Unite the
Fraternity
Enrich the
Society

MAHAHOSPICON 2018

Maharashtra State Conference of IMA Hospital Board of India

IMAFEST 2018

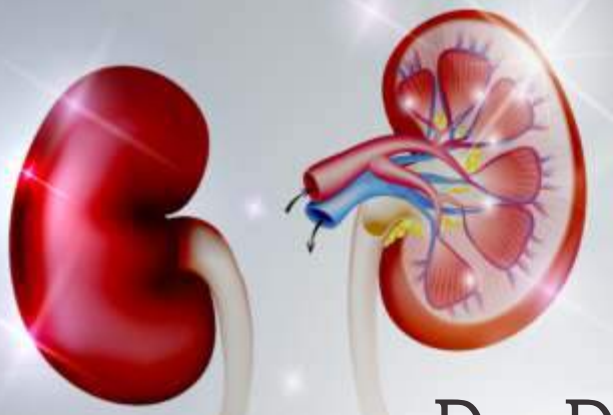
19th Annual Conference of IMA Dombivli

1st & 2nd December 2018 at Dombivli Gymkhana, MIDC, Dombivli (E)

Organised by : **IMA Maharashtra State** | Hosted By : **IMA Dombivli**

SOUVENIR

Editors : Dr. Archana Pate | Dr. Suchitra Kamat



Dr. Dinesh P. Mahajan

MD (Medicine, JJH), D.M. (Nephrology, K.E.M. Hospital)
Consultant Nephrologist & Kidney Transport Physician

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Message from IMA National President

Dr Ravindra Wankhedkar
National President, IMA

It is very heartening to note that MAHAHOSPICON/ IMAFEST 2018 will be held on 1st & 2nd December 2018 by IMA Dombivli Branch.

Your branch has been one of our active arms. The Strength of any organization comes from its periphery and IMA is proud to have an active and vibrant branch like yours.

The medical science and technology is developing so fast that it has become very important for the doctors to keep abreast of the latest developments in medical science, so as to be able to pass on the benefits of latest advances to the people - especially in rural areas.

I hope that this Conference will bring together academicians and practicing doctors to a common platform so as to exchange ideas and stimulate discussions on current problems – to be able to develop strategies in the field of monitoring the performance of medical system. The deliberations at the conference will enhance the knowledge and expertise of the participants on latest advancements in the field of medicine and medical technology.

The medical profession has since time immemorial been regarded as a Noble profession. The doctors continue to perform their sincere duties for the prevention and cure of diseases. IMA Maharashtra State Branch has been at the fore front in the pursuit of these objectives and deserves our heartiest congratulations.

Quality medical education & quality health care are prime objectives of our association. In this regard IMA HQ stands upright in its principles without any compromise. At the same time IMA is concerned and committed towards common man's health needs.

As everyone is aware IMA is striving hard to change the opinion of government towards the medical profession. I expect the same fighting spirit and solidarity from all state and local branches of IMA. I will appreciate if everyone takes efforts to appraise and convey the concerns of our fraternity to local political leaders and legislative members.

I congratulate Branch President Dr. Archana Pate, Secretary Dr. Vandana Dhaktode & Team IMA Dombivli for organizing this great conference. I wish the Conference a grand success.

Long Live IMA!

Message from IMA HBI National Chairman

Dr R V Asokan

Chairman IMA Hospital Board of India, HQ

IMA HBI MS chapter is the jewel in the crown of HBI. Maharashtra State chapter has been nurtured by stalwarts of IMA HBI. Rightfully IMA HBI is headquartered in Maharashtra. The growth of this nascent wing of IMA in Maharashtra is a text book study case of any organisation. The team work and the enthusiasm displayed are infectious on other states. I congratulate Dr Archana Pate, President of IMA Dombivli branch and Dr Mangesh Pate, the organising committee Chairman for their exemplary efforts for the successful conduct of this conference. I congratulate all the members of the organising team.

Message from Hon. Secretary IMA HBI HQ

Dr. Jayesh Lele
Hon Secretary, IMA HBI HQ

IMA DOMBIVALI is hosting the Conference MAHAHOSPICON 2018 along with IMAFEST 2018.

This conference has special features related to Hospital issues, as today the scenario of managing any healthcare establishment is changing. Delegates will have very useful knowledge about solving these problems.

The scientific sessions are very interesting and innovative. Cultural events shall be bonus for the delegates. TEAM IMA DOMBIVALI has taken lots of efforts for this conference. I am sure the conference will be a great success.

Best wishes to TEAM IMA DOMBIVLI!

I am sure IMA DOMBIVLI in future will continue its good work and attain newer and higher achievements.

Message from President IMA MS (2017-18)

Dr. Y. S. Deshpande
President IMA MS (2017-18)

Greetings from Maharashtra State IMA !

We have seen changes in the healthcare scenario and not always for the best. Issues that have been around since long keep changing their outfit. How do we deal with these problems as an organization? I tend to look for answers from within and lessons teach us to move forward. Doctors are problem solvers by nature; however we alone cannot be a cure-all for the multitude of current injustices single handedly. We can do it as an organization together.

It is my hope to eventually create safe environment for doctors & to continue our mission to be a voice for the fraternity.

I welcome all the delegates to this wonderful conference of IMA HBI on behalf of IMA Maharashtra State. I congratulate IMA Dombivli for MAHAHOSPICON, another feather in the cap for a wonderful branch of IMA! My best wishes to the organising chairman and the entire team of MAHAHOSPICON for the success of this conference!

Best Wishes!

Long Live IMA !!

Message from President IMA MS (2018 -19)

Dr. Hozie Kapadia
President IMA MS (2018 -19)

I am happy to know that MAHAHOSPICON 2018 Conference is being organized by IMA Dombivli Branch.

IMA hospital board of India has come a long way since its inception. It has conducted a lot of NABH programs & hands on training in hospital practice.

I wish the conference all the success.

Message from Hon. State Secretary

Dr. Parthiv Sanghvi
Hon. Secretary IMA MS

It gives me immense pleasure in writing for a conference which is one of its kind and a game changer. Hospital Board of India is the most sought after branch of IMA today. And the itinery of the conference speaks for itself. With such interesting topics on board, it does not take anything more to lure delegates to this academic feast. If one is armed with the skills taught here, I am sure it will really be a boost in clinical practice.

IMA Dombivli has been known for its hospitality and I am sure, the vibrant team under the Presidency of Dr. Archana Pate will leave no stone unturned to see that the memories of this conference linger with us for years together.

Wishing you all the best!

Message from Chairman, IMA HBI MS

Dr. Dinesh B. Thakare
Chairman, IMA HBI MS

Dear delegates,

Welcome to MAHAHOSPICON 2018, the Conference of IMA HBI MS Chapter...

IMA HBI MS Chapter is working relentlessly since its inception to tackle issues of hospitals. We have adopted three steps strategy to deal with the issues…

1. Identify & Define Issues Faced By Hospitals
2. Study Facets of Each Issue
3. Come Out With A Solution or Guideline or Mode of Further Action….

No one else will do this for us, we ourselves have to do it. All of us divide and give time to patients, family, friends, hobbies, etc. To build up image of our profession, thereby ourselves, we should donate some time to our association also.

We have identified 18 different issues faced by hospitals and formed 18 committees for these issues. But, many more efforts need to be put in a right way.If each and every member decides to contribute, accepts a work in area of his interest and takes at least one responsibility, nothing is impossible.

I am sure MAHAHOSPICON 2018 will give us direction, clear our vision and imbibe camaraderie in us so as to achieve aims & objectives of IMA Hospital Board of India.

I am grateful to Dr.Archana Pate madam and Dr. Mangesh Pate sir for holding this conference and to organising committee including Dr.Vandana Dhaktode, Dr.Sunit Upasani, Dr.Niti Upasani, Dr.Makrand Ganpule, Dr.Utkarsh Bhingare & Dr.Meena Pruthi, for pouring in efforts to make it successful.

Jai IMA.

Message from Organising Chairman,
MAHAHOSPICON, IMAFEST 2018

Dr Mangesh Pate
Organising Chairman, MAHAHOSPICON / IMAFEST 2018

I am very pleased to welcome you all to the MAHAHOSPICON / IMAFEST 2018 - Conference of IMA Mahatashtra State Hospital Board of India & Annual Conference of IMA Dombivli.

The title of this year's Conference, "Unite the Fraternity, Enrich the Society" reflects our mission to contribute to unity and progress of the medical fraternity. It reflects our collective desire to represent, speak for, and protect the interests of all those in our fraternity whose voices are too often quelled or ignored.

This conference is an academic feast and it also throws light on all important fraternity issues. This event will enable the exchange and dissemination of useful information about various everyday problems of hospitals.

I look forward to the discussion on all important topics and issues. All ideas & suggestions are welcome and important. We are here to identify and promote solutions to the issues.

I congratulate the entire organizing team of IMA Dombivli for the untiring efforts & perfection in organizing this event. The meticulous planning will surely make this event one of the most memorable one!!

Again I welcome all delegates for this mega event MAHAHOSPICON / IMAFEST 2018 and I hope everyone takes back with them happy memories of the conference!!

Thank you.

Long Live IMA.

Message from President, IMA Dombivli

A warm welcome to everyone for this IMA Maharashtra State Conference of Hospital Board of India – **MAHAHOSPICON 2018**. It's an absolute honor to host such a prestigious conference and welcome such esteemed guests!! IMA Dombivli is also celebrating its annual festival – **IMAFEST 2018 -** the 19th Annual Conference of IMA Dombivli, which is celebrated every year with great fanfare!

IMA Dombivli has always remained on the forefront in stepping new stones and setting landmarks! This is the 4th consecutive major conference which is being hosted by IMA Dombivli. It started with IMA HBI National Conference 'VIBRANCE' in 2015, IMA Maharashtra State Women Doctor's wing Conference 'EVECON' in 2016, IMA Thane District Conference 'IDICON' in 2017 and now 'MAHAHOSPICON'!! With its unparalleled and unmatched hospitality, all events hosted by team IMA Dombivli are intricately woven and flawlessly executed!!

IMA Dombivli has also remained in the forefront in doing social and philanthropic work. In last 4 years, IMA Dombivli has undertaken multiple projects of Mission Pink Health (anemia Prevention and eradication program), Aao School Chalein (School Health educational and medical check-up), Project Aadhar (Old age Home health check up), Community education programs, Project Sanjeevan (Life support training Programs for medical / non medical People), Organ Donation Awareness drives, Blood Donation camps and many more…we are committed to doing good work for the community.

This year IMA Dombivli has undertaken **Pre Conference workshop on ICU Management for Non Intensivists**. The main objective of the workshop is to be able to identify and handle a deteriorating patient in your set up. There have been multiple such educational workshops this year – American Heart association certified Basic Life Support workshops, ECG and treadmill test workshop, Nursing communication workshop, multiple CMEs and many more and we will continue to have many such wonderful programs in future as well.

This souvenir is compiled keeping in mind the various problems faced by hospital owners / medical practitioners in day to day practice and hence an attempt has been made to compile a book having all necessary acts / provisions / rules which are applicable to us as medical practitioners.

We announce our next grand event – IMAFEST 2019 – the 20th annual conference of IMA Dombivli on 30th November and 1st December 2019 and it is my sincere request to all delegates to take advantage of the early bird registration offer.

Once again, on behalf of the entire IMA Dombivli Family and Team MAHAHOSPICON / IMAFEST 2018, I welcome everyone to this gala event. My sincere thanks to everyone who worked relentlessly to make this conference a grand success, Thank you to all the sponsors of the event and my sincere gratitude to all dignitaries and delegates for gracing this event with their esteemed presence! Hope everyone enjoys the event as much as we enjoyed putting it together.

Long Live IMA!!

Dr. Archana Pate
President, IMA Dombivli

Message from Hon. Secretary, IMA Dombivli

Dr. Vandana Dhaktode
Hon. Secretary, IMA Dombivli

IMA Dombivli has always been on the forefront in taking up new and challenging projects. For 4 consecutive years, IMA Dombivli has organized excellent conferences of state and National level. This time, IMA Dombivli is hosting MAHAHOSPICON 2018, Maharashtra State conference of IMA HBI along with IMAFEST 2018 , its 19th Annual Conference on 1st and 2nd Dec at Dombivli Gymkhana.

Every year we strive hard to bring something new to the conference. This year, for the first time we have pre-conference workshop on 30 Nov on ICU management for Non intensivist Doctors and on the same evening, we have our gala cultural event NAVRANG where the entire IMA family will bond together.

I'm sure the scientific sessions will be enjoyed by everyone and the panel discussions will give fruitful insights to everyone regarding day to day problems.

Our next year's conference IMAFEST 2019 is announced on 30th November and 1st December 2019. The registrations for the same have already begun. We request everyone to register at the earliest and avail the early bird registration offer. We promise to make IMAFEST 2019 an event to remember!!

The entire Organizing Committee chaired by Dr Mangesh Pate, co chaired by Dr Archana pate along with Dr Niti Upasani, Dr Makarand Ganpule, Dr Meena Pruthi, Dr Uttkarsh Bhingare and others have toiled hard to make this conference successful. On behalf of IMA Dombivli, I welcome everyone to this grand event - MAHAHOSPICON / IMAFEST 2018. Please do share your experiences with us on imadbl2010@gmail.com. For any queries or any issues, please feel free to contact any member of the organizing team…

Ayushman Bharat - Bane or Boon

Dr. R.V.Asokan
Chairman, IMA HBI HQ
Hon. Secretary General Elect IMA HQ

For years IMA has been pushing the agenda of Health to the fore. Politicians ignored Health due to lack of commensurate electoral gains. At last the moment for Health has arrived with the launching of Ayushman Bharat. Unfortunately in its current format it will eliminate modern medicine from care and decimate private clinics and small and medium private hospitals.

WELLNESS CENTERS

The 1,50,000 wellness centers are expected to be manned by mid level practitioners. No one knows who they will be. It can be any non medical person with dubious training or worse a person from AYUSH. Wellness centers are infact our sub centers. Creation of wellness centers effectively mean dismantling of the current primary Health centre structure. These sub centers are the forward posts of modern medicine into the community providing preventive and primary care. They carry the burden of antenatal care, vaccination, House visits, surveillance and Health awareness . All National Health Programmes require these foot prints near the people.

IMA is willing to partner the Government in Wellness centres if the Government wishes to provide services under a medical doctor. Clinical services from clinicians will ensure patient care and safety. Non clinicians providing clinical care will actually be part of the problem rather than a solution. IMA is also concerned that the sub-centres which were created for public Health aims are being converted into dispensaries. In fact, a parallel system is being evolved.

NHPS

The money allotted for the National Health Protection Scheme would have better served the nation if every Government District Hospital had been strengthened with an infrastructure of Rs 2 crores each. The highly optic NHPS fails to create any new national asset. The same money invested in our public hospitals would have brought secondary and tertiary care closer to poor in our Government hospitals. In addition to non creation of new public sector hospitals the scheme will lose around Rs 400 corers to private health insurance companies to manage the scheme. The insurance driven healthcare is a failed experiment.

IMA is of the firm opinion that the way forward for the country is to invest in our Government hospitals for better health infrastructure and manpower. 14 % of the GDP of USA is expended on Health. Yet 20 % of the American population do not have any health coverage due to the highly wasteful insurance model. The current policy change in India will only end up strengthening the insurance business. Moreover, fragmented approach to healthcare is unfortunate.

IMA has suggested to the Union Government that NHPS should be modelled as Health care purchase directly from the provider hospitals removing the insurance companies and Third Party Administrators. These intermediaries siphon off 40 % of the budgeted money and are breeders of corruption and unethical practices. Such a direct model without insurance companies and TPAs was envisaged by the High power expert group constituted to study Universal Health Coverage.

Apart from such conceptual deficits the operational flaws of the scheme will ensure it as a non starter. The rates quoted by the Government are abysmal and impracticable. Most of them do not cover even 30 % of the cost of the procedure. No hospital can work on these rates without seriously compromising patient safety. In the garb of cost cutting the Government is exposing the people to danger in the hospitals. Caesarean sections underwritten for Rs 9000/- cannot ensure safety of the mother and the child. Safe confinement will require quality drugs as well as services of an Anaesthetists and Paediatrician. The Government has ordered for costing of the procedures as an afterthought after announcing the rates, IMA demands that the costing undertaken be transparent and be in public domain.

GAPS

1. **Insufficient funds allotment**

   a) If the funding has to be raised to atleast CGHS level then money required is around 1,60,000 crores. The money being provided now is 12,000

crores. It is not possible to deficit finance any programme to this level. The huge gap in funding will result in mediocre services at the ground level and wide spread corruption . It is either a non starter or could face collapse in the very first year. (Annexure 1 and 2)

b) Insufficient fund allotment is the root cause of unrealistically low package rates. Because of unsustainably low rates there is lack of enthusiasm in empanelling of private hospitals. (Annexure 3)

c) If empanelling was only about public hospitals, there was no need to raise the expectations of the public. When the people become aware that the services are mainly from Government hospitals the possibility of negative backlash is very real. The services are anyway free in public hospitals already. Then it only boils down to transferring the money to public hospitals for their services. The common man does not really feel the benefit. With the work pressure and patient load increasing in Government hospitals , the services will be stressed and will lead on to wide spread dissatisfaction.

2. **Lack of creation of Health infrastructure**

The scheme is all about demand side. There is absolutely nothing that is being added to the national Health infrastructure either in the Government sector or in the private sector. Ideally there should be a judicious mixture of supply and demand sides .

3. **Lack of creation of new jobs**

The myth that is being created that AB-NHPS will create millions of jobs is patently untrue. Government have not provided for any new job creation. Private Health sector has so much surplus unused capacity that the entire volume load will simply be absorbed without any additional job creation.

4. **Open to misuse and corruption**

Most of the states have opted for trust model. Such model in Arogyasree schemes of Telengana and Andhra Pradesh have created huge dens of corruption . Every single step is available for purchase and the system is heavily stressed . It has also been identified that the agent posted in every hospital called Arogya Mithram is the final common path way for all malpractices.

5. **Potential elimination of small and medium hospitals.**

Small and medium neighbourhood hospitals are holding the health care cost low in our country. With AB NHPS, the most disruptive initiative in Health sector they are left with the Hobson's choice of not joining and loosing clients or joining at rates much below their sustainability levels. IMA is apprehensive that AB NHPS will wipe away the small and medium hospitals.

