and his written report dated 26-04-2006.

ii) OP-2 replied the letter on 24-08-2007, the relevant paragraph is;

"As per standard neonatal protocol, ophthalmological check-up was requested on 25-04-2005 to rule out ROP.

The ophthalmological examination was done in the Nursery on 26-04-2005 morning by Dr. S. N. Jha, Senior Consultan Ophthalmologist. The written report of the Ophthalmological unit is stated on page no.102 of the case record. "

On perusal of page No.102 of the case record reveals some illegible handwriting noting, it is reproduced as below:

26/4 by Dr. SNJ

No ROP

Review, 2 weeks.

Sign.

17. Therefore, on careful reading of paras 15 and 16 (supra), we are not convinced whether the ROP screening was done by OP-5 on 26.4.2006?. The progress sheet is devoid of details about ROP examination viz. who performed it, the method, instruments used and drugs (midrates/ tropicamide)/anaesthesia used during ROP testing. The doctor has not mentioned any details of dilatation of pupil and findings of Indirect Ophthalmoscope findings, the intra ocular or extra retinal findings. Thus, it was a casual approach of OPs towards premature baby. The OP-5 has not followed standard ROP screening protocol. Thus "No record means, it was Not done". Even the nurses' daily record on 25.4.2005 to 27.4.2005 does not show any ROP examination was done by OP 5.

Expert Opinion

18. The Medical Board at AIIMS gave the expert opinion in compliance of the order of this Commission dated 29-02-2012. It is reproduced as below:

Treatment of Mother:-

After examining the documents in the case file it was found that the medical treatment provided by Sharma Medical Centre, New Delhi was in accordance with normal protocol of treatment for Mrs. Pooja Sharma's medical condition.

• Treatment of Baby:-

A. Referral of the baby to better care facilities of Neonatal ICU at Maharaja Agrasen Hospital, Punjabi Bagh, New Delhi from Sharma Medical Centre, B-112, Subhadra Colony, New Delhi at treatment continued from 02.04.2005 to 29.04.2005for hyaline membrane disease, neo-natal jaundice, bilateral pneumothorax with fungal septicemia was also found to be in accordance with normal protocol of treatment.

B. As per standard guidelines (National Neonatology Forum), newborn babies who are born at 32 weeks gestation or lesser should have their eyes examined at 3 - 4 weeks of age and more frequent check-ups are to be done thereafter. Dr. S.N. Jha, examined the baby at 24 days of age which was in accordance with established protocol.

C. If ROP screening does not reveal any ROP, then repeat examination should be performed after two weeks. In case offinding of any ROP a closer follow up is required. Dr. S.N. Jha did not find any ROP in his first examination of the baby on 26.04.2005 and advised a follow up visit after two weeks which again was in accordance with established protocol. The baby was discharged after 3 days (on 29.04.2005) of eye examination and was advised to report back after two weeks period in Paediatrics OPD Clinic on Wednesdays or Saturdays from 4 PM to 6 PM.

D. As per records, the baby was brought after 5 days i.e. on 04.05.2005for morning general OPD (09.00 to 11.00).

E. Thereafter, the patient was brought again after more than two months i.e. on 13.07.2005 again to morning general OPD of this hospital.

F. There are no records to show that the baby was brought after two weeks of discharge to the Pediatrics OPD Clinic on Wednesdays or Saturdays from 4 PM to 6 PM (the special clinic for follow up of such babies where these examinations are done) as per advice given in the discharge slip.

It seems the baby was not brought to the Pediatrics OPD Clinic on Wednesdays or Saturdays from 4 PM to 6 PM after two weeks of discharge when subsequent progression of ROP could have been assessed and treated on time.

We find that, this report did not comment about details of ROP screening and the follow up findings on 4.5.2005.

Medical Literature on ROP:

19. In this regard, we have accessed number of medical literatures on ROP and text books of Paediatrics, Neonatology to know about the guidelines for screening of ROP and its treatment.

20. About the screening programme in NICU, the article, 'Programme planning and screening strategy in retinopathy of prematurity", Indian J Opthalmol 2003; 51:89-97, its relevant text is reproduced as below:

When should screening begin ?

A premature infant is not born with ROP. The retina is immature, but this is perfectly natural for their age. It is the post natal developments in the retinal vessels that could lead to ROP. The sequence of events leading to ROP usually takes about 4-5 weeks except in a small subset of premature infants who develop rush disease in 2-3 weeks. Therefore, routine screenings should begin at no later than four weeks after the birth and possibly even earlier for infants at higher risk (2-3 weeks) It is strongly recommend that one session of retinal screening be carried out before day 30 of the life of any premature baby.

The examination should be done with the dilation of pupil by tropicamide .5% to 1% with phenylapinephrine 2.5%.

Where the examination should be done?

When preparing the screening away from one's own office, the ophthalmologist should ensure from a checklist that all instruments/forms needed are packed. The place of screening must be warm and clean enough for the baby. This is often the nursery/office of the neonatologist but can also be the office of the ophthalmologist. The baby should be well clothed and wrapped; and the baby should be preferably fed and burped an hour before evaluation. Babies who are critically ill or in NICU are evaluated in the NICU/incubator under the guidance of the neonatologist, monitored by a pulse oximeter.

21. The revised policy statement on "Screening examination of premature infants for retinopathy of prematurity (ROP) of American Academy of Paediatrics (AAP) was published in the February 2006 issue of Paediatrics. http://pediatrics.aappublications.org/cgi/content/full/117/2/572). It is recommended that,

- A retinal screening examination should be performed after pupillary dilation using binocular indirect ophthalmoscopy on all infants with a birth weight of less than 3 lb, 5 oz (1,500 g) or a gestational age of 32 weeks or less. Examination also should be performed on selected infants with a birth weight of 3 lb, 5 oz to 4 lb, 6 oz (1,500 to 2,000 g) or a gestational age of more than 32 weeks with an unstable clinical course.
- Knowledgeable and experienced ophthalmologists should perform retinal examinations on preterm infants and classify, diagram, and record findings using the standards from the International Committee for the Classification of Retinopathy of Prematurity.
- The initiation of acute-phase ROP screening should be based on the infant's age because the onset of serious ROP correlates more with postmenstrual age (i.e., gestational age at birth plus chronologic age) rather than postnatal age. Thus, the youngest infants at birth take the longest time to develop serious ROP.

