INDIAN MEDICAL ASSOCIATION

IMA NEWS

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Reunion of Former National Presidents and Former Honorary Secretaries General at IMA HQs., New Delhi

ACTIVITIES OF NATIONAL PRESIDENT & SECRETARY

From the pen of National President, IMA

Health is an orphan

Covid pandemic has changed nothing. Neither the Government investment in Health nor the Health Care seeking habit of the people. The indifference continues. We as a people are under prepared for falling ill.

It is well known that investment in Health brings back higher returns in GDP. The impact however is indirect and delayed. There is no electoral dividend. A Health minister is rarely a celebrity.

We paid a price during the pandemic for having general administrators and the police manage the crisis. We could have done better in the hands of professionals. Indian Medical Services a la Indian Administrative Services, a pre independence institution was abolished in 1948.

5 crore Indians go below poverty line every year due to catastrophic Health Care expenditure. 66% of the expenditure is for buying outpatient care especially drugs. No one covers this cost. This is not rocket science. Investment in Health, Public Hospitals and Primary Care is the way to go.

To the pointed question

Why Health is not an election issue the answers may be fragmented.

1. Health is a state issue. Atleast in well performing states like Kerala and Delhi the Government's performance has influenced the electorate.
2. Health seeking behaviour of the population is determined by factors like female literacy and availability of services.
3. As for as the Parliamentary elections are concerned the Covid pandemic should have been an election issue. The only reason we could see is the short memory of the people. The infrastructural deficiencies and the gaps in Human Resources were glaring. Yet it is also true that the Government managed the supply chains of masks etc well and rolled out a vaccine free for all programme which was an envy of other countries.
4. However what is intriguing neither the shortcomings nor the successes of the Covid management are being discussed. It is probably a stalemate.
5. Yes. AB PM JAY is being projected as a success story. For every single point scored by the Government there is a negative point to consider as well.

Long Live IMA !

Dr. R.V. Asokan

National President, IMA

Dear Friends,

Greetings from Indian Medical Association HQs.!

It is my privilege to meet all of you through the IMA NEWS Bulleting which is a genuine source of communication and to keep our members updated about IMA. I request those members who are not receiving IMA News regularly can inform IMA HQ. So that we can confirm their name and address in our list.

Strength is the voice of any Association. During the IMA membership drive, I am very happy to inform you that few states have enrolled quite a good number of members but few states are still lacking to increase their membership. During the above discounted period, more than 11000 members have been enrolled. I especially request the office bearers of the Northern States of IMA to focus on increasing their membership as nothing has been enrolled by these States. I request all of you to work hard to enroll more members under the umbrella of IMA

IMA has organized zoom meetings of State Presidents and Secretaries, alongwith leaders and office bearers on 11thMarch, 2023 as well as the Members of the IMA Standing Committee for Action to setup the strategy that how to proceed further during the Parliamentary Elections and how to sensitize the politicians about the "IMA Health Manifesto" and "Charter of Demands".A meeting of IMA Standing Committee for Building was also held on zoom to discuss the issues related to Building.

A physical meeting of all Past National Presidents and Hony. Secretary Generals was organized on 17th March 2024at IMA HQs to discuss about the issues related to the medical profession and IMA New Building.During the above meeting, few resolutions onHBI, Cashless Insurance and CGS Rates, Ayushman Bharat, Young Doctors and Academic front of IMA were made and the members requested IMA HQs to make the above resolutions and place them before the ensuing CWC meeting at Chennai for further necessary action.

Since the above meeting was the last meeting of the past National Presidents and Honorary Secretaries General in the existing building of IMA Headquarters, it was everyone's wish that a group photograph of all the leaders be taken in the presence of our Chief Patron Dr.Ketan Desai Sir. This photo is memorable and is meant to preserve the memories of the old IMA building.

As you all know that 231st meeting of the Central Working Committee of Indian Medical Association is scheduled to be held on 13th & 14th, April, 2024 (Saturday & Sunday) at Chennai, please come prepared with the positive thinking that how we can uplift our mother organization.

Relocation of the Indian Medical Association (IMA) office has become necessary due to redevelopment and demolition of the current IMA Headquarters building. In view of this, IMA deeply appreciates the Indian Institute of Public Administration (IIPA), (near IMA Headquarters) for its cooperation in providing rental space. We will soon be transferred to IIPA to facilitate a smooth transition for the organization, ensuring its continued operations in service to its members and the community.

Once again, I would like to draw your attention that for the reconstruction of the new IMA Headquarters building, the estimated cost of the redevelopment project is Rs. 70 crores, as quoted by NBCC. This financial commitment is in line with IMA's long-term vision of providing state-of-the-art facilities to its members. It was decided to collect money from our members. In this regard, we have sent an appeal with QR Code to all our office-bearers, state leaders, CWC, CC and all our members with a request to donate to the IMA New Building account. Donors will also get income tax exemption under Section 80-G. I appeal to all our members to donate generously in the IMA New Building Account. I am sure that with the efforts and sense of belongingness of every member of IMA, we can achieve the desired contribution for the redevelopment of IMA Headquarters building.

As you all know that IMA Aao Gaon Chalen Project was relaunched on 25th June, 2023, all over the country by our Chief Patron Dr. Ketan Desai Sir. In this regard, I request all of you to adopt at least one village and conduct various activities on regular basis under this project. You are also requested to send village adoption activity report alongwith photographs to IMA HQs. so that a compiled document can be created. The Awards for this noble cause will be given by IMA HQs. either after the completion of one year on 24th June 2024 or on the occasion of Doctors Day.

I, further, request all of you to create awareness about the Organ Donation and motivate the donors to donate their organs after their death to save more lives.

Together we can achieve anything……..

Long Live IMA !!

Dr Anilkumar J. Nayak
Hony. Secretary General, IMA

AP LINKS NDHM TO CEA

MEDICAL AND HEALTH DEPARTMENT
OFFICE OF THE DISTRICT MEDICAL AND HEALTH OFFICER,NANDYAL

CIRCULAR

Rc.No.Spl/DMHO – NDL/DEMO/2024 Dated : - 19.03.2024

Sub : - DMHO – NDL – DPMO – NHM, DEMO – ABDM – Adoption of ABDM (Ayushman Bharath Digital Mission) in Private Health Care Facilities – certain instructions issued – Reg

Ref : - File No.HMF04 – 26022 (33)/208/2023 – NHM of the Director of Health and Family Welfare,State Mission Director,NHM,Mangalagiri.

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This is to inform you that, the Director of Health and Family Welfare,State Mission Director,NHM,Mangalagiri has instructed to the District Medical and Health officer,Nandyal District implement Ayushman Bharath Digital Mission in all the Private Health Care Facilities.

As you aware, the State Governement has actively engaging in various initiative to facilitate the saturation of registries such ABHA (Ayushman Bharath Health Account),HPR (Health care Professionals registries) and HFRs (Health Facility Registry) and promote the usage of Ayushman Bharath Digital Mission (ABDM) – enabled HMIS solutions

In view of this the institutions involved in Clinical Establishment Act activities and facilities like Clinics,Hospitals,Laborataries,Diagnostic centres and Pharmacies are instructed to register their HPR (Health care Professionals registries) and HFRs (Health Facility Registry) and actively link patients health records to their ABHAs using and ABDM enabled HMIS

The District Programme Management Officer,District Arogyasree Coordinator and District Extension and Media Officers are directed to take initiative in generation of HPR and HFR in all the Private Health Care Facilities during their registrations and renewals and also monitor the patients health records to the linked to their ABHAs using and ABDM in HMIS

19/03/24

District Medical and Health officer
Nandyal

19/03/24

To

Copy to all the Private Nursing Homes/Hospitals,Clinics,Laborataries,Diagnostic centres and Pharmacies in the District

Copy to the District Coordinator, Arogyasree,Nandyal

Copy Submitted to the Commissioner of Health and Family Welfare,Mangalagiri,Guntur District

Copy Submitted to the Collector and District Magistrate,Nandyal for kind information

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 purcahsing 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.

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.

3. 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.

Dr R V Asokan

National President, IMA

Dr Rajan Sharma

Past National President, IMA

MINUTES OF THE MEETING WITH PAST NATIONAL PRESIDENTS AND HONY. SECRETARY GENERALS

on 17.03.2024 at IMA HQs

A meeting of all the Past National Presidents and Hony. Secretary Generalswith National President, Dr R V Asokan, Hony. Secretary General, Dr. Anilkumar J Nayak was held on 17.03.2024 at IMA HQs.