SOLUTIONS

a) **To broad base service delivery**

1. The easiest way to move forward is to increase the number of service outlets so that there is atleast one hospital in each taluk which can provide secondary care and one hospital in each district which can provide tertiary care. No such geographical strategy has been enunciated.

2. Another strategic move is to involve more and more small and medium hospitals. Proactive identification and involvement of such hospitals has to be done on war footing. These hospitals may be able to provide exclusive NHPS services provided their viability can be guaranteed . It is possible to rope in considerable number of small hospitals and nursing homes especially in aspirational districts and rural areas to function as exclusive NHPS outlets.

b) **To include primary care in NHP**

Non inclusion of primary care in NHPS is a serious gap in its conceptualisation. It can be argued that wellness centers are being equipped for the same. Wellness centers to be enabled to provide primary care will require huge investment in infrastructure and human resources. This will not be possible in short team. The easiest route to primary care in door step is to empower the clinics and the less than ten bed hospitals. These are easy to recruit on retainer basis and again can be converted into exclusive NHPS centers.This will be similar to NHS model of UK. More over with non inclusion of primary care in NHPS, such patients will move over to secondary care centers thereby increasing the expenditure.

c) **Option to co pay**

Among the schemes enlisted above Arogya Karnatak Yonjne is relatively successful. It can be seen that the scheme is also efficiently serving a larger population with lesser expenditure. The essential difference is the provision for co payment. This is an important option if NHPs should survive.

To sum up, to improve satisfaction of people who use AB--NHPS following steps have to be taken:

1. Broadbase the number of hospitals that are involved
2. A geographical strategy of providing service uniformly in every taluk has to be evolved simultaneously
3. Priority involvement of small and medium hospitals as exclusive outlets.
4. Inclusion of primary care in AB NHPS
5. Increase the package rates immediately atleast up to CGHS rates
6. Evolve a dynamic and transparent costing and pricing system
7. Government and Hospital interface to be entirely online eliminating points of corruption like Arogya Mithran.

Annexures

1) Comparison of different schemes
2) AB NHPS Allocation requirements
3) Comparative Rate of ten procedures

Annexure 1

Scheme	Coverage	Beneficiaries	Families	Allocation/Exp	Per Capita/Exp	Copay	Co-Contribution to Pool
CG RS/MSBY	50,000	2.6 Cr	0.55-0.60 Cr	450 Cr	176	No	
CGHS	No Limit	0.3 Cr		1300 Cr	4333	No	
Ayusman Bharat	5,00,000	50 Cr	10 Cr	Exp 10000-12000	240	No	
Swasthya Sathi	1,50,000-5,00,000	2.5 Cr	0.45 Cr	1365 Cr	546	No	
Arogya Karnatak Yonjne	30,000-1,50,000	6.5 Cr	1.4 Cr	870 Cr	134	APL 70%, For upgradations also	Rural 300 Urban 700
ESI	No Limit	8.28 Cr		6113 Cr	738	No	
Group Mediclaim	Optional	5.7 Cr		11621 Cr	2039	Yes	
Individual Mediclaim	Optional	2.87 Cr		10353 Cr	3607	Yes	

Annexure 2

AB NHPM Allocation Requirments

(Population X Enrollment Factor X Utilization Factor X Avg Hospitalisation Exp X Hospitalization Rate)+ Admin Cost

	Scenario I	Scenario II	Current Allocation	Scenario III	Scenario IV
Populaiton Under Cover	50,00,00,000	50,00,00,000	50,00,00,000	50,00,00,000	50,00,00,000
Index Year for Hosp Exp	2014	2018	-	2014	2018
Avg Hospitalization Exp Rural/Urban	19686	29323	9227	19686	29323
Enrollment Ratio	85%	85%	85%	100%	100%
Utilisation ratio	85%	85%	85%	85%	85%
Hospitalization Rate	3%	3%	3%	3%	3%
Hosp Exp Reqd (InCr) (A)	21335	31779	10000	25100	37387
Admin Cost(B) ?	15%	15%	15%	15%	15%
Allocation Reqd (A + B) In Cr	24535	36546	11500	28865	42995

Note

1 Hospitalization Rate will increase over the years 3-6%
2 Inflation Considered: CAGR 10.12% Rural, CAGR 10.69% Urban based on NSSO Data
3 Current Allocation of 10-12 K Cr Brings Hosp Exp to 9-10K which is almost third of current Hosp Expenditure
4 Avg Hospitalization Expenditure taken From NSSO Data

Annexure 3

SNO	Case Description	Ayushman Rate	IMA Tamil Nadu COSTING Rate
1	ADENOTONSILECTOMY	8,000.00	38,902.00
2	TOTAL KNEE REPLACEMENT	80,000.00	1,47,789.00
3	LSCS	9,000.00	57,515.00
4	INGUINAL HERNIA	10,000.00	53,669.00
5	LAP APPENDECTOMY	18,000.00	51,686.00
6	LAP CHOLE	15,000.00	51,099.00
7	LAVH	20,000.00	54,290.00
8	PCNL	25,000.00	62,885.00
9	URSL	20,000.00	53,801.00
10	TURP	25,000.00	60,205.00

Medical Negligence - A Legal Conundrum For Practising Physicians

Prof. Dr Shivkumar S Utture
President, Maharashtra Medical Council

Negligence is simply the failure to exercise due care. The three ingredients of negligence are as follows:

1. The defendant owes a duty of care to the plaintiff.
2. The defendant has breached this duty of care.
3. The plaintiff has suffered an injury due to this breach.

The term "medical negligence" is an omnibus one, which has come in vogue to refer to wrongful actions or omissions of professionals in the field of medicine, in pursuit of their profession, while dealing with patients. Medical Negligence basically is the misconduct by a medical practitioner or doctor by not providing enough care resulting in breach of their duties and harming the patients which are their consumers. It is the omission to do something which a reasonable man, guided by those considerations which ordinarily regulate the conduct of human affairs, would do or doing something which a prudent and reasonable man would not do.

The existence of doctor–patient relationship is a prerequisite to fasten liability pertaining to medical negligence on the doctor. The relationship is fiduciary in nature. A basic knowledge of how judicial forums deal with the cases relating to medical negligence is of absolute necessity for doctors. The need for such knowledge is more now than before in light of higher premium being placed by the Indian forums on the value of human life and suffering. The judicial forums tend to give sufficient leeway to doctors and expressly recognize the complexity of the human body, inexactness of medical science, the inherent subjectivity of the process, genuine scope for error of judgment, and the importance of the autonomy of the doctors. The law does not prescribe the limits of high standards that can be adopted but only the minimum standard below which the patients cannot be dealt with.

Basic Features of Medical Negligence and Standard of Care

To comprehend the scope of negligence, it is important to understand the scope of the duty imposed on a doctor or medical practitioner. A doctor or other medical practitioner, among others, has a duty of care in deciding whether to undertake the case or not, duty in deciding what treatment to give, duty of care in administration of that treatment, duty not to undertake any procedure beyond his or her control, and it is expected that the practitioner will bring a reasonable degree of skill and knowledge and will exercise a reasonable degree of care. Negligence, simply put, is a breach of duty of care resulting in injury or damage. It is well accepted that in the cases of gross medical negligence the principle of *Res Ipso loquitur* is to be applied. *Res Ipso loquitur* means things speaks for itself; while deciding the liability of the doctor it has to be well established that the negligence pointed out should be a breach in due care which an ordinary practitioner would have been able to keep.

The consequences of legally cognizable medical negligence can broadly be put into three categories:

(I) Criminal liability,

(ii) Civil liability-monetary liability, and

(iii)Disciplinary action – by Medical Councils.

Criminal liability under Section 304A of IPC3 (which deals with the death of a person by any rash or negligent act and leads to imprisonment up to 2 years) is used to deal with medical negligence leading to the death of a patient. Similarly, other general provisions of IPC,such as Section 3374 (causing hurt) and 3385 (causing grievous hurt), are also often deployed in relation to medical negligence cases. Here the Medical Practitioner can be jailed or fined or both as per the discretion of the judge.

Civil liability, i.e., monetary compensation can be fastened under the general law by pursuing a remedy before appropriate civil court or consumer forums.

Professional misconduct by medical practitioners is governed by the Indian Medical Council (IMC) (Professional Conduct, Etiquette, and Ethics) Regulations, 2002, made under IMC Act, 1956. Medical Council of India (MCI) and the appropriate State Medical Councils are empowered to take disciplinary action whereby the name of the practitioner could be removed forever or be suspended or a warning can be issued.

The line between civil liability and criminal liability is thin, and no sufficiently good criteria have yet been devised by the Supreme Court providing any clear and lucid guidance. The Supreme Court put the standard for fastening criminal liability on a high pedestal and required the medical negligence to be "gross" or "reckless." Mere lack of necessary care, attention, or skill was observed to be insufficient to hold one criminally liable for negligence. In Jacob Mathew v. State of Punjab case the judiciary endorsed the approach of high degree of negligence being the prerequisite for fastening criminal liability. In order to hold the existence of criminal rashness or criminal negligence, it shall have to be found out that the rashness was of such a degree as to amount to taking a hazard knowing that the hazard was of such a degree that injury was most likely imminent. It has been held by the courts that in the cases of medical negligence, **Bolam test** is to be applied, i.e., "standard of the ordinary skilled man exercising and professing to have that special skill," and not of "the highest expert skill." This is applicable to both "diagnosis" and "treatment." Errors of judgment do not necessarily imply negligence. Gross mistakes would, however, invite the finding of negligence such as use of wrong drug or wrong gas during the course of anesthetic process, delegation of the responsibility to a junior with the knowledge that the junior is incapable of performing the duties properly, removal of the wrong limb, performing an operation on the wrong patient or injecting a drug which the patient is allergic to without looking at the outpatient card containing the warning, and leaving swabs or other items inside the patients.

In the cases involving medical negligence, at the beginning, the person alleging the negligence has the initial onus to make out a case of negligence, and thereafter the onus shifts on to the doctor or the hospital to satisfy that there was no lack of care or diligence. While dealing with medical negligence cases, the opinions of the medical experts are often called for from both sides. The real function of the expert is to put before the court all the material together with reasons which induce him to come to a certain conclusion so that the court, even though not an expert, may form its own judgment using its own observation of those materials

Keeping in the view the rise in criminal prosecution of doctors, which is both embarrassing and harassing for them, and to protect them from frivolous and unjust prosecutions Supreme Court laid certain binding guidelines till statutory rules or instructions by the government in consultation with MCI are issued, which are as follows

(1) Private complaint may not be entertained unless the complainant has produced prima facie evidence in the court in the form of a credible opinion given by another competent doctor

(2) Investigation officer should obtain an independent and competent medical opinion preferably from a doctor in government service qualified in that branch of medical practice who can normally be expected to give an impartial and unbiased opinion applying Bolam test to the facts collected in the investigation

(3) The necessity for obtaining independent medical opinion was insisted upon considering that the knowledge of medical science to determine whether the acts of medical professional amounts to negligent act within the domain of criminal law could not be presumed. This requirement was subsequently sought to be made a necessity by the Supreme Court even for initiating the action seeking imposition of civil penalties but was done away with thereafter for civil actions.

(4) Doctor may not be arrested in a routine manner unless the arrest is necessary for furthering the investigation or for collecting the evidence or if the investigation officer is satisfied that doctor may flee.

MEDICAL NEGLIGENCE AND STATE MEDICAL COUNCILS

Medical councils have the disciplinary control over the medical practitioners. They have the power to remove the names of medical practitioners permanently or for a specific period from the medical registers when after due inquiry they are found to have been guilty of serious professional misconduct. There are two grounds on which the council may initiate disciplinary against any medical practitioner namely (a) conviction of any offence by a court of law and (b) guilty of professional misconduct. Any conduct of the practitioner which brings in disgraceful to the professional status what is known as "serious professional misconduct," for e.g. adultery or improper conduct or association with a patient, conviction by a court of law for offences involving moral turpitude, issuing false certificates, reports and other documents; issuing certificate of efficiency in modern medicine to unqualified person or non-medical person; performing an abortion or illegal operation for which there is no medical, surgical or psychological indication; contravening the provisions of the Drugs Act and regulation made there under; using touts or agents for procuring patients; publication of identity of a patient without his permission; performing an operation which results in sterility, without obtaining the written consent of patient/relative and refusing on religious grounds alone to extend medical

assistance etc. Generally, the council by itself does not start proceedings. The proceedings are started: (i) when a medical practitioner has been convicted by a court of law, and (ii) on a complaint lodged by any person or body against the practitioner. On receipt of the complaint, the same will be placed before the Ethical sub-committee or the Executive Committee which considers the complaint, causes, further investigation and takes legal advise. If no prima facie case is made out the complainant is communicated accordingly. On contrary, a prima facie case is established, a notice is issued to the practitioner specifying the nature and particulars of the charge and directing him to answer the charge in writing or to appear before the committee on the appointed day. It is extremely important to respond to the notice sent by the Council and send a detail answer to all the allegations made by the complainant within the timeframe given by the Council. The complainant and the Medical Practitioner are allowed to personally give evidence or be represented by a Legal Professional during the preliminary hearing. (If the Doctor is very sure that he has not been negligent then he could personally defend himself, but if there is any doubts then it is always advisable to hire a lawyer who is well conversant with Medico-Legal cases. This is where Medical Indemnity especially thru a recognized association would go a long way to tide over this critical phase.) After the proved, then a Charge sheet is filed against the Medical Practitioner and a full-fledged hearing is conducted wherein both parties are allowed to bring in expert witnesses. At the end of the hearing the Executive Committee / Council must vote again and decide whether the name of the practitioner should be removed from the register permanently or temporarily or he should be warned, not to repeat the offence or acquitted.

Any person working in a profession like medicine, law, accounting, etc where specialized training, experience, and judgment are involved will get sued. The focus shouldn't be on avoiding lawsuits since they are inevitable. The focus should be on being prepared for the inevitable suit. This can mean many things, such as having the proper paper trail, having good insurance, knowing a good lawyer, etc.

The Cardinal rules to be followed to avoid potential litigations and protect oneself are:

(1) Documentation: this is a big one.

Full record of the diagnosis, treatment, etc., should be maintained."

In many potential conflicts there is a he-said-she-said scenario and the courts must decide who is telling the truth. The doctor's documentation of every patient interaction is not simply to facilitate continuity of care, but to protect the doctor against invalid or inaccurate reports from their patients.

(2) Doctor's demeanor: as a counterpoint to the last item, it is well accepted that doctors are much less likely to be sued if they are liked by their patients. Being friendly and conveying care and compassion in patient interactions is important.

(3) No prescription should ordinarily be given without actual examination. The tendency to give prescription over the telephone, except in an acute emergency, should be avoided

(4) A doctor should not merely go by the version of the patient regarding his symptoms but should also make his own analysis including tests and investigations where necessary

(5) A doctor should not experiment unless necessary and even then he should ordinarily get a written consent from the patient

(6) An expert should be consulted in case of any doubt.

Doctors can best handle a medical malpractice lawsuit by remaining calm. The process generally takes a long time, and much of it is beyond the physician's control. Following the standards of care, keeping good documentation and having malpractice coverage are important steps to preventing a case. In the event of a lawsuit, make sure to lean on a support group, trust legal counsel and continue doing the best job possible.

There is nothing more frightful than ignorance!

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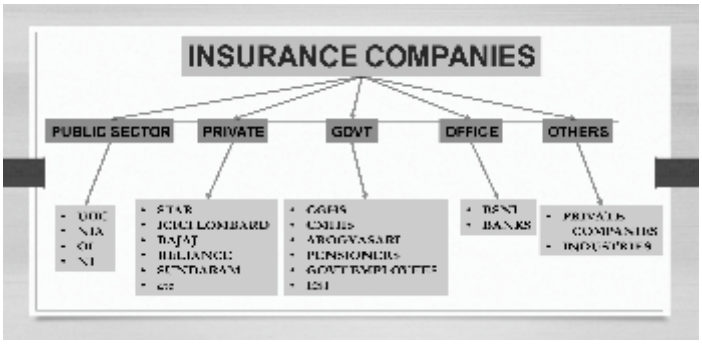
Health insurance in India - Role of IMA HBI

Dr. A. K. Ravikumar
NATIONAL COORDINATOR OF
IMA HBI (INSURANCE)

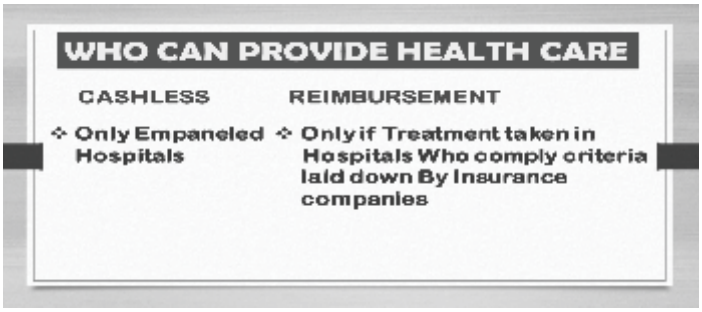
- **Health insurance** is a type of insurance coverage that covers the cost of an insured individual's medical and surgical expenses. Depending on the type of health insurance coverage, either it can be CASH LESS OR REIMBURSEMENT.