- The ophthalmologist should recommend follow-up examination based on retinal findings categorized by the international classification. Physicians who are involved in ophthalmologic care of preterm infants should be aware that the findings calling for consideration of ablative treatment were recently revised using results from the Early Treatment for Retinopathy of Prematurity Randomized Trial Study. Acute retinal screening examination conclusions should be based on ophthalmoscopy findings and infant age.
- Parent and staff communication about ROP is important, and documentation of these conversations is recommended. Each new-born intensive care unit should define responsibility for examination of at-risk infants. Each unit should have specific criteria based on birth weight and gestational age, and the criteria should be established through discussion and agreement between the neonatal and ophthalmology departments.

22. The recent article "Retinopathy of Prematurity: Past, present and future" World J Clin Pediatr 2016;5(1):35-46 discussed about screening of ROP. The important text is reproduced as hereunder;

Examination technique:

The examination technique traditionally involves two steps namely the dilatation of pupil and indirect ophthalmoscopy preferably with a 28D lens. It is preferred to perform pupillary dilatation 45 min prior to commencement of the screening. Dilating drops used are a mixture of cyclopentolate (0.5%) and phenylephrine (2.5%) drops to be applied two to three times about 10-15 min apart.

Alternatively, tropicamide (0.4%) may be used instead of cyclopentolate. Diluted cyclopentolate may also be used to reduce probable systemic adverse effects. Use of atropine is to be avoided. The neonatal nurse should be instructed to wife any excess drops from the eye lid to prevent systemic absorption and complications like tachycardia and hyperthermia. If the pupil is resistant to dilatation, it may indicate presence of persistent iris vessels (tunica vasculosa lentis) and must be confirmed by the ophthalmologist before applying more drops. The United Kingdom guidelines do not mandate use of eye speculum (e.g., Barraquer, Sauer, Alfonso specula) and scleral depression (e.g., Flynn depressor) with topical anaesthesia. However, meticulous examination, warrants its use.

Treatment modalities:

- Cryotherapy treatment of avascular retina.
- Indirect laser photocoagulation of the peripheral retina using indirect delivery system has proved to be the gold standard, time tested and successful means of treatment since many years. The biggest advantage is that it can be done under topical anesthesia.Pharmacologic therapy is thus ushering a new era of ROP management.
- Anti-vascular endothelial growth factors drugs which block the effects of VEGF, and a single intravitreal injection is less time consuming and less expensive as

compared to lasers. Exceptionally successful results with anti-VEGF drugs in adult retinal vascular diseases led to its trial in paediatric retinopathy as a monotherapy as well as in combination with lasers.

23. AIIMS-NICU Protocols 2010 and NNF guidelines:

Retinopathy of prematurity (ROP) is emerging as one of the leading causes of preventable childhood blindness in India. Screening for ROP should be performed in all preterm neonates who are born < 34 weeks gestation and/or < 1750 grams birth weight; as well as in babies 34-36 weeks gestation or 1750-2000 grams birth weight if they have risk factors for ROP. The first retinal examination should be performed not later than 4 weeks of age or 30 days of life in infants born > 28 weeks of gestational age. Infants born < 28 weeks or < 1200 grams birth weight should be screened early, by 2-3 weeks of age, to enable early identification of AP-ROP. The retinal findings should be classified and documented based on the International Classification of Retinopathy of Prematurity guidelines (ICROP). Follow up examinations should be based on the retinal findings and should continue until complete vascularization or regressing ROP is documented or until treated based on the ETROP guidelines. Laser photocoagulation delivered by the indirect ophthalmoscopic device is the mainstay of ROP treatment. The responsibility of recognition of infants for screening lies with the paediatrician/neonatologist. Communication with the parents regarding timely screening for ROP, seriousness of the issue, possible findings and consequences is extremely imp. The Pre-term babies who have had problems after birth such as lack of Oxygen, infections, blood transfusions breathing trouble, etc., are also vulnerable. Follow the "Day-30" strategy. The retinal examination should be completed before "day-30" of the life of a premature baby. It should preferably be done earlier (at 2-3 weeks of birth) in very low weight babies (<1200 grams birth weight). ROP is treated with Laser rays or a freezing treatment (Cryopexy). The treatment helps stop further growth of abnormal vessels thus preventing vision loss. ROP can progress in 7-14 days and therefore, needs a close follow-up till the retina matures. Therefore, ROP needs to be treated as soon as it reaches a critical stage called Threshold ROP. There is 50% or greater risk of vision loss if left untreated after this. Time is crucial. After treatment if treated in time, the child is expected to have reasonably good vision. All premature babies need regular eye examinations till they start going to school. ROP is easily detected by periodic fundoscopy starting from 20-30 days of birth. Any person trained in neonatal fundoscopy can screen for ROP. Main instrument used is the binocular indirect ophthalmoscope.

Conclusion:

24. Because ROP is sequential and timely treatment has been proven to reduce the risk of vision loss, it is imperative that at-risk, infants receive carefully timed retinal examinations and that all physicians who care for at-risk, preterm infants should be aware of the importance of timing.It should be borne in mind that, screening

for ROP needs to be initiated timely after birth to prevent blindness. It is the responsibility of the caring pediatrician to initiate screening by referring to an ophthalmologist and it is the responsibility of the ophthalmologist to do correct screening and treatment. This has immense medico legal implications because if a child goes blind due to missed or late screening, then the pediatrician and the ophthalmologist are at a very high risk of litigation.

25. In the instant case, the main question swirls around, whether, the OP-5 performed ROP screening or not, at OP-2 hospital? ROP screening is a team work of paediatrician, ophthalmologist and NICU nurse. On the basis of discussion in foregoing paras, we find many lapses on the part of the OPs like no proper medical documentation of ROP screening procedural details. It should be borne in mind that, as per referral on 25.4.2006, the OP-5 should have performed retinal examination with binocular indirect ophthalmoscope on dilatation of pupil with scleral depression to ascertain avascular zone at periphery of retina. Nothing is forthcoming from page 102 of the medical record. Therefore, it appears to be a bare visual examination done by OP 5 in haste to cover up the case.