The following members were present:

1. Dr. Ketan Dhirajlal Desai, Past National President
2. Dr. S. Arulrhaj, Past National President
3. Dr. Sudipto Roy, Past National President
4. Dr. Ajay Kumar, Past National President
5. Dr. Goparaju Samaram, Past National President
6. Dr. Vinay Aggarwal, Past National President
7. Dr. K. Vijaya kumar, Past National President
8. Dr. A. Marthanda Pillai, Past National President
9. Dr. Rajan Sharma, Past National President
10. Dr. J.A. Jayalal, Past National President
11. Dr. Sahajanand Prasad Singh,Past National President
12. Dr. Sharad Kumar Agarwal,Imm. Past National President
13. Dr. D.R. Rai, Past Honorary Secretary General
14. Dr. R.N. Tandon, Past Honorary Secretary General
15. Dr. Jayesh M. Lele. Past Honorary Secretary General
16. Dr.Shitij Bali, Honorary Finance Secretary
17. Dr. MunishPrabhakar, Special Invitee
18. Dr. Thakur Padmanabhan, Special Invitee

Honorary Secretary General adorned the National President with the Presidential Medallion, who then called the meeting to order. Dr. Munish Prabhakar, HJS, recited the IMA Prayer and Flag Salutation.

Dr. Anilkumar J. Nayak, HSG: He welcomed all the Past NPs and HSGs, informing them of the initiative to capture memories of the existing IMA HQs building before its demolition by preparing a Documentary Film. He further requested members to contribute donations, also reminding them of commitments made in CWC/CC meetings held in Kerala.

He apprised the members about the Membership Drive run by IMA and the number of new members enrolled during this period. Few states have enrolled quite a good number of members but few branches are still lacking to increase their membership. He also requested the House to give suggestions to divide 3 Union Territories.

During his speech,Dr R V Asokan, National President informed the House about the various activities done by IMA HQs in the last two and a half months.

1. He informed that to give a dedicated time to all the State Branches of IMA, we had Zone wise meetings of the State Presidents and Secretaries.
2. He informed that during the Membership Discount period, 10,592 new members have been enrolled.
3. Covid Martyrs Day was observed by various State and Local Branches on 30th January, 2024.
4. MPs Meet was organised on 7th February, 2024 where 56 MPs attended the same and our Health Manifesto was released on the same day. Our Charter of Demands were also presented before them.
5. We met the concerned authorities and cleared our stand on NExT issue.
6. On the issue of Insurance, IMA' s stand – No to Cashless was also informed to the concerned authorities.
7. IMA is participating in the following legal interventions:
   - Patanjali Case is still on
   - PIL on Integrative Medicine in Delhi Hight Court; &
   - Inflict in CGS Rates
8. National Councils of MSN and JDN have been formed.
9. JDN initiative for National Employment Scheme, Overseas Employment Scheme and Overseas career facilitation Programme have been started and we are hiring professional agencies for the same.
10. IMA has actively started working on AMR, TB Standard Care, Adoption programme with Govt. of India, Disaster Management, Vector Borne diseases and preparation of Coffee Table Book which will have the information about the states who are having their own building and blood banks. We will have a programme on Stop TB Partnership with the help of CMA, in the month of June, 2024.

11. We are also working on the various amendments which have been passed in the last CWC/CC meetings through our Constitutional Amendment Committee.

NP requested Dr. Vinay Aggarwal to give a brief introduction on the new building of IMA.

Dr. Vinay Aggarwal: Dr. Vinay Aggarwal presented plans for the rebuilding of the IMA Headquarters building through a PowerPoint presentation. Plans of our new building have been submitted to all the relevant authorities. He urged members to donate generously towards this initiative. It was informed that until the project is completed, the IMA HQs will temporarily shift to IIPA, nearby the current building.

Dr. Shitij Bali informed about the current position of the funds of IMA HQs. He informed till date Rs. 50,64,000/- have been collected as donation for the new Building of IMA HQs.

All Past NPs and HSGs wereenthused for the re-development of IMA Building and presented their viewson the rebuilding project and other pertinent issues, which are as follows:

Dr. S. Arulrhaj: Dr. S. Arulrhaj emphasized finding a suitable place for members and exploring alternative methods for fundraising, including acquiring land in Delhi. He also stressed the need to address issues such as Mixopathy.

Dr. Sudipto Roy: He was of the opinion to strengthen the IMA voice, membership has to be increased and even we can approach the other Specialist Organisations to become the members of IMA.

Dr. Ajay Kumar: He emphasized fostering a sense of belongingness among members to encourage donations. He was of the opinion that we can collect the funds and as the building gets built, people will join together. He further said that IMA should keep the pressure on Government for our other related demands like Integrated Medicine, CGHS Rates and Insurance etc. He said that the future of our medical profession is young doctors and IMA should inspire them to become the member of IMA and involve them in all our activities.He suggested to make a Committee as far as Mixopathy is concerned who will see and watch all the advertisements.

Dr. G Samaram: He said we will be able to get the funds for the redevelopment of the building. He appreciated the Health Manifesto prepared by IMA along with Charter of Demands. He said that we should keep our fight on with Govt to get our demands.

Dr. Vinay Aggarwal: He said that donation has to be collected from our own members and we as the Past National Presidents of IMA have to work hard to get the donation from our members.He was also of the opinion that the work for which HBI was created was not accomplished. It was meant to protect the right of the members. IMA Leadership should take a note of this and take necessary action accordingly. We should strength HBI and its functioning.

Dr K Vijayakumar: Whie talking about the building issue, he said that determination of the leadership should be there and he hoped that we will collect the donation from our members. He was of the opinion that other matters related to medical profession should also be dealt with priority.

Dr. A Marthanda Pillai: He said that we should try to make the young doctors to become the members of IMA at an early stage, otherwise they will join the Specialist Organisations instead of IMA. He further spoke about Criminalization of Medical Profession, CPA and entry of our medical graduates in the Administrative Posts.

Dr. Rajan Sharma: He was the opinion that IMA should send a request to all its members to donate Rs.1000/- and above for the redevelopment of IMA Building and it can be collected through the efforts of Local, State and Headquarters' leadership. He said today the main threat is for the Single and Couple set ups. He spoke about the need of Wellness Centres. He apprised the members that the Ayurvedic Medicines are having allopathic contents. He said that the vacancies are not being filled by various state Governments in their respective states. He spoke about Pharmacy and Jan Aushadhi issues also.

Dr J A Jayalal: He said while observing the Centenary Year, IMA should give more priority to its Academic front. IMA should make a Research Cell and publish various Publications on TB Care and issue of importance.We should make every effort toinclude the young doctors under the IMA Umbrella. He further opined that HBI is not performing well, it should be brought to IMA HQs.

Dr. SNP Singh: He was of the opinion that IMA should contact various Medical Colleges in the country and other Specialist Organisations and convenience them to become the members of IMA. While talking about the issue of donation for Building, he suggested to take the donation from every State Conference and State Wings of that respective State. He also spoke about CEA issue.

Dr. Sharad Aggarwal: He was of the opinion that we the leaders of IMA should come with the solutions of the problems and there is a need to introspect ourselves also. We should learn lessons from Southern States of IMA

whether it is increase in membership, unity or something else. Are the wings which we decentralized, doing their job properly? If they are not performing well, they should be brought back to IMA HQs

Dr. D R Rai: He was of the opinion that each and every member should be a part for the collection of funds. IMA should make it mandatory for each local and state branch, according to their strength, to give donation. We should start working for the welfare of our young doctors and we will have to produce the work that we have done for their welfare, only then they can trust us and become the members of IMA.

Dr R N Tandon: He appreciated the idea of Documentary Film of IMA Building before demolishing it. Hefurther said that the states which are giving money to build IMA new buildings, we should percolate that information to other states to encourage them also for the donation for the IMA new Building. He ws of the opinion that HBI is not concentrating on small and nursing homes.

Dr. Jayesh Lele: He suggested the fee structure for MSN members so that they can easily think of becoming the member of IMA. He was also of the opinion that every IMA Scheme should make efforts to increase its membership.

A Resolution was passed by the House that HBI should be revitalized and it should be brought to IMA HQs and this Resolution should be forwarded to the next CWC meeting.

NP informed the members that IMA HQs will make Resolutions on HBI, Cashless Insurance and CGS Rates, Ayushman Bharat, Young Doctros and Academic front of IMA and after approval from the House, it will be placed before the ensuing CWC meeting at Chennai.

Dr. Ketan Desai: During his speech, he said that success should come from the top. He said that NP/HSGs keep coming and going, but fix the system.

HBI was created with the aim that it will take up the issues of the medical professional having their Hospitals and Nursing homes. But it could not get the desired results. HBI requires introspection. He requested NP/HSG to make a committee of 3 to 4 members who will interact with HBI office bearers and State leaders and submit its report before CWC that how to make it more active and vibrant. There is a need to add new value additions in HBI. IMA HQs should need to find such avenues.

For the Building Issue, he suggested to make the Regional Coordinator for the donation for the building funds.