  In health insurance terminology, the "provider" is a clinic, hospital, doctor, laboratory, health care practitioner, or pharmacy. The "insured" is the owner of the health insurance policy; the person with the health insurance coverage. "Insurer " is the Insurance company who issues the policy. "TPA"s do the claim settlement process for the Insurer.
- Only 17 % of the population are covered under some form of Health Insurance (majority are APL). 70 % People spend out of pocket on Health Health Insurance Market is Increasing by 20% annually. Universal health coverage is the motto of the central government as first step. Ayushman bharat scheme has been rolled out. *So Health Insurance Traffic is going to increase day by day.*
- Rs. 20,430 crore collected as Premium in 2014-15. 80 to 90 % of this money has gone to Corporate Hospitals and City HospitalsBut 60% of the Health Care is being given by Smaller Hospitals
- Our Aim must be to move Health Insurance towards smaller towns, villages - Diversion of Insurance money towards smaller hospitals, Empanel more smaller hospitals



FUNDS ARE BEING COLLECTED IN THE FORM OF

- Premium, Health Fund, Government Contribution, Employer Contribution
- Cost of health care given through
- Cashless process
- Reimbursement



PAYMENT FOR THE HEALTH CARE WILL BE DONE BY

- Directly the INSURANCE COMPANY
- TPA – Third Party Administrator

ISSUES FACED BY PATIENT / INSURED PERSON

- Choice of selecting Doctor / Hospital of his choice curtailed
- During Emergencies golden hour lost in

searching for Empanelled Hospitals

- Reimbursement may not be done in some Insurance schemes
- Reimbursement not allowed
- Not Aware of Policy norms

ISSUES FACED BY HOSPITALS (Health Care Providers)

1) Empanelment

- Only selective Hospitals in an Area Empanelled
- Package Rates for selective Surgical Cases as Criteria
- Compelling to Sign for Low Package Rates with Stringent criteria for Empanelment
- Quality Health Care Involves Finance and Package Rates Curtails the Freedom of Treatment

2) Pre Authorization Issues

3) Settlement Issues and Depanelment Issues

ISSUES FACED BY INSURANCE COMPANIES / TPA'S

- Hospitals not providing genuine details of patients
- Gross variation in charges among hospitals
- Not having uniform quality standards
- Competition among themselves in catching clients decreasing the premium
- Settlements more than premium collected so end up in loss.

SOLUTION FOR THIS

- IMA HBI Insurance FORUM started at HBI Headquarters with all stake holders as members to solve Insurance related problems
- Similar forums at state and district levels is the need of the hour.
- IMA HBI Representation in
  - IRDA Health Insurance Advisory Committee
  - In Policy making bodies of Insurance companies / TPAs / Government
- **"General Insurance Public Sector Association"(GIPSA) -** Public Sector Insurance (PSU) Companies, United India Insurance, National Insurance, New India Assurance, Oriental Insurance Joined to form GIPSA. Now they have formed their own TPA and negotiate with Healthcare Provider Promising Case Volume to cut the Charges and fix packages for which hospitals should agree.
- Government fixes the Packages for their schemes as in CGHS, Arogyashri, Ayushman etc. Private Insurance companies demands concession in the charges you make and fixes his own packages. **When Insurance Companies, Government can do - so why don't we as Service Providers, who give 60 % Health care join together and ask for?**
- Empanelment for all eligible hospitals, Easy Processing, Fast Settlement.
- Streamlining Gross Difference in Rates among us and fix common minimum rates.

  IMA TN has already done a scientific costing study as per government standards and derived at various charges and package rates which can be followed across the country.(for details visit www.imanhb.org). **60% HEALTH CARE IS BEING GIVEN BY SMALLER & MEDIUM HOSPITALS AND ALL SHOULD GET UNITED**

  JOIN IMA HBI...WE CAN DO WONDERS!!!

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Bombay Act No. XV of 1949

THE MAHARASHTRA NURSING HOMES REGISTRATION ACT

(As modified upto 7th May 2013)

CONTENTS

BOMBAY ACT No. XV OF 1949[1].

[THE MAHARASHTRA NURSING HOMES REGISTRATION ACT.]†

[*6th May 1949*]

Adapted and modified by the Adaptation of Laws Order, 1950.

Adapted and modified by the Bombay Adaptation of Laws (State and Concurrent Subjects) Order, 1956.

Amended by Bom. 42 of 1959.

Adapted and modified by the Maharashtra Adaptation of Laws (State and Concurrent Subjects) Order, 1960.

Amended by Mah. 2 of 2006.

Amended by Mah. 24 of 2012.

An Act to provide for the registration and inspection of nursing homes in the [2][State of Bombay] and for certain purposes connected therewith.

WHEREAS, it is expedient to provide for the registration and inspection of nursing homes in the Province of Bombay and for certain purposes connected therewith; It is hereby enacted as follows :—

Short title, extent and commencement.

1. (*1*) This Act may be called [3][the Maharashtra Nursing Homes Registration Act.]

[4][(*2*) This section extends to the whole of the [5][State of Maharashtra].

The remaining provisions of this Act extend to Greater Bombay, the [6][City of Poona] as constituted under section 3 of the *Bombay Provincial Municipal Corporations Act, 1949, the City of Nagpur as constituted under the **City of Nagpur Corporation Act, 1948 and the Municipal Borough of Sholapur. The State Government may, by notification in the *Official Gazette*, direct that the said provisions shall extend to such other areas as may be specified in the notification.]

Bom. LIX of 1949. C.P.and Berar II of 1950.

(*3*) This section shall come into force at once. The [7][State] Government may, by notification in the *Official Gizette*, direct that the remaining provisions of this Act shall come into force in any area to which the said provisions extend or may have been extended under sub-section (*2*) on such date as may be specified in the notification.

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[1] For Statement of Objects and Reasons, *see Bombay Government Gazette*, 1949, Part-V, page 84.

† This Act was extended to that part of the State of Bombay to which immediately before the commencement of Bom. 42 of 1959, it did not extend. (*vide* Bom. 42 of 1959, s. 27).

[2] These words were substituted for the words "Province of Bombay" by Bom. 42 of 1959, s. 3.

[3] The short title was amended by Mah. 24 of 2012, s. 2, Sch, entry no. 36, w.e.f. 1-5-1960.

[4] This sub-section was substituted for the original by Bom. 42 of 1959, s. 4.

[5] These words were substituted for the words "State of Bombay" by the Maharashtra Adaptation of Laws (State and Concurrent Subjects) Order, 1960.

[6] These words were substituted for the words "Cities of Poona and Ahmedabad", *ibid*.

[7] This word was substituted for the word "Provincial" by the Adaptation of Laws Order, 1950.

* The short title of this Act was substituded as " the Maharashtra Municipal Corporation Act" by Mah. 23 of 2012, s. 4.

** This Act was repealed, *ibid*. s.7.

Definitions.

2. In this Act, unless there is anything repugnant in the subject or context—

(*1*) "by-laws" means by-laws made by the local supervising authority;

[1][(*1-a*) "district local board" in relation to any area other than a municipal area, means a district local board, district board, district panchayat or *Janapada Sabha* or similar local authority established under any law for the time being in force relating to the constitution of such authorities and having jurisdiction over such area;]

[2][(*2*) "local supervising authority" means,—

(*i*) in the areas falling within the jurisdiction of the Municipal Corporation—the Health Officer of the concerned Municipal Corporation;

(*ii*) in the areas falling within the jurisdiction of the Municipal Council—— the Civil Surgeon of the District in which such Council is situated;

(*iii*) in the areas falling within the jurisdiction of a Cantonment—
the Health Officer of the concerned Cantonment;

(*iv*) in the areas not falling in sub-clauses *(i)*, *(ii)* and *(iii)* above—the District Health Officer of the concerned *Zilla Parishad;*]

(*3*) "maternity home" means any premises used or intended to be used, for the reception of pregnant women or of women in or immediately after child birth;

[3][(*3-a*) "Municipality" means a municipal corporation, municipality, municipal committee, town committee or similar local authority established under any law for the time being in force relating to the constitution of such authorities and "municipal area" means the local area within the jurisdiction of a municipality;]

(*4*) "nursing home " means any premises used or intended to be used, for the reception of persons suffering from any sickness, injury or infirmity and the providing of treatment and nursing for them and includes a maternity home; and the expression "to carry on a nursing home" means to receive persons in a nursing home for any of the aforesaid purposes and to provide treatment or nursing for them;

(*5*) "prescribed" means prescribed by rules made under this Act;

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[1] Clause (*1-a*) was inserted by Bom. 42 of 1959, s. 5(*1*).

[2] This clause was substituted for the original by Mah. 2 of 2006, s. 2.

[3] Clause (*3-a*) was inserted by Bom. 42 of 1959, s. 5(*2*).

Bom. VI of 1912.

(*6*) "qualified medical practitioner" means a medical practitioner registered under the Bombay Medical Act, 1912 or any other law for the time being in force;

Bom. XIVof 1954.

[1][(*7*) "qualified midwife" means a midwife registered or deemed to be registered under the Bombay Nurses, Midwives and Health Visitors Act, 1954 or any other corresponding law for the time being in force;

Bom. XIV of 1954.

(*8*) "qualified nurse " means a nurse registered or deemed to be registered under the Bombay Nurses, Midwives and Health Visitors Act, 1954 or any other corresponding law for the time being in force ;]

(*9*) "register" means to register under section 5 of this Act and the expressions "registered" and "registration" shall be construed accordingly;

(*10*) "rules" means rules made under this Act.

Prohibition to carry on nursing home without registration.

3. No person shall carry on a nursing home unless he has been duly registered in respect of such nursing home and the registration in respect thereof has not been cancelled under section 7:

Provided that nothing in this section shall apply in the case of a nursing home [2][which is in existence in any area at the date of the coming into force of section 3 in that area] for a period of three months from such date or if an application for registration is made within that period in accordance with the provisions of section 4 until such application is finally disposed of.

Application for registiation.

4. (*1*) Every person intending to carry on a nursing home shall make every year an application for registration or the renewal of registration to the local supervising authority :

Provided that in the case of a nursing home [3][which is in existence in any area at the date of the coming into force of section 3 in that area] an application for registration shall be made within three months from such date.

(*2*) Every application for registration or the renewal of registration shall be made on such date and in such form and shall be accompanied by such fee, as may be prescribed.

Registration.

5. (*1*) Subject to the provisions of this Act and the rules, the local supervising authority shall, on the receipt of an application for registration, register the applicant in respect of the nursing home named in the application and issue to him a certificate of registration in the prescribed form:

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[1] Clauses (*7*) and (*8*) were substituted for the original by Bom. 42 of 1959, s. 5(*3*).

[2] These words were substituted for the words "which is in existence at the date of the commencement of this Act", *ibid.*, s. 6.

[3] These words were substituted for the words "which is in existence at the date of the commencement of this Act", *ibid.*, s. 7.

Provided that the local supervising authority may refuse to register the applicant if it is satisfied—

(*a*) that he, or any person employed by him at the nursing home, is not a fit person, whether by reason of age or otherwise, to carry on or to be employed at a nursing home of such a description as the nursing home named in the application; or

[1][(*b*) that the nursing home is not under the management of a person who is holding a degree in medical sciences and who is resident in the home, or that there is not a prescribed proportion of qualified nurses employed in the nursing home to the number of patients in it; or]

(*c*) that in the case of a maternity home it has not got on its staff a qualified midwife; or

[2][(*c-1*) that the area of the premises of the nursing home is less than the prescribed area;

(*c-2*) that the number of beds available in the nursing home exceeds than those prescribed;

(*c-3*) that the nursing home is owned or is under the management of a Government Medical Officer;]

(*d*) that for reasons connected with the situation, construction, accommodation, staffing or equipment, the nursing home or any premises used in connection therewith are not fit to be used for a nursing home of such a description as the nursing home mentioned in the application or that the nursing home or premises are used or are to be used for purposes which are in any way improper or undesirable in the case of such nursing home.

[3][(2) A certificate of registration issued under this section shall, subject to the provisions of section 7, be in force and shall be valid until the 31st day of March of the third year next following the date on which such certificate is issued or renewed, as the case may be.]

(*3*) The certificate of registration issued in respect of a nursing home shall be kept affixed in a conspicuous place in the nursing home.

Penalty for non-registration.

[4][**6.** Whoever contravenes the provisions of section 3, shall, on conviction, be punished with imprisonment which may extend to six months or with fine which may extend to ten thousand rupees or with both.]

[1] This clause was substituted for the original by Mah. 2 of 2006, s. 3 (*a*)(*i*).

[2] These clauses were inserted, *ibid.*, s. 3 (*a*)(*ii*).

[3] This sub-section was substituted, *ibid.*, s. 3 (*b*).

[4] This section was substituted *ibid.*, s. 4.

Cancellation of registration.

7. Subject to the provisions of this Act, the local supervising authority may at any time cancel the registration of a person in respect of any nursing home on any ground which would entitle it to refuse an application for the registration of that person in respect of that home, or on the ground that person has been convicted of an offence under this Act or that any other person has been convicted of such an offence in respect of that home.

Notice of refusal or cancellation of registration.

8. (*1*) Before making an order refusing an application for registration or an order cancelling any registration, the local supervising authority shall give to the applicant or to the person registered, as the case may be, not less than one calendar month's notice of its intention to make such an order, and every such notice shall state the grounds on which the local supervising authority intends to make the order and shall contain an intimation that if within a calendar month after the receipt of the notice the applicant or person registered informs the authority in writing that he desires so to do, the local supervising authority shall, before making the order, give him (in person or by a representative) an opportunity of showing cause why the order should not be made.

(*2*) If the local supervising authority, after giving the applicant or the person registered an opportunity of showing cause as aforesaid, decides to refuse the application for registration or to cancel the registration, as the case may be, it shall make an order to that effect and shall send a copy of the order by registered post to the applicant or the person registered.

(*3*) Any person aggrieved by an order refusing an application for registration or cancelling any registration may, within a calendar month after the date on which the copy of the order was sent to him, appeal to the [1][State] Government against such order of refusal. The decision of the [1][State] Government on any such appeal shall be final.

(*4*) No such order shall come into force until after the expiration of a calendar month from the date on which it was made or where notice of appeal is given against it, until the appeal has been decided or withdrawn.

Inspection of nursing homes.

9. (*1*) The Health Officer of the local supervising authority or the Civil Surgeon of the district in which a nursing home is situated or any other officer duly authorised by the local supervising authority or the Civil Surgeon, may, subject to such general or special orders as may be made by the local supervising authority, at all reasonable times enter and inspect any premises which are used, or which that officer has reasonable cause to believe to be used, for the purpose of nursing home, and inspect any records required to be kept in accordance with the provisions of this Act:

[1] This word was substituted for the word "Provincial" by the Adaptation of Laws Order, 1950.

Provided that nothing in this Act shall be deemed to authorise any such officer to inspect any medical record relating to any patient in a nursing home.

(2) If any person refuses to allow any such officer to enter or inspect any such premises as aforesaid, or to inspect any such records as aforesaid or obstructs any such officer in the execution of his powers under this section, he shall be guilty of an offence under this Act.

Income of local supervising authority.

10. Any fees received under this Act shall be paid into the fund of the local supervising authority.

Expenses of local supervising authority.

11. Notwithstanding anything contained in any enactment in regard to any municipal or local fund; all expenses incurred by a local supervising authority under and for the purposes of this Act and the rules and by-laws may be paid out of the municipal or local fund, as the case may be.

Penalty for offences under Act.

12. Whoever contravenes any of the provisions of this Act or of any rule shall, if no other penalty is elsewhere provided in this Act or the rules for such contravention, on conviction, be punished with fine which may extend to[1]|five thousand rupees| and in the case of continuing offence to a further fine of [2]| fifty rupees| in respect of each day on which the offence continues after such conviction.

Offences by corporations.

13. Where a person committing an offence under this Act is a company or other body corporate or an association of persons (whether incorporated or not), every person who at the time of the commission of the offence was a director, manager, secretary, agent or other officer or person concerned with the management thereof shall, unless he proves that the offence was committed without his knowledge or consent, be deemed to be guilty of such offence.

Court competent to try offences under Act.

14. No Court other than that of a Presidency Magistrate or a Magistrate of the first class shall take cognizance of or try any offence under this Act.

Indemnity to persons acting under this Act.

15. No suit, prosecution or other legal proceeding shall be instituted against any person for anything which is in good faith done or intended to be done under this Act, rules or by-laws.

Rules.

16. (*1*) The [3]| State| Government may, by notification in the *Official Gazette*, make rules to carry out all or any of the purposes of this Act.

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[1] These words were substituted for the words "fifty rupees" by Mah. 2 of 2006, s. 5(*a*).

[2] These words were substituted for the words "fifteen rupees", *ibid.*, s. 5(*b*).

[3] This word was substituted for the word "Provincial" by the Adaptation of Laws Order, 1950.

(*2*) Without prejudice to the generality of the foregoing provisions such rules may prescribe—

(*a*) the form of the application to be made under section 4,

(*b*) the date on which an application for registration or renewal of registration to be made and the fees to be paid for such registration or renewal of registration:

[1][Provided that, the State Government may prescribe different rates of fees for registration of nursing homes, having regard to the area in which such nursing home is situated, the number of beds therein, the number of specialisations offered in such nursing home.]

(*c*) the form of the certificate of registration to be issued under section 5,

(*d*) for any other matter for which no provision has been made in this Act, and for which provision is, in the opinion of the [2][State] Government, necessary.

(*3*) The power to make rules under this section shall be subject to the condition of previous publication in the *Official Gazette*.

17. (*1*) The local supervising authority may make by-laws not inconsistent with this Act or rules— By-laws.

(*a*) prescribing the records to be kept of the patients received into a nursing home, and in the case of the maternity home, of miscarriages, abortions or still births occuring in the nursing home and of the children born therein and of the children so born who are removed from the home otherwise than to the custody or care of any parent, guardian or relative;

(*b*) requiring notification to be given of any death occuring in the nursing home.

(*2*) Any by-law made by a local supervising authority under this Act may provide that a contravention thereof shall be punishable—

(*a*) with fine which may extend to fifty rupees; or

(*b*) with fine which may extend to fifty rupees and in the case of a continuing contravention, with an additional fine which may extend to fifteen rupees for every day during which such contravention continues after conviction for the first such contravention; or

(*c*) with fine which may extend to fifteen rupees for every day during which the contravention continues after the receipt of a notice from the local supervising authority by the person contravening the by-law requiring such person to discontinue such contravention.

[1] This proviso was inserted by Mah. 2 of 2006, s. 6.

[2] This word was substituted for the word "Provincial" by the Adaptation of Laws Order, 1950.

(*3*) No by-law made by the local supervising authority shall come into force until it has been confirmed by the [1][State] Government with or without modification.

(*4*) All by-laws made under this section shall be published in the *Official Gazette*.

Saving.

18. Nothing in this Act shall apply to—

(*i*) any nursing home carried on by Government or a local authority or by any other body of persons approved by the [1][State] Government in this behalf; and

(*ii*) any asylum for lunatics or patients suffering from mental diseases, within the meaning of the Indian Lunacy Act, 1912. IV of 1912.

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[1] This word was substituted for the word "Provincial" by the Adaptation of Laws Order, 1950.

The Maharashtra Nursing Homes Registration Rules, 1973.

