



**INDIAN MEDICAL ASSOCIATION**

Dr

*Protect the Single and Couple Doctor Setups*

# IMA NEWS

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**IMA National President Dr. Rajan Sharma being honoured by Commissioner Delhi Police Shri S N Shrivastava for Smoothly and Successfully running CORONA Helpline for Delhi Police**





**Dr. Rajan Sharma**  
National President, IMA



**Dr. R.V. Asokan**  
Hony Secretary General, IMA

## **DHARAMSHETRA – KURUKSHETRA**

The medical fraternity of our country is highly perturbed by the recent policy changes regarding medical education practice, research and administration. The radical changes that are being institutionalized will have series impact on the health of our people.

Niti Aayog has officially formed 4 Committees to integrate all systems of medicine. These Committees are in the area of medical education, clinical practice, public health, medical research and administration. The theoretical basis of policy seems to emanate from the new National Education Policy which envisages the following things:

- Provides for mixing of all systems of medicines under the garb of medical pluralism.
- Allows multiple entry and multiple exit in medical courses.
- Abolishes dedicated Health Universities.

Adding on to the above developments, Notification of National Medical Commission on 25th September, 2020 has reactivated the already existing avenues of quackery, mixopathy and crosspathy.

Section 32 of NMC Act provides for legalized quackery by empowering non-medical persons in the name of community health providers to practise primary care independently. It is strange that they can be employed in secondary care and Tertiary care settings when two of them are employed together.

Section 50 of NMC Act provides for mixopathy by mixing of curriculum of all the streams of medicine.

Section 51 of NMC Act outsources Bridge Courses to the States thereby promoting crosspathy. To add to the conundrum, the Allied Healthcare Bill lying on the table of Rajya Sabha empowers para medical discipline to practise independently.

The most important policy shift is from multiple dedicated medical streams to a system of integrative medicine. In simple words, what is being envisaged is to mix systems of medicine together in curriculum, practice and research. This retrograde step of unscientific mixing of systems of medicine will produce hybrid doctors who are nowhere.

IMA opposes mixing of system of medicine. IMA warns the people that millions of lives will be lost before any rectification can be made. IMA stands for purity of systems of modern medicine as well as Ayush. It is not in the interest of traditional systems either to lose their identity and further development. As such 96% patients in IPD and 94% of patients in OPD are being served by modern



medicine. Currently, a patient has the choice of choosing either modern medicine or alternative system as per their desire. Unfortunately, the Khichdi medical system that is being envisaged will provide only hybrid doctors and the choice of the patient is effectively nullified.

IMA is concerned about the developments and has taken upon itself the campaign to sensitize the people on the dangers of shifting to integrative system of medicine.

IMA appeals to people for their understanding of the issues involved and the impact it can have on health of the people. IMA brings to the attention of the people that the life expectancy of an ordinary Indian when the British left was 27 and currently, we are approaching 70. Small pox and polio have been eradicated by vaccination. Vaccine development and its application to the society is a shining example of modern medicine research.

IMA has an IMA-Medical Student Network in 287 medical colleges of the country. The Medical Students of this country are equally concerned about their career and future.

IMA MSN has joined hands with IMA in this campaign against quackery, mixopathy and crosspathy. IMA also demands that the PG NEET examination postponed without any notice should be held on schedule.

The health enjoyed by the ordinary citizens of the country is due to the modern medicine. There is no reason whatsoever to shift to an integrative system of medicine of Khichdi medical system and hybrid doctors.

IMA resolves to resist these ill conceived moves. We bring to your attention another serious development. NITI Aayog has constituted four committees for rolling out and implementing Integrative Health System. IMA proclaims that we are against conceiving an Integrative Health System. Structuring and Rolling out such an unscientific system is blasphemy.

Let the call for action reach every branch and member. Strategy of our resistance and response will reach everyone. Be prepared. Share the information unto the last member.

Dr Rajan Sharma  
National President, IMA

Dr R V Asokan  
Hony. Secretary General, IMA



F. No. 3(7)/2020-H&FW  
NITI Aayog  
Health & Family Welfare Division

Yojana Bhawan, New Delhi  
Dated 29<sup>th</sup> September, 2020

**OFFICE MEMORANDUM**

**Subject: Constitution of the Working Groups by the Committee on formulation of Integrative Health System.**

Attention is invited to the minutes of the 1<sup>st</sup> meeting of the Committee constituted to formulate Integrative Health Policy wherein it was inter-alia decided to constitute four working groups in the four main core areas of Education, Research, Clinical Practice, Public Health & Administration.

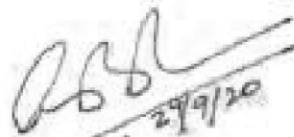
2. It has been decided to constitute four Working Groups in the four main core areas of Education, Research, Clinical Practice, Public Health & Administration.

3. The composition and terms of reference of these Working Groups are annexed.

4. The Working Groups shall submit an Interim report within 4-5 weeks and the final reports within 8 weeks.

5. The Working Groups can co-opt any other member, if required.

This issues with the approval of the Chair of the Committee.

  
(Ashish Kumar)  
Director (Health)

**To**

**Members of the Committee.**

**Copy to:**

1. PS to VC, NITI
2. PS to Member (H)
3. PPS to CEO, NITI
4. PPS to AS (Health)

**Working Groups and their ToRs for Integrative Medicine.****WG 1: Education**

	<b>Names</b>
<b>Chair</b>	<b>Dr. S.K Sarin, Director ILBS, New Delhi</b>
<b>Members</b>	Dr. K.K. Talwar, Former Director PGIMER (Chandigarh), New Delhi
	Dr. S Ramji, Former Dean Maulana Azad Medical College, New Delhi
	Lt. Gen Dr. Madhuri Kanitkar, Office of Chief of Defense Staff, Delhi
	Prof S.P.Thyagarajan, Ex VC, Madras Univ
	Prof Darshan Shankar, VC, TDU
	Prof Sanjeev Sharma, Director NIA
	Dr. Ram Manohar, Director Ayurveda, Amrita University
	Chairman, NMC (Ex Officio)
	Chairman, CCH (Ex officio)
	President, Indian Nursing Council (Ex officio)
Chairman, CCIM (Ex officio) <b>Convenor</b>	

**Terms of Reference:**

1. To analyse international models in integrative medical education.
2. To assess the need and potential of Integrative Medicine course(s) in the country blending Ayurveda, Yoga and other traditional systems of medicine with modern medical system.
3. To assess potential pathways for job opportunities, career progression and demand of future graduate and postgraduate professionals in Integrative Medicine.
4. To outline the broad principles and content of curriculum for such course(s) (including teaching-learning strategy, immersive training, pedagogy and assessment etc.) grounded in the Indian context.
5. To suggest model(s) of institutional arrangements required for teaching schools/colleges in terms of departments, faculty, infrastructure, clinical services, and academic governance, etc.,
6. To suggest regulatory system to oversee Integrative Medicine education in the country.
7. To develop an implementation plan for phased roll-out of Integrative Medicine education program in the country outlining estimates of infrastructure requirements, capacity development needs and financial resources etc.
8. To outline need for integrative nursing education and suggest next steps for a sustained scale up of integrative nursing care.