    Thus, we are of considered view that, on 26.4.2005 the OP3 to 5 have neither performed ROP screening nor advised follow up of ROP for the child. The patient visited hospital on 3.5.2006 for follow up, but nothing is in record about ROP testing. It is not a standard of practice or due care of the patient. Thus, a medical negligence.

26. It is pertinent to note that, in the instant case, the baby was premature, 32 weeks, the weight was 1500 gms. The team of doctors at OP-2 should have been alert about the chances of ROP in the premature baby/complainant No. 1. It is very vital that judicious oxygen therapy and judicious use of blood transfusions Transfusion of packed RBCs is another risk factor of ROP. Adult RBCs are rich in 2,3 DPG and adult Hb binds less firmly to oxygen, thus releasing excess oxygen to the retinal tissue. Packed cell transfusions should be given, when haematocrit falls below, following ranges: ventilated babies 40%, babies with cardio-pulmonary disease but not on ventilators 35%, sick neonates but not having cardiopulmonary manifestations 30%, symptomatic anemia 25%. But, in the instant case blood component therapy was given. Therefore, we hold both the Paediatricians (OP 3 and 4,) along with OP-5 liable for the said negligence.

27. Expert's silence:

The counsel for complainant vehemently resisted the AIIMS medical board report. On perusal of said report, we also agree that, the opinion did not discuss the details about the ROP screening, whether done by OP-5 or not. In the case Ramesh Chandra Aggarwal vs. Regence Hospital Ltd. & Ors. (2009) 9 SCC 709, the Hon'ble Supreme Court held that;

"the real function of an expert is to put before the court all the material, together with reasons which induce him to come to the conclusion, so that the court, although not an expert may from its own judgment by its own observation of those materials

Who is liable?

28. In Rogers v Whitaker, [1992] HCA 58; 175 CLR 479 where the issue was the extent of a doctor's obligation to inform a patient of the risks inherent in proposed treatment, the Court based its decision squarely upon the duty of the doctor to observe the appropriate standard of care and not upon any fiduciary relationship. The majority said:

    "The law imposes on a medical practitioner a duty to exercise reasonable care and skill in the provision of professional advice and treatment. That duty is a 'single comprehensive duty covering all the ways in which a doctor is called upon to exercise his skill and judgment'; it extends to the examination, diagnosis and treatment of the patient and the provision of information in an appropriate case . It is of course necessary to give content to the duty in the given case. "

29. Hon'ble Apex court discussed the duty of doctor in the judgment Laxman Balkrishna Joshi vs Trimbak Bapu Godbole And Anr. 1969 AIR 128. Court observed that;

    "A person who holds himself out ready to give medical advice and treatment impliedly holds forth that he is possessed of skill and knowledge for the Purpose. Such a

    person when consulted by a patient, owes certain duties, namely, a duty of care in deciding whether to undertake the case, a duty of care in deciding what treatment to give, and a duty of care in the administration of that treatment. A breach of any of these duties gives a right of action of negligence against him. The medical practitioner has a discretion in choosing the treatment which he proposes to give to the patient and such discretion is wider in cases of emergency, but, he must bring to his task a reasonable degree of skill and knowledge and must exercise a reasonable degree of care according to the circumstances of each case. "

    It is thus clear that, the OP-3- to 5 in the instant case failed to exercise reasonable care and skill.

Vicarious Liability:

30. Hon'ble Supreme Court and this Commission, in a number of judgments held that, hospital will be vicariously liable on numerous grounds, on different occasions. Employers are also liable under the common law principle represented in the Latin phrase, "qui facit per alium facit per se", i.e. the one who acts through another, acts in his or her own interests. We place reliance upon Savita Garg Vs. National Heart Institute, (2004) 8 SSC 56 , Balram Prasad v. Kunal Saha, (2014) 1 SCC 384 and Smt. Rekha Gupta v. Bombay Hospital Trust & Anr. [2003 (2) CPJ 160 (NCDRC)]. In another judgment by the Madras High Court in Aparna Dutta v. Apollo Hospitals Enterprises Ltd. [2002 ACJ 954 (Mad. HC)], it was held that; "it was the hospital that was offering the medical services. The terms under which the hospital employs the doctors and surgeons are between them but because of this it cannot

be stated that the hospital cannot be held liable so far as third party patients are concerned. It is expected from the hospital, to provide such a medical service and in case where there is deficiency of service or in cases, where the operation has been done negligently without bestowing normal care and caution, the hospital also must be held liable and it cannot be allowed to escape from the liability by stating that there is no master-servant relationship between the hospital, and the surgeon who performed the operation. The hospital is liable in case of established negligence and it is no more a defense to say that the surgeon is not a servant employed by the hospital, etc. "

In the instant case, the hospital OP-2 is vicariously liable for the wrongs of OP 3,4 and 5.

Compensation:

31. Adverting to the extent of compensation, the complainants had prayed for the total compensation of Rs.1,30,25,000/-. In this context, we rely upon several judgments of Hon'ble Supreme Court like Reshma Kumar and Ors. Vs. Madan Mohan and Anr. (2009) 13 SCC 422, Nizams Institute of Medical Sciences Vs. Prasanth S. Dhananka and Ors. (2009) 6 SCC 1 and the recent judgment in Balram Prasad Vs. Kunal Shah and Ors. (2014) 1 SCC 384.

    The Hon 'ble Supreme Court in Nizams Institute o f Medical Sciences Vs. Prasanth S. Dhananka and Ors. (2009) 6 SCC 1 held that;

    We must emphasize that the court has to strike a balance between the inflated and unreasonable demands of a victim and the equally untenable claim of the opposite party saying that nothing is payable. Sympathy for the victim does not, and should not, come in the way of making a correct assessment, but if a case is made out, the court must not be chary of awarding adequate compensation. The adequate compensation that we speak of, must to some extent, be a rule of thumb measure, and as a balance has to be struck, it would be difficult to satisfy all the parties concerned.

    In Balram Prasad Vs. Kunal Shah and Ors. (2014) 1 SCC 384, the Honble Supreme Court has again emphasized that it is the duty of the Tribunals, Commissions and the Courts to consider relevant facts and evidence in respect offacts and circumstances of each and every case for awarding just and reasonable compensation.