In exercise of the powers conferred by sub-section (1) and clauses (a) to (d) of sub-section (2) of section 16 of the Bombay Nursing Homes Registration Act, 1949 (Bom. XV of 1949), and of all other powers enabling it in that behalf, the Government of Maharashtra hereby makes the following rules, the same having been previously published as required by sub-section (1) of the said section 16, namely :-

I – General

1. Short Title. - These rules may be called the Maharashtra Nursing Homes Registration Rules, 1973.

2. Definitions. - In these rules, unless the context requires otherwise-

a) "Act" means the Bombay Nursing Homes Registration Act, 1949.

b) "Form" means a form appended to these rules : and

c) "Section" means a section of the Act.

II - Maintenance of Register

3. Register. - The Local supervising authority shall maintain a register in Form 'A' showing the names of persons registered under section 5.

4. Application for registration. - Any person intending to carry on a nursing home shall make an application to the local supervising authority in Form 'B' at least one month before the date on which he intends to carry on such a nursing home. Such application shall be accompanied by a fee prescribed in sub-rule (1) of rule 7.

5. Grant of certificate of registration. - The Local supervising authority shall if satisfied that there is no objection to registration, register the applicant in respect of nursing home and issue to him a certificate of registration in Form 'C'.

6. Renewal of registration. -

1) An application for renewal of registration shall be made every year in advance in Form ‘B' in the month of January and shall be accompanied by the fee prescribed in sub-rule(2) of rule 7.

2) On receipt of an application made under sub-rule (1) the local supervising authority shall, if satisfied that the application is in order, issue a fresh certificate of registration in form ‘C'.

7. Fees for registration and renewal of registration. -

(1) The fees to be paid for registration shall be charged as under:-

a) Rs 100 in respect of nursing home having more than 10 beds;
b) Rs 200 in respect of a nursing home having not more than 10 beds;

(2) The Fees for the renewal of registration shall, in each case, equal to of the amount payable for the first registration.

8. Transfer of ownership etc. of nursing home. - Immediately after the transfer of the ownership or management of nursing home, the transferor and the transferee shall jointly communicate the transfer effected to the local supervising authority and the transferee shall make an application for registration in accordance with the provisions of rule. 4.

9. Change of Address. - A person registered under the Act in respect of a nursing home shall communicate to the local supervising authority any change in his address or in the situation of the nursing home in respect of which he is registered not later than seventy-two hours after such change.

10. Change in staff. - Any change in the medical, nursing or midwifery staff together with the dates on which such changes has taken place shall be communicated to the local supervising authority immediately and in any case, not later than three days of such change.

11. Lost certificates. - In the event of certificate of registration being lost or destroyed, the holder may apply to the local supervising authority for a fresh certificate and the local supervising authority may, if it thinks fit, issue such certificate upon payment of a fee of Rs.5 A certificate issued under this rule shall be marked "Duplicate".

12. Repeal. - The Bombay Nursing Homes Registration Rules, 1951, are hereby repealed, except as respects thing done or omitted to be done thereunder.

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Cyber Security for Healthcare Professionals

Mr. Prashant Deo

Cyber Security Expert & Adviser assisting Global & Domestic Customers of various industry sectors including Healthcare sector to build the Cyber Security Strategy, setting up Cyber Defense Operations and protection of critical infrastructure from cyber threats. Actively involved in creating security awareness in schools, colleges and community. Holds Globally recognized Cyber Security Certifications like CISSP, CISM, GCIH and CEH.

We are currently witnessing digital revolution where each sector and individual are widely adopting the digital technology for transforming the traditional business/service models and achieving the cost efficiencies. Digital revolution encompasses usage of technologies like Mobile, Cloud, Social Media, Artificial Intelligence (AI), Blockchain, Internet of Things (IoT) and Big Data to explore the new growth possibilities/business models. Ever increasing internet speed with commercially viable data connections are positively contributing to this revolution.

Amongst all other industry and service sectors, Healthcare sector is one of the leading sector to adopt the digital technologies for various use cases with the underlying aim to improve the current patient care from reactive to proactive towards preemptive care model. Healthcare professionals have also started using these digital technologies to stay connected with the various stake holders including patients and hospitals, and also in some case for remote diagnosis, virtual care and tele-consulting. One of the recent example of this revolution is booming preventive and detective healthcare services using the wearable devices. While these digital technologies certainly help healthcare sector and professionals to improve the services, these technologies and healthcare professionals are unfortunately not immune to nefarious use of these technical advancements by cyber criminals. Cyber criminals are individuals (hackers, script kiddies), organized gangs (group of hackers with financial interest) or nation state actors (group of hackers employed by nation) aimed at exploiting the weaknesses in systems/individuals to fulfill various motives.

There are increasing cyber-attacks reported on the healthcare information systems to gain an access to sensitive Personal Health Information (PHI), disrupt the healthcare networks resulting critical health monitoring system inaccessible, injecting malware into implantable devices to modify the diagnosis parameters and encrypting the data on healthcare systems to render it unusable. Weaknesses like unsecure medical devices, improperly configured healthcare information systems and networks, poor security hygiene, poor risk management practices, lack of awareness in professionals are exploited by these attackers to launch such attacks. Impact of these attacks are severe including the risk to the life of patient, disclosure of sensitive medical information causing heavy data breach penalties, and reputation of healthcare institute and treating professional. Healthcare professionals and their systems are the weakest links in this overall chain which are mostly targeted by these cyber attackers to gain an entry to the healthcare network.

While these looming threats are scary and inevitable, opportunities provided by usage of digital technologies are immense. One must overcome these threats and leverage these digital technologies for improving healthcare services.

There are lot of similarities in Human healthcare and Cyber care of Individuals and supporting systems. Cyber care is nothing but a security related to your Digital Avatars and supporting systems. Drawing an analogy with the ever growing pathogens and diseases to human health, cyber security threats continue to proliferate and impact the digital technologies. The way we adopt a human wellness program to treat the risks to human life, there is a need of adopting a similar Cyber Wellness program to cure these ever growing threats for safety of your Digital Avatars and supporting systems.

This wellness program should ensure the systems and individuals are treated to become resistant to attacks,

resilient under stress situation, avoiding dangerous environments, treatable if diseased and able to limit the contagious infections. Cyber wellness program is a holistic program of cyber security to mitigate these risks to an acceptable risk level by deploying appropriate preventive, detective and reactive controls.

Following measures are the typical prescription for healthcare professionals and supporting systems to cope up with these threats.

Preventive Measures:

1. **The way you take care of your personal health by adhering to healthy personal discipline, one should ensure safety of your digital avatars including your digital devices (Individual PCs, laptops, mobiles) by following safe computing practices like;**

a. Keeping all your credentials (ID & password) including social media identities private and confidential

b. Keeping the complex passwords and not using the same passwords across all your digital IDs

c. Changing the passwords frequently and at the instance of any suspicious activities

d. Avoid sharing any personal information (e.g. – Digital IDs, passwords, birthdates, addresses, unique identifiers like Aadhar numbers or social security numbers) on the public websites

e. Keep track of digital conversations related to you and manage it proactively before it becomes viral to avoid the reputation damage

f. Undergoing through preventive diagnosis by regularly scanning digital devices for any infections and applying necessary immunizations for the identified threats

g. Not opening the unsolicited emails which claim the big bounties and favors, emails received from known senders with subject and content looking like relevant but suspicious

h. Avoiding clicking on the URLs embedded into pop-ups and digital advertisements

i. Avoid visiting unknown sites and downloading the free utilities. These sites and utilities are typically used to host the hostile programs (viruses, worms, Trojans)

j. Deploying the virus protection software on your digital devices the way we immunize ourselves from viruses and enabling it real time to protect from any virus attacks

k. Deploying the filters (firewall, web security & email security software) on your digital devices to scrutinize any incoming and outgoing web/email traffic

l. Undergoing through security awareness session to keep individual abreast of various cyber security attacks and its remedies

m. Take regular backups of your important data to avoid the data loss in case of cyber-attacks resulting into entire system encryption or system disruption

n. Keep your personal data and files protected by native protections provided by Digital devices like encrypted folders

2. **Supporting Networks, Systems and Software of healthcare environment should also adopt following preventive measures;**

a. The way natural immune system works in human body, similarly supporting healthcare systems and software should be infused with security controls to increase the immunity to cyber attacks

b. Medical devices should have security controls inbuilt and these devices should undergo penetration tests, similar to the drug trials, to check the exploitability

c. Preventive controls like firewall, intrusion prevention, web and email filters should be deployed to filter the viral traffic entering into network

d. Deployment of anti-malware software and network security controls to prevent the contagious infections

e. Deployment of advance security controls to identify the unknown viruses by determining the abnormal patterns and systems behaviors, similar to detecting the emerging diseases

f. Deploying monitoring probes to detect abnormal activities like healthcare surveillance systems or recent personal implanted devices like insulin pumps

g. Regular diagnostic test to detect the weaknesses and exploitability of the weaknesses identified, and accordingly strengthening the controls to overcome the weaknesses

h. Perform risk assessment, like regular health checkups, of healthcare systems to identify the adequacy of the controls deployed to mitigate the perceived cyber risks

i. Take regular backups of the systems and do the regular restore tests. Plan for the disaster recovery drills to test the critical system continuity from the alternate locations

j. Protect the Patient Healthcare Information (PHI) and other sensitive information with appropriate data protection controls (encryption, password protection, masking)

k. Allow restricted remote access to healthcare professionals with appropriate access permission and accountability

l. All healthcare staff should undergo through regular security awareness sessions to understand the various security risks and techniques to handle such threats

Detective and Reactive Measures:

1. The way you take care of your personal health post detection of any disease, you need to take similar care for any misuse / infections identified of your digital identity / your digital device

a. Any suspicious / fraudulent activities identified by using your identity, one should immediately report to respective authority (respective web sites, social media channels) and/or cyber criminal cell

b. Change the passwords of compromised accounts and keep the complex passwords

c. Take a treatment to cure the infection by cleaning the infection or quarantining the infected system to carry out further investigation. If the system is not repairable, restore it or reinstall it from the clean image

d. If your device is found to be infected with Ransomware rendering all your data unusable, do not pay the ransomware demanded by cyber attacker. Try to restore your data from the backups. Try to rebuild the files. Look for an available encryption decoder; many forms of ransomware have been successfully decrypted. Work with security partners to help you mitigate the spread of the attack and possibly help you recover the data.

e. If any PHI data or sensitive data has been found stolen, report the breach to appropriate authority and carry out due investigation to detect the cause of breach, and deploy the controls to mitigate the cause of weakness

f. Devise a formal incident response plan and crisis plan, like the epidemiology addresses the epidemics situation, to address the large virus outbreaks

Above prescribed controls if followed appropriately, it will lead to improved Cyber Wellness of healthcare professionals and enable secure use of digital technologies to improve healthcare services. Some of the above prescriptions are generic one and can be adopted as a best practice. However some situations needs special consultation from the cyber practitioner for appropriate assessment / investigation and recommendation on suitable controls.

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Maharashtra Medicare Service Persons and Medicare Service Institutions Act 2010
Law and Judiciary Department, Govt Of Maharashtra

महाराष्ट्र शासन राजपत्र

असाधारण भाग आठ

वर्ष २, अंक १६] बुधवार, एप्रिल २८, २०१०/वैशाख ८, शके १९३२ [पृष्ठे ४, किंमत : रुपये १९.००

असाधारण क्रमांक ३६

प्राधिकृत प्रकाशन

महाराष्ट्र विधानमंडळाचे अधिनियम व राज्यपालांनी प्रख्यापित केलेले अध्यादेश व केलेले विनियम आणि विधि व न्याय विभागाकडून आलेली विधेयके (इंग्रजी अनुवाद).

In pursuance of clause (*3*) of article 348 of the Constitution of India, the following translation in English of the Maharashtra Medicare Service Persons and Medicare Service Institutions (Prevention of Violence and Damage or Loss to Property) Act, 2010 (Mah. Act No. XI of 2010), is hereby published under the authority of the Governor.

By order and in the name of the Governor of Maharashtra,

H. B. PATEL,
Secretary to Government,
Law and Judiciary Department.

MAHARASHTRA ACT No. XI OF 2010.

(First published, after having received the assent of the Governor in the "*Maharashtra Government Gazette*", on the 28th April 2010.)

An Act to provide for the prevention of violence against Medicare Service Persons and prevention of damage or loss of property of Medicare Service Institutions in the State of Maharashtra and for matters connected therewith or incidental thereto.

WHEREAS acts of violence of causing injury or danger to life of Medicare Service Persons and damage or loss to the property of Medicare Service Institutions were on increase in the State creating unrest in Medicare Service Persons and professionals resulting in total hindrance of such services in the State ;

AND WHEREAS it had become necessary to provide for the prevention of violence against Medicare Service Persons and prevention of damage or loss of property of Medicare Service Institutions from such violent activities ;

AND WHEREAS both Houses of the State Legislature were not in session ;

AND WHEREAS the Governor of Maharashtra was satisfied that circumstances existed which rendered it necessary for him to take immediate action to make necessary provisions, for the purposes aforesaid ; and, therefore, promulgated the Maharashtra Medicare Service Persons and Medicare Service Institution (Prevention of Violence and Damage or Loss to Property) Ordinance, 2010, on the 17th February 2010 ; Mah. Ord. I of 2010.

AND WHEREAS it is expedient to replace the said Ordinance by an Act of the State Legislature ; it is hereby enacted in the Sixty-first Year of the Republic of India as follows :—

Short title, extent and commence-ment.

1. (*1*) This Act may be called the Maharashtra Medicare Service Persons and Medicare Service Institutions (Prevention of Violence and Damage or Loss to Property) Act, 2010.

(*2*) It extends to the whole of the State of Maharashtra.

(*3*) It shall be deemed to have come into force on the 17th February 2010.

Definitions.

2. In this Act, unless the context otherwise requires,—

(*a*) " Medicare Service Institution " means an institution, providing medicare service to people either in Medicare Service Institution or through Mobile Medicare Unit or by arranging medical check up camps, under the control of the State Government or the Central Government, or a local body including any private hospital having facilities for treatment of the sick and used for their reception or stay in any private maternity home, where women are usually received and accommodated for the purpose of confinement and ante-natal and post-natal care in connection with the child birth or anything connected therewith and any private nursing home used or intended to be used for the reception and accommodation of person suffering from any sickness, injury or infirmity, whether of body or mind, and providing of treatment or nursing or both of them and includes convalescent home ;

(*b*) " Medicare Service Person", in relation to Medicare Service Institution, shall include,—

(*i*) Registered Medical Practitioner, Practitioner or Registered Practitioner (including a person having provisional registration) working in a Medicare Service Institution other than the public servant within the meaning of section 21 of the Indian Penal Code ; 45 of 1860.

Mah. XL of 1966. 45 of 1860.

(*ii*) Registered Nurse, registered under the Maharashtra Nurses Act, 1966, other than the public servant within the meaning of section 21 of the Indian Penal Code ;

(*iii*) Medical Student ;

(*iv*) Nursing Student ; and

(*v*) Para-Medical Worker and other member staff or worker directly or indirectly employed by a Medicare Service Institution for providing required services other than the public servant within the meaning of section 21 of the Indian Penal Code.

45 of 1860.

Explanation.—For the purpose of this Act, the expression Registered Medical Practitioner, Practitioner or Registered Practitioner, Nurse, shall have the same meanings, as assigned to them in the Maharashtra Medical Practitioners' Act, 1961, the Maharashtra Medical Council Act, 1965, the Bombay Homoeopathic Practitioners' Act, 1959 and the Maharashtra Nurses Act, 1966 ;

Mah. XXVIII of 1961. Mah. XLVI of 1965. Bom. XII of 1960. Mah. XL of 1966.

(*c*) "Medical Student" means a student, who is undergoing training or studies in medical profession ;

(*d*) "Mobile Medical Unit" means an ambulance equipped with medical equipment, used for providing medicare services ;

(*e*) "Nursing Student" means a student, who is undergoing training or studies in nursing profession ;

(*f*) "Offender" means any person, who either by himself or as a member or leader of a group of persons or organization commits or attempts to commit or abets or incites the commission of violence under this Act ;

(*g*) "Para-Medical Worker" means a person, who assists the Medicare Service Person providing medicare services ;

(*h*) "Property" means any property, movable or immovable or medical equipment or medical machinery owned by or in possession of, or under the control of any Medicare Service Person or Medicare Service Institution ;

(*i*) "Violence" means an act, which causes or may cause any harm, injury or endangering the life of, or intimidation, obstruction or hindrance to, any Medicare Service Person in discharging his duty in a Medicare Service Institution or causing damage or loss to the property in a Medicare Service Institution.

Prohibition of violence.

3. Any act of violence against a Medicare Service Person or damage or loss to the property in a Medicare Service Institution, shall be prohibited.

Penalty.

4. Any offender, who commits or attempts to commit or abets or incites the commission of any act of violence in contravention of the provisions of section 3, shall be punished with imprisonment which may extend to three years and with fine, which may extend to fifty thousand rupees.

Cognizance of offence

5. Any offence committed under this Act, shall be cognizable and non-bailable and triable by the Court of Judicial Magistrate of the First Class.

Liability to pay compensation for loss or damage caused to property.

6. (*1*) In addition to the punishment specified in section 4, the offender shall be liable to pay compensation of twice the amount of damage or loss caused to the property, as may be determined by the Court referred to in section 5.

(*2*) If the offender has not paid the compensation imposed under sub-section (*1*), the same sum shall be recovered as if it were an arrear of land revenue.

Authority to aid and advise victims of medical negligence.

7. (*1*) The State Government shall, by notification in the *Official Gazette*, establish the Authority for the area as may be specified in such notification, to hear grievances of victims of medical negligence or mismanagement and to aid and advise such victims for taking recourse to an appropriate forum for suitable relief.

(*2*) The Authority shall consist of experts one each from the field of medical, law, consumer movement and health management.

(*3*) The conditions of service of the experts mentioned in sub-section (*2*), and the procedure to be followed by the Authority shall be such as may be specified by the State Government by an order in this behalf.

Act not in derogation of any other law

8. The provisions of this Act shall be in addition to and not in derogation of, the provisions of any other law for the time being in force.

Repeal of Mah. Ord. 1 of 2010 and saving.

9. (*1*) The Maharashtra Medicare Service Persons and Medicare Service Institutions (Prevention of Violence and Damage or Loss to Property) Ordinance, 2010, is hereby repealed. Mah. Ord. 1 of 2010.