**WG 2: Research**

	<b>Names</b>
<b>Chair</b>	<b>Dr VM Katoch, Former Secy DHR &amp; DG ICMR</b>
<b>Members</b>	Dr Madhu Dikshit, Ex Director, CSIR-CDRI
	Dr Ashwini Kumar Raut, KHS Mumbai
	Dr Rama Jayasundar, AIIMS New Delhi
	Dr. Arvind Chopra, Director CRD, Pune
	Dr. Y.K Gupta, Ex AIIMS, New Delhi
	Dr. Gautam Sharma, AIIMS, New Delhi
	Prof Anurag Agarwal, Director CSIR IGIB, Delhi( <b>Convenor</b> )
	ICMR Representative not below the rank of JS (Ex Officio)
	DG, CCRH (Ex Officio)
	DG, CCRUM (Ex Officio)
	Representative of DBT not below the rank of JS (Ex Officio)
DG, CCRAS (Ex Officio)	

**Terms of Reference:**

1. To analyse the present state of Integrative Medicine research in the country.
2. To diagnose major barriers to high impact research in Integrative Medicine.
3. To suggest steps for building a world-class capacity in research methods in basic, translational, clinical and population-based research in Integrative Medicine.
4. To identify high priorities in Integrative Research with potential to impact health, wellness and clinical outcomes on scale, and how to take these priorities forward in a time-bound mission mode.
5. To suggest how to strengthen and expand institutional and human resources base, collaborative networks and doctoral/post-doctoral programs for research in Integrative Medicine in academia and industry aimed at impacting clinical practice and public health, and developing health products/solutions for the country and the world.
6. To suggest how to generate optimum and sustainable resources to support quality research in Integrative Research through existing government organizations as well as by developing novel funding mechanisms in public and non-government space.
7. To suggest policy, regulatory and other enabling steps to unleash a transformative and far-reaching research and innovation enterprise in Integrative Medicine to make India a global leader in 5 years.

**WG 3: Clinical Practice**

	<b>Names</b>
<b>Chair</b>	<b>Dr. Randeep Guleria, Director AIIMS, New Delhi</b>
<b>Members</b>	Dr Naresh Trehan, Medanta
	Dr. Ashok Kukde, Vivekanada Hospital, Latur
	Dr Suresh Patankar, Integrative Urologist, ACE Hospital
	Dr B S Prasad, Principal KLE Ayurveda College
	Dr Geetha Krishnan Pillai, WHO TM Division, Geneva
	Prof M CMisra, Ex Director AIIMS
	Prof TanujaNesari, AIIA, New Delhi ( <b>Convenor</b> )
	President Ethics and Medical Registration Board, NMC (Ex officio)
	President, IMA (Ex officio)
	President/Chairman, Arogya Bharati (Ex officio)
	Director, National Institute of Homoeopathy, Kolkata (Ex officio)

**Terms of Reference:**

1. To analyze models of clinical practice in Integrative Medicine in other countries.
2. To summarize experiences, barriers and enablers of clinical practice in Integrative Medicine in the country.
3. To define vision, scope and strategy for promoting the practice of Integrative Medicine in the country.
4. To outline ethical and professional framework(s) for the practice of Integrative Medicine.
5. To recommend regulatory mechanisms and other enabling steps for a sustainable system for Integrative Medicine practice in the country.



**WG 4: Public Health & Administration**

	Names
<b>Chairperson</b>	<b>AS &amp; MD, NHM (Ex officio)</b>
<b>Members</b>	Prof Rakhal Gaitonde, Sri Chitra
	Dr Ravi Narayan, SOCHARA
	Dr Yogesh Jain, Jan SwasthyaSahyog
	Dr. Sanjay Zodpe, PHFI
	Dr Abhay Bang, SEARCH
	Dr Rajesh Kumar, Ex Head School of Public Health, PGIMER
	Principal Secretaries of Health of 3 States (Ex officio)
	Principal Secretaries of AYUSH of 3 States (Ex officio)
	President, Indian Public Health Association (Ex officio)
	Director, NIHFV (Ex officio)
	MoAYUSH nominee not below the rank of AS/JS
	Executive Director, NHSRC (Ex officio)
Dr. Madan Gopal, Consultant, NITI ( <b>Convenor</b> )	

**Terms of Reference:**

1. To analyze the existing policies, programs and efforts in integrative approach to public health in India by relevant Ministries and departments through national and State level initiatives (including but not limited to objectives, impact, gaps, best practices, missed opportunities etc.).
2. To analyze international frameworks and experiences in integrative and holistic approach to public health.
3. To propose a strategy and implementation plan for a comprehensive integrative public health system in India building on the existing initiatives (such as the Ayushman Bharat Health and Wellness Centres, National Health Mission, National AYUSH Mission etc.) and with an emphatic focus on health promotion, disease prevention and holistic primary health care.
4. To recommend solutions for meeting the human resource, infrastructure, and financing requirements for a sustainable integrative and holistic public health system in the country.



## **DHARAMSHETRA KURUSHETRA**

### **STEP 1**

- IMA campaign against Quackery, Mixopathy, Crosspathy and Mediocrity.
- IMA campaign against KITCHIDI medical education and KITCHIDI doctors.

### **ISSUES**

1. **One Nation One System concept.** Four committees formed by NITI AAYOG on integrative medical education, practice, public health and research.
2. **National Educational Policy** abolishing dedicated Health Universities as well as forming the legal platform for mixing the systems into a KITCHIDI to produce KITCHIDI doctors. Multiple entries and exits make it a total anarchy.
3. **National Medical Commission:** Notified on 25 th September. Concerns of Community Health Provider, NEXT, outsourcing of Bridge course to the states, KITCHIDI curriculum, state medical councils and fee in private medical colleges all remain intact.
4. **Allied and Health Care Bill** permitting independent practice of paramedics.

### **CAMPAIGN**

1. **Sensitisation of IMA members.**
  - a. Leadership training meetings
  - b. Social media communication
  - c. Forwarding of simple relevant documents.
2. **Sensitisation of press and visual media.**
  - a. Press statements and briefings restricted to IMA Hq and State Branches.
  - b. Media debates and write ups by authorised leaders from the State and Hq.
3. **Political Liasoning**
  - a. Communication from IMA Hq and state branches
  - b. One to one liasoning by Hq and state teams.

**Indian Medical Association (HQs.)**

1. Documents
2. IMA MSN
3. IMA JDN
4. Website, Media and PR agency

**IMA State Branches**

1. Emergency SWC or State Council or Branch Presidents Secretaries meeting
2. Updating list of office bearers of Local branches
3. Form a group of official spokes persons.
4. Form a group capable of handling liaison with ministers, MPs, MLAs and other opinion makers.
5. Form a social media group capable of technical intervention.
6. List the names of local branches with medical colleges.

**IMA Local Branches**

1. Emergency branch meeting
2. Meet the local MLA, MP and Municipal/ Panchayat members as well as the Chairman and brief about the issues.
3. Communication to all members
4. Posters in all clinics and hospitals

**STRATEGY****Priority Issues**

1. Mixopathy: NITI Aayog prime culprit. The four committees constituted for ushering in KITCHIDI medical system in the country, KITCHIDI medical colleges and KITCHIDI doctors.
2. Quackery: NMC prime culprit. Section 32 : Community Health Providers as Doctors in clinics, hospitals and critical care. Non medical Quacks as doctors with Registration.
3. NEXT: Decoupling of PG NEET from Final year exams.