Decisions

1. To work together for the construction of the new building and raise adequate funds from the members
2. To revitalise IMA HBI to countenance the issues of the hospital
3. To increase membership by forming new branches
4. To form branches in all medical colleges to bring in medical teachers and also to serve as the the parent branches of respective IMA JDN and IMA MSN units.

Following members donated in the IMA New Building Fund:

- Dr. K Vijayakumar donated a sum of Rs. 1.25 Lakh in the above fund and promised to pay it yearly till the completion of the new building. He further promised to forgo his TA for his meetings for the next 4 years.
- Dr. Jayesh Lele donated a Cheque of Rs. 5 Lakhs from the Mumbai West Branch.
- Dr R N Tandon donated a sum of Rs.31,000/- in the above fund.

NP informed the members that inspite of the death of the father of Dr. Anilkumar J Nayak, he gave full attention to his work. A moment of silence was observed for the father of Dr. Anilkumar J Nayak, who passed away on 6th March, 2024.

A photograph session of all Past NPs & HSGs was conducted to preserve memories of the old IMA building.

The meeting ended with vote of thanks to the chair.

Dr. Anilkumar J Nayak
Honorary Secretary General, IMA

MEETING WITH WHO ON DISASTER PREPAREDNESS

The World Health Organization (WHO) in India represents a specialized organization engaged in comprehensive public health initiatives spanning various sectors within the nation. Central to its operations, the Health Security and Emergencies (HSE) team at WHO focuses primarily on creating resilient health systems to effectively address health emergencies and disasters. Concurrently, the Indian Medical Association (IMA), as the premier professional association of doctors has a vast and dedicated network of trained doctors distributed throughout the country, extending from major urban centers to the grassroots level, to deliver healthcare services.

A strategic partnershipforged between the World Health Organization (WHO) and the Indian Medical Association (IMA) will a very significant step as it can brings together the global expertise, technical knowledge of WHO with the IMA's extensive network of Doctorsto enhance public health outcomes, contribute to health emergency preparedness, and disaster risk reduction by building partnership and fostering innovation.

Objectives

- Capacity Building: Facilitate knowledge exchange and training for healthcare professionals in the field of Health emergencies and Disaster Risk Management
- Partnerships to build a strong IMA network of the grassroot level that understands health and disaster management and will be a stakeholder in all the disaster management activities of the government.
- Develop and implement comprehensive response strategies for health emergencies and natural disasters.

Planned activities

Phase 1: Assessment and Strengthening the existing system

Objective: To assess the current capabilities and needs of the IMA and develop a detailed plan for strengthening its systems.

1. Identify a Focal Point, person who can lead the activities from the side of IMA and will be the point of contact for communication with the World Health Organization.
2. Conduct a comprehensive Needs Assessment
   - Evaluate the System within IMA for the disaster management activities.
   - Strengthen the existing system and identify the gaps within the structure

3. Develop a strategic plan in line with the activities mentioned in the IMA health manifesto 2024 like identify a state and district focal point for disaster and advocacy for a place in District level Disaster management Authority and State level disaster management authority meetings.

Phase 2: Training and Capacity building phase

1. Collaborative training and capacity building exercises with the World Health organization to develop on capacities of IMA members (includingDM committee/cell of IMA,IMA-JDN,IMA-MSN, IMA-HBI in the field of health emergencies and disaster risk management.
2. Training of Master trainers from IMA at state level to equip them with sufficient skills and knowledge in Disaster management and health Emergencies.

Phase 3: Specific Projects in WHO – IMA Collaboration

1. Create IMA knowledge platforms on disaster management to be a platform for training and repository for best practices.
2. Conduct Mock drills and medical emergency management exercise on various thematic areas like complex disasters and seasonal extreme weather events.

Conclusion

The proposed partnership between WHO and the Indian Medical Association represents a strategic and timely initiative to address the multifaceted health challenges especially in the field of Health emergencies and disaster risk management faced by India today. By combining resources, expertise, and a shared commitment to improving public health, this collaboration stands to make a significant impact on the health and well-being of India's population.

CONCEPT NOTE: STOP TB PSP CONSTITUENCY

Background and Purpose

With an estimated 10.6 million people falling ill annually, and 1.3 million dying each year from the disease, tuberculosis (TB) remains a leading global health priority. While TB can affect anyone, is present in all regions and countries, and impacts all age groups, it is both curable and preventable.

The Global Plan to End TB advocates government stewardship, strong coalitions, protection and promotion of human rights, and global collaboration. Some of the key actions recommended include early diagnosis and effective treatment of TB, collaborative management of co-morbidities, and inter-sectoral partnerships with engagement of private healthcare providers.

Private healthcare providers have an important role to play in providing early, quality and affordable TB care, and in partnering to share resources and expertise. Substantial co-existence of public and private healthcare in countries, especially in high TB burden ones, augurs well for collaboration on TB elimination efforts. Private providers improve access and availability of quality health care and in many countries, a large proportionof people with symptoms of TB, including thepoor, seek care first at private clinics and hospitals.

TB and IMA

Indian Medical Association isthe professional Association of modern medicine doctors in India. It has a membership of around 4,00,000. It is spread over all the 600 plus districts of India. IMA has long history of working independently and with the Government in TB Care and Control.It has been part of implementing DOTs strategy,STOP TB Strategyand now End TB strategy as well.IMA was associated with the GFATM between 2007 to 2014 has Government of India in Round-6 (Oct 2007 to Mar 2010), RCC (Apr2010 – Sept 2011), SSF1 (Oct11– Mar13), SSF-2 (Apr13-Mar15) phases.

October 2007 to March 2014

IMA GFATM Project

Round-6and RCC	No. of PP sensitized	No. Of PP trained	Number of MoU signed	No. of DOTS centers created	Number of DMCs formed	No.of TB patient notified	Formation o PHIs
Total	92,700	15,730	7,124	4,314	95	100000	1648

With long experience in TB care and control IMA is a bonafide partner of STOP TB partnership from inceptionsteps forward to bring together professional medical associations in other countries to expand the canvas of Private sector provider constituency across Asia and Africa.

Associations of medical professionals – national and international – are in a unique positiontoadvocatefortheapplicationofprinciplesandstandardsforTBcareamongtheirmembers. WithTB beinga serious globalhealth problem, professionalassociations have a moral obligationtoadvocate for adoption of TB care standards, and to be willing to 'interface' between government-lednational TBprograms(NTP)and privatehealthcarepractitionersmanagingpeoplewithTB.

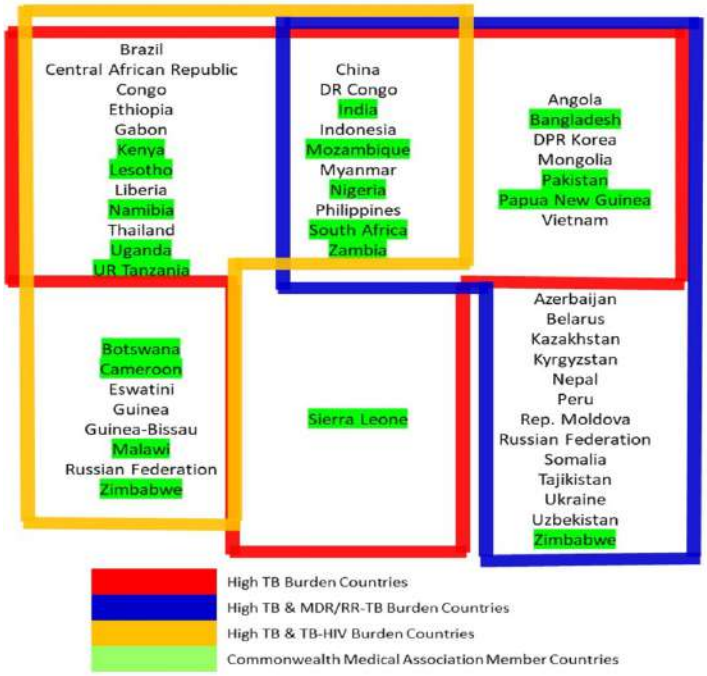
The Commonwealth Medical Association (CMA) is willing to collaborate with the Stop TB Partnership and the Indian Medical Association to conduct a symposium to promote adoption of principles and standards for TB care, and encourage collaboration with respective NTPs, among member associations across high TB burden countries.Countries that can be represented at the symposium are illustrated alongside.

Objectives

The overarching objective of this initiative is to build salience on efforts to end TB among medical associations with substantial private health care provider base or membership, in nations with high TB burdens. Its specific objectives are:

1. Conduct an international symposium for member associations of the Commonwealth Medical Association (CMA) and other national medical associations belonging to select high TB burden countries and where the medical association are well organized and strong.

2. Seek a commitment and plan of action from participating member associations towards advocacy on private sector adoption of principles and standards for TB care.