(*2*) Notwithstanding such repeal, anything done or any action taken (including any notification or order issued) under the said Ordinance, shall be deemed to have been done, taken or issued, as the case may be, under the corresponding provisions of this Act.

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Consumer Protection Act 1986 (CPA)

Dr. Jayant Navarange
MD, DCH, LLB
Medicolegal Consultant

This act is a benevolent piece of legislation enacted under obligations of United Nations and it does not substitute any prevalent acts, specifically designed to safeguard against consumers' exploitation, speedy compensation in case of defective goods or services and for consumer education. Formal Civil litigations used to drag on for years together even when the consumers could show and prove their grievance in obvious cases and used to cost also more, and hence to expedite the justice, rather informal, cheap justice was made available to people through the various forums established under the Act.

It has 4 Chapters and 31 Sections. It came in effect on 24-12-1986 and since then, it is observed as Consumers' Rights day in India.Some amendments came in effect on 18-12-2003 and whatever is described below is inclusive of latest changes.

The opening remark states: An Act to provide for better protection of the interests of consumers and for that purpose to make provision for the establishment of consumer councils and other authorities for the settlement of consumers' disputes and for matters connected therewith—

Chapter I

Section 2 is the Definition clause----Following definitions are important for us:

S.2(1)(b) "complainant" means—

(i) Consumer; or

(ii) Any voluntary consumer association registered under the Companies Act, 1956 (1of 1956)or under any other law for the time being in force; or

(iii) The Central Government or any State Government,

(iv) One or more consumers, where there are numerous consum ers having the same interest;

(v) In case of death of a consumer, his legal heir or representative; who or which makes a complaint;

S.2(1)(d) "consumer" means any person who —

(i) buys any goods for a consideration which has been paid or promised or partly paid and partly promised, or under any system of deferred payment and includes any user of such goods other than the person who buys such goods for consideration paid or promised or partly paid or partly promised, or under any system of deferred payment, when such use is made with the approval of such person, but does not include a person who obtains such goods for resale or for any commercial purpose; or

(ii) hires or avails of any services for a consideration which has been paid or promised or partly paid and partly promised, or under any system of deferred payment and includes any beneficiary of such services other than the person who hires or avails of the services for consideration paid or promised, or partly paid and partly promised, or under any system of deferred payment, when such services are availed of with the approval of the first mentioned person but does not include a person who avails of such services for any commercial purpose;

S.2(1)(f) "defect" means any fault, imperfection or shortcoming in the quality, quantity, potency, purity or standard which is required to be maintained by or under any law for the time being in force under any contract, express or implied, or as is claimed by the trader in any manner whatsoever in relation to any goods;

S.2(1)(g) "deficiency" means any fault, imperfection, shortcoming or inadequacy in the quality, nature and manner of performance which is required to be

maintained by or under any law for the time being in force or has been undertaken to be performed by a person in pursuance of a contract or otherwise in relation to any service;

S.2(1)(m) "**person**" includes,—

(i) a firm whether registered or not;

(ii) a Hindu undivided family;

(iii) a co-operative society;

(iv) every other association of persons whether registered under the Societies Registration Act, 1860 (21 of 1860) or not;

S.2(1)(o) "service" means service of any description which is made available to potential users and includes, but not limited to, the provision of facilities in connection with banking, financing insurance, transport, processing, supply of electrical or other energy, board or lodging or both, housing construction, entertainment, amusement or the purveying of news or other information, but does not include the rendering of any service free of charge or under a contract of personal service;

S.2(1)(oo) "spurious goods and services" mean such goods and services which are claimed to be genuine but they are actually not so;

Medical service included through judicial decision in IMA v V P Shantha, SC13-11-1995

Section 3 - This act is in addition and not in any derogation of any Law

CHAPTER II

S.4- to 8 A—Consumer councils—national and State levels

CHAPTER III

Section 9: Establishment of District (1 or more) consumer forum per district, State level Commission 1 for 1 or 2 states/UT; National Commission at Delhi

Section 10: District forum—1 President + 2 other members (one of them a lady)—for 5 yrs—

Section 11: Jurisdiction up to 20 lacs (likely to go up to 1 Cr soon as of 2018)

Sections 11 & 12: Complainant to make application with requisite fees, then admissibility is checked.

Section 13: Once admitted, forum to send copy to defendant in 3 wks giving period of 30 days which may be further extended by 15 days (total 45 days) If complaint is admitted, no problem—decision is given. If contested, summary Trial—no elaborate evidence—lawyer not a must.

Section 14: Decision - signed by 2 out of 3 members, out of which 1 has to be of the president.

All the proceedings have the same powers of CPC and force of a decree.

Section 15: **Appeal -** Appeal within 1 month to State Commission---if compensation is awarded, 50% of the amount or 25,000, whichever is less needs to be deposited with State Commission before appeal is admitted.

***S*ection 16: Sate Commission**—1 President and not less than 2 and not more than certain number (in Maharashtra, 5 members + 1 President)—S17: Jurisdiction 20 lacs to 1 Cr (likely to go up to 10 Cr soon 2018) + appeals from district forums S.18: Procedure S.19—Appeals to national forum after decision within 1month and deposit of 50% of award or 35000, whichever is less

Section 20: National forum—1 President +4 or members (currently 7 members) and one of them a woman—S.21: Jurisdiction 1 Cr and appeals from State commissions (soon likely to go >10Cr). S.22: Procedure same as district and State levels. S.23—Appeals to SC after deposition of 50% or 50,000 whichever is low.

Section 24: **Limitation period.** The District Forum, the State Commis sion or the National Commission admit a complaint within two years from the date on which the cause of action has arisen but Condonation may be done with reasons to be recorded.

Section 25: Execution of orders. The property of the person, not complying with order of district, state or National Forum may be attached, sold and damages may be paid to the complainant or amount may be collected in the same manner as arrears on Land Revenue by collector

Section 26: Penalties for frivolous and vexatious complaints—up to Rs 10,000!

Section 27: **Penalties for not complying**: Imprisonment for a term not less than one month but which may extend to three years, or with fine not less than two thousands rupees but which may extend to ten thousand rupees, or with both:

Section 28: Protection of action taken in good faith

Sections 29 to 31 are technical point not relevant to us in this course.

So, the salient features of CPA are:

1. Easy, Cheap and Fast system of justice
2. No or less formal
3. Pecuniary jurisdiction i.e. forum solely decided as per compensation demanded
4. Unique appeal system, to deposit stipulated amount before appeal to next forum
5. Non-judicial and women members on bench
6. Pro-consumer Civil litigations
7. Practically no stamp fees—maximum of 10,000Rs.

Doctors and hospitals are very adversely affected since the Supreme Court brought their services under CPA on 13th Nov 1995 and thousands of cases are filed in various District, State and national forums. As of today, Nov. 2018, over 2250 cases related to 'alleged' Medical Negligence are pending for over 2 decades in Maharashtra State forum! Doctor is needed by each one, poor to rich, from birth (or even before birth!) to death (and even after death!). Hence among professionals, our community is affected the worst. And one more thing, medical services are the only one which are taken up by Consumer Forums, even if no payment is received or promised, rest all need either of the two! It has become an easy tool for the patients, consumer associations and so called activists to trouble doctors as they have nothing to lose—and probably the distrust created by this act is a dangerous fall out, particularly for the poorer countries like ours, where costs escalate phenomenally by following defensive medicine, as well as tendency to do violence has roots in this distrust.

As a positive outcome, doctors have started keeping better records, better indemnity coverage and remain within their speciality. They are becoming more legally oriented and careful.

But overall, for doctors and the profession, pros are less and cons are dangerously much more!

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INDIAN MEDICAL COUNCIL

(Professional Conduct, Etiquette and Ethics)

Regulations, 2002

(AMENDED UPTO 8th OCTOBER 2016)

MEDICAL COUNCIL OF INDIA
Pocket-14, Sector 8, Dwarka
New Delhi - 110077

Indian Medical Council

(Professional Conduct, Etiquette and Ethics) Regulations, 2002

(Published in Part III, Section 4 of the Gazette of India, dated 6th April, 2002)

MEDICAL COUNCIL OF INDIA

NOTIFICATION

New Delhi, dated 11th March, 2002

No. MCI-211(2)/2001/Registration. In exercise of the powers conferred under section 20A read with section 33(m) of the Indian Medical Council Act, 1956 (102 of 1956), the Medical Council of India, with the previous approval of the Central Government, hereby makes the following regulations relating to the Professional Conduct, Etiquette and Ethics for registered medical practitioners, namely:-

Short Title and Commencement: (1) These Regulations may be called the Indian Medical Council (Professional conduct, Etiquette and Ethics) Regulations, 2002. (2)They shall come into force on the date of their publication in the Official Gazette.

CHAPTER I

1. **CODE OF MEDICAL ETHICS**

A. Declaration: Each applicant, at the time of making an application for registration under the provisions of the Act, shall be provided a copy of the declaration and shall submit a duly signed Declaration as provided in Appendix 1. The applicant shall also certify that he/she had read and agreed to abide by the same.

B. Duties and responsibilities of the Physician in general:

1.1 Character of Physician (Doctors with qualification of MBBS or MBBS with post graduate degree/ diploma or with equivalent qualification in any medical discipline):

1.1.1 A physician shall uphold the dignity and honour of his profession.

1.1.2 The prime object of the medical profession is to render service to humanity; reward or financial gain is a subordinate consideration. Who- so-ever chooses his profession, assumes the obligation to conduct himself in accordance with its ideals. A physician should be an upright man, instructed in the art of healings. He shall keep himself pure in character and be diligent in caring for the sick; he should be modest, sober, patient, prompt in discharging his duty without anxiety; conducting himself with propriety in his profession and in all the actions of his life.

1.1.3 No person other than a doctor having qualification recognised by Medical Council of India and registered with Medical Council of India/State Medical Council (s) is allowed to practice Modern system of Medicine or Surgery. A person obtaining qualification in any other system of Medicine is not allowed to practice Modern system of Medicine in any form.

1.2 Maintaining good medical practice:

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.

1.2.2 Membership in Medical Society: For the advancement of his profession, a physician should affiliate with associations and societies of allopathic medical professions and involve actively in the functioning of such bodies.

1.2.3 A Physician should participate in professional meetings as part of Continuing Medical Education programmes, for at least 30 hours every five years, organized by reputed professional academic bodies or any other authorized organisations. The compliance of this requirement shall be informed regularly to Medical Council of India or the State Medical Councils as the case may be.

1.3 Maintenance of medical records:

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

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

1.3.3 A Registered medical practitioner shall maintain a Register of Medical Certificates giving full details of certificates issued. When issuing a medical certificate he / she shall always enter the identification marks of the patient and keep a copy of the certificate. He / She shall not omit to record the signature and/or thumb mark, address and at least one identification mark of the patient on the medical certificates or report. The medical certificate shall be prepared as in Appendix 2.

1.3.4 Efforts shall be made to computerize medical records for quick retrieval.

1.4 Display of registration numbers:

1.4.1 Every physician shall display the registration number accorded to him by the State Medical Council / Medical Council of India in his clinic and in all his prescriptions, certificates, money receipts given to his patients.

1.4.2 Physicians shall display as suffix to their names only recognized medical degrees or such certificates/diplomas and memberships/honours which confer professional knowledge or recognizes any exemplary qualification/achievements.

1.5 Use of Generic names of drugs: Every physician should, as far as possible, prescribe drugs with generic names and he / she shall ensure that there is a rational prescription and use of drugs.

The above Clause – 1.5 is substituted in terms of Notification published in the Gazette of India on 08.10.2016 as under.

"Every physician should prescribe drugs with generic names legibly and preferably in capital letters and he/she shall ensure that there is a rational prescription and use of drugs"

1.6 Highest Quality Assurance in patient care: Every physician should aid in safeguarding the profession against admission to it of those who are deficient in moral character or education. Physician shall not employ in connection with his professional practice any attendant who is neither registered nor enlisted under the Medical Acts in force and shall not permit such persons to attend, treat or perform operations upon patients wherever professional discretion or skill is required.

1.7 Exposure of Unethical Conduct: A Physician should expose, without fear or favour, incompetent or corrupt, dishonest or unethical conduct on the part of members of the profession.

1.8 Payment of Professional Services: The physician, engaged in the practice of medicine shall give priority to the interests of patients. The personal financial interests of a physician should not conflict with the medical interests of patients. A physician should announce his fees before rendering service and not after the operation or treatment is under way. Remuneration received for such services should be in the form and amount specifically announced to the patient at the time the service is rendered. It is unethical to enter into a contract of "no cure no payment". Physician rendering service on behalf of the state shall refrain from anticipating or accepting any consideration.

1.9 Evasion of Legal Restrictions: The physician shall observe the laws of the country in regulating the practice of medicine and shall also not assist others to evade such laws. He should be cooperative in observance and enforcement of sanitary laws and regulations in the interest of public health. A physician should observe the provisions of the State Acts like Drugs and Cosmetics Act, 1940; Pharmacy Act, 1948; Narcotic Drugs and Psychotropic substances Act, 1985; Medical Termination of Pregnancy Act, 1971; Transplantation of Human Organ Act, 1994; Mental Health Act, 1987; Environmental Protection Act, 1986; Pre–natal Sex Determination Test Act, 1994; Drugs and Magic Remedies (Objectionable Advertisement) Act, 1954; Persons with Disabilities (Equal Opportunities and Full Participation) Act, 1995 and Bio-Medical Waste (Management and Handling) Rules, 1998 and such other Acts, Rules, Regulations made by the Central/State Governments or local Administrative Bodies or any other relevant Act relating to the protection and promotion of public health.

CHAPTER 2

2. DUTIES OF PHYSICIANS TO THEIR PATIENTS

2.1 Obligations to the Sick

2.1.1 Though a physician is not bound to treat each and every person asking his services, he should not only be ever ready to respond to the calls of the sick and the injured, but should be mindful of the high character of his mission and the responsibility he discharges in the course of his professional duties. In his treatment, he should never forget that the health and the lives of those entrusted to his care depend on his skill and attention. A physician should endeavour to add to the comfort of the sick by making his visits at the hour indicated to the patients. A physician advising a patient to seek service of another physician is acceptable, however, in case of emergency a physician must treat the patient. No physician shall arbitrarily refuse treatment to a patient. However for good reason, when a patient is suffering from an ailment which is not within the range of experience of the treating physician, the physician may refuse treatment and refer the patient to another physician.

2.1.2 Medical practitioner having any incapacity detrimental to the patient or which can affect his performance vis-à-vis the patient is not permitted to practice his profession

2.2 Patience, Delicacy and Secrecy : Patience and delicacy should characterize the physician. Confidences concerning individual or domestic life entrusted by patients to a physician and defects in the disposition or character of patients observed during medical attendance should never be revealed unless their revelation is required by the laws of the State. Sometimes, however, a physician must determine whether his duty to society requires him to employ knowledge, obtained through confidence as a physician, to protect a healthy person against a communicable disease to which he is about to be exposed. In such instance, the physician should act as he would wish another to act toward one of his own family in like circumstances.

2.3 Prognosis: The physician should neither exaggerate nor minimize the gravity of a patient's condition. He should ensure himself that the patient, his relatives or his responsible friends have such knowledge of the patient's condition as will serve the best interests of the patient and the family.

2.4 The Patient must not be neglected: A physician is free to choose whom he will serve. He should, however, respond to any request for his assistance in an emergency. Once having undertaken a case, the physician should not neglect the patient, nor should he withdraw from the case without giving adequate notice to the patient and his family. Provisionally or fully

registered medical practitioner shall not willfully commit an act of negligence that may deprive his patient or patients from necessary medical care.

2.5 Engagement for an Obstetric case: When a physician who has been engaged to attend an obstetric case is absent and another is sent for and delivery accomplished, the acting physician is entitled to his professional fees, but should secure the patient's consent to resign on the arrival of the physician engaged.

CHAPTER 3

3. DUTIES OF PHYSICIAN IN CONSULTATION

3.1 Unnecessary consultations should be avoided:

3.1.1 However in case of serious illness and in doubtful or difficult conditions, the physician should request consultation, but under any circumstances such consultation should be justifiable and in the interest of the patient only and not for any other consideration.

3.1.2 Consulting pathologists /radiologists or asking for any other diagnostic Lab investigation should be done judiciously and not in a routine manner.

3.2 Consultation for Patient's Benefit: In every consultation, the benefit to the patient is of foremost importance. All physicians engaged in the case should be frank with the patient and his attendants.

3.3 Punctuality in Consultation: Utmost punctuality should be observed by a physician in making themselves available for consultations.

3.4 Statement to Patient after Consultation:

3.4.1 All statements to the patient or his representatives should take place in the presence of the consulting physicians, except as otherwise agreed. The disclosure of the opinion to the patient or his relatives or friends shall rest with the medical attendant.

3.4.2 Differences of opinion should not be divulged unnecessarily but when there is irreconcilable difference of opinion the circumstances should be frankly and impartially explained to the patient or his relatives or friends. It would be opened to them to seek further advice as they so desire.

3.5 Treatment after Consultation: No decision should restrain the attending physician from making such subsequent variations in the treatment if any unexpected change occurs, but at the next consultation, reasons for the variations should be discussed/ explained. The same privilege, with its obligations, belongs to the consultant when sent for in an emergency during the absence of attending physician. The attending physician may prescribe medicine at any time for the patient, whereas the consultant may prescribe only in case of emergency or as an expert when called for.

3.6 Patients Referred to Specialists: When a patient is referred to a specialist by the attending physician, a case summary of the patient should be given to the specialist, who should communicate his opinion in writing to the attending physician.

3.7 Fees and other charges:

3.7.1 A physician shall clearly display his fees and other charges on the board of his chamber and/or the hospitals he is visiting. Prescription should also make clear if the Physician himself dispensed any medicine.

3.7.2 A physician shall write his name and designation in full along with registration particulars in his prescription letter head.

Note: In Government hospital where the patient–load is heavy, the name of the prescribing doctor must be written below his/her signature.

CHAPTER 4

4. RESPONSIBILITIES OF PHYSICIANS TO EACH OTHER

4.1 Dependence of Physicians on each other : A physician should consider it as a pleasure and privilege to render gratuitous service to all physicians and their immediate family dependants.

4.2 Conduct in consultation : In consultations, no insincerity, rivalry or envy should be indulged in. All due respect should be observed towards the physician in-charge of the case and no statement or remark be made, which would impair the confidence reposed in him. For this purpose no discussion should be carried on in the presence of the patient or his representatives.