**Tools:**

1. Leadership training meetings
2. Social media
3. Political liaison.

**Target:**

1. NITI AAYOG
2. NMC

Dr Rajan Sharma  
National President

Dr. R V Asokan  
Honorary Secretary General



**Dr. Rajan Sharma**  
National President, IMA



**Dr. Ketan Desai**  
Past President, WMA



**Dr. R. V. Asokan**  
Hony. Secretary General, IMA

## INDIAN MEDICAL ASSOCIATION

### IMA Dedicated fund (for IMA Covid martyrs) ordinance (02/2020)

**Issued on Monday 26.10.2020**

I, Dr Rajan Sharma, National President of Indian Medical Association by the powers vested in me by Bye laws 37 F proclaim the institution of IMA Dedicated fund (for IMA COVID martyrs) ordinance (02/2020) on this twenty sixth day of October two thousand and twenty.

#### **Preamble:**

COVID 19 pandemic has had a serious impact on members of IMA who are in the frontline of COVID care and control. As of today, 624 modern medicine doctors have sacrificed their lives in the service of the nation for COVID care.

Indian Medical Association hereby institute a dedicated fund to financially help the families of IMA members who are COVID 19 martyrs. This will exclude the families who have access to the Government solatium and compensation as well as the doctors who were more than 70 years of age.

#### **Relevance and Privilege:**

Object III 2 of the memorandum of the Association directs and empowers IMA to uphold the interest of the medical profession.

Methods IV 12 of the memorandum empowers the Association to raise money by donations.

IMA Benevolent Fund 70 A Objects a and d enable IMA to help its members and their families.

#### **Source of Funding:**

The donations raised from the members and the public including registered firms will be parked separately in the name of Indian Medical Association.

The contribution from the IMA Benevolent Fund, the quantum of which would be decided by the National President to be ratified by the Central Working Committee will be transferred to this dedicated account and will form the seed money.

#### **Eligibility criteria for financial help:**

- a. The deceased should have been a life member of Indian Medical Association on the date of death.
- b. The cause of death of the member should be due to Covid 19 disease.



- c. The member should have been in active practice while acquiring Covid 19.
- d. The deceased member should be below the age of 70 years at the time of death.
- e. The deceased member should not be eligible for any grant or compensation from the Central or State Governments.

**Flexibility criteria:**

Irrespective of membership and age the case of a modern medicine doctor who has martyred in the service of the nation in COVID 19 will be taken up by the National President of IMA by an appeal from the family if there are genuine situations of need for help.

**Who can apply?**

The legal heir of the deceased member of Indian Medical Association can apply for financial help.

The legal heir can submit the application to the local branch secretary of IMA who will forward it through the State Secretary of IMA to the Honorary Secretary General of IMA. The local branch secretary or the state secretary or the Honorary Secretary General can initiate the process suo moto as well.

**Scrutiny and sanction:**

The scrutiny of the applications and the sanction of the money will be done by the team of office bearers at IMA HQs consisting of:

1. National President
2. Immediate Past National President
3. National President Elect
4. National Vice Presidents as per jurisdiction
5. Honorary Secretary General
6. Honorary Finance Secretary

The Quantum of money to be paid will be decided by the National President in consultation with the above team of office bearers as per the availability of funds. The quantum will be determined as per the family situation including employment, income, children, assets, liabilities etc. Money will be paid to the legal heir. In case of more than one legal heir the money will be divided equally between the heirs.

**Operation:**

1. The fund will be operated as per the rules and byelaws of Indian Medical Association
2. Scrutiny and oversight of the accounts will be done by the Finance Standing Committee of IMA.
3. Accounts shall be audited by the auditor of IMA.
4. HSG shall formulate the operational procedures and the application form.

**Dissolution:**

If there is excess of fund after disbursement at the end of one year the money will be transferred to the IMA Benevolent Fund.

Dr Rajan Sharma  
National President



### OPERATIONAL ASPECT

The financial assistance proposed by this dedicated fund is basically intended for the family members of IMA Covid martyrs who have a dire need for support and care.

The quantum of financial assistance will vary from case to case depending on the situation of the family. An unemployed young housewife with school going children and dependant parents will merit the most benevolence and quantum of assistance.

The following documents are required:-

1. Application form duly filled in
2. Xerox copy of Life membership certificate. IMA HQ office will assist in ascertaining membership and issuing a duplicate copy if required.
3. Death certificate from competent authorities.
4. Recommendation letter from the local or state branch President endorsing or certifying the Covid death and active medical practice during the epidemic.
5. (a) Income tax returns of the immediate family members (wife and children).  
(b) Copy of income tax returns of the deceased in the previous three years.
6. Legal heir certificate/s of the beneficiaries.

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### **THANK YOU TO OUR HEROS IN HEALTHCARE - ITC HOTEL**

Dear Sir/Madam,

I may introduce myself as Ishan Wanchoo, Assistant Sales Manager for ITC Hotels & Welcomhotels, PAN Indian.

During these unprecedented times, We at ITC are truly grateful to our doctors who have been selflessly fighting on the front lines in this difficult time.

As a gesture of gratitude for your services, we are delighted to announce some exclusive benefits for you to avail.

We are offering you 50% off on stay and dining on all are hotels.

More details have been attached.

I would be obliged if you could share this message across all members of your association.

Please contact me for further assistance on [Ishan.Wanchoo@itchotels.in](mailto:Ishan.Wanchoo@itchotels.in).

Thank You with regards

Ishaan Wanchoo

Assistant Manager - Sales

Regional Sales Office - Gurugram

ITCLimited - Hotels Division

+91-9654255063



**INDIAN MEDICAL ASSOCIATION**  
**IMA Dedicated fund for IMA Covid martyrs**  
**Application for Financial assistance**

<b>Name of the deceased doctor</b>		
<b>Date of Death</b>		
<b>IMA Membership Number</b>		
<b>Address</b>		
<b>Name of IMA Branch</b>		
<b>Name of the Legal heirs</b>	1	
	2	
	3	
	4	
<b>Name of the applicant</b>		
<b>Address for correspondence</b>		
<b>E mail</b>		
<b>Mobile Number</b>		



<p><b>Details of the family and its current status</b></p>	
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**For Local Branch President/ Secretary**

**The above details have been verified by me and found correct .The deceased died due to Covid 19 and was in active practice when the infection occurred.**

**Date :**

**Branch:**

**President /Secretary Name**





## **COVID MORTALITY AMONGST DOCTORS**



As the pandemic spreads deeper and wider in India, doctors are at a disadvantage for severe illness as well as mortality. The trend is already evident; over 627 doctors having succumbed to the disease as of 30<sup>th</sup> October.



It is crucial that we critically analyse these deaths and come up with scientific solutions. These can only be obtained by a detailed ongoing study of the COVID-19 deaths that have occurred among healthcare workers. We need to collect data about each SARS-CoV-2 infection among healthcare workers as an ongoing project. One of our primary aims must be to identify specific work-related risk factors that could lead to bad outcomes.

This study must include details of how exactly the infection was acquired in fatal and complicated cases--with emphasis on how it was different from less severe cases. Among other important data to be collected include detailed information of the work pattern of the doctor, PPE use, clinical history including comorbidity and treatment received.

If the country loses more doctors and other healthcare workers, it could have serious implications. If the healthcare sector became demoralised, the quality of care will suffer. COVID mortality of the population is heavily dependent on the quality of healthcare delivery. Without the unstinted support and expertise of doctors and skilled staff, the entire country's mortality will increase.