Activity

A two-day symposium is proposed to be held in Kochi, Indiaon June 1 and 2, 2024. The broad agenda along with expected results from each segment of the symposium is outlined in the table below:

Session Number	***Details***	***Expected Results***
Day 1 / Session 1 INTRODUCTIONS	• Introductions of associations, countries represented, TB burdens, and private provider size • Introduction to the symposium objectives/purpose and proposed follow-up action from participating associations	Understanding of the target audience, and of what is expected from member associations, post symposium
Day 1 / Session 2 GLOBAL TB BURDEN & EFFORTS TO END TB	• Overview of the global and national TB burdens, with country-wise focus on prioritiyareas needing private partnership • Overview of the principles and standards for TB care as applicable to private medical practitioners	Understanding of global and national burdens of TB and of principles and standards for TB care
Day 2 / Session 3 ROLE OF PRIVATE SECTOR IN ENDING TB	• Private health care providers: their role in efforts to end TB, engagement options, lessons learned from global experiences, challenges expected, and recommendations	Clarity on how private health care providers can contribute to ending TB, and the factors impacting their effective engagement
Day 2 / Session 4 WAY FORWARD	• Documenting next steps for associations to act on in their respective professional communities • Recommendations to escalate or open dialogue with NTP managers on effective and acceptable ways to engage with, and enable, private health care providers to adopt principles and standards for TB care in their practices	Consensus on way forward for associations to dialogue with NTP managers, and with their membership base

All the sessions are expected to be participative and interactive, with members sharing national and personal experiences, challenges, learnings and suggestions. Time is allotted for assimilation of information, discussions, and planning of proposed actions, going forward.

Participation

Thesymposium will be held under the umbrella of the STOP TB partnership (PSP constituency) and Indian Medical Association.Invitations to CMA-member medical associations are prioritized by their burden of TB and/or TB-HIV, and/or MDR/RR-TB. The indicative list of invited member associations, the countries they represent, and the type of TB burden of the countryinclude the following:

1. Bangladesh – Bangladesh Medical Association; TB & MDR/RR-TB
2. Botswana – Botswana Medical Association; TB-HIV
3. Cameroon – Ordre National des Médecins du Cameroun; TB-HIV
4. India – Indian Medical Association; TB, TB-HIV, & MDR/RR-TB
5. Kenya – Kenya Medical Association; TB & TB-HIV
6. Lesotho – Lesotho Medical Association; TB & TB-HIV
7. Malawi – The Medical Association of Malawi; TB-HIV
8. Mozambique – Mozambican Medical Association; TB, TB-HIV, & MDR/RR-TB
9. Namibia – Medical Association of Namibia; TB & TB-HIV
10. Nigeria – Nigeria Medical Association; TB, TB-HIV, & MDR/RR-TB
11. Pakistan – Pakistan Medical Association; TB & MDR/RR-TB
12. Papua New Guinea – Medical Society of Papua New Guinea; TB & MDR/RR-TB
13. Sierra Leone – Sierra Leone Medical and Dental Association; TB
14. South Africa – The South African Medical Association; TB, TB-HIV, & MDR/RR-TB
15. Uganda – Uganda Medical Association; TB & TB-HIV
16. UR Tanzania – Tanzania Medical Association; TB & TB-HIV
17. Zambia – Zambia Medical Association; TB, TB-HIV, & MDR/RR-TB
18. Zimbabwe – Zimbabwe Medical Association; TB-HIV & MDR/RR-TBCountries where the professional associations are strong outside the CMA

1. Indonesia
2. Philippines

Countries that may be invited to strengthen CMA intervention

1. Sree Lanka
2. Malaysia
3. Myanmar

CRITICAL APPRAISAL OF THE PROPOSED SCHEME OF NATIONAL EXIT TEST (NEXT)

Dr. Vedprakash Mishra
Dean, Academic and Accreditation Board,
National Indian Medical Association, New Delhi

The core component which needs to be primarily examined is as to whether the entire proposition of NEXT is in conformity with the operational mandate as is brought out in Section 15(1) of National Medical Commission Act, 2019. The said Section clearly stipulates as under:

"15(1) A common final year undergraduate medical examination, to be known as the National Exit Test shall be held for granting licence to practice medicine as medical practitioners and for enrolment in the State Register or the National Register, as the case may be."

Further, Section 15(2) stipulates as under:

"15(2) The Commission shall conduct the National Exit Test through such designated authority and in such manner as may be specified by regulations."

Further, Section 15(5) stipulates as under:

"15(5) The National Exit Test shall be the basis for admission to the postgraduate broad-speciality medical education in medical institutions which are governed under the provisions of this Act or under any other law for the time being in force and shall be done in such manner as may be specified by regulations"

A plain reading of the aforesaid provisions inevitably makes one conclude that a single final Undergraduate Medical Examination would be serving the purpose of licencing as well as admission to postgraduate courses in broad specializations in various medical colleges that come under the ambit of the provisions of NMC Act, 2019 or any other law in force at the given point of time.

In the context of section 15(1) of the NMC Act a grave error of legal wrong stands committed in as much as the final MBBS examination of the MBBS Programme in case conducted by any authority other than the examining/ affiliating University, cannot be computed by the said examining University for the purposes of conferment of the MBBS Degree, as the same would be in contravention of the binding inclusions in Indian Medical Universities Act, 1960 read with University Grants Commission Act, 1956.

The said anomaly is palpable in as much as that all the First Professional, Second Professional, Part-1 and Part-2 of Third Professional Examination would be conducted by the examining / affiliating University on the strength of which the learner would be entitled for the conferment of MBBS degree. However, the material question is the proposed scheme stipulates two examinations styling it as fourth professional examinations in two parts designated as 'NEXT-I' and 'NEXT-II' respectively of which NEXT-I would be a common examination on the basis of MCQs to be conducted by the designated authority / the National Medical Commission in accordance with Section 15(2) of the Act and clearance thereof would entitle the examinee to go ahead for his / her one year rotating internship.

Upon the completion of the said internship the said examinee would be required to appear for NEXT-II examination which would be assessment of the psychomotor skill to be conducted by the examining / affiliating University which would be the licentiate examination and the clearance thereof would be the basis for his / her entitlement to be included in the State Medical Register or the Indian Medical Register as the case may be.

It is NEXT-I which would be availed for the purposes of admission to Postgraduate Courses in broad specialities.

Apart from the implications and complications of the system that have been mooted the material question is under what provisions and mandate of the Act, the NEXT examination is split into two parts as NEXT-I and NEXT-II respectively. How is it and under what mandate it has been named as Fourth Professional Examination, which otherwise is also outside the ambit of the conferment of degree from the point of view of its consideration. What is the validity of NEXT-II being conducted by the same examining / affiliating University which has already cleared and certified him on the very count one year ago. Imagine a situation

where in the very University the learner passes Third Professional Examination successfully and is entitlement for the conferment of the degree but the very University does not find him to be fit for passing one year later thereto in NEXT-II? All these situations and many more are nothing but a consequential creation of non-application of mind and sole attempt at hiding the wrong that has already crept in framing of Section 15(1) of the NMC Act, 2019.

The present mandate is very clear under section 15(2) of the NMC Act, 2019 NEXT will be conducted by the commission and how is it NEXT-II is required to be conducted by the examining / affiliating University. Where is the mandate for the said dispensation?

Contemplate a situation where the learner clears NEXT-I, completes his internship but fails in NEXT-II and therefore is not eligible to seek the registration with the State Medical Council, then what has he achieved with clearing the NEXT-I. Such a chronology so badly ill conceived without authority and jurisdiction is nothing but playing havoc with the fate, future and the lives of the young learners.

As if, the aforesaid dichotomies are not enough yet another dimension which merit huge consideration is that the scheme of examination in terms of the Notified regulation that has binding effect being mandatory in character mandates that 'Theory and Practical Clinical and Viva Voce' are separate heads of passing. The Third Professional Part-II examination can be cleared by any examinee exclusively on clearing the examination of theory and practical separately in all the subjects of examination. It is on clearance of the Part-II of Third Professional Examination that is held in the month of January, the concerned examinee would be eligible to take the NEXT one examination conducted by the National Medical Commission, in the month of March. The failures at the Third Professional Examination would be getting an attempt in terms of a supplementary examination to be held in the Month of February.

The material question is that the examinee who has passed Third Professional Examination both in Theory and Practical alone in terms of the prescribed scheme of examination and binding regulation thereto is entitled to commence his / her rotating internship by seeking provisional registration with the concerned State Medical Council. However, in the present instance the learner is made to begin with his internship after NEXT- Part-I without his examination in Practical Clinical and Viva-Voce which would be held after his / her completion of internship in the form of NEXT-II which would be exclusively conducted for skill assessment by the concerned affiliating / examining University. The premise of letting a learner do his internship without certification of his clearance in practical clinical and viva voce is untenable because such a person would not be entitled to procure his / her provisions registration with the State Medical Council and on the very ground would not be entitled to do his internship for the want of provisional registration.