4.3 Consultant not to take charge of the case: When a physician has been called for consultation, the Consultant should normally not take charge of the case, especially on the solicitation of the patient or friends. The Consultant shall not criticize the referring physician. He / she shall discuss the diagnosis treatment plan with the referring physician.

4.4 Appointment of Substitute: Whenever a physician requests another physician to attend his patients during his temporary absence from his practice, professional courtesy requires the acceptance of such appointment only when he has the capacity to discharge the additional responsibility along with his / her other duties. The physician acting under such an appointment should give the utmost consideration to the interests and reputation of the absent physician and all such patients should be restored to the care of the latter upon his/her return.

4.5 Visiting another Physician's Case: When it becomes the duty of a physician occupying an official position to see and report upon an illness or injury, he should communicate to the physician in attendance so as to give him an option of being present. The medical officer / physician occupying an official position should avoid remarks upon the diagnosis or the treatment that has been adopted.

CHAPTER 5

5 DUTIES OF PHYSICIAN TO THE PUBLIC AND TO THE PARAMEDICAL PROFESSION

5.1 Physicians as Citizens: Physicians, as good citizens, possessed of special training should disseminate advice on public health issues. They should play their part in enforcing the laws of the community and in sustaining the institutions that advance the interests of humanity. They should particularly co-operate with the authorities in the administration of sanitary/public health laws and regulations.

5.2 Public and Community Health: Physicians, especially those engaged in public health work, should enlighten the public concerning quarantine regulations and measures for the prevention of epidemic and communicable diseases. At all times the physician should notify the constituted public health authorities of every case of communicable disease under his care, in accordance with the laws, rules and regulations of the health authorities. When an epidemic occurs a physician should not abandon his duty for fear of contracting the disease himself.

5.3 Pharmacists / Nurses: Physicians should recognize and promote the practice of different paramedical services such as, pharmacy and nursing as professions and should seek their cooperation wherever required.

CHAPTER 6

6. UNETHICAL ACTS : A physician shall not aid or abet or commit any of the following acts which shall be construed as unethical -

6.1 Advertising:

6.1.1 Soliciting of patients directly or indirectly, by a physician, by a group of physicians or by institutions or organisations is unethical. A physician shall not make use of him / her (or his / her name) as subject of any form or manner of advertising or publicity through any mode either alone or in conjunction with others which is of such a character as to invite attention to him or to his professional position, skill, qualification, achievements, attainments, specialities, appointments, associations, affiliations or honours and/or of such character as would ordinarily result in his self aggrandizement. A physician shall not give to any person, whether for compensation or otherwise, any approval, recommendation, endorsement, certificate, report or statement with respect of any drug, medicine, nostrum remedy, surgical, or therapeutic article, apparatus or appliance or any commercial product or article with respect of any property, quality or use thereof or any test, demonstration or trial thereof, for use in connection with his name, signature, or photograph in any form or manner of advertising through any mode nor shall he boast of cases, operations, cures or remedies or permit the publication of report thereof through any mode. A medical practitioner is however permitted to make a formal announcement in press regarding the following:

(1) On starting practice.
(2) On change of type of practice.
(3) On changing address.
(4) On temporary absence from duty.
(5) On resumption of another practice.
(6) On succeeding to another practice.
(7) Public declaration of charges.

6.1.2 Printing of self photograph, or any such material of publicity in the letter head or on sign board of the consulting room or any such clinical establishment shall be regarded as acts of self advertisement and unethical conduct on the part of the physician. However, printing of sketches, diagrams, picture of human system shall not be treated as unethical.

6.2 Patent and Copy rights: A physician may patent surgical instruments, appliances and medicine or Copyright applications, methods and procedures. However, it shall be unethical if the benefits of such patents or copyrights are not made available in situations where the interest of large population is involved.

6.3 Running an open shop (Dispensing of Drugs and Appliances by Physicians): - A physician should not run an open shop for sale of medicine for dispensing prescriptions prescribed by doctors other than himself or for sale of medical or surgical appliances. It is not unethical for a physician to prescribe or supply drugs, remedies or appliances as long as there is no exploitation of the patient. Drugs prescribed by a physician or brought from the market for a patient should explicitly state the proprietary formulae as well as generic name of the drug.

6.4 Rebates and Commission:

6.4.1 A physician shall not give, solicit, or receive nor shall he offer to give solicit or receive, any gift, gratuity, commission or bonus in consideration of or return for the referring, recommending or procuring of any patient for medical, surgical or other treatment. A physician shall not directly or indirectly, participate in or be a party to act of division, transference, assignment, subordination, rebating, splitting or refunding of any fee for medical, surgical or other treatment.

6.4.2 Provisions of para 6.4.1 shall apply with equal force to the referring, recommending or procuring by a physician or any person, specimen or material for diagnostic purposes or other study / work. Nothing in this section, however, shall prohibit payment of salaries by a qualified physician to other duly qualified person rendering medical care under his supervision.

6.5 Secret Remedies: The prescribing or dispensing by a physician of secret remedial agents of which he does not know the composition, or the manufacture or promotion of their use is unethical and as such prohibited. All the drugs prescribed by a physician should always carry a proprietary formula and clear name.

6.6 Human Rights: The physician shall not aid or abet torture nor shall he be a party to either infliction of mental or physical trauma or concealment of torture inflicted by some other person or agency in clear violation of human rights.

6.7 Euthanasia: Practicing euthanasia shall constitute unethical conduct. However on specific occasion, the question of withdrawing supporting devices to sustain cardio-pulmonary function even after brain death, shall be decided only by a team of doctors and not merely by the treating physician alone. A team of doctors shall declare withdrawal of support system. Such team shall consist of the doctor in charge of the patient, Chief Medical Officer / Medical Officer in charge of the hospital and a doctor nominated by the in-charge of the hospital from the hospital staff or in accordance with the provisions of the Transplantation of Human Organ Act, 1994.

The Clause No. 6.8, as under, is included in terms of Notification published on 14.12.2009 in Gazette of India .

"6.8 Code of conduct for doctors and professional association of doctors in their relationship with pharmaceutical and allied health sector industry.

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

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

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

c) Hospitality: A medical practitioner shall not accept individually any hospitality like hotel accommodation for self and family members under any pretext.

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

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

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

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

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

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

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

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

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

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

g) Affiliation: A medical practitioner may work for pharmaceutical and allied healthcare industries in advisory capacities, as consultants, as researchers, as treating doctors or in any other professional capacity. In doing so, a medical practitioner shall always:

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

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

The title of Section 6.8 shall be further amended by deleting the words "*and professional association of doctors"* in terms of Notification published on 01.02.2016 in Gazette of India as under:-

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

The Section 6.8.1(b) shall be substituted in terms of Notification published on 01.02.2016 in Gazette of India, as under:-

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

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

SECTION	***ACTION***
6.8.1 *In dealing with Pharmaceutical and allied health sector industry, a medical practitioner shall follow and adhere to the stipulations given below:-*	
a) ***Gifts****: A medical practitioner shall not receive any gift from any pharmaceutical or allied health care industry and their sales people or representatives.*	***Gifts*** *more than Rs. 1,000/- upto Rs. 5,000/- : Censure* ***Gifts*** *more than Rs. 5,000/- upto Rs. 10,000/-: Removal from Indian Medical Register or State Medical Register for 3*

	(three) months. ***Gifts** more than Rs. 10,000/- to Rs. 50,000/- : Removal from Indian Medical Register or State Medical Register for 6(six) months.* ***Gifts** more than Rs. 50,000/- to Rs. 1,00,000/- : Removal from Indian Medical Register or State Medical Register for 1 (one) year.* ***Gifts** more than Rs. 1,00,000/-: Removal for a period of more than 1 (one) year from Indian Medical Register or State Medical Register.*
b) ***Travel facilities**: A medical practitioner shall not accept any travel facility inside the country or outside, including rail, road, air, ship, cruise tickets, paid vacations etc. from any pharmaceutical or allied healthcare industry or their representatives for self and family members for vacation or for attending conferences, seminars, workshops, CME programme etc. as a delegate.*	***Expenses for travel facilities** more than Rs. 1,000/- upto Rs. 5,000/-: Censure* ***Expenses for travel facilities** more than Rs. 5,000/- upto Rs. 10,000/-: Removal from Indian Medical Register or State Medical Register for 3 (three) months.* ***Expenses for travel facilities** more than Rs. 10,000/- to Rs. 50,000/-: Removal from Indian Medical Register or State medical Register for 6 (six) months.* ***Expenses for travel facilities** more than more than Rs. 50,000/- to Rs. 1,00,000/-: Removal from Indian Medical Register or State Medical Register for 1 (one) year.* ***Expenses for travel facilities** more than Rs. 1,00,000/-: Removal for a period of more than 1 (one) year from Indian Medical Register or State Medical Register.*
c) ***Hospitality**: A medical practitioner shall not accept individually any hospitality like hotel accommodation for self and family members under any pretext.*	***Expenses for Hospitality** more than Rs. 1,000/- upto Rs. 5,000/-: Censure* ***Expenses for Hospitality** more than Rs. 5,000/- upto Rs. 10,000/-: Removal from Indian Medical Register or State Medical Register for 3 (three) months.* ***Expenses for Hospitality** more than Rs. 10,000/- to Rs. 50,000/-: Removal from Indian Medical Register or State medical Register for 6 (six) months.* ***Expenses for Hospitality** more than more than Rs. 50,000/- to Rs. 1,00,000/: Removal from Indian Medical Register or State Medical Register for 1 (one) year.* ***Expenses for Hospitality** more than Rs. 1,00,000/-: Removal for a period of more*

	than 1 (one) year from Indian Medical Register or State Medical Register.
d) ***Cash or monetary grants**:- A medical practitioner shall not receive any cash or monetary grants from any pharmaceutical and allied healthcare industry for individual purpose in individual capacity under any pretext. Funding for medical research, study etc. can only be received through approved institutions by modalities laid down by law / rules / guidelines adopted by such approved institutions, in a transparent manner. It shall always be fully disclosed.*	***Cash or monetary grants** more than Rs. 1,000/- upto Rs. 5,000/-: Censure* ***Cash or monetary grants** more than Rs. 5,000/- upto Rs. 10,000/-: Removal from Indian Medical Register or State Medical Register for 3 (three) months.* ***Cash or monetary grants** more than Rs. 10,000/- to Rs. 50,000/-: Removal from Indian Medical Register or State Medical Register for 6 (six) months.* ***Cash or monetary grants** more than more than Rs. 50,000/- to Rs. 1,00,000/-: Removal from Indian Medical Register or State Medical Register for 1 (one) year.* ***Cash or monetary grants** more than Rs. 1,00,000/-: Removal for a period of more than 1 (one) year from Indian Medical Register or State Medical Register.*
e) ***Medical Research**: A medical practitioner may carry out, participate in, work in research projects funded by pharmaceutical and allied healthcare industries. A medical practitioner is obliged to know that the fulfillment of the following items (i) to (vii) will be an imperative for undertaking any research assignment/project funded by industry – for being proper and ethical. Thus, in accepting such a position a medical practitioner shall :-* *(i) Ensure that the particular research proposal(s) has the due permission from the competent concerned authorities.* *(ii) Ensure that such a research project(s) has the clearance of national/state/institutional ethics committees/bodies.* *(iii) Ensure that it fulfils all the legal requirements prescribed for medical research.* *(iv) Ensure that the source and amount of funding is publicly disclosed at the beginning itself.* *(v) Ensure that proper care and facilities are provided to human volunteers, if they are necessary for the research project(s).*	*First time censure, and thereafter removal of name from Indian Medical Register or State Medical Register for a period depending upon the violation of the clause.*

(vi) Ensure that undue animal experimentations are not done and when these are necessary they are done in a scientific and a humane way. *(vii) Ensure that while accepting such an assignment a medical practitioner shall have the freedom to publish the results of the research in the greater interest of the society by inserting such a clause in the MoU or any other documents/agreement for any such assignment.*	
*f) **Maintaining Professional Autonomy** :- In dealing with pharmaceutical and allied healthcare industry a medical practitioner shall always ensure that there shall never be any compromise either with his/her own professional autonomy and/or with the autonomy and freedom of the medical institution.*	*First time censure, and thereafter removal of name from Indian Medical Register or State Medical Register.*
*g) **Affiliation**:- A medical practitioner may work for pharmaceutical and allied healthcare industries in advisory capacities, as consultants, as researchers, as treating doctors or in any other professional capacity. In doing so, a medical practitioner shall always :-* *(i) Ensure that his professional integrity and freedom are maintained.* *(ii) Ensure that patients interest are not compromised in any way.* *(iii) Ensure that such affiliations are within the law.* *(iv) Ensure that such affiliations/ employments are fully transparent and disclosed.*	*First time censure, and thereafter removal of name from Indian Medical Register or State Medical Register for a period depending upon the violaton of the clause.*
*h) **Endorsement**:- A medical practitioner shall not endorse any drug or product of the industry publically. Any study conducted on the efficacy or otherwise of such products shall be presented to and/or through appropriate scientific bodies or published in appropriate scientific journals in a proper way.*	*First time censure, and thereafter removal of name from Indian Medical Register or State Medical Register.*

CHAPTER 7

7. MISCONDUCT : The following acts of commission or omission on the part of a physician shall constitute professional misconduct rendering him/her liable for disciplinary action

7.1 Violation of the Regulations: If he/she commits any violation of these Regulations.

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

7.3 If he/she does not display the registration number accorded to him/her by the State Medical Council or the Medical Council of India in his clinic, prescriptions and certificates etc. issued by him or violates the provisions of regulation 1.4.2.

7.4 Adultery or Improper Conduct: Abuse of professional position by committing adultery or improper conduct with a patient or by maintaining an improper association with a patient will render a Physician liable for disciplinary action as provided under the Indian Medical Council Act, 1956 or the concerned State Medical Council Act.

7.5 Conviction by Court of Law: Conviction by a Court of Law for offences involving moral turpitude / Criminal acts.

7.6 Sex Determination Tests: On no account sex determination test shall be undertaken with the intent to terminate the life of a female foetus developing in her mother's womb, unless there are other absolute indications for termination of pregnancy as specified in the Medical Termination of Pregnancy Act, 1971. Any act of termination of pregnancy of normal female foetus amounting to female foeticide shall be regarded as professional misconduct on the part of the physician leading to penal erasure besides rendering him liable to criminal proceedings as per the provisions of this Act.

7.7 Signing Professional Certificates, Reports and other Documents: Registered medical practitioners are in certain cases bound by law to give, or may from time to time be called upon or requested to give certificates, notification, reports and other documents of similar character signed by them in their professional capacity for subsequent use in the courts or for administrative purposes etc. Such documents, among others, include the ones given at Appendix –4. Any registered practitioner who is shown to have signed or given under his name and authority any such certificate, notification, report or document of a similar character which is untrue, misleading or improper, is liable to have his name deleted from the Register.

7.8 A registered medical practitioner shall not contravene the provisions of the Drugs and Cosmetics Act and regulations made there under. Accordingly,

a) Prescribing steroids/ psychotropic drugs when there is no absolute medical indication;
b) Selling Schedule 'H' & 'L' drugs and poisons to the public except to his patient;
in contravention of the above provisions shall constitute gross professional misconduct on the part of the physician.

7.9 Performing or enabling unqualified person to perform an abortion or any illegal operation for which there is no medical, surgical or psychological indication.

7.10 A registered medical practitioner shall not issue certificates of efficiency in modern medicine to unqualified or non-medical person.

(Note: The foregoing does not restrict the proper training and instruction of bonafide students, midwives, dispensers, surgical attendants, or skilled mechanical and technical assistants and therapy assistants under the personal supervision of physicians.)

7.11 A physician should not contribute to the lay press articles and give interviews regarding diseases and treatments which may have the effect of advertising himself or soliciting practices; but is open to write to the lay press under his own name on matters of public health, hygienic

living or to deliver public lectures, give talks on the radio/TV/internet chat for the same purpose and send announcement of the same to lay press.

7.12 An institution run by a physician for a particular purpose such as a maternity home, nursing home, private hospital, rehabilitation centre or any type of training institution etc. may be advertised in the lay press, but such advertisements should not contain anything more than the name of the institution, type of patients admitted, type of training and other facilities offered and the fees.

7.13 It is improper for a physician to use an unusually large sign board and write on it anything other than his name, qualifications obtained from a University or a statutory body, titles and name of his speciality, registration number including the name of the State Medical Council under which registered. The same should be the contents of his prescription papers. It is improper to affix a sign-board on a chemist's shop or in places where he does not reside or work.

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.

7.15 The registered medical practitioner shall not refuse on religious grounds alone to give assistance in or conduct of sterility, birth control, circumcision and medical termination of Pregnancy when there is medical indication, unless the medical practitioner feels himself/herself incompetent to do so.

7.16 Before performing an operation the physician should obtain in writing the consent from the husband or wife, parent or guardian in the case of minor, or the patient himself as the case may be. In an operation which may result in sterility the consent of both husband and wife is needed.

7.17 A registered medical practitioner shall not publish photographs or case reports of his / her patients without their permission, in any medical or other journal in a manner by which their identity could be made out. If the identity is not to be disclosed, the consent is not needed.

7.18 In the case of running of a nursing home by a physician and employing assistants to help him / her, the ultimate responsibility rests on the physician.

7.19 A Physician shall not use touts or agents for procuring patients.

7.20 A Physician shall not claim to be specialist unless he has a special qualification in that branch.

7.21 No act of invitro fertilization or artificial insemination shall be undertaken without the informed consent of the female patient and her spouse as well as the donor. Such consent shall be obtained in writing only after the patient is provided, at her own level of comprehension, with sufficient information about the purpose, methods, risks, inconveniences, disappointments of the procedure and possible risks and hazards.

7.22 Research: Clinical drug trials or other research involving patients or volunteers as per the guidelines of ICMR can be undertaken, provided ethical considerations are borne in mind. Violation of existing ICMR guidelines in this regard shall constitute misconduct. Consent taken from the patient for trial of drug or therapy which is not as per the guidelines shall also be construed as misconduct.

The following Clause No. 7.23 & 7.24 are deleted in terms of Notification published on 22.02.2003 in Gazette of India.

7.23 If a physician posted in rural area is found absent on more than two occasions during inspection by the Head of the District Health Authority or the Chairman, Zila Parishad, the same shall be construed as a misconduct if it is recommended to the Medical Council of India/State Medical Council by the State Government for action under these Regulations.