32. In this instant case, the facts and findings are similar, the negligence and deficiency in service is proved against OP2 to 5. Considering the entirety, we follow the decision of the bench of Hon'ble Mr. Justice J. S. Khehar and Hon'ble Mr. Justice S. A. Bobde of Apex Court in the case of V.Krishna Kumar Vs. State of Tamil Nadu & Ors. JT 2015 (6) SC 503. Hon'ble Mr. Justice S.A. Bobde awarded compensation of 1.38 Crores considering the apportioning for inflation and apportionment of liability.

33. The child, Master Rishabh, has been rendered blind for life. The darkness in his life can never be really compensated for, in money terms. Blindness can have terrible consequences. The family belongs to the middle class, which incurred expenses on the child. The father is no more. Undoubtedly, the care of visually disabled child needs reasonable spells of time. Master Rishabh may also face great difficulties in getting education, marriage and social life. It is, thus, obvious that there should be adequate compensation for the pain and suffering, and the future care that would be necessary while accounting for inflationary trends. Almost one decade has elapsed during treatment and the litigation; certainly the complainants incurred huge expenditure. It is, therefore, necessary to consider the loss which Master Rishabh and his parents had to suffer and also to make a suitable provision for Rishabh's future. It is pertinent to note that, the father of child Kuldeep Sharma was working as temporary employee in MCD, New Delhi. He expired during pendency of this case. Hence, the complainant 2, the mother of Master Rishabh, is a home maker. She will have to take care of entire family including her two kids. Therefore, we assume that, for an average middle class family, yearly expenses will be to the tune of Rs.200,000/-, out of which Rs. 50,000/- would be a need for Master Rishabh's living including medical expenses.

34. As observed in V. Krishnakumar's Case, Inflation over time certainly erodes the value of money. The rate of inflation (Wholesale Price Index-Annual Variation) in India, presently, is 2 percent 4 as per the Reserve Bank of India. Therefore, having considered the present economy and medical inventions, the child may need treatment in future. Master Rishabh's present age is about 11 years. If his life expectancy is taken to be about 70 years, for the next 59 years. The average inflationary rate between 1990-91 and 2014-15 is 6.76% and 2015-16 is 5.65% as per data from the RBI. In the present case, we are of the view that this inflationary principle must be adopted at a conservative rate of 1 percent per annum to keep in mind, fluctuations over the next 59 years. The amount of expenditure, at the same rate will work out to be Rs.53,06,193.32/- rounded to Rs.53,00,000/- by applying formula for Apportioning for Inflation as

    FV = PV x (1+r)n (PV = Present Value = 50,000, r = rate of return = 1.01, n = time period = 59)

35. **Compensation to mother:**

    Hon'ble Supreme Court, in Spring Meadows Hospital and Another v. Harjol Ahluwalia [1998 4 SCC 39] this court acknowledged the importance of granting compensation to the parents of a victim of medical negligence in lieu of their acute mental agony and the lifelong care and attention they would have to give to the child. This being so, the financial hardships faced by the parents, in terms of lost wages and time, must also be recognized. Thus, the above expenditure must be allowed. It is true that, the mother Smt. Pooja Sharma has to take care of the blind child, throughout her life. She has to suffer mental agony and social stigma due to visually disabled child. Therefore, we are of considered view that, an award of sum of Rs. 10,00,000/- to the mother(complainant No.2) is just and proper.

36. Therefore, on the basis of the aforementioned discussion, the relevant medical literature and decisions of Hon'ble Supreme court on medical negligence, we allow this complaint and fix the liability for total sum of Rs.63 lacs(53L+10L) upon the OPs 2 to 5. Further we impose Rs.1,00,000/- toward costs of litigation.

37. For the reasons stated herein above, we direct the OP 2 to 5 to pay Rs. 64,00,000/- (64 lacs), to the complainants jointly and severally within 2 months from the date of receipt of this order, failing which, entire amount will carry the interest @ 9% per annum from today i.e date of pronouncement till its realisation. It is further directed that, out of the total compensation, Rs.50,00,000/- to be kept in fixed deposit in any Nationalised Bank, in the name of Master Rishabh Sharma till he attains the age of 21 years. The periodic interest shall be paid to the mother for 21 years. The remaining amount of Rs. 14 lacs be paid to the Smt Pooja Sharma (Complainant No 2), the mother of Master Rishabh.

    A copy of this order as per the statutory requirements be forwarded to the parties free of charge. List for compliance on August 1,2016.

.....J

J.M. MALIK

PRESIDING MEMBER

DR. S.M. KANTIKAR

MEMBER

Answers

Chhota Sudoku

2	1	6
15	20	
3	9	4
24	26	
7	5	8

7 BR OK EN Words

1 RUMMY
2 MAMMAL
3 SUMMER
4 MAMMOTH
5 SHIMMER
6 SWIMMER
7 SKIMMING

Sudoku

8	7	6	3	4	2	5	1	9
1	3	4	9	8	5	6	2	7
5	9	2	6	7	1	8	4	3
7	8	5	2	9	3	1	6	4
3	2	1	5	6	4	9	7	8
4	6	9	8	1	7	3	5	2
2	1	3	4	5	8	7	9	6
9	4	7	1	3	6	2	8	5
6	5	8	7	2	9	4	3	1

KEN KEN PUZZLE

1- 4	3	24x 6	1	10+ 2	5
3- 5	2- 2	1	4	3	7+ 6
2	4	45x 5	3	120x 6	1
3÷ 1	6 6	3	5	4	2÷ 2
3	11+ 5	2	3÷ 6	15x 1	4
5- 6	1	4	2	5	3

UTILITY PAGES

EMERGENCY

Emergency - Medical, police, Fire 108
Police 100
Fire 101
Ambulance 102

POLICE

Police Control Room 25630100
Police Commissioner 25633636
P.R.O. To Commissioner.....25633333
Navrangpura.....26563711
Saherkotda.....22111632