Yet another dichotomy which is inbuilt in the proposed system is that an examinee in terms of the present stipulations in the governing regulations would be declared as clearing the Third Professional Part-II examination by the examining University exclusively on he / she clearing the theory and practical examinations separately of the concerned subjects. It is a binding rule that an examinee who has availed an examination with the University and has been declared as 'Pass' thereto is barred from taking the same examination not only by the concerned examining University but by any other statutory University in the country. The said binding rule disentitles the learner to take NEXT- Part-II examination by the examining University that has declared him already Pass in the very examination of Part-II of Third Professional Examination.

Further, the proposed scheme provides for a supplementary examination to failures of Third professional Part-II Examination. However, the availability of such supplementary examination in respect of NEXT-Part-I and NEXT-Part-II have not been indicated in the scheme in any manner whatsoever.

As such the entire scheme is not only a bundle of contradictions, impossibilities, untenability and inconsistent with the binding provisions of the NMC Act, itself but it also makes the mockery of the entire medical educational system and the binding governing stipulated procedures in the Universities in the country in terms of the stipulations included in University Grants Commission Act, 1956 as well as Indian Medical Universities Act, 1916. It is difficult to comprehend because the present proposed scheme conveys a picture as if the provisions of the NMC Act 2019 have an overriding effect over the University Grants Commission Act, 1956 and Indian Medical Universities Act, 1916, which is evidently erroneous. As such the very edifice on which the proposed scheme of NEXT is formulated is full of contradictions, fallacies and seems to have been made without any understanding of educational system as in vogue and is more of a imagination in wilderness. In nutshell it is an open invitation unconditionally extended to impending disaster to rule the roost.

CRITICAL APPRAISAL OF THE POSTGRADUATE MEDICAL EDUCATION REGULATION BY NATIONAL MEDICAL COMMISSION

Dr. Vedprakash Mishra
Dean, Academic and Accreditation Board,
National Indian Medical Association, New Delhi

PGMER 2023 – The Good, The Bad, The Ugly Analysis

The Good

Many Good things have been envisaged by the Government in terms of

1. District Residency Program, Clause 5.2 (xv) – Pivotal to Hon. Prime Minister's vision of Ayushyaman Bharat – District Residency Program is a very proactive step by the regulators in terms of accomplishing tertiary care services to the remotest possible sector during pendency of actualization of One Medical College Per District. The program, if implemented in its true essence, can also expose the post graduate residents to a variety of clinical material and real-life handling of the emergencies with limited resources – a quintessential component of the skill training for the residents
2. Early Start to the PG Programs, Clause 3.1 (ii) :The medical college/institution can apply for starting the post-graduate course(s) one year after the medical college/institution has been permitted to start an undergraduate course (i.e. during the second year of the undergraduate course).
3. Recognition of Qualification/ Increase in intake, Clause 3.1 (iv) and 3.2 - Once permitted, the course for the qualification will be considered recognised and seats permitted will be considered as recognised seats for registration of the degree awarded. Medical colleges/Institutions running such courses will be considered as Accredited Medical colleges/Institutions for the said course of qualification. Thus the learner is free of the dilemma while selecting postgraduate seat of her/ his choice and the institute can be benefitted by not having to wait till recognition of earlier granted seats for applying for increase in intakes
4. Leave Rules for Post-graduate Students, Clause 5.5.– A prominent step towards addressing fatigue and mental wellness of the residents
5. Post Doctoral Certificate Courses (PDCC) Chapter 2 Annexure-4 are back -Post Doctoral Certificate Courses started by the erstwhile MCI have made a comeback in these regulations – PDCCs were an important link towards developing a sub specialty trained manpower which is relevant even in the current context

The Bad

1. Many Touch Points – No Specific SOPs – Many good initiatives find a mention in these regulations; however, their SOPs need to be evolved at the earliest. Mere mentioning of the points would not suffice in the vast spectrum of institutes in the country. Just to mention few examples:

a. Clause 5.2 (xiv) : Institutions may arrange training in any other courses like awareness in medical audit, medical law, exposure to human behaviour studies, finance, accounts, etc, which are beneficial to the post- graduate students – Specific guidelines such as credits/ hours/ syllabus missing

b. Clause 5.2 (ii): All post-graduate students will work as full-time resident doctors. They will work for reasonable working hours and will be provided reasonable time for rest in a day.

c. Clause 5.2 (XIII): Application for Proportionate Enhancement of Postgraduate Seats against District Residency Program – SOPs missing

d. Clause 9.1 and 9.2 : For non-compliance or omission, the PGMEB will penalize the medical college/institution – SOPs Missing

2. Clause 11.3: Repeal of PG Medical Education regulation 2000 without providing specific inputs in terms of PG Guide : Student Ratio, Number of Seats permitted per clinical unit, Number of Beds per Unit has potential to create confusions amongst the current applicants who have applied for the start or increase

in intake for PG programs. Thus PGMSR2023/24 needs to be notifies on an urgent basis

3. No Clarity about the applicability whether to the prospective batches or to the current Batches

The Ugly

With due respect to the authors of the said notification following points are a total Juxtapose to spirit and ethos of the Medical Education and its high standards achieved and recognized over a period of time. The pointers mentioned in this section are also in contrast with the International Charter of the medical Education put forth by the WFME and may hamper the Vishwa guru image of the Country in the domain of the medical education.

1. The Research is given a Complete go by.
   a. Clause 5.2 (xi), (xii): While there is a compulsory research methodology and ethics courses introduced in the syllabus the outcome of the same is not assessed. Further there are no specific measures to inculcate the research skills in the PG residents.
   b. Clause 5.2 (x): From initially having a PPP Model (Compulsory Paper Presentation and Poster) it is now either of the three being made compulsory. The sad part being all the three components are complimentary and the substitute to each other.
   c. Clause 8.4: Thesis is no more a separate head of passing: in parlance of higher education MD/MS Qualifications are considered at par with PhD – Thesis being sidelined this may not exist anymore.

2. Dilution of Standards of Examination
   a. Clause 8.2 b : At least two shall be external examiners and least one of them shall be from different university outside the state in place of previous provision both the external examiners from Different University outside the state
   b. Clause 8.4 b: Giving Benefit of Best of the two - All the answer scripts shall be subjected for two valuations by the concerned University. The average of the total marks awarded by the two valuators for the paper, which is rounded o to the nearest integer (whole number), shall be considered for computation of the results. All the answer scripts, where the di erence between two valuations is 15% and more of the total marks prescribed for the paper, shall be subjected to third valuation. The average of the best two total marks, awarded by the three evaluators for the paper, rounded o to the nearest integer (whole number), shall be considered for final computation of the results – It will sabotage the whole process of assessment and hence the earlier provision of the nearest two valuation can be give a thought
   c. Clause 8.4 a: All the teachers of the other colleges of the concerned University or other Universities, who are eligible to be post-graduateexaminers, can perform the valuation of the answerscripts – Should not be permitted to smaller universities like Deemed Universities having two or more colleges under its ambit
   d. The Authors have missed an opportunity to for a credit framework/ Continuous Internal Assessments models so as to have international parity for the PG training in our Country.

3. Clause 3.1 (iii) : Starting of PG Programs at Government run Hospitals Without UG Program - Existing or proposed non-teaching hospitals owned and managed by government can start post-graduate courses without having undergraduate college. This clause has a potential to substantially dilute training of the residents

   – more so in basic sciences

INDIAN MEDICAL ASSOCIATION
HOSPITAL BOARD OF INDIA HQs.

www.imahbi.in; Contact : hbihqima@gmail.com, 8888129007

Secretariat :- Dr.Dinesh B. Thakare, B/H Irwin Hospital, Khaparde Bagicha, Amravati - 444 602, Maharashtra.
IMA HQs. Address :- IMA House, Indraprastha Marg, New Delhi - 110 002

IMA HBI/ INS/03/2024 Date 05.03.2024

Advisory to State IMA chapters and IMA HBI units on the Honble Supreme Court Of India Order on Writ petition (Civil) No 648 of 2020 dtd 27.02.2024.

Dear Sir/ madam,

Greetings

Sub: The Secretary Department of Health Union of India in consultation with the States to come out with a proposal of Standardization of Rates chargeable to the patients by Health Care Facilities.

Ref: 1. Honbl Supreme Court order dtd 27.02.2024 on writ petition civil no 648/2020 (Encl-1).

2. Clinical Establishment (Registration &Regulation) Act 2010 Rules 2012 Section 9 (i) (ii) (Encl-2).

On the basics of the writ petition civil no 648/2020 Referred above Honbl. Supreme Court has directed the Secretary Department of Health union of India to hold meeting with his counterparts in the State govt./ Union Territories to come out with Concrete proposal by next hearing ie April 1st week on standardization of rates chargeable to the patients by Health Care Facilities Based on Rule 9 (i) (ii) of central CEA 2010 rules 2012.