7.24 If a physician posted in a medical college/institution both as teaching faculty or otherwise shall remain in hospital/college during the assigned duty hours. If they are found absent on more than two occasions during this period, the same shall be construed as a misconduct if it is certified by the Principal/Medical Superintendent and forwarded through the State Government to Medical Council of India/State Medical Council for action under these Regulations.

CHAPTER 8

8. PUNISHMENT AND DISCIPLINARY ACTION

8.1 It must be clearly understood that the instances of offences and of Professional misconduct which are given above do not constitute and are not intended to constitute a complete list of the infamous acts which calls for disciplinary action, and that by issuing this notice the Medical Council of India and or State Medical Councils are in no way precluded from considering and dealing with any other form of professional misconduct on the part of a registered practitioner. Circumstances may and do arise from time to time in relation to which there may occur questions of professional misconduct which do not come within any of these categories. Every care should be taken that the code is not violated in letter or spirit. In such instances as in all others, the Medical Council of India and/or State Medical Councils have to consider and decide upon the facts brought before the Medical Council of India and/or State Medical Councils.

8.2 It is made clear that any complaint with regard to professional misconduct can be brought before the appropriate Medical Council for Disciplinary action. Upon receipt of any complaint of professional misconduct, the appropriate Medical Council would hold an enquiry and give opportunity to the registered medical practitioner to be heard in person or by pleader. If the medical practitioner is found to be guilty of committing professional misconduct, the appropriate Medical Council may award such punishment as deemed necessary or may direct the removal altogether or for a specified period, from the register of the name of the delinquent registered practitioner. Deletion from the Register shall be widely publicized in local press as well as in the publications of different Medical Associations/ Societies/Bodies.

8.3 In case the punishment of removal from the register is for a limited period, the appropriate Council may also direct that the name so removed shall be restored in the register after the expiry of the period for which the name was ordered to be removed.

8.4 Decision on complaint against delinquent physician shall be taken within a time limit of 6 months.

8.5 During the pendency of the complaint the appropriate Council may restrain the physician from performing the procedure or practice which is under scrutiny.

8.6 Professional incompetence shall be judged by peer group as per guidelines prescribed by Medical Council of India.

8.7 The following Clause No. 8.7 & 8.8 are included in terms of Notification published on 27.05.2004 in Gazette of India.

"8.7 Where either on a request or otherwise the Medical Council of India is informed that any complaint against a delinquent physician has not been decided by a State Medical Council within a period of six months from the date of receipt of complaint by it and further the MCI has reason to believe that there is no justified reason for not deciding the complaint within the said prescribed period, the Medical Council of India may-

(i) Impress upon the concerned State Medical council to conclude and decide the complaint within a time bound schedule;
(ii) May decide to withdraw the said complaint pending with the concerned State Medical Council straightaway or after the expiry of the period which had been stipulated by the

MCI in accordance with para(i) above, to itself and refer the same to the Ethical Committee of the Council for its expeditious disposal in a period of not more than six months from the receipt of the complaint in the office of the Medical Council of India."

"8.8 Any person aggrieved by the decision of the State Medical Council on any complaint against a delinquent physician, shall have the right to file an appeal to the MCI within a period of 60 days from the date of receipt of the order passed by the said Medical Council:

Provided that the MCI may, if it is satisfied that the appellant was prevented by sufficient cause from presenting the appeal within the aforesaid period of 60 days, allow it to be presented within a further period of 60 days.

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PROFESSION TAX FAQs

Registration

1) **Who is liable to pay Profession Tax in the State of Maharashtra?**

Ans Any person who is engaged in any profession, Trade, callings and employment in the State of Maharashtra is liable to pay Profession Tax. A person includes Hindu undivided family, firm, company, corporation or other corporate body, any society, club or association.

2) **What are the types of Profession Tax payers?**

Ans There are 2 types of Profession Tax payers

a) **Profession Tax Enrollment Certificate (PTEC) :** Any person engaged in Profession, Trade and Callings and falling under one or the other of the classes mentioned in the second column of Schedule I shall obtained PTEC

b) **Profession Tax Registration Certificate (PTRC) :** Every employer who has employed even a single employee whose salary is above the prescribed limit for deducting Profession Tax shall obtain PTRC.

3) **What is the time limit to apply for Enrollment / Registration?**

Ans A person / employer shall apply within 30 days of becoming liable to pay tax.

4) **Which forms to be used for applying PTEC and PTRC. What is the method of application?**

Ans The person who is liable to obtain PTEC shall apply in Form II and an employer who is liable to obtain PTRC shall apply in Form I. Both the applications shall be made online on Maharashtra Goods and Services Tax Department's (MGSTD) web-site www.mahagst.gov.in

5) **Whether I have to create profile for application of PTEC and / or PTRC?**

Ans Every entity who wants to apply for registration for any of the Act govern by MGSTD shall create profile on www.mahagst.gov.in.

a) If any applicant has already obtained registration under any of the Act and wants to apply for registration under another Act shall create his profile by selecting option

"Create Profile for New System" under "Log in for e-services". After creation of profile he can use the e-services also.

b) applicant other than 'a' above shall create his profile by selecting option "New Dealer Registration" under "Other Acts Registration".

6) **What are the documents required to be uploaded along with application?**

a) For PTEC no documents is required to be submitted.

b) For PTRC the list of required documents is given in Trade Circular 20T of 2017 Dt 16/6/2017.

7) **What are the penalty provisions, if I apply late for registration / Enrollment?**

Ans As per Section 5(5) of PT Act, where an employer or a person liable to registration or enrolment has failed to apply for such certificate within the required time, the prescribed authority may, impose penalty of rupees five for each day of delay in case of such employer and rupees two for each day of delay in case of such person

8) **How do I know that the application submitted by me is in order or any query has been raised against my application?**

Ans If the query is raised against the application a defect memo is sent of the registered mail-ID of the applicant. Applicant has to comply the query within 30 days from the date of query raised. If he do not comply within 30 days, his application gets rejected. However he can reapply using the same application again. He can check the status of his application by entering his PAN at "RC Download" in "Other Acts Registration".

a) If the status is shown "With STO" then the

application is with nodal officer.

b) If the status is shown as "With Applicant" then either the application is not submitted by the applicant or the officer has raised the query.

9) **How do I know that PTEC / PTRC Tax Identification Number (TIN) has been allotted to me?**

Ans A mail is send on registered mail-ID containing digitally signed PTRC / PTEC immediately after granting TINs. The user can check the same by entering his PAN at "RC Download" in "Other Acts Registration". He can download the Registration / Enrollment certificate by clicking 'Print / Preview' button.

10) **What are the due date for PTEC payment after obtaining TIN?**

Ans a) If PTEC TIN holder have any previous year's liability shown in the certificate, he has to discharge the same immediately.

b) Current year's tax liability can be discharged upto 30th June of that financial year if the enrollment is taken before 31st May. If the enrollment is taken after that the liability shall be discharged within 30 days from the data of enrollment.

c) For future financial year, he has to discharge his tax liability upto 30th June of every financial year.

11) **What are the due dates for making payments of PTRC?**

Ans Due data for making payment is the last date of the month to which the return relates.

12) **What are the periodicities for PTRC payment and return after obtaining TIN?**

Ans a) As per Rule 11A employer has to discharge his liability and file the return monthly upto the end of the financial year in which he has obtained PTRC TIN.

b) From next year, if his previous year's tax liability was

I) less than Rs 50,000/- then his periodicity to pay tax and file return for current financial year is annual. However employer can discharge his liability multiple times by selecting yearly period while making payment.

ii) Rs 50,000/- or above then his periodicity to pay tax and file return for current financial year is monthly.

13) **I want to change the Address of Place of Activity, what is the procedure ?**

Ans The user can apply for amendment by login >> Registration >> Amendment >> Email / Mobile or Other.

14) **How to apply for cancellation?**

Ans The user can apply online for cancellation by login >> Registration >> Cancellation.

Payment :

15) **Whether it is mandatory for PTRC and PTEC holder to make e-Payment ?**

Ans As per notification No PFT.1012/ C.R.29/ Taxation-3 Date 14-June-2012 e-Payment is made mandatory for Profession Tax Registration Certificate (PTRC) holders. However, it is optional for Profession Tax Enrollment (PTEC) holders.

16) **From which web-site payment can be made?**

Ans e-Payment shall be made through www.mahagst.gov.inwww.mahagst.gov.in >> e-Payment.

17) **What are the options available in e-Payment for Profession Tax payers?**

Ans Options available for Profession Tax payers are a) Advance Payment b) Order Dues Payment.

18) **Which option I should select for payment of Profession Tax deducted from the salary of my employees (PTRC) and / or payment of PTEC?**

Ans The tax payer should select 'Advance Payment' option to make payment of PTRC and PTEC.

19) **Which option I should select for payment of Profession Tax liability arising out of any order passed by the Profession Tax Department.**

Ans : Tax payers shall select 'Order Dues payment' for discharging liability other than 16 above.

20) **What is the procedure to make payment?**

Ans I) go to www.mahagst.gov.in

ii) put your mouse point on e-Payment. The tile will flip and option will be displayed.

iii) Select appropriate option

iv) Enter Your TIN, captcha and Press Next button

v) Select Act, form ID, Financial Year, Period and Location. Enter the amount and then press Proceed for Payment.

vi) Agree to refund policy by clicking radio button and then select payment gateway and click on Proceed

vii) Draft chalan will be displayed

viii) Click on Make Payment

ix) Payment gateway page will be displayed Select Bank in which you hold net banking account.

xi) Click on Proceed for Payment

xii) Gateway will redirect you to bank web-page

xiii) enter your login credentials of net banking and make payment.

xiv) Final receipt in MTR-6 will be generated.

Stepwise detail process is given in the Trade Circular 48T of 2017

21) **How to make payment if I don't have net banking account or I don't have account in any of the listed bank for e-payment ?**

Ans The tax payer can make the payment by using "Payment Across the Bank Counter" provided by GRAS. The detail procedure for generating chalan for "Payment Across the Bank Counter" is given in What's New section under "Process for chalan generation for Payment Across Bank Counter through GRAS."

22) **Which period I have to select in chalan while making PTRC payment if my periodicity is monthly?**

Ans While making PTRC monthly payment, in period dropdown, employer shall select succeeding month of the month to which salary pertains. e.g. select June in the period dropdown to deposit PT deducted from the salary of May. Refer Rule 11 of PT Rule 1975, illustration given under Rule 11 and point no 7 of Trade Circular 48T of 2017 clarifying the Rule.

23) **Which period I have to select in chalan while making PTRC payment, if my periodicity is yearly?**

Ans While making PTRC yearly payment in the period dropdown, employer shall select 01/04/YYYY to 31/3/YYYYY i.e. full financial year. The user can discharge is liability multiple times by selecting yearly period.

24) **Error is coming as "Balance payable should not be more than zero" though I have made the payment by selecting proper period ?**

Ans Sometime status of the chalan and bank CIN is not updated on real time basis by bank. So if the Chalan Identification Number (CIN) is not available in the payment details then system does not auto populate chalan details in the Draft Return and hence it is resulted into this error. User can obtain the real time status by clicking "Get Status". If the status of the payment is updated as successful from bank then "Get Status" will be converted into "View Chalan". Then this chalan will be auto populated in the return and it will resolve the error.

25) **What is the process to generate the chalan if I am unable to take printout at the time of payment?**

Ans : a) After login to the departments web-site www.mahagst.gov.inwww.mahagst.gov.in user can reprint the chalan by path Payments >> Pending Transaction History >> View Chalan. A PDF of chalan will get generated when the user clicks on "View Chalan".

b) If the status of the payment is not updated by the bank on real time basis, the status of the chalan is shown as "Get Status". User can obtain the real time status by clicking "Get Status". If the status of the payment is updated as successful from bank then "Get Status" will be converted into "View Chalan". A PDF of chalan will get generated when the user clicks on "View Chalan".

26) **What is the process to correct the period, if I have selected the wrong period in chalan?**

Ans Tax payer shall apply to the Nodal Profession Tax Officer of his jurisdiction for any type\ of corrections in the chalan.

Profile Creation :

27) **Though I have created profile on new system, I am unable to access e-services (file return / Make Amendment application).**

Ans The dealers / employers who are registered under any of the Acts governed by the Maharashtra Goods and Services Tax Department (MGSTD), shall create their profile through option 'Profile for Registered Dealer' which is available under the 'Login for e-Services' Tile. However it is observed that employers have created profile by choosing the option 'New Dealer Registration' available under 'Other Act Registration' Tile. This option is to be chosen by the dealers / employers who does not have registration under any of the Acts governed by the MGSTD. If the employers have created profiles by using 'New Dealer Registration', they should raise a service request Ticket by using "May I Help You >> Service Request" The issue should be described in details. MGSTD will remove such profile from the system and inform the dealer on the registered mail-ID. After this employer can create profile by using proper option.

Returns :

28) How can I file the PTRC Return ? Ans :

a) The employer shall use his login credentials for using e-services of www.mahagst.gov.in

b) Click on Returns

c) Select "Return Submission Other Than VAT/CST"

d) Select Act then press Next

e) Select "Return Type" and press Next

f) Select Month and press Next'

g) Select File by clicking Browse button and then Click OK

h) Click on "Upload file"

i) Draft Return will be shown

j) Click on "Submit" and return will get uploaded and final receipt with the return will be generated.

29) **What period I should select in the return at "Period Covered by the Return" and in which month I have to show the number of employees ?**

a) If the periodicity is monthly, then user should select succeeding month of the month to which the salary pertains. And he should enter number of employees in the column of Salary month. e.g. User shall select June in the column "Period Covered by the return", if he is filling return for salary month May. He should enter number of employees in the column May.

b) If the periodicity is yearly, then user should select financial year in the column "Period Covered by the return". He should consider Salaries paid for the month March of previous financial year to February of current financial year.

30) **When I am trying to upload return error is coming as "Balance Payable should not be more than zero"?**

Ans a) As per Rule 11 of the PT Rules 1975, if the employer is monthly, then while making payment, tax payer should select succeeding month of the month to which the salary pertains. It is noticed that employers are mentioning salary month while making payment. SAP system matches return month and payment month. So if the return period and payment period does not matches, then this error occurs. If such error occurs and it is noticed that payment period and return period differs, then tax payer should apply to the concern nodal Profession Tax Officer for period correction. After period correction this error will be resolved. Detailed instructions are given in Trade Circular 48T of 2017 at point no 7. Further the instructions are given by way of pop up window in payment utility.

b) Sometimes the status of the payment is not updated by the bank on real time basis. If the status of the chalan is shown as "Get Status" then this chalan will

not get auto populated in return. User can obtain the real time status by clicking "Get Status". If the status of the payment is updated as successful from bank then "Get Status" will be converted into "View Chalan". Then this chalan will get auto populated in the return.

31) **When I am trying to upload the return error is occurring as "Period Key does not match"?**

Ans The period mentioned in the template the selected at the time of uploading in SAP should be same. If both the period differs then such error occurs. User should select same period in return as well as uploading utility.

32) **At the time of return uploading error is coming as "Credit carried forward cannot be more than excess credit available"**

Ans Excess amount paid over the liability is shown as Refund in the return. Tax Payer has to enter it as excess credit carried forward. Then only system will allow tax payer to use the amount for subsequent period. Or some time the dealer does not enter the late fee and shows entire amount as carried forward. System deducts the late fees if applicable and then remaining amount is posted as carried forward in the system. But tax payer mentions the amount in full as brought forward, then this error occurs. Tax payer should refer his earlier period return to ascertain how much amount is carried forward and then same should be entered as carried forward.

As per the Maharashtra state tax on professions, trades, calling and employment act 1975 every working professional and self-employed professionals like lawyers, doctors and chartered accountants etc need to pay professional tax to the state government. Professional tax in Maharashtra is applicable to the employees whose monthly salary is 7501 Rs or more than it.

As per the latest professional tax slab in Maharashtra 2018-19 there is no need to pay professional tax up to a salary of 7500 Rs, from 7501 Rs to 10000 Rs there is a professional tax of 175 Rs and for above 10000 Rs there is a professional tax of 200 Rs & 300 Rs (in Feb only).

Professional Tax Slab In Maharashtra 2018-19:

Monthly Salary	Professional Tax In Rs
Up to 7500	RsNil
7501 – 10000	Rs175, Nil for women
Above 10001 Rs	200 Rs for 11 months, 300 Rs (Only In February)

Women employee whose monthly salary is below 10000 Rs are exempted from professional tax payment.

Due Date For Payment Of Professional Tax In Maharashtra 2018-19:

The last date for professional tax payment in Maharashtra varies in Two cases:

- Companies whose annual professional tax liability is more than 50000 Rs in the previous year has to pay PT payments annually by the end of 31 March of next year.
- Companies whose annual professional tax liability is less than 50000 Rs in the previous year has to pay PT payments monthly, by the end of next month of salary month.

Note: In case of the first year of PT registration, PT payments have to be done monthly by the end of the next month of salary month.

• • •

GST rate for goods and services is decided by the GST Council in India based on SAC code. SAC code or Services Accounting Code is a classification methodology created by the service tax department for classifying services for the purposes of levy of service tax. GST on goods on the other hand is levied based on HSN code, an internationally adopted classification methodology for goods in the course of import and export. GST rate for services fall under 0%, 5%, 12%, 18% or 28% slab. Here, we look at the GST rate for medical services, hospitals and doctors in detail.

GST Rate for Medical, Hospital, Doctor and Social Services

Majority of the medical, hospital and doctor services are exempt from GST.

Health care services by a clinical establishment, an authorised medical practitioner or para-medics is exempt from GST. Services by a veterinary clinic in relation to health care of animals or birds is also exempt from GST.

Services provided by cord blood banks by way of preservation of stem cells or any other service in relation to such preservation is exempt from GST.

Also, services provided by way of transportation of a patient in an ambulance is exempt from GST.

The GST rate for services has a catch-all clause which mentions that if a service is not exempt from GST explicitly or the GST rate for the service is not provided for explicitly, then a 18% GST rate would be a applicable. Hence, some of the above services not rendered by a clinical establishment or an authorised medical practitioner or a para-medics could be subject to GST.

In case a person supplying services is taxable under GST, then GST registration must be obtained and GST returns must be filed. Know more about GST compliance at the India Filings GST Portal.