POLICE STATIONS

Amraiwadi 22770280
Khadia 22142828
Bapunagar.....22700585
Danilimda.....25320153
Dariapur.....22160906
Ellisbridge.....26578202
Ghatlodia.....27489127
Gomtipur.....22941921
Haveli 25392647
Kagdapith.....25454446
Kalupur 22167530
Karanj 25507580
Madhavpura 25632100
Maninagar 25460089
Meghaninagar.....22681555
Naranpura 27472043
Naroda 22821480
Navrangpura.....26440698
Odhav 22871091
Rakhial.....22743609
Sabarmati.....27517887
Saherkotda.....22927072
Sardarnagar 22864345
Satellite.....26860333
Shahibaug 22868025
Shahpur 25600545
Sola Police Station 27664590
Vatva 25710074
Vatva G1DC 25830004
Vejalpur 26810614
Women's Police Station.....25507967

FIRE STATIONS

Gomtipur 22776996
Jamalpur 25397959
Jashodanagar 32981439
Manianagar 25470221
Naroda 22200715
Odhav 22875434
Panchkuva.....22120388
Sabarmati.....27507302
Chief Fire Officer HQ 22148466

TELEPHONE SERVICES

General Inquiry 197
Morning Alarm.....116 + Time
Fault Repair
.....Exchange Code + 2198
BSNL Customer Service Centre (Land Line) 1500
BSNL Customer Service Centre (Mobile).....9426024365
BSNL Phonogram / (India/International).....1585
BSNL Trunk Booking 1580
BSNL Trunk Booking International 1586
BSNL - Railwaypura 22124660
Air Tel - Ashram Road 40072668/
.....9898954321
Hutch Ltd. - Navrangpura 9825098250
Idea Cellular Ltd. - Stadium 9824012345
Reliance Infocomm Ltd 30337777
Tata Teleservices Ltd - Ellisbridge 92270001 21

AMBULANCE SERVICES

Ambulance - Danapith 22148465

Ambulance - AMC Danapith 22148468
Emergency Medical Council of Ahmedabad [EMS] - Ellisbridge.....1056
Mission Life India -Drive In 26854849
Mission Life India - 24 Hrs 9825006000
Navdeep Emergency Service
Income Tax - Day.....27543333
- Night 9825029977
Sadvichar Parivar Civil Hospital 22680450

EYE BANKS / HOSPITALS

Asopalav Eye Hospital -Shahibaug 22865537
CH.Nagri Eye Bank -Ellis bridge.....26466724
C.S.Samaria Red Cross Int.Eye Bank Thaltej.....1053 & 27450633
Hargovandas Prabhudas Sadvicriar ParivarEye Hospital -Naroda.....22811476
Lions Karnavati Shantaben Vishnubhai Patel Eye Hospital -Ognaj 952717244052
M and J Inst. of Ophthalmology Eye Bank-Civil Hospital 22680314

CIVIC SERVICE CENTRE

East Zone 32982474
Lal Darwaja.....32091243
Law Garden 32981247
Maninagar 32981246
North Zone 32982471
West Zone 32981242

AMC CONTROL ROOM (FOR COMPLAINTS)

Main 25353858/25353717
West Zone 27550910
North Zone 22801182
East Zone.....22970422-24
New West Zone Bodakdev 32981396
Central Zone 25353717

TELEVISION

Aaj Tak -Panchvati 26405253
CNBC -S G Road 40040825
Doordarshan -Thaltej 26853025
ETV Gujarati -Bodakdev 26871210
NDTV -C G Road.....9825030011
Set India Ltd (Sony TV) Stadium 26565908/9825329091
Star News -S G Road 26872529
Zee News -Satellite 26922717
TV 9 26810999

PRINT

Business Standard ltd -Ellisbridge 26577772
Chitralekha Group -Parimal Garden 26461711
Divya Bhaskar -S G Highway 39888850
Gujarat Samachar -Khanpur 30410000
Hindustan Times -Navrangpura 26560037
India Today -Panchvati 26569156/26560393
Indian Express -Bodakdev.....26872481
Jaihind Press -Navrangpura 26587053
Jansatta -Bodakdev.....26873995
Mumbai Samachar -Panchvati 26421783
Press Information Bureau -Bhadra.....25507217
Press Trust of India Ltd. -Navrangpura 26430507
Rajasthan Patrika C.G. Road 30611565

Sambhav-Bodakdev.....26873914
The Sandesh Ltd.
-Bodakdev 40004000
The Times of India Fadia
Chambers 26553300/26582527
The Times of India
- Sakar 1 26554455
The Times of India
- Vejalpur.....26761495
Young Leader
-Khanpur 25502999

RADIO

All India Radio
- Income Tax 27542672
My FM-S G Highway 26927943
Radio City
- S G Highway.....66119911
Radio Mirchi - Vejalpur.....66001100
Radio One.....67010013

MIEDICAL COLLEGE

BJ.Medical College
- Asarwa 22680074
College of Nursing
-Asarwa 22681406
Suresh Brahmkumar
Bhatt College
of Physiotherapy.....26583435
Smt. N.H.L. Municipal Medical College
Ellisbridge.....26576275
Institute of Kidney
Diseases and Research Centre
Asarwa 22685601
U N Mehta Institute of Cardiology
and Research Centre
-Asarwa.....22682395

ENTERTAINMENT HALLS

Dinesh Hall
- Ashram Road.....26582123
Tagore Hall - Paldi 26575741
Thakorbhai Desai Hall
- Law Garden 26400651
Town hall - Ellisbridge.....26582092

AIRLINES

Airport Authority of
India 22867261
Air India Domestic City
Office Ashram Road 26585633/44
Laldarwaja 25503061/2/3
Airport.....22869233/44
Airport
Tele-Check-in 22850376
Cargo 22869236
International
Airport.....22867237/5211/9238
Cargo 22862976/29292100/03
Jet Airways
Ashram Road.....27543304 to 10
Airport.....22866540/240
Cargo 22861407/8533
TeleCheck-in 22866540/240
Jet Lite/Sahara 1800223020
...../22858003
Spice Jet 18001803333/
.....09871803333

TOURIST INFORMATION CENTRE

Goa Tourism 0832-2438750
Gujarat Tourism.....26589172
Himachal Tourism 27544800
Kerala Tourism 18004254747
M P State Tourism 26462977
Rajasthan Tourism 26565187
Uttaranchal Tourism.....26564245

TELEPHONE NUMBERS

A.M.A. 2658 8775
A.M.A. (Fax).....2658 7498
G.S.B. 2658 7370
S.S.S. 2658 0690
P.P.S. 2658 8929
N.S.S.S.....2658 5430
PHY.ASSO.....2657 4763
A.O.G.S. 2658 6426