On this Regards IMA (Hqrs) HBI wish to give advisory to all the State IMA & their HBI Units to follow.

1. IMA State units to write & also to meet in person the Secretary of their Respective State Dept. of Health and insist that IMA & their HBI Unit must be involved in any Discussion & Decision there after Regarding the above order from Honbl Supreme Court.
2. Insist that as per the Central CEA or Respective State CEA's there is no provision for standardization of rates and Act. It says only registration & regulation, so do not Accept for any form of Rate Fixation
3. IMA HQS & HBI are impleading in the above case.
4. State units of IMA need not file separate cases as of now.
5. Sensitise all your members not to sign any document related of rate standardization.
6. There are number of Variables in Health Care Cost and is Individual health care unit centric & patient centric.
7. There need to be a scientific methodology to be followed which IMA HBI will share when necessarycont
8. Since IMA Hqrs and HBI are impleading legally in the case kindly get contribution of minimum Rs.5000/ from each health care facility of your state and send to HBI Ac no 90672010071909 Ifsc Code CNRB0019067 Canara bank.
9. Kindly e mail your State CEA urgently to IMA HBI HQ hbihqima@gmail.com

"IMA and HBI Fights for Your Autonomy-Join Hands"

Urgent Appeal for Legal Fund to Challenge Standardization of Charges of Doctors and Private Hospitals

As you may be aware, recent developments in the health care sector have posed significant challenges to the autonomy and integrity of medical professionals and private healthcare institutions across the country.

Specifically, we are referring to the ongoing efforts to standardize charges of Doctors and private hospitals, a move that we firmly believe is

unconstitutional and invalid for several compelling reasons.

First and foremost, Standardization of charges of Doctors and Private Hospitals directly violates Article 19(1)(g) of the Constitution, which guarantees the right to practice any profession, trade, or occupation. By allowing the government or judiciary to determine the professional fees of doctors, this fundamental right is at risk of being violated, under mining the autonomy and livelihoods of medical professionals.

Moreover, Rule 9.ii) of the Clinical Establishment Rules contradicts the

Clinical Establishments (Registration and Regulation) Act, creating a legal ambiguity that needs to be addressed urgently. .

Furthermore, we draw your attention to a previous Supreme Court judgmentinJuly2021, where it was ruled that the government cannot fix rates for non-Covid patients in private hospitals. This landmark ruling upheld the sanctity of private healthcare establishments and recognized the importance of preserving their autonomy in setting prices for their services.

In light of these legal precedents and constitutional principles, we must take a stand against the recent directive from the Supreme Court to standardize treatment charges nationwide. This move not only undermines the autonomy of Doctors and private hospitals butal so fails to consider the diverse healthcare needs and realities across different regions of our country.

This issue requires immediate legal action. We are impleading in this case in the Supreme Court to challenge the standardization of charges.

However, we cannot do this alone. We urgently need your support to finance this judicial fight and ensure that the rights and autonomy of

medical professionals and private healthcare institutions are protected.

Your contribution to this legal fund will make a significant difference in our ability to defend the constitutional rights of medical professionals and uphold the integrity of private healthcare in India. We appeal to your sense of duty and commitment to the medical profession to stand with us in this critical moment.

We request you to donate to the legal fund and spread the word among your colleagues and fellow members of the Indian Medical Association, Hospital Board of India and sister associations in FOMA. Each clinical establishment is requested to donate at least Rs.5000 to the following bank account..

Account Details:-
Name:-IMA Hospital Board of India
Bank :- Canara Bank
Branch:-C.R. Building, I.P. Marg, Delhi
Account Number:- 90672010071909
IFS Code :- CNRB0019067
QR Code :-

केनरा बैंक Canara Bank
भारत सरकार का उपक्रम A Government of India Undertaking
Syndicate

INDIAN MEDICAL ASSOCIATION

200665224071909@cnrb

Together, we can make a difference and ensure that the voice of the medical community is heard and respected in matters that affect our profession and the healthcare system as a whole.

Thank you for your attention and support.

Sincerely,

Dr.A.K.Ravikumar
Chairman, IMA HBI HQs.
9842222404.

Dr.Dinesh B. Thakare
Secretary, IMA HBI HQs.
88881 29007

Dr. K M Abul Hasan
Chairman, IMA JDN

Suicide Rates and Dropout Rates in Medical Students: Exploring Challenges and Solutions

The escalating incidence of suicides & Dropout among medical students in India is a critical issue within our medical education system that demands immediate attention and intervention.

Some common issues include:

1. Failure of Mentorship: Mentor Mente System is there in all colleges but not followed in proper manner. Just for namesake they are having it.
2. Financial Constraints: PG faces financial challenges, especially if they are self-financing their education.
3. High Academic Pressure: Rigorous coursework, demanding clinical rotations.
4. Long working hours, irregular schedules, affecting their mental well-being.
5. Mental Health Struggles: The Academic Stress leads mental health issues such as anxiety, depression and suicides.

The staggering statistics of medical student suicides and dropouts underscore the urgent need to address the pervasive mental stress and harsh working conditions experienced by postgraduate residents. These dedicated professionals endure shockingly long hours, often facing a rude and unsupportive atmosphere as they navigate their training. This toxic combination of factors not only jeopardizes the well-being of residents but also undermines their ability to provide quality patient care and hampers their career development.

Solutions:

Improved mental health support: Increased access to mental health services: Providing readily available, confidential counselling and support systems specifically tailored to the needs of medical students.

Mental health literacy programs: Educating students about mental health, reducing stigma, and encouraging help-seeking behaviour.

Peer support groups: Creating safe spaces for students to connect with peers, share experiences, and build a sense of community and belonging.

Promoting work-life balance:

Advocating for reasonable working hours: Implementing stricter regulations and promoting healthy work practices to prevent burnout.

Encouraging breaks and time for personal well-being: Emphasizing the importance of self-care and leisure activities to maintain a healthy balance.

Flexible learning options: Exploring alternative learning models that accommodate individual needs and circumstances, potentially reducing stress levels.

Addressing academic pressures:

Promoting a supportive learning environment: Fostering a culture of collaboration, mentorship, and constructive feedback instead of intense competition.

Enhancing teaching methods: Implementing innovative and engaging teaching methods to improve learning efficiency and reduce academic burden.

Rethinking assessment strategies: Exploring alternative assessment methods that go beyond standardized tests and focus on holistic development of students' skills and knowledge.

Fostering a supportive medical community:

Promoting open communication and empathy: Encouraging faculty, staff, and peers to create an environment where students feel comfortable discussing challenges and seeking help.

Developing anti-bullying and anti-discrimination policies: Implementing and enforcing policies that create a safe and inclusive environment for all students.

Addressing systemic issues: Recognizing and working to address systemic issues within the medical education system that may contribute to student well-being concerns.

By implementing these solutions and fostering a culture of empathy, support, and well-being, we can work towards reducing suicide rates and dropout rates among medical students, ultimately creating a healthier and more sustainable learning environment for future generations of healthcare professionals.

NOTIFICATION FOR 231ST MEETING OF THE CENTRAL WORKING COMMITTEE OF IMA TO BE HELD ON 13TH & 14TH, APRIL 2024 AT CHENNAI, TAMIL NADU

To,

- All members of the Central Working Committee, IMA
- Ex-officio members of Central Working Committee, IMA

Dear Doctor,

It is notified that the 231st meeting of the Central Working Committee of Indian Medical Association is scheduled to be held on 13th & 14th, April, 2024 (Saturday & Sunday) at Chennai.

VENUE: MGM Beach Resort, Beside MGM Dizzee World, 1/74, SH 49, ECR-603112, Chennai.

Please note that one night accommodation will be arranged for you for attending the above meeting. (13th night)

Accommodation will be provided only to those participants who confirm their participation alongwith their travel itinerary to IMA HQs latest by 10th March, 2024.

TA will be reimbursed as per IMA Rules and only as per fares prevalent as on 5th March, 2024.

13th April, 2024	
12:00 noon to 1:00 pm	Lunch
1:00 pm to 7:00 pm	Central Working Committee Meeting
8:00 pm onwards	Dinner

14th April, 2024	
7:00 am to 9:00 am	Breakfast
9:00 am to 1:00 pm	Central Working Committee Meeting
1:00 pm to 3:00 pm	Dinner

If a Regular CWC Member is unable to attend the meeting, an alternate CWC Member may attend in his/her place. In that case, the official information should be sent to IMA HQs. on or before March 31st, 2024. The information of Alternate CWC members received after March 31, 2024 shall not be considered for the privileges of voting and T.A.