According to the information available so far, doctors of all ages have died, the majority being general practitioners.

The chief reason for this is that India being a densely populated nation, the doctor- patient ratio is not the same as in western nations. A typical outpatient clinic in the west might give appointments to 15-25 patients per doctor per day. In contrast, many doctors in India see extraordinarily large numbers of patients—each of whom is a potential source of disease. Naturally, the average droplet exposure per day per doctor is higher than in developed nations.

Every time the patient talks, there is invisible micro-droplet output (< 5 micron) from their throat. Also called aerosol, this is similar to mist and does not settle with gravity. It circulates in closed rooms for hours. The greater the patient turnover, the more the droplet load—particularly if the patient drops the mask while speaking.

Even the best PPE might not protect 100% when there is relentless heavy droplet exposure over extended periods of time, day after day. Besides, there are occasions when the doctor removes the mask or there are gaps on the sides of the mask, allowing aerosols to be breathed in.

When they practice in ill-ventilated cramped conditions, doctors get exposed more than other professionals.

Spacing apart the patient appointments and enforcing universal mask use are effective interventions to reduce the droplet load inside the doctor's cubicle. Opening the windows and doors, or shifting to a better-ventilated setting will be helpful. Engineering consultation will be helpful to improve air flow and ventilation. IMA initiatives such as I SAFE of the Kerala State IMA can help assist each doctor or hospital with COVID-safe practice.

Dedicated doctor-helplines at IMA branch level are helpful, both to answer practice- related questions on COVID-19, and also to promptly assist the doctor in case they get the infection. Regular webinars providing scientific updates are also helpful as COVID-19 is a fast-changing science.

In India, unlike the West, doctors do not generally retire. A large number of doctors continue their practice till their health fails. Many doctors have home-based general practice clinics—which is a great service to the common man without having to rush to a large hospital for every trivial complaint. The downside is that senior doctors are getting exposed to people carrying the virus. Unfortunately, the mortality risk from COVID-19 is higher for older people. The exact reason for this is unknown; it may not



necessarily be comorbidity alone.

The unfortunate aspect of COVID-19 is that the virus spreads most in the earliest stages of the disease, that is on day 1 and day 2 of symptom onset—when the patient might not even appear sick. In other words, the patient who comes to the doctor with just one day's fever or sore throat will be the most infective.

In fact, by the time this patient is tested, results found and then referred to a COVID care centre, the patient would become less infective. Thus, general practitioners being the point of first contact, appear to be at greatest risk of contracting the infection.

The same trend was observed in Italy when over 100 doctors died in very short time. Many of those who died in Italy were senior doctors who were practising in individual clinics, unaware that the pandemic had already reached their country.

PPE is helpful only when used in combination with all other measures, including administrative and engineering controls—primarily to reduce the viral load.

Importantly, health workers, as they are at high risk of being infected with SARS-CoV-2 virus, need to be well protected from getting COVID-19, with the assurance that if they or their families are infected, they will receive the best possible medical care, at no cost.

Health workers should also be protected from physical harm/threats, and should have acceptable work environments that are conducive to optimal service delivery.

Finally, health workers involved in COVID-19 care should have substantial life insurance that protects their dependents/families from additional financial catastrophe in the event of death.

As on 30.10.2020, 2683 doctors (out of this Residents : 927, House Surgeons :382 and Practising Doctors : 1374) have been infected and 627 doctors have laid down their lives in fighting against COVID. Over 87000 healthcare workers are infected with the virus. The health Ministry has said that 155 Healthcare workers including 64 doctors had died across India from Covid 19 upto 11th September, based on the claims it had received under a special Covid 19 insurance plan. The insurance plan does not cover healthcare workers in the private sector.

IMA has demanded that all the doctors who have laid down their lives in fighting this epidemic should be treated at par with the martyrs of Indian armed forces and acknowledged appropriately. The surviving spouse or dependent should be provided a Government job as per their qualification. Substantial differences are noticed from district to district in how doctors and health care workers are deployed. District administration are not sensitive to the safety angle and the concerns of stress and fatigue of the medical manpower. Deploying doctors 24X7 without intermittent quarantine periods or long working hours in PPE for COVID care is not the same as 24X7 COVID control from safe offices. Uniform practices have to be put in place throughout the country.

Dr. P. Gangadhar Rao  
Chairman  
IMA National Covid Registry

Dr. K M Abul Hasan  
National Coordinator  
IMA National Covid Registry



## IMA OPINION ON NDHM ECOSYSTEM



The key principles of citizen centricity, quality of care, better access, universal health coverage and inclusiveness are defined in the National health policy 2017 and continuum of care is the concept strongly advised. The NDHB documents envisages a holistic, comprehensive and inter operable digital architecture is drafted and adopted by all the stake holders. The document also wish to create a



national digital health ecosystem managed by a specialized organization called National Digital Health Mission. (NDHM).

NDHB document published by Government of India, comprises of an ambitious plan to bring a digital ecosystem comprising of digital health network under NATIONAL DIGITAL HEALTH MISSION.

We do not favour the content of the NDHB document, its roll out plan and the administrative mechanism. Our opinion is based on the following contentions.

India still lacks adequate health care infrastructure and man power. There is no standardisation of many streams of treatment adopted in our country. The Government is adopting strategies to allow untrained and partially trained individuals to practice medicine to address the manpower shortage. Infrastructure deficiencies have not been addressed to. Strategic purchasing through Ayushman Bharath ( PMJY) has not made any impact due to lack of adequate fund allocation and non empanelment of tertiary care hospitals due to unrealistic package rates. Primary care has lost focus and the proclaimed Wellness centres are yet to make an impact. There is skewed distribution of medical training infrastructure. Primary care, strengthening of public Health infrastructure and HR as well as addressing the social determinants of Health are our priority.

Funding for such an ambitious plan is not appropriately described. any diversion of funds from NHM will further jeopardise the public funded health care, especially primary care. Hence there is a definite possibility of the plan to become a non starter if the investment in health care is not significantly increased. Out of pocket expenditure in health care will increase further in such a situation.

Privacy is of utmost concern. Privacy protection laws in India are weak and practically nonexistent. Privacy is being ensured through consent manager in NDHB. The consent in digital platform in a country where literacy is low is cause of concern. The consent mechanism described in the document is inadequate to address the concern.

Accessibility of health documents to treating doctors is ill defined. Medical records are considered to be a document equally owned by the treating doctor, patient and the institution with right of accessibility to remain with all the three. The concepts of data ownership, erasure etc described in the document is in violation of this principle and is objectionable.

Data protection is another area of grave concern. Apart from the issue of privacy, management of analytical data by the agency is poorly defined in the document. The management of analytical data will be governed by data protection laws which is practically nonexistent at present.

The National Digital Health Mission, stemming from the National Health Policy of 2017, is purported to digitise the entire healthcare eco-system in India. The self-proclaimed guiding principle of the NDHM is "Security and Privacy by Design" for the protection of individuals' data privacy. It is paramount to see whether the principle satisfies the test of Right to Privacy of the stakeholders under the Act, including, but not limited to, patients and their family members.