TOLL FREE NUMBER

Airlines

Indian Airlines - 1800 180 1407
Jet Airways - 1800 22 5522
Spice Jet - 1800 180 3333
Air India - 1800 22 7722
Kingfisher - 1800 180 0101

Banks

ABN AMRO - 1800 11 2224
Canara Bank - 1800 44 6000
Citibank - 1800 44 2265
Corporation Bank - 1800 443 555
Development Credit Bank - 1800 22 5769
HDFC Bank - 1800 227 227
ICICI Bank - 1800 333 499
ICICI Bank NRI - 1800 22 4848
IDBI Bank - 1800 11 6999
Indian Bank - 1800 425 1400
ING Vysya - 1800 44 9900
Kotak Mahindra Bank - 1800 22 6022
Lord Krishna Bank - 1800 11 2300
Punjab National Bank - 1800 122 222
State Bank of India - 1800 44 1955
Syndicate Bank - 1800 44 6655

Automobiles

Mahindra Scorpio - 1800 22 6006
Maruti - 1800 111 515
Tata Motors - 1800 22 5552
Windshield Experts - 1800 11 3636

Computers/IT

Adrenalin - 1800 444 445
AMD - 1800 425 6664
Apple Computers - 1800 444 683
Canon - 1800 333 366
Cisco Systems - 1800 221 777
Compaq - HP - 1800 444 999
Data One Broadband - 1800 424 1800
Dell - 1800 444 026
Epson - 1800 44 0011
eSys - 3970 0011
Genesis Tally Academy - 1800 444 888
HCL - 1800 180 8080
IBM - 1800 443 333
Lexmark - 1800 22 4477
Marshal's Point - 1800 33 4488
Microsoft - 1800 111 100
Microsoft Virus Update - 1901 333 334
Seagate - 1800 180 1104
Symantec - 1800 44 5533
TVS Electronics - 1800 444 566
WeP Peripherals - 1800 44 6446
Wipro - 1800 333 312
Xerox - 1800 180 1225
Zenith - 1800 222 004

Indian Railway General Enquiry 139
Indian Railway Central Enquiry 139
Indian Railway Reservation 139
Indian Railway Railway Reservation Enquiry 1345,1335,1330
Indian Railway Centralised Railway Enquiry 1330/1/2/3/4/ 5/6/7/8/9

Couriers/Packers & Movers

ABT Courier - 1800 44 8585
AFL Wizz - 1800 22 9696
Agarwal Packers & Movers - 1800 11 4321
Associated Packers P Ltd - 1800 21 4560
DHL - 1800 111 345
FedEx - 1800 22 6161
Goel Packers & Movers - 1800 11 3456
UPS - 1800 22 7171

Home Appliances

Aiwa/Sony - 1800 11 1188
Anchor Switches - 1800 22 7979
Blue Star - 1800 22 2200
Bose Audio - 1800 11 2673
Bru Coffee Vending Machines - 1800 44 7171
Daikin Air Conditioners - 1800 444 222

GUEST HOUSE OF IMA LIST

State Branch	IMA Branch with Address	Contact Person & Contract Detail	Tariff & Meals - Yes / No
Anadhra Pradesh	**Bhimavaram** Branch, IMA Building, Mothupallivari Street, Bhimavaram West Godawari - 534201	**Dr. M Venketramna** (M) 9491014817 Mr. I.S. Prasad Fax : 08816- 234231	1 AC double bedded Room @ Rs. 500/- per day yes
	Hyderebad Branch, IMA Building, Near Esamia Bazar, Hyderbad	**Dr. Raju Ch. Srinivas** M : 09490172569 TEL:- (040) 24656378 FAX : (040) 24738197 E-: hydcityvima@yahoo.co.uk	Single A/C. RS. 400/- Double A/C - Rs. 600/- (12 Rooms) Double A/C. RS. 500/- (8 Rooms) No.
	Kakinada Branch, IMA Road, Kakinada, East Godavari Mehabudabad- 506101 , Warangal	**Dr. Y K Chaturvedi** (M) 9848162300, 0884-2361323 E-: imakakinada@yahoo.com	2 AC Suits @ Rs. 800/- per Day (for doctors @ 500/- per day)
	Nellor Branch, Saraswathi Nagar, Opp. Ratan School, Nellore : 5240003	**Dr. Y Krishna Mohan Rao,** 0861- 2329420	
	Tirupathi Branch,29, Housing Board Colony, Alipiri Barpeta - 781315	0877-3959546	
Assam	**Barpeta** Road Branch Tourist lauge Bareta Road, Barpeta - 781315	**Dr. Kankan Goswami** M : 9435025239	5 non AC Rooms @ Rs. 400/- per room (per day)
	Tezpur Branch I MA House, Tezpur- 784001	**Dr. H K Borah,** M : 9435081697	4 A/c. Rooms @ Rs. 750 /- per room
	Tinsukia Branch chinarapatti, Nr. SBI Main Br. Tinsukia - 786125	**Dr. Phanindra Saikia,** M : 09435134550	2 non AC double bedded rooms @ Rs. 250 per Rooms
Bihar	**Patna** Branch, IMA Building Dr. A k nsinha Path South East of Gandhi Maidan: Patna - 800004.	**Dr. Manvendra :** M : (Dr. Thakur) 9334114657, Tel : 0612-2321542 Fax : 0612-2321542 Email : info@imabihar.org	6 non A/C. Rooms @ rs. 150/- & 3 Rooms (AC will be installed shortly)
	Samastipur Branch , Satish Chander Sarkar Bhawan, Opp. KHE inter college, Kashipur, Samastipur - 848101	M : 09431245533 (Dr. D S singh : 06274-224094)	4 double non AC Rooms @ Rs. 250/- per person
Chandigarh	**Chandigarh** Branch IMA house., sector - 35, chandigrah	**Mr. Ramswarup** Tel >; 0172-2602595 ; Fax : 0172-2602595 Email : singh_zora@yahoo.co.in	A/C room Rs. 600/- Cooler Rs. 350/- Noon A/C. RS. 350
Delhi	IMA H.Q.s. IMA House Indraprastha Marg. Delhi - 110002	TEL.: 011-23370009,8819, 8680, 0473, 0492,8424, Fax 23379470, 23370375 Email:- imabuilding@gmail.com	A.C. Super Delux - Rs. 2080/- per day for two persons. A.C. Delux - Rs. 787/- per Day per person in shared dormitory