Contact Person of IMA Hqs:

Dr. Shitij Bali
Honorary Finance Secretary, IMA Hqs.
Mobile: +91 9910755660
Email Id: shitij.bali@yahoo.com

Dr. Anilkumar J. Nayak
Honorary Secretary General

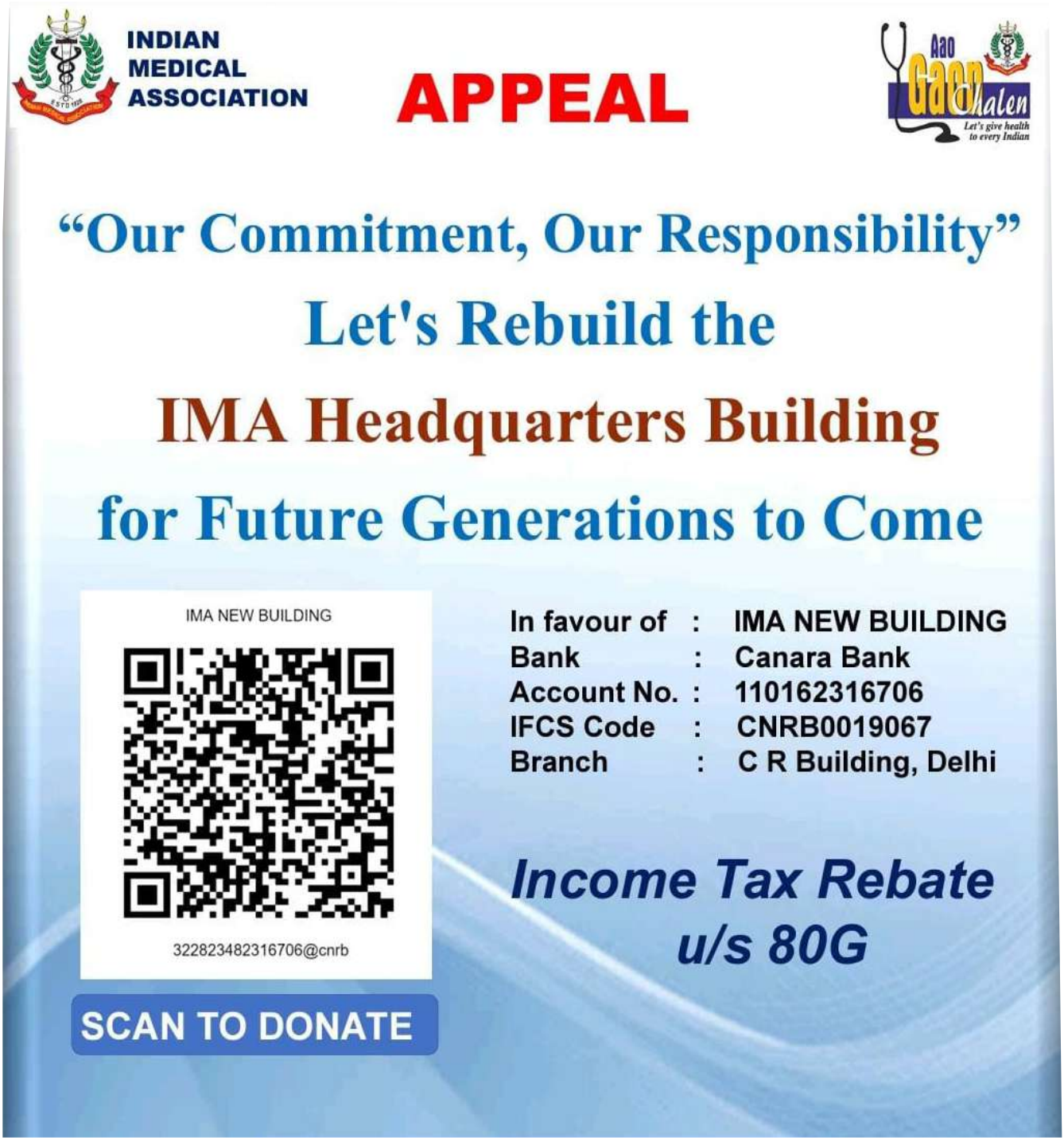
LIST OF DONORS FOR REDEVELOPMENT OF IMA HQs. BUILDING

Sno		Name	Place	State	Amount (Rs)
1	Dr	Ketan Desai	Ahmedabad	Gujarat	5,00,000.00
2	Dr	Abul Hassan	Erode	Tamil Nadu	5,00,000.00
3	M/S	IMA College of General Ptactitioners - Bihar	Patna	Bihar	5,00,000.00
4	M/S	IMA Academy of Medical Specialities-Bihar	Patna	Bihar	5,00,000.00
5	M/S	Board of Trustees, Patna Trust	Patna	Bihar	5,00,000.00
6	Dr	Honorary Secretary	IMA Mumbai West Branch	Maharashtra	5,00,000.00
7	Dr.	S Arul Rhaj	Tuticorin	Tamil Nadu	3,00,000.00
8	Dr	Vinay Aggarwal	East Delhi	Delhi	1,25,000.00
9	Dr	Rajan Sharma	Yamunanagar	Haryana	1,25,000.00
10	Dr	SNP Singh	Patna	Bihar	1,25,000.00
11	Dr	Vijaya Kumar K.	Kanyakumari	Tamil Nadu	1,25,000.00
12	Dr	Shitij Bali	New Delhi	Delhi	1,00,000.00
13	Dr	R Gunasekhran	TRICHIRAPALLI	Tamil Nadu	1,00,000.00
14	Dr	Shiv Kumar Utture	Mumbai	Maharasthra	1,00,000.00
15	Dr	Gutta Suresh	Hyderabad	Telangana	1,00,000.00
16	Dr	G Samaram	Vijayawada	Andhra Pradesh	1,00,000.00
17	Dr.	J A Jayalal	Marthandam	Tamil Nadu	1,00,000.00
18	Dr	Shri Ram Agrawal	IMA Dwarka Branch	Delhi	1,00,000.00
19	Dr.	Arvind Kumar Sharma	Kashipur	Uttaranchal	1,00,000.00
20	Dr	Gyan Vatsa	Dwarka	Delhi	1,00,000.00
21	Dr	Jitendra H Shah	Ahmedabad	Gujarat	1,00,000.00
22	Dr	Ramesh Kumar Datta	Westown	Delhi	51,000.00
23	Dr	Anil Aggarwal	Westown	Delhi	51,000.00
24	Dr	Alok Bhandari	Westown	Delhi	51,000.00
25	Dr	Naresh Chawla	DNZ	Delhi	51,000.00
26	Dr	Vinod Monga	East Delhi	Delhi	51,000.00
27		City X-Ray and Scan Clinic Pvt Ltd	Dwarka	Delhi	51,000.00
28	Dr	Narendra Saini	East Delhi	Delhi	50,000.00
29	Dr	Dev Raj Rai	East Delhi	Delhi	50,000.00
30	Dr.	Arvind Nath	ICMR	Delhi	50,000.00
31	Dr	Vinod Khetarpal	Westown	Delhi	31,000.00
32	Dr	R N Tandon	Karol Bagh	Delhi	31,000.00
33	Dr	R V Asokan	Punalur	Kerala	30,000.00
34	Dr	Shobha Ahuja	IMA Mumbai West Branch	Maharashtra	25,000.00
35	Dr	Jayesh M Lele	IMA Mumbai West Branch	Maharashtra	25,000.00
36	Dr	Praksh Lalchandani	Dwarka	Delhi	21,000.00
37	Dr	Mukesh Verma	Dwarka	Delhi	21,000.00
38	Dr	Anil Goyal	East Delhi	Delhi	21,000.00
39	Dr	Vibhavri	IMA Westown Branch	Delhi	21,000.00
40	Dr	Kanav Anand	Karol Bagh	Delhi	11,000.00