GST RATE FOR MEDICINES

The GST Rates for medicines were decided by the GST council in the meeting held on 3rd June, 2017. GST is levied under 5 different rates, namely NIL, 5%, 12%, 18% and 28% based on the HSN code of the item. Medicines and pharmaceuticals are classified under 37th chapter of the HSN Code. In this article, we look at the GST rate for medicines and the associated HSN code.

NIL GST Rate Medicines

The following types of medicines and pharmaceutical products are exempt from GST:

- Human Blood and its components
- All types of contraceptives

5% GST Rate

Goods under the following HSN categories are taxed at 5% GST rate:

- Animal or Human Blood Vaccines
- Diagnostic kits for detection of all types of hepatitis
- Desferrioxamine injection or deferiprone
- Cyclosporin
- Medicaments (including veterinary medicaments) used in bio-chemic systems and not bearing a brand name
- Oral re-hydration salts
- Drugs or medicines including their salts and esters and diagnostic test kits
- Formulations manufactured from the bulk drugs

12% GST Rate

The following types of medicines and pharmaceutical products are taxed at 12% GST rate:

- Organs for organo-therapeutic uses, dried, whether or not powdered; extracts of glands or other organs or of their secretions for organo-therapeutic uses; heparin and its salts; other human or animal substances prepared for therapeutic or prophylactic uses, not elsewhere specified or included
- Animal blood prepared for therapeutic, prophylactic or diagnostic uses; antisera and other blood fractions and modified immunological products, whether or not obtained by means of biotechnological processes; toxins, cultures of microorganisms (excluding yeasts) and similar products.
- Medicaments consisting of two or more constituents which have been mixed together for therapeutic or prophylactic uses, not put up in measured doses or in forms or packings for retail sale, including

Ayurvaedic, Unani, Siddha, homoeopathic or Biochemic systems medicaments.

- Medicaments consisting of mixed or unmixed products for therapeutic or prophylactic uses, put up in measured doses (including those in the form of transdermal administration systems) or in forms or packings for retail sale, including Ayurvaedic, Unani, homoeopathic siddha or Biochemic systems medicaments, put up for retail sale.
- Wadding, gauze, bandages and similar articles (for example, dressings, adhesive plasters, poultices), impregnated or coated with pharmaceutical substances or put up in forms or packings for retail sale for medical, surgical, dental or veterinary purposes.
- Pharmaceutical goods such as Sterile surgical catgut, similar sterile suture materials (including sterile absorbable surgical or dental yarns) and sterile tissue adhesives for surgical wound closure; sterile laminaria and sterile laminaria tents; sterile absorbable surgical or dental haemostatics; sterile surgical or denatal adhesion barriers, whether or not absorbable, etc.,
- Waste pharmaceuticals

18% GST Rate

Nicotine polacrilex gum is the only medicine or pharmaceutical product taxed at 18% GST rate. No pharmaceutical or medicines have been taxed at 28% GST. Hence, the highest applicable GST rate for medicines is 18%.

GST RATE FOR MEDICAL EQUIPMENTS

Medical equipments and apparatus are taxed under all five rates of GST , namely 0%, 5%, 12%, 18% and 28%. Only hearing aids are not taxable under GST. Rest of all goods under chapter 90 of the HSN code are taxable as follows:

Medical Equipments attracting 5% GST

- Coronary stents and coronary stent systems for use with cardiac catheters.
- Artificial kidney
- Disposable sterilized dialyzer or microbarrier of artificial kidney
- Parts of the following goods, namely:
- Crutches
- Wheel chairs
- Walking frames
- Tricycles
- Braillers
- Artificial limbs
- Assistive devices, rehabilitation aids and other goods for disabled

Medical Equipments attract 12% GST

- Blood glucose monitoring system (Glucometer) and test strips
- Patent Ductus Arteriousus
- Instruments and appliances used in medical, surgical, dental or veterinary sciences, including scintigraphic apparatus, other electro-medical apparatus and sighttesting instruments
- Mechano-therapy appliances; massage apparatus; psychological aptitude-testing apparatus; ozone therapy, oxygen therapy, aerosol therapy, artificial respiration or other therapeutic respiration apparatus
- Other breathing appliances and gas masks, excluding protective masks having neither mechanical parts nor replaceable filters
- Orthopaedic appliances, including crutches, surgical belts and trusses; splints and other fracture appliances; artificial parts of the body; hearing aids and other appliances which are worn or carried, or implanted in the body, to compensate for a defect or disability
- Apparatus based on the use of X-rays or of alpha, beta or gamma radiations, for medical, surgical, dental or veterinary uses, including radiography or radiotherapy apparatus, X-ray tubes and other Xray generators, high tension generators, control panels and desks, screens, examinations or treatment tables, chairs and the light

The following items attract 18% GST:

- Optical fibres and optical fibre bundles; optical fibre cables other than those of heading 8544; sheets and plates of polarising material; prisms, mirrors and other optical elements, of any material, unmounted, other than such elements of glass not optically worked.
- Lenses, prisms, mirrors and other optical elements, of any material, mounted, being parts of or fittings for instruments or apparatus, other than such elements of glass not optically worked.
- Machines and appliances for testing the hardness, strength, compressibility, elasticity or other mechanical properties of materials (for example, metals, wood, textiles, paper, plastics).

- Hydrometers and similar floating instruments, thermometers, pyrometers, barometers, hygrometers and psychrometers, recording or not, and any combination of these instruments.
- Instruments and apparatus for measuring or checking the flow, level, pressure or other variables of liquids or gases (for example, flow meters, level gauges, manometers, heat meters), excluding instruments and apparatus.
- Instruments and apparatus for physical or chemical analysis (for example, polarimeters, refractometers, spectrometers, gas or smoke analysis apparatus); instruments and apparatus for measuring or checking viscosity, porosity, expansion, surface tension or the like; instruments and apparatus for measuring or checking quantities of heat, sound or light (including exposure meters); microtomes.
- Gas, liquid or electricity supply or production meters, including calibrating meters.
- Revolution counters, production counters, taximeters, mileometers, pedometers and the like; speed indicators and tachometers.
- Oscilloscopes, spectrum analysers and other instruments and apparatus for measuring or checking electrical quantities; instruments and apparatus for measuring or detecting alpha, beta, gamma, X ray, cosmic or other ionising radiation.
- Measuring or checking instruments, appliances and machines, not specified or included elsewhere in this Chapter; profile projectors.

The following items will attract 28% GST:

- Compound optical microscopes, including those for photomicrography cinephotomicrography or microprojection,
- Microscopes other than optical microscopes; diffraction apparatus.
- Liquid crystal devices not constituting articles provided for more specifically in other headings; lasers, other than laser diodes; other optical appliances and instruments, not specified or included elsewhere in this Chapter.
- Balances of a sensitivity of 5 cg or better, with or without weights.
- Instruments for measuring length, for use in the hand (for example, measuring rods and tapes, micrometers, callipers), not specified or included elsewhere in the chapter.
- Apparatus based on the use of X-rays or of alpha, beta or gamma radiations, for other than medical, surgical, dental or veterinary uses, including radiography or radiotherapy apparatus, X-ray tubes and other X-ray generators, high tension generators, control panels and desks, screens, examinations or treatment tables, chairs and the light.
- Instruments, apparatus and models, designed for demonstrational purposes (for example, in education or exhibitions), unsuitable for other uses.

Important Considerations for GST:

1. It is must for all associations to have a Pan number and GST number.
2. Though medicines dispensed by hospitals are excluded from GST, all purchases made by hospitals from chemists (If chemist shop is in house) are liable for GST payment.
3. If an individual doctor does not have GST no, the provisions under reverse GST charges cannot become applicable.

Services under Reverse Charge 9(3)

- Following are services where doctors will be liable for compulsory registration u/s 24 liable to tax under Reverse Charge.
- Services by a goods transport agency (GTA) in respect of transportation of goods by road
- Services by individual advocate or firm of adv. by way of legal services, directly or indirectly
- Services received from person located in Non Taxable Territory.
- Services from Government or Local Authority
- Sponsorship to any body corporate or partnership

Dr. will become liable for GST

The doctors will become liable for taking registration and pay taxes on taxable services & taxes under reverse charge u/s 9(4) in following cases:-

1. If he becomes liable to pay tax under RCM u/s 9(3) See slide no. 22.
2. a. Receive rent for equipments
   b. Taking honorarium for giving lectures
   c. Beauty treatment.
   d. Sale of medicines
   e. Receiving rent for commercial use of premises.
   f. Receiving money for/ from locum
   g. Gym center or weight loss center.

(Provided total value of supply (tax free + taxable) made exceeds Rs. 20/10 lacks for point no. 2)

Latest on Shop and Establishment Act for Medical Establishments
(taken online from latestlaws.com)

Bombay High Court has recently (6th November 2018) dismissed a challenge to provisions of the new Maharashtra Shops & Establishments (Regulation of Employment & Conditions of Service) Act, 2017 ('new Act'), which enables the regulation of medical establishments.

The Act particularly focuses on monitoring the conditions of employees working in regulated establishments.

Before its introduction, the erstwhile ***Maharashtra Shops & Establishments Act, 1948*** ('old Act') did not regulate medical establishments since they could not be termed as commercial establishments as per ***Section 2 (4) of the old Act.***

In fact, attempts made by the State to bring medical & other non-commercial establishments under the purview of the old Act were reversed by the courts on various occasions.

In D Devendra M Surti v. State of Gujarat, the Supreme Court ruled that the old Act was not intended to cover medical establishments.

In State of Maharashtra v. Dhanlaxmi Meisheri, a similar ruling was made by the Bombay High Court with respect to maternity homes.

In Narendra Keshrichand Fulandi and another v. State of Maharashtra, the High Court concluded that legal practitioners would not come within the purview of the old Act.

The common thread in all these challenges was that the establishments involved did not qualify as a commercial trade or business, which was the confined area that the old Act sought to regulate.

New Act though dropped the term commercial and broadened its purview to any establishment, including medical establishments and medical practitioners.

Specifically, ***Section 2(4)*** of the new Act expanded the definition of an ***"establishment"*** to include the establishment of any medical practitioner (including hospital, dispensary, clinic, polyclinic, maternity home and such others).

According to the new Act, medical establishments with ten or more employees had to be registered & certain other statutory obligations regarding employee working conditions are required to be complied with.

Adding to it, medical establishments with a lesser number of employees were expected to intimate the existence of the establishment, although they did not have any further statutory obligations thrust upon them.

The new scheme was challenged by a medical practitioner, Dr Pradeep Arora, whose medical clinic had been registered under the ***Maharashtra Medical Council Act, 1965.***

Depending on above-mentioned cases, he contended that his medical establishment could not be further regulated by the new Act.

He argued that the same would be beyond the state's legislative competence and in violation of his freedom to practice his trade under ***Article 19 of the Constitution.***

Court though did not find any merit in these arguments.

Bench comprising of Justice RK Deshpande & Justice Vinay Joshi noted that the only reason why medical establishments were not included within the purview of the old Act was because the old Act only provided for commercial establishments.

Court also noted that the new Act appeared to have modeled its definition of ***"establishment"*** along the lines of an **"industry"**, to regulate employee conditions in public interest.

Court in this regard has agreed with the state's arguments that a medical establishment would also involve the three basic ingredients which define an industry, i.e.

- there should be systematic activity,
- organized by cooperation between employer and employee, and
- for the production and/or distribution of goods and services calculated to satisfy human wants and wishes.

Court thus observed, "In our view, it is the harmonious activity carried out in cooperation amongst all the partners in the establishment to render material services to the community with the help of capital, which is covered by the definition of "establishment" under Section 2(4) of the new Act. Whether the establishment is running in profit or loss is of no consequence."

In view of these observations, the Court dismissed Dr Arora's challenge, while also noting that the state was well within its legislative competence to bring about such an enactment in public interest.

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Professional Indemnity Insurance

Dr Jayant Navarange
MD, DCH, LLB
Medicolegal Consultant

In these days of increasing litigations and consumerism, it is essential that the medical personnel be covered with Professional Negligence and Hospital error and omission policy, thereby giving peaceful daily routine and night sleep! If we consider the amounts claimed for alleged professional negligence with the advent of Consumer Protection Act, (CPA) it is essential that we understand the basic infrastructure, provisions, limitations and loopholes, traps and exclusions of such policies. For convenience, we will use the short form, **PIP** for Professional Indemnity Policy for negligence and errors as well as hospital indemnity policies. **We are not considering** Medi-claim policies for patients at this stage.

Please note that Insurance policies cover only compensatory aspects of Civil Negligence (and hence cover the CPA also) and cannot cover Criminal Liability-though its monitory aspects may be covered by some newer policies—like the legal costs. The civil laws and Indian Contract Act essentially govern the policies. In short, insurance means a third party (here, Insurance company) is taking responsibility of paying compensation to the aggrieved party for the 'proved' negligence of civil nature on the part of the insured (i.e. doctor or the hospital). For this the doctor has to pay regular fees on annual basis to the Insurer (i.e. the Insurance Company).

Contract of Insurance has the following elements: -

- Insured has to fill a proposal form disclosing all the facts about the insured and the objectives
- Insured pays the fees called consideration or premium in proportion to the amount of insurance as per the tariff.
- Liability of insurer arises when the loss occurs to the insured due to contingencies described in the policy to the extent of policy limits
- Contract of insurance is called as Insurance Policy (henceforth referred to as policy or PIP), which is the document regulating the claim process
- Basis of insurance is to cover the happening of a risk, by paying in turn loss suffered by the insured, for paying compensations for errors/negligence
- In short, doctors pay for indemnity policy through premium and out of that, the company pays to doctors against whom, medical negligence claims are decreed.
- Law of average happening of a risk is very rare and hence the feasibility for insurance companies-it is like several people bearing burden of one unfortunate
- Risk is an event that is harmful to someone somewhere -rare but does happen in reality. Risk is an unpredictable chance event. It can be expressed in percent. It may or may not happen

PIP belongs to General Insurance (non-life insurance) category and hence it is not an investment option with any returns. Secondly the premium is on annual renewal basis.

PIP covers claims arising out of medical negligence case against doctors. Hospital error and omission policy is different and covers various categories of staff including nurses, doctors, para-medical services and even unqualified staff (with 7.5% extra premium.).

What does PIP cover?

- It covers compensations awarded by courts against doctors for medical negligence-to the extent of insurance coverage
- It covers defence costs as per the tariff prescribed for different courts
- It also includes incidental costs like paper work, Xeroxes, etc.
- Insurance co may have advocates on panel or may consent for you employing your own lawyer
- Policy will indemnify any act committed and legally

proved act by the insured, who shall be RMP, giving rise to civil liability to 3rd party, arising out of negligence

- Insured includes policy holder and his qualified assistant / emloyee named in the proposal
- It is applicable to any place in India and as per Indian laws
- **Strict restriction to his branch or pathy is a pre-requisite**

Retroactive date:-

First date on which the policy commences and then continues **meticulously uninterrupted** is important. It mentions 'from date _____to midnight of date _____.' As we have seen earlier, policy period is 1 year.

SCHEDULE OF CHARGES: (these rates may change)

1. Physician without dispensing facilities, GPs, Radiologist/Patho etc 0.5/millie/aoy
2. Diagnostic centers (non-surgical) 1.0/millie/aoy
3. Surgeons/Dental/Lithotripsy 2.0/millie/aoy
4. Plastic surgeons/super specialists and anesthetists 3.0/millie/aoy

+ 18% GST!

10% additional premium for each facility subject to max. 25% e.g dispensing, pathology, USG etc

HOW TO SELECT THE SUM INSURED IN PROFESSIONAL INDEMNITY POLICY:

The sum insured is referred to as Limit of Indemnity. This limit is fixed per accident and per policy period which is called Any One Accident (AOA) limit and Any One Year (AOY) limit respectively. The ratio of AOA limit to AOY limit can be chosen from the following: a. 1:1 b. 1:2 c. 1:3 d. 1:4 The AOA limit, which is the maximum amount payable for each accident, should be fixed taking into account the nature of activity of the insured and the maximum number of people who could be affected and maximum property damage that could occur, in the worst possible accident.

**You have an option of having cover in the proportion of 1:1, 1:2, 1:3; or 1:4 in any one claim, i.e. the cover can be fully or partially divided as per your needs and apprehended damages (we strongly recommend you to go for 1:1 option only)

Hospital Policy: Hospital omission and error policy—it covers hospital services.

The Policy will indemnify the Insured in respect of any act committed by the Professionals or Qualified Assistants named in the Proposal engaged by the Medical Establishment which gives rise to any Third Party Legal Liability. Such activities will be part of the declared medical activities of the establishment.

- Rate: 1.8/1000 Rs insured + Rs 5/indoor patient + Rs1/OPD patient based on your approximations and last year's balance sheet.
- Minimum Rs 1000 as premium.
- Group discount up to 10% is possible
- Always cover your unqualified staff also by paying extra premium. Have a hospital policy for 50 lacs or so.

IMPORTANT POINTS:

1. **Have cover of 40 lacs to 2 Crore in a ratio 1:1**
2. Uninterrupted cover till you stop practice and then further 3 yrs
3. Do not publicise that you have a PIP of big amount
4. Remain within your field
5. Inform Insurer about any anticipated trouble or notice (even advocate's notice) and take and preserve their acknowledgement
6. Cooperate with their reasonable demands
7. Make Insurance company a co-defender (co-responder) in case you face a compensation litigation.
8. Take help of medico-legal expert in dealing with insurers, if needed
9. You may have to fight against insurer if they avoid or unduly delay settling your claim of compensation, if such is awarded against you by a competent court

EXCLUSIONS:

- Criminal cases and even fines under it
- Intoxicated doctors etc!
- Third party public liability
- Cosmetic surgery
- HIV patients
- Deliberate and willful non-compliance

- Loss of goodwill, market etc.
- War, insurgency or natural disasters
- Ionising radiations

NOTIFIACTION EXTENSION CLAUSE:

Once the insured informs during the policy period and the company accepts the notice, it will assist till the end of limitation period under law

HURDLES:

- Red tape
- Delays
- Harassment
- Unnecessary and unjust rejection of claims-then you may be needed to fight the insurer
- Claim settled only if you are proved negligent-out of court settlement is not their preferred principle- hence damage to reputation is a major negative factor
- Settlement deduction: 0.25% of award to the maximum of Rs1,000/- in hospital policy

The largest claim we know of that has been settled by Insurance co