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Gujarat	**AHMEDABAD** Branch 2nd Floor, AMA House Opp. H k college Ashram road, Ahmedabad - 380 009	**Dr. Jitendra N. Patel** (M) 09825325200, Tel/Fax.: 079-26587370 Email.: imagsb@youtele.com imagsb@gmail.com	**5 AC Rooms @Rs. 800/- 1 AC room @Rs. 500/- 1 non A.C. Dormitory Rs. 300/- extra bed @ Rs. 100/-**
Karnataka	**Karnataka** Branch, IMA House, Nr. IMA Circle, A V Road - bangalore - 560018	**Mr. Puttuswamy,** Hon State Secretary : 9008828303; 080-26800409 : 080-26703255 Email : imaksb@bsnl.in	10 non A/C Single Bed Rooms @ Rs. 250/- , 6 non AC Double Bedded Rooms @ rs. 400/- 1 A C Deluxe @ Rs. 700/- , 1 Suite @ Rs. 800/- extra Bed : 150/- yes
	Tumkur Branch IMA House, Town Hall Circle , Tamkur - 572101	**Dr. Prashant** (M) 9632222233 , 0816-2254938	1 Single Bed Rooms @ rs. 200/- 1 Double Bedded @ rs. 300/-
	Shimoga Branch Mc. Gann Hospital Compound, Shimoga	Hon. Secretary : 9448421951 08182-224622 : doc_vishwanath@hotmail.com	
	Chitradurga Branch opp. Dist. Hospital chitradurga - 577501	Hon Secretary : 9972328698 08194-228485	single Bed Rs. 50/- Double Bed rs. 100
	Arsikere Branch, IMA House , B/h. Sai natha Temple, J C Hospital Compound Arsikere - 573103	(M) : 9448997377 hareeshkv@yahoo.com Chancheku@gmail.com	single Bed Rs. 100 /-
Kerala	**Thiruvananthapuram** Branch, IMA State Headquaters, Ananyara. Thiruvananthpuram - 695029	**DR.J R Nair :-** 9447154066 TEL. 0471-2741144, Fax :- (0471) 2741155, Email:- imaksb@yahoo.co.in	AC Double bedded room @Rs. 1200/- for non IMA Member & IMA Member from other state and Rs. 800/- for IMA Members. 4 bedded Rooms Rs. 1600 for IMA Members and Rs. 2400 for Non IMA Members and RS. 2400 for IMA Members from other states.
	Kottarakara Branch, Ima House, Bubby Kottarakara Road P.O. Kotarakaro, Dist. Kollam	**DR. Radhamony** M: 9447801337 Tel : 0474-2454066, 2060777: Fax 0474-2454066, rradhymoney@yahoo.co.in	Can be arragned In some other private hotel
Maharasthra	**Mumbai** Branch IMA CHOWK, 16 keshav rao ""Khadye Marghaji Ali Mumbai - 4000034	**Mrs. Jyotsna,** Tel :- (022) 23543255, Fax : (022) 23545510 ima_mumbai@rediffmail.com; mumbai@mtnl.net.in	Rs. 500/- (1 room) No.
	Mumbai West Branch, J R Mhtre Marg JVPD Scheme, behind Chandan Cinema juhu, Mumbai 400049	**Ms. Aparna :** Tel :- 022-26206517, 65235579, 26254368, imamumbaiwest@yahoo.com	2 Rooms Rs. @ Rs. 1275/- + 10.30 %, 2 Rooms @ Rs. 1200/- + 10.30 % No.

State Branch	IMA Branch with Address	Contact Person & Contract Detail	Tariff & Meals - Yes / No
	Nagpur Branch, IMA house North Ambbazari Road, Nagpur - 440010	Te; : - (0712) 2550777. 2522421 Fax :- 0712-2550777 E :- imacon2007@gmail.com	AC RS. 340/- NO.
MP	**Indore** Branch, IMA Bhawan, Dr S K Mukharji IMA, Parisar M.O.G. Lines Indore - 452002	**Dr. Shekhar D Rao.** (M) 09826060629. Tel : 0731-2787988, E :- imasecretaryindore@gmail.com	Non A C Double bedded room @ Rs. 650 /- No.
	Jabalpur Branch , IMA House , wright town, jabalpur - 482001	**Dr. L S Bais** : 9425159767, Tel .:- 0761-2404940, 4005715, Fax: 4005715	I double bedded ! Hour bedded room @ RS. 150/- /Bed / day no.
	Ratlam Branch, Subhedara IMA House Rajendra ngr. Ratlam	**Dr. Ghate :** 9425103800: 07412-231737 Email : pkghate@yahoo.com	6 Single bedded @ Rs. 200/- day No.
	Gwalior Branch IMA House - 32 Gndhi Enclave Behind Hotel Sita, Manor, Gwalior	**Dr. Ashwini Bhatnagar :** 9827062860 Email : ima_gwaliro@yahoo.in	1 AC double bed @ Rs. 500/-
Orissa	**Berhampur** IMA Berhampur M K C G Medical College Campus Berhampur - 760004, Orissa	Hony Secretary M: 9643706627 Tel : (0680) 2283848 E - kkpl1000@hotmail.com	All AC Rooms with color TV & Geyser Facility. Room 301, 302 & 303 RS. :- 400/ Room 304 & 305 RS. :- 500/-
	Bhubaneswar BHUBANESWAR IMA INSTITUTE, 656 & 781 GANGA NAGAR UNIT - 6 Bhubandeswar, Orissa	**Dr. Sarojo Kumar Sahu** (for Hall) Mob :- 9437002424 **Mr. Umakanta** (For Room) ph:- 0674-239008 Mob : 9237014514 imabahubaneshwar@gmail.com sahudrasaroj@yaho.co.in	* Auditorium 250 Capacity * Executive Conf Room of 50 Capacity six Rooms 1. Two A/C Double Rooms . 2. Two A/C Three Bed Rooms 3. One A/C Four Bed Room All are A/C. Fixed with LCD, Round the Clock water and Electricity Backup Tariff raning from Rs. 800/- to Rs. 1400/- per day Only 1 km from Bhuneswar Airport And 3 km From Railway Station
	IMA State Hqr., **Cuttack** IMA House, Medical Road, Ranihat, Cuttack - 753007, Orissa	Office Tel. : (0671) 2121225 /2413060 Mob. : 8763349498 Email : imaorissa@gmail.com	All AC Rooms with LCD TV, Geyser Facility. round the clock water and Electricity backup Facility 1 suite : 1,000/- 3 Double bed Rooms : 500 /- 1 Triple bed Rooms : 750 /- Conference Hall 100 Capacity Rs. 3000/- (For 6 hour only) Meals shall be provided on request from local market