Sno		Name	Place	State	Amount (Rs)
41	Dr.	Junu Sankhla	Karol Bagh	Delhi	11,000.00
42	Dr.	Sanjay Mahindru	IMA Dwarka Branch	Delhi	11,000.00
43	Dr.	Bharti Seth	IMA Dwarka Branch	Delhi	11,000.00
44	Dr.	Satish Sangwan	IMA Dwarka Branch	Delhi	11,000.00
45	Dr.	Ankur Jain	IMA Dwarka Branch	Delhi	11,000.00
46	Dr	Piyush Ranjan	Dwarka	Delhi	11,000.00
47	Dr	Ajay Kumar Gupta	East Delhi	Delhi	11,000.00
48	Dr	Sanjay Garg	East Delhi	Delhi	11,000.00
49	Dr	Neelam Lekhi	East Delhi	Delhi	11,000.00
50	Dr	M K Saxena	East Delhi	Delhi	11,000.00
51	Dr	P D Garg	East Delhi	Delhi	11,000.00
52	Dr	Sushil Kumar Vimal	East Delhi	Delhi	11,000.00
53	Dr	Ajay Lekhi	East Delhi	Delhi	11,000.00
54	Dr	Shama Batra	East Delhi	Delhi	11,000.00
55	Dr	Preeti Gaur	East Delhi	Delhi	11,000.00
56	Dr	Kumar Gandhi	East Delhi	Delhi	11,000.00
57	Dr	Ashok Sharma	East Delhi	Delhi	11,000.00
58	Dr	V K Goyal	East Delhi	Delhi	11,000.00
59	Dr	Piyush Jain	East Delhi	Delhi	11,000.00
60	Dr	Padma Iyer	Pune	Maharasthra	10,001.00
61	Dr	Shamik Chakraborty	Karol Bagh	Delhi	10,000.00
62	Dr	Pushpinder Khurana	Karol Bagh	Delhi	10,000.00
63	Dr.	Dinesh Larohia	Karol Bagh	Delhi	10,000.00
64	Dr.	Rajesh Jagga	Karol Bagh	Delhi	10,000.00
65	Dr.	Ankush Sabharwal	Karol Bagh	Delhi	10,000.00
66	Dr.	Nijhara	Karol Bagh	Delhi	10,000.00
67	Dr.	Ashok Tuli	Karol Bagh	Delhi	10,000.00
68	Dr.	Ajay Kumar	Patna	Delhi	10,000.00
69	Dr.	Pankaj Taneja	IMA Dwarka Branch	Delhi	10,000.00
70	Dr.	Nipun Sharma	IMA Dwarka Branch	Delhi	6,000.00
71	Dr.	G B Arora	IMA Dwarka Branch	Delhi	5,100.00
72	Dr.	Suresh Kumar Dargan	IMA Dwarka Branch	Delhi	5,100.00
73	Dr.	R K Pandey	IMA Dwarka Branch	Delhi	5,100.00
74	Dr	Ashish Pitale	Dwarka	Delhi	5,011.00
75	Dr	Amit Kumar Tyagi	Dwarka	Delhi	5,001.00
76	Dr.	Ashwani Kapoor	Karol Bagh	Delhi	5,000.00
77	Dr.	Pradeep Suri	Karol Bagh	Delhi	5,000.00
78	Dr.	Ashok Damir	Karol Bagh	Delhi	5,000.00
79	Dr.	Rashmi Garg	IMA Dwarka Branch	Delhi	2,000.00
80	Dr.	Sanjeev Divyadarshi	IMA Dwarka Branch	Delhi	1,111.00
81	Dr.	Madhulika Sinha	IMA Dwarka Branch	Delhi	1,111.00
82	Dr.	Gajveer Singh	IMA Dwarka Branch	Delhi	1,100.00
			Total		**58,42,635.00**

ADDITIONAL LIST OF IMA MEMBERS WHO DONATED THEIR TRAVEL ALLOWANCE FOR THE REDEVELOPMENT OF IMA HQs. BUILDING.

Sr. No.	Name	State	Sr. No.	Name	State
25	Dr. Shobha Ahuja	Mumbai	30	Dr. Ketan K Mehta	Maharashtra
26	Dr. Rashmi Mehta	Mumbai	31	Dr. Saurabh Sanjanwala	Maharashtra
27	Dr. Pradeep Padwal	Goa	32	Dr. Sanjay Dudhat	Maharashtra
28	Dr. Bakulesh Mehta	Maharashtra	33	Dr.K.Vijayakumar	Tamilnadu
29	Dr. Rohini Badwe	Maharashtra			



BRANCH ACTIVITIES

BRANCH ACTIVITIES

दूरभाष/Phone : 25367033, 25367035, 25367036
फैक्स/Fax : 0091-11-25367024
ई-मेल/E-mail : pgmeb section@nmc.org.in

पॉकेट -14, सेक्टर-8, द्वारका, फेस1-, नई दिल्ली77-
Pocket- 14, Sector- 8, Dwarka,
Phase – 1, New Delhi-77

राष्ट्रीय आयुर्विज्ञान आयोग
National Medical Commission
स्नातकोत्तर आयुर्विज्ञान शिक्षा बोर्ड
Post Graduate Medical Education Board (PGMEB)

F.No. N-P018(20)/7/2023-PGMEB-NMC Dated:20.03.2024

Public Notice

Subject: **NEET PG-2024 – reg.**

In a meeting held by the Post Graduate Medical Education Board (PGMEB), National Medical Commission with Medical Counseling Committee, Directorate General for Health Sciences and National Board of Examinations for Medical Sciences, the following timeline has been decided with regard to conduct of NEET PG-2024:-

i. Conduct of NEET PG-2024: 23 June 2024
ii. Declaration of result: by 15th July,2024
iii. Counselling : 5th August 2024-15 Oct 2024
iv. Start of academic session: 16th Sep 2024
v. Last date of joining: 21st Oct 2024

2. It has also been decided that the cut off date for completion of internship to become eligible for NEET PG-2024 is 15th August 2024.

3. All candidates desirous of taking the NEET PG-2024 are requested to take cognizance of the above dates.

(Aujender Singh)
Deputy Secretary, PGMEB

Copy To:

i. Member EMRB and Head of Media Cell with a request to give it wide publicity
ii. Director IT, with a request to get the public notice uploaded on website

INDIAN MEDICAL ASSOCIATION

Aao Gaon Chalen
Let's give health to every Indian

NATIONAL SAFE MOTHERHOOD DAY

11TH APRIL 2024

"Safe Motherhood: Nurturing Lives, Ensuring Health!"

Dr. Sharad Kumar Agarwal
Imm. Past National President

Dr. R V Asokan
National President

Dr. Ketan Desai
Chief Patron, IMA
Past President-IMA, WMA & MCI

Dr. Anilkumar J. Nayak
Hony. Secretary General

Dr. Shitij Bali
Honorary Finance Secretary

R.N.I No. : 14447/1967
Date of Publication 7-8th of the same month
Date of Posting 28-29 Same Month

Postal Registration No. DL-(C)-01/1385/2024
Posted at LPC Delhi RMS Delhi - 110006

Dr. Ketan Desai
Chief Patron
Past President, WMA, MCI & IMA

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IMA Dream Project

Aao Gaon Chalen

Let's give health to every Indian

All branches are requested to adopt one village

Dr. R. V. Asokan
National President

Dr. Anilkumar J. Nayak
Hony. Secretary General

Dr. Shitij Bali
Hony. Finance Secretary

Dr. Bipin M. Patel
Chairman, IMA Standing Committee for Aao Gaon Chalen

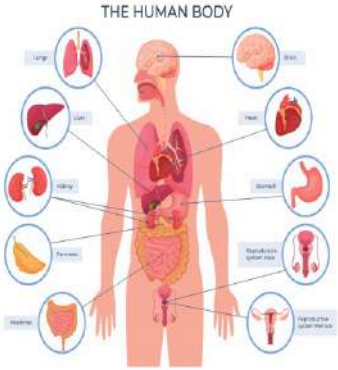
Dr. V. K. Monga
Convenor, IMA Standing Committee for Aao Gaon Chalen

"LIVE LIFE, PASS IT ON"

"Be a Hero, Be an Organ Donor"

अंगदान, जीवन का महादान

- सभी उम्र के लोग अंग और देह दान कर सकते है
- एचआईवी, कैंसर और सक्रिय टी.बी. रोगी दान नहीं कर सकते
- HBsAg और HCV मरीज अपने ही प्रकार के मरीजों को दान कर सकते हैं



- 500000 people die because of non-availability of organs.
- 200000 people die of liver disease.
- 50000 people die from heart disease.
- 150000 people await a kidney transplant but only 5000 get one.
- 1000000 people suffer corneal blindness and await transplant.
- In India 6000 people die every day waiting for organ transplant.
- Every 17 minutes someone die waiting for transplant.
- Every 13 minutes someone is added to a waiting list.

- 500000 लोग अंगों की अनुपलब्धता के कारण मर जाते हैं।
- 200000 लोग लीवर की बीमारी से मरते हैं।
- 50000 लोग हृदय रोग से मरते हैं।
- 150000 लोग किडनी ट्रांसप्लांट का इंतजार करते हैं लेकिन केवल 5000 को ही किडनी ट्रांसप्लांट मिल पाता है।
- 1000000 लोग कॉर्निया अंधापन से पीड़ित हैं और प्रत्यारोपण का इंतजार कर रहे हैं।
- भारत में हर दिन 6000 लोग अंग प्रत्यारोपण के इंतजार में मर जाते हैं।
- हर 17 मिनट में एक व्यक्ति प्रत्यारोपण के इंतजार में मर जाता है।
- हर 13 मिनट में किसी को प्रतीक्षा सूची में जोड़ा जाता है।

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