1. Before addressing that issue, it is prudent to understand whether the Union Government is vested with the requisite legislative powers to formulate a pan-India policy to establish the mechanism outlined by the NDHM. After all, the legislative powers of a state government stemming from Entry 6, List II under the 7th Schedule of the Constitution of India cannot be superseded by a policy fronted by the Union Government. Entry 6 in List II reads as follows: "Public health and sanitation: hospitals and dispensaries." Prima facie, it appears that the proposed policy would not find shelter under the residual powers of the Parliament in the light of the aforesaid entry. It would also raise serious questions as to whether a legislation having far reaching implications on public health can be proposed as a policy.



2. Assuming that the Union Government is competent to bring forth the NDHM Policy into force, it appears to face hurdles in its implementation. The practice prevalent in the healthcare community vis a vis the confidentiality of a patient's medical records is entrenched in the fundamental principle of doctor-patient confidentiality relationship. This principle finds legislative backing in the Indian Medical Council (Etiquette and Ethics) Regulations 2002. The relevant provisions from the Regulations read as follows:

*"1.2.1 The Principal objective of the medical profession is to render service to humanity with full respect for the dignity of profession and man. Physicians should merit the confidence of patients entrusted to their care, rendering to each a full measure of service and devotion. Physicians should try continuously to improve medical knowledge and skills and should make available to their patients and colleagues the benefits of their professional attainments. The physician should practice methods of healing founded on scientific basis and should not associate professionally with anyone who violates this principle. The honoured ideals of the medical profession imply that the responsibilities of the physician extend not only to individuals but also to society."*

*"7.14 The registered medical practitioner shall not disclose the secrets of a patient that have been learnt in the exercise of his / her profession except –*

- i) in a court of law under orders of the Presiding Judge;*
- ii) in circumstances where there is a serious and identified risk to a specific person and / or community; and*
- iii) notifiable diseases.*

*In case of communicable / notifiable diseases, concerned public health authorities should be informed immediately."*

As evident from the aforesaid provisions, there is a duty cast upon the medical practitioner to maintain utmost secrecy of a patient's medical records in the course of his/her practice. The policy does not appear to account for these Regulations, although it attempts to salvage itself with a boilerplate clause offering itself to be read along with, and not in contradiction to, laws presently applicable in India. The Regulations make it clear that only under specified circumstances can the confidential medical information of a patient be divulged by the physician. This would then beg the question as to the ability and requirement of seeking the consent of a patient to share the medical information including health records with a party not specified in Regulation 7.14 of the Indian Medical Council (Etiquette and Ethics) Regulations 2002. This would further call into question the competence of the Union Government to propose a policy akin to the NDHM Policy in its present nature.

i3. We have taken the liberty to assume the definitions of various terms used hereafter in the context they are used in the proposed policy. Although the policy sets out "Privacy by Design" as its guiding principle, it does not explicitly recognize a data principal's fundamental right to privacy, inasmuch as according a legislative recognition of the said right of the data principal. Merely because the participation of the data principal is made voluntary under the policy, the information including sensitive personal data does not cease to lose its ability to violate the data principal's fundamental right to privacy. Personally identifiable information of the data principal, including but not limited to financial information such as bank account details, caste or tribe status, and religious or political beliefs or affiliation as categorized under "sensitive personal data" in para 4 (ee) of the policy make it paramount to recognize the fundamental right of privacy of the data principal, namely a patient who voluntarily consents to sharing the information. This is all the more important when seen from a point of practicality. For the sake of illustration, considering a scenario where a patient requiring critical and time sensitive healthcare, may not be in the right frame of mind to review the potential effect of granting express consent to the sharing of his/her health and medical information for the purposes of this policy. Subsequent attempts to review the consent initially provided could be an exercise in futility. This also puts the healthcare provider and other data fiduciaries at risk. This concern is amplified in situations where the information is made available to companies and other juristic entities with commercial interests. Naturally, the risk of information being shared with



entities outside the territorial jurisdiction of India could seriously jeopardise the fundamental right to privacy of the data principal unless the policy accounts for such situations.

4. As per para 26.4 of the policy, data fiduciaries are given the option of adopting either an "opt-in" or "opt-out" mechanism to gain the consent of the data principal. The risk of a data principal unknowingly and unwittingly sharing their medical and health information and other sensitive data sought to be collected under this policy is substantially higher if the data fiduciary chooses the "opt-out" mechanism, where it is for the data principal to actively express revocation of consent to collect personally identifiable data. From a practical viewpoint, even an "opt-in" mechanism might not subserve the interests of the data principal, as illustrated previously, the data principal could very well inadvertently offer their consent and "opt-in" to share sensitive personal information. Therefore it cannot be said that the policy provides sufficient safeguards against attempts at infringing the fundamental right of privacy of data principal namely a patient or any person to whom the personal data relates. Furthermore, the policy makes a distinction between anonymization and de-identification. As per para 4(a), anonymization is an irreversible process whereas, as per para 4(l), de-identification does not claim to be an irreversible process. Therefore, there is a risk of data fiduciaries opting for de-identification instead of anonymization, for the purposes listed out in para 29 of the policy.
5. It must also be borne in mind that there are existing policies that provide for collection of relevant medical data for the broader purpose of medical research and analysis. In such circumstances, it appears that the NDHM policy poses higher risk to sensitive data protection in return for a repetitive policy exercise.

Therefore, it is our considered opinion that the NDHM policy does not satisfy the rigours of protecting the fundamental right to privacy under Article 21 of the Constitution of India. It is also our considered opinion that the policy strikes a discordant note with the existing rules and regulations pertaining to medical practice in India.

### Concerns of the Medical profession

- The implementation of National EHR is a complex task and it requires serious well thought out planning backed with strong global healthcare informatics expertise. A badly designed national EHR system will not only be a pain for clinicians for but also could endanger patients as we have seen in other countries where the cost of redesign is significant.
- For Single Doctor & Couple Doctors Establishments.
  - a) Becomes an Insurance driven practice.
  - b) Accreditation based practice.
  - c) Purely technology driven practice, due to which doctors .
  - d) Leads to revenue model profession.
- It is also stated that this blueprint is optional and the incentive will be given to the institutions that are joining this network but it can be made compulsory later.
- Another major concern is that India doesn't have appropriate laws regarding the data privacy and data protection. So even if any company or institution violates data protection and use this software for commercial or any other use with the present legislation they cannot be punished accordingly.
- Whether this ambitious policy is necessary for the patient or for the interest of the pharmaceutical companies or insurance companies is also a big question.
- Data error: Uniformity in data entry among all healthcare professionals is very difficult to achieve and can result in the wrong interpretation of the medical records.
- Data availability to the insurance companies to decide on the payments, can be misused by these companies for not paying to the clients.
- There is a high chance of leakage of the medical records data and the confidentiality can be breached under this policy. Therefore, privacy of the patient is a major concern where data can be shared with insurance or Pharmaceutical Companies.



- There will be an increased workload on the doctors because treatment details need to be uploaded on the database/ software by the doctors themselves.
- Digital health system will also lead to the mandatory evidence-based practice and there will be a counter effect on the patients especially the poor patients.
- (4q) Health facility ID –One more entity for registration of Hospitals and Clinics.
- (9.2) Consent is free and voluntary then how do we ensure that all details will be revealed to practicing physicians especially relevant past history and investigations (patient may hide H/o HIV, HbsAg, etc)
- (14 bi) Data principal can rectify personal data is defined in 4. ee. Then who is responsible if physician manages the patient as per any false entries done by patient or deletion of relevant past history?
- (14 b ii) Too much power of manipulating data has been given to data principal.