State Branch	IMA Branch with Address	Contact Person & Contract Detail	Tariff & Meals - Yes / No
Rajasthan	**Ajmer** Branch, Informat of L.N. Hospital, Ajmer	**Dr. H.S. DUA** (M) 9414300220, Mr. Lajpat Raj (M) 9782946739	2 Rooms @ Rs. 600/- (for 24 Hours) (cooler)
	Kota Branch, MBS Hosptial Campus ; Nayapura, Kota	M : 0941479558 Rs. 600/- for 24 Hours (2 Rooms)	1 AC double bedded Room @ Rs. 600/- , 1 non AC room @ 400/-
Tamil Nadu	**State HQ** Branch, Sindur Gardens, 423 Kilpauk Garden Road, kilpauk, **Chennai -10**	**Dr. N. Muthurajan** (M) 9444224754, 0944733792, Mr. Mani - 044 - 26443055, Fax :- 22395004, E :- imatamilnadu@yahoo.co.in	Pallar (AC Single bedded) RS. 500/- (without bath attached) Kaveri -Double Bedded: Rs. 600/- Nilgiris - Triple bedded: Rs. 900/-
	IMA TN State HQs. Building Doctors colony, Via. Bharathi Nr. 1st Main Road, off. Mudichur rd, Tamba ram West, Chennai - 45	**Dr. Balasubramanianm,** M: 094440070465, **Dr. Karunanidhi** M - 09444261385, Office 044-29000324, 29000325, Email :- egpima@gmail.com	7 AC deluxe Room @ Rs. 800/- per day
	TN State PPLSSS Chetpet Building, H. NO 11 & 12, Sankara Heritage Apts, Super Tank Road, Chetpet, Chennai - 31	**Dr. K. Thangamuthu** M - 9443151164, Tel :- 044-28361866 Email:- pplsssofimatn@gmail.com	5 AC Double bedded Room: @ Rs. 1000/- IMA PPLSSSS Member 900/- Single - 700 (IMA PPLSSS Member - 600
	IMA PPLSSS - Tenyampet Old No. 501, New NO. 626, Opp. To State Bus Termianal, Anna Salai (Mount Road) , Teynampet , Chennai - 6000018	**Dr. K. Thangamuthu** M - 9443151164, Tel :- 044-28361866 Email:- pplsssofimatn@gmail.com	11 Double Bedded Rooms . Rs. 1500/- per day per room
	Salem Branch, 12, Sardha College Road, New Fivr Road, Salme - 6360004	**Mr. Parameswaran** 9789517833, Tel.: 0427-2448033	3 Double bedded@ Rs. 500/- yes
UP	**Allahbad** Branch, 29, Stanley Road, Allahbad	TEL .: 0532-26000909, 2607513, Email :- ama@sancharnet.in	
	Banaras Branch, I MA house, IMA Building, C-7/31, Chetganj, Varansai - 221001	**Dr. Alok C Bhardwaj, Mr. Madhu Pathak,** Tel.:- 0542-2403194, Fax :- 0542-2403194	3 AC double bedded Rooms @ Rs. 600/ 1 Dormitory of 6 Beds @ Rs. 100/- per bed per day
	Bereilly Branch IMA Bhawan 110, Civil Lines, Bareilly	**Mr. Sunil Karan** (M) 9410498049, Tel.: 0581-2511716, 2511259	4 AC Rooms double @ rs. 1000/- per days + 10.30 Tax, No.
	Lucknow Branch, IMA Bhawan, No. 1, River Bank Colony:, Lucknow	**Dr. A M Khan** : 9415409188, 415409188, Mr. Anil Yadav, Tel : 0522-2626440: Fax : 0522-2626440	2 AC Double Bedded Rooms @ 500/-1 big Rooms @ Rs. 600 / (for IMA members 400/-) no.

State Branch	IMA Branch with Address	Contact Person & Contract Detail	Tariff & Meals - Yes / No
West Bengal	**IMA Bengal State Branch,** IMA House, 1, 1/3 **Dr. Biresh Guha** Street, Kolkata - 700 017	**Dr. Amitabha Bhattacharya** M: 9339768287 Tel.: 033-22810758, 22873252 Fax : 033-22810758, 22893729 E : imabengalstate@yahoo.co.in	1 AC Dormatary for 6, NO.
	IMA HQs. At KOLKATA, JIMA Building 53, Creek Row, Kolkata 700014	**Mr. A S Das** Tel : 033-222257010,22360573 extn. 26, Fax - 22366437 M:- 9432960446 Email :- j_ima@vsnl.net	AC Rooms : Single bed Deluxe (1): 750/- day - delux double bedded (1) : 650/- bed / day double bedded (1) : 550/- bed/day - Triple Bedded (4): 550- /bed / day Non AC, - Dormitory (5 beds) -350/- / bed/ day incl. bed tea@breakfast
	Krishnanagar Branch 9 , Church Road, Krishnanagar, Nadia.	**Dr. A+C43 K Basu Malik** (M) 9434105232 **Mr. Akhoy Biswas** (M) 9434335297	2 AC double Bedded Rooms @ Rs. 250/- per bed per day
	Malda Branch, R K Mission Road, Malda - 732101	Hony. Secretary : 943.4040368 **Mr. Brindavan Rao**	1 double bedded non AC Rooms @ Rs. 250/- per day
Uttaranchal	**Dehradun** Branch 47, Ballapur Road, Dehradun.	**Dr. Umang Sahai** M - 9359873284 **Dr. D.D. Choudhary** M - 9897296200 **Dr. Bhim S Pandhi** M - 9837070913	1 A C double bedded room