## Technical Comments of IMA

### 1. PHR, EMR & EHR

It is proposed that NDHB would ensure the interoperability of data, creation of standardized "EHR" and providing continuum of care. The NDHM Architecture has mentioned building only a "PHR". However to achieve the key objectives of NDHM both EHR as well as PHR to be built as part of the minimum viable architecture. The concept of EHR, EMR and PHR should be as follows.

#### a. **Electronic Medical Record (EMR)**

An electronic record of health-related information on an individual that can be created, gathered, managed, and consulted by authorized clinicians and staff within one health care organization.

#### b. **Electronic Health Record (EHR)**

An electronic record of health-related information on an individual that conforms to nationally recognized interoperability standards and that can be created, managed, and consulted by authorized clinicians and staff across more than one health care organization.

#### c. **Personal Health Record (PHR)**

An electronic record of health-related information on an individual that conforms to nationally recognized interoperability standards and that can be drawn from multiple sources while being managed, shared, and controlled by the individual.

### 2. UHID

Unique identification of persons, facilities, diseases and devices is a key requirement as well as a challenge in the National Digital Health Ecosystem (NDHE).

The Blueprint handles this requirement through 2 building blocks, viz. Unique Health Identifier (UHID) and the Health Locker.

The ability to automate the process of matching records and maintaining cross reference index of identifiers for individuals and organizations is seen as a key enabler for efficient and accurate Unique Health Identifier (UHID). For a patient or an organization in particular, the ability to support standards-based applications and programs that allow it to be integrated to support Personal Health Record, is a key enabler of health information exchange. Appropriate technology like Integrating the Health Enterprise (IHE) based profiles for the patient, provider and facility registry will be useful.

### 3. Access

The Electronic Health Record (EHR) has two key dimensions i.e. the physician view and patient view. The Health Locker addresses the ability to store PHR but how the doctors will be able to access patient's family history, allergies, vital signs etc. need to be mentioned in detail. In addition to the Health Locker there is a



need to have unified portal for clinicians and citizens to access their health records.

#### 4. Consent Manager

It is important that NDHM leverages well defined consent management frame work. There are several consent models used by HIEs and the consent management framework should be flexible to adopt varying needs of the citizens.

No consent- Patient health information at a participating healthcare organization is automatically included in and available through the HIE (NOTE: This is not recommended, and is rarely used.)

Opt-out - All or some pre-defined data sets are qualified to be included and available for exchange, after patients are given the opportunity to opt out in full.

Opt-out with exceptions - All or some pre-defined data sets are qualified to be included and available for exchange after patients are given the opportunity to:

Opt-in - No patient data sets are made available for electronic exchange until patients actively express whether they would like to make all, or a pre-defined set, of their information available.

Opt-in with restrictions - No patient data sets are made available for electronic exchange until patients actively give their consent to participate.

The NDHB document suggests opt-in model for voluntary citizen participation in the NDHM. Opt out model may have better compliance.

The technology based consent mechanism should be fool-proof from exploitation as the majority of be beneficiaries are illiterate rural people. Ensuring that the EHR is prudently citizen controlled is a task which has to be meticulously undertaken.

#### 5.Data Exchange & Health Information Exchange (HIE)

There should be appropriate regulations to define how the data and health information will be shared, between whom and to what extent.

Preventing commercial exploitation of health data by Insurance companies, Medical devices manufactures, Pharmaceutical companies, corporate facilities etc.is of paramount importance.

An individual's personal health record can be assembled and stored locally by an authorised user ( Hospital, Doctors) through the query mechanism provisioned in the eco-system. This may be with consent of the individual. How the data movement can be traced and acted on when an individual ask the data fiduciary to delete the health record/opt-out from the eco system to be defined.

#### 6.AVAILABILITY

Ready to use HIS/EMR with minimum customisation to be made available in cloud with a reasonable subscription fee for use by individual, small and medium healthcare providers.

Dr. Rajan Sharma  
National President

Dr. R V Asokan  
Honorary Secretary General

Dr. Shiv Kumar Utture

Dr. K M Abul Hasan



### **Bio-Medical Waste and Central Pollution Control Board**

BMW Management Rules and Amendments had posed huge threat to the existence of private hospitals across the country. IMA had formed a National Working Group consisting of Dr. Mangesh Pate, Dr. A V Jayakrishnan, Dr. Ajay Mahajan, Dr. Rajender Sharma and Dr. Sharafudheen.

The NWG with National President Dr. Rajan Sharma, HSG Dr. R. V. Asokan held series of meetings with Union Minister Hon. Shri. Prakash Jawadekar ji, MoEFCC, CPCB. Many MPs were apprised with the facts and serious issues faced by the hospitals. We are happy to inform you that healthcare establishment has been removed from industrial category. HCEs are now listed as Non-Industrial Category. It was the root cause for all the issues.

Further the order states that CBMWTFs will also be Non-Industrial Category.

HCEs without incinerators &/or < 100 KLD liquid output discharge are now in ORANGE Non-Industrial category.

HCEs with incinerators &/or > 100 KLD liquid output discharge are now in RED Non-Industrial category.

As per the current protocols even small hospitals have to take consent to establish, consent to operate

etc like any other industry. But this categorization can take away such restrictions. There can be changes

in other requirements like ETP/ STP etc.

Dr. Rajan Sharma  
National President

Dr. R V Asokan  
Honorary Secretary General



Dr. Mangesh Pate



Dr. Sharafudheen



Dr. Rajender Sharma



Dr. Ajay Mahajan



Dr. A.V. Jayakrishnan





केन्द्रीय प्रदूषण नियंत्रण बोर्ड  
CENTRAL POLLUTION CONTROL BOARD  
पर्यावरण, वन एवं जलवायु परिवर्तन मंत्रालय भारत सरकार  
MINISTRY OF ENVIRONMENT, FOREST & CLIMATE CHANGE GOVT. OF INDIA

**SPEED POST**

F.No. B-29016/ROGW/IPC-VI/2020-21/

April 30<sup>th</sup>, 2020

To

**The Chairman  
All SPCBs/PCCs**

**SUB: DIRECTIONS UNDER SECTION 18(1)(b) OF THE WATER (PREVENTION & CONTROL OF POLLUTION) ACT, 1974 and THE AIR (PREVENTION & CONTROL OF POLLUTION) ACT, 1981 REGARDING HARMONIZATION OF CLASSIFICATION OF INDUSTRIAL SECTORS INTO RED, ORANGE, GREEN AND WHITE CATEGORY.**

**WHEREAS**, under Section 17 of the Water (Prevention & Control of Pollution) Act, 1974, and under Section 17 of the Air (Prevention & Control of Pollution) Act, 1981, one of the functions of the State Pollution Control Boards (SPCBs)/Pollution Control Committees (PCCs) is to plan a comprehensive programme for the prevention, control or abatement of pollution of streams, wells and air pollution in the States/ Union Territory and to secure the execution thereof; and

**WHEREAS**, under Section 16 of the Water (Prevention and Control of Pollution) Act, 1974 and under Section 16 of the Air (Prevention & Control of Pollution) Act, 1981, one of the functions of the Central Pollution Control Board (CPCB), constituted under Water (Prevention and Control of Pollution) Act, 1974 is to coordinate activities of the State Pollution Control Boards and Pollution Control Committees and to provide technical assistance and guidance to SPCBs / PCCs; and

**WHEREAS**, CPCB has categorized 242 industrial sectors into red, orange, green & white category and directed all SPCBs/PCCs on 07.03.2016 for its adoption and implementation. The SPCBs/PCCs were also directed that addition of any new or left-over industrial sectors and their categorization which is not listed in the categorization done by CPCB, shall be done by a committee at the level of concerned SPCB/PCC, in accordance with the revised criteria and guidelines of CPCB; and

**WHEREAS**, carrying out the responsibility assigned to MoEF&CC/CPCB/SPCB, under, Steel Scrap Recycling Policy, notified by Ministry of Steel on 07.11.2019, a meeting was held under chairmanship of Joint Secretary (HSM Division) at MoEF&CC on 07.11.2019 for uniform categorization of scrapping activities as Red/Orange/Green/White Category. During the meeting it was decided that such uniform categorization of scrapping centres has to be developed by CPCB. The CPCB has categorized "Scrapping Centres (for End of Life of Vehicles and other scraps such as plant and machineries, structural material, railway coaches and wagons etc.)" under "Orange Category" of industries; and

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Parivesh Bhawan, East Arjun Nagar, Delhi-110032  
दूरभाष/Tel : 43102030, 22305792, वेबसाइट/Website : www.cpcb.nic.in



**WHEREAS**, a need was felt to categorize some industrial sectors on PAN-India level and to resolve anomalies in categorization, if any. Accordingly, CPCB through Office Order No. B-29012/IPC-VI/2019-20, dated 17.02.2020, constituted a Committee to deal with the matter related to categorization of industrial sectors under red/orange/green/white category; and

**WHEREAS**, the meetings of the Committee were held on 02.03.2020 at CPCB, Delhi and 15.04.2020 & 21.04.2020, through video conferencing. During the meeting, the categorization of Railway Stations, Compressed/Refined Bio-Gas Production from Bio-degradable Wastes and Used Cooking Oil (UCO) collection centers was finalized. The details regarding categorization are enclosed as **Annexure-I**. Further, based on the few representations, the Committee has also segregated the list of Non-Industrial Operations (Activities/ Facilities/ Infrastructure/ Services), which were covered under classification of industrial sectors in CPCB's document on categorization. The list of such Non-Industrial Operations is enclosed as **Annexure-II**.

**NOW THEREFORE**, in view of the above and exercising the powers conferred to Chairman, Central Pollution Control Board under Section 18(1)(b) of the Water (Prevention & Control of Pollution) Act, 1974, and 18(1)(b) of the Air (Prevention & Control of Pollution) Act, 1981, all the SPCBs/PCCs are directed to:

- i. Adopt the categorization finalized by CPCB for following sectors:
  - a. Scrapping Centres (for End of Life of Vehicles and other scraps such as plant and machineries, structural material, railway coaches and wagons etc.).
  - b. Used Cooking Oil (UCO) collection centers.
  - c. Compressed/Refined Bio-Gas Production from Bio-degradable Wastes.
  - d. Railway Stations.
- ii. Consider the sectors given at Annexure-II under Non-Industrial Operations (Activities/ Facilities/ Infrastructure/ Services).

The SPCBs/PCCs shall acknowledge the receipt of directions and submit the action taken report (ATR) in compliance of these directions to CPCB within 15 days from the receipt of directions.

(Ravi S. Prasad)  
Chairman

PK  
h/s

Copy to:

- 1 The Joint Secretary (CP Division)  
Ministry of Environment, Forests & Climate Change  
Indira Paryavaran Bhawan  
3rd Floor, Prithivi, Aliganj, Jor Bagh Road  
New Delhi -110 003
- 2 All Regional Directors, CPCB
- 3 DH, IT

: with a request to upload the copy of Directions on CPCB website

(Prashant Gargava)  
Member Secretary

O/c



Annexure-I

The list of newly categorized sectors by CPCB

S. No.	Entry at S. No. of respective category in CPCB's classification	Industry Sector	W1	W2	W	A1	A2	A	H	Pollution Index (PI)	Category	Remarks	
1	85	Scrapping Centres (for End of Life of Vehicles and other scraps such as plant and machineries, structural material, railway coaches and wagons etc.)										Orange	
		a. Collection, De-Pollution, Dismantling Centres and Shredding Centres	20	-	20	15	-	15	20	55	Orange	i. Process will generate waste water from vehicle washing, surface washing, spillage while depolluting the vehicle. ii. Emission of particulate matter. iii. Residue generated during the process needs stabilization before disposal as it may contain asbestos.	
		b. Collection, De-Pollution and Dismantling Centres	20	-	20	10	-	10	20	50	Orange	i. Process will generate waste water from vehicle washing, surface washing, etc. ii. Fugitive emission may be generated from dismantling and other activities. iii. Residue generated during the process needs stabilization before disposal as it may contain asbestos.	
		c. Shredding Centres (can include white goods*/other scraps also)	15	-	15	15	-	15	15	45	Orange	i. Waste water may be generated from floor washing, etc. ii. Residue generated may be incinerated/landfilled. iii. Emission of particulate matter.	
Note- * Recycling/dismantling of white goods are covered under E-Waste (Management & Handling) Rules, 2016, and have already been categorised in CPCB document "Classification of Industrial Sector" (Feb, 2016)													

Annexure-I

S. No.	Entry at S. No. of respective category in CPCB's classification	Industry Sector	W1	W2	W	A1	A2	A	H	Pollution Index (PI)	Category	Remarks
2	37	Used Cooking Oil (UCO) collection centers	-	-	-	-	-	-	-	00	White	i. Generally, there is no waste water generation or air emissions from UCO collection centers. ii. Concerned SPCB/PCC shall ensure the above.
3	86	Compressed/Refined Bio-Gas Production from Bio-degradable Wastes	30	-	30	10	-	10	10	50	Orange	i. All digesters requiring discharge of excess wastewater to be treated in orange category, ii. Domestic bio-digesters based on cow-dung or household biodegradable wastes (such as Gobargas plant) - White category. iii. No wastewater discharge from digester and also feed slurry to digester having Volatile Organic Fraction more than 75% to be considered as Green category; iv. Wastewater may be generated from wet processes for gas refining, cooling towers and cooling re-circulation processes. v. Odour generation from pretreatment of organic waste and composting. vi. Exhausted adsorption media/filters and spent solvents may also get generated.



S. No.	Entry at S. No. of respective category in CPCB's classification	Non-Industrial Operations (Activities/Facilities/Infrastructure/Service sector)	W1	W2	W	A1	A2	A	II	Pollution Index (PI)	Category	Remarks
1	<b>Railway Stations</b>											
	61	Railway Stations (Waste Water Generation $\geq$ 100 KLD)	20	10	30	15	0	15	10	75	Red	<ul style="list-style-type: none"> <li>i. Mainly water polluting, scores are normalized. Wastewater generating from public toilets, public-taps, platform and apron washing, coach cleaning, laundry, restaurants etc.</li> <li>ii. Air emissions may be generated from boilers, DG sets (&gt;1MVA), railway sidings etc.</li> <li>iii. Small amount of hazardous waste such as used oil from DG sets, waste oil from coach cleaning, etc. may be generated</li> </ul>
	84	Railway Stations (Waste Water Generation $\geq$ 10 KLD, but < 100 KLD)	20	0	20	12	0	12	10	50	Orange	<ul style="list-style-type: none"> <li>i. Mainly water polluting, scores are normalized. Waste water generating from various uses such as public toilets, public-taps, platform and apron washing, restaurants etc.</li> <li>ii. Air emissions may be generated from railway sidings, DG sets etc.</li> <li>iii. Small amount of hazardous waste such as used oil from DG sets etc. may be generated</li> </ul>
	64	Railway Stations (Waste Water Generation < 10 KLD)	12	0	12	0	0	0	0	30	Green	<ul style="list-style-type: none"> <li>i. On small railway stations, waste water generation mainly from public taps and toilets. Scores are normalized.</li> <li>ii. Small railway stations normally may not have boilers or any other prominent stationary air emission sources.</li> </ul>



## Annexure-II

## List of Non-Industrial Operations (Activities/Facilities/Infrastructure/Services)

Covered Under Red Category of Industries Earlier				
Sl. No.	Sl. No. (as per CPCB Document)	Industry Sector	Pollution Index	Remarks
1	23	Airports and Commercial Air Strips	75	<ul style="list-style-type: none"> <li>i. The Airports are generating mainly the wastewaters.</li> <li>ii. This is the water pollution normalized score for airports having discharge more than 100 KLD.</li> <li>iii. The airports / strips having discharge less than 100 KLD will have score of 50 and hence orange category.</li> <li>iv. If the score is normalized wrt water + HW both, then all the airports will come under Orange category ( score - 58.33).</li> </ul>
2	30	Health-care Establishment (as defined in BMW Rules)	75	<ul style="list-style-type: none"> <li>i. Mainly water polluting.</li> <li>ii. The water pollution score is normalized to 100 &amp; valid for Hospitals having total waste-water generation &gt; 100 KLD.</li> <li>iii. The hospitals with incinerator will be categorized as Red irrespective of the quantity of the wastewater generation.</li> <li>iv. The hospitals having total waste-water generation less than 100 KLD and without incinerator, the normalized water pollution score will be 50 and will be categorized as Orange category.</li> </ul>
3	31	Hotels having overall wastewater generation @ 100 KLD and more.	75	<ul style="list-style-type: none"> <li>i. Mainly water polluting. Small boiler may be installed.</li> <li>ii. The water pollution score is normalized to 100 &amp; valid for Hotels having waste-water generation &gt; 100 KLD.</li> <li>iii. The hotels having more than 20 rooms and waste-water generation less than 100 KLD and having a coal/ oil fired boiler, the pollution score will be 35/40 &amp; are categorized as orange.</li> <li>iv. The hotels having more than 20 rooms and waste-water generation less than 10 KLD and having no-boiler &amp; no hazardous waste generation, the pollution score will be 20 &amp; are categorized as Green.</li> </ul>
4	39	Railway locomotive work shop/Integrated road transport workshop/ Authorized service centers	75	<ul style="list-style-type: none"> <li>i. Mainly water polluting industry. Water is used in the washing of locomotives, road transport vehicles during servicing.</li> <li>ii. This score is valid for those Centers having discharge more than 100 KLD.</li> <li>iii. Service Centers having waste-water generation &lt; 100 KLD, the normalized score will be <math>= (100 * 20) / 40 = 50</math>.</li> </ul>
5	46	Ports and harbour, jetties and dredging operations	85	This category contain all sorts of pollution
6	-	Common treatment and disposal facilities (CETP, TSDF, CBMWTF, effluent conveyance project, incinerator, MSW sanitary land fill site)	-	<ul style="list-style-type: none"> <li>i. All such facilities are classified as Red but special category projects as these are parts of pollution control facilities.</li> <li>ii. In case of CETP, the categorization will depend upon the category of member industries being served.</li> </ul>



Note: Solvent/acid recovery plant and E-waste recycling are considered as industrial operation.				
List of Sectors Covered Under Orange Category of Industries Earlier				
Sl. No.	Sl. No. (as per CPCB Document)	Industry Sector	Pollution Index	Remarks
1	18	Automobile servicing, repairing and painting (excluding only fuel dispensing)	50	Normal water & air polluting and recyclable waste oil generating. If the waste water generation is more than 100 KLD, it will become mainly water polluting and Red category unit.
2	21	Building and construction project more than 20,000 sq. m built up area	50	i. In the pre-construction stage, it is mainly air polluting due to generation of dust ( PM ) emissions. ii. After construction, it is mainly water polluting. If the discharge is more than 100 KLD, it will be having the normalized score of 75 and be categorized as Red.
3	38	Hotels (< 3 star) or hotels having > 20 rooms and less than 100 rooms.	50	Mainly water polluting. WP score is normalized to 100.
4	46	Mechanized laundry using oil fired boiler	50	Both air and water pollution are generated.
5	50	New highway construction project	50	Mainly air polluting project.
List of Sectors Covered Under Green Category of Industries				
Sl. No.	Sl. No. (as per CPCB Document)	Industry Sector	Pollution Index	Remarks
1	19	Facility of handling, storage and transportation of food grains in bulk	25	Some fugitive emissions of PM during handling of grains.
2	52	Hotels (up to 20 rooms and without boilers)	30	This score is valid for hotels having overall waste-water generation less than 10 KLD.
3	58	Flyash export, transport & disposal facilities	37.5	i. This is mainly air polluting activity. ii. This is the normalized score based on air pollution.
4	59	Mineral stack yard / Railway sidings	37.5	Mainly air pollution due to loading, unloading, storage and transportation of the minerals.
5	60	Oil and gas transportation pipeline	37.5	i. Contains small gas based power plants up-to 5 MWs. ii. Air pollution score is normalized to 100. iii. In case, if these power plants are bigger / liquid fuel / oil based, scores will be calculated accordingly.
6	-	Diesel generator sets (15 KVA to 1 MVA)	-	i. Normal operation – 12 hrs a day. ii. Consumption of diesel = 1680 litres for 1 MVA DG set at full load @ 0.21 litres / KVA / hr. iii. Stand-alone DG Sets having total capacity 1 MVA or less and equipped with acoustic enclosures alongwith adequate stack height may be exempted from the purview of Consent management. Higher capacity DG sets have already been covered under Red / Orange categories.
7	-	Automobile fuel outlets (only dispensing)	-	Minor air pollution due to some fugitive emissions during fuel filling operations. May be exempted from the purview of Consent management.



**INDIAN MEDICAL ASSOCIATION**

**24X7 HELPLINE**

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Started on 15th March 2020



**INDIAN MEDICAL ASSOCIATION**

**IMA PSYCHO SOCIAL  
COUNSELLING**



**TALK  
TO A  
COUNSELLOR**

for Doctors, Nurses  
and Healthcare workers

**HELPLINE NUMBERS**

**+91 9999 11 6375**

**+91 9999 11 6376**

**TIMING:**

**09:00 AM to 09:00 PM 7 days a week**

Started on 15th March 2020 (conclude)



**INDIAN MEDICAL ASSOCIATION**

*Protect the Single & Couple Doctor Setups*

**LAUNCHES**

**CORONA HELPLINE**

**FOR**

**DELHI POLICE**

**on**

**DOCTORS' DAY**

*Wednesday, July 1<sup>st</sup>, 2020*

**+91 9999672238 / 39**

**10 AM to 4 PM (DAILY)**



**INDIAN MEDICAL ASSOCIATION**

*Protect the Single & Couple Doctor Setups*

**Launches** on August 15th, 2020

**Mask Initiative**

for

**IMA Members**

across the Country

with Affordable Cost



**+91 9310068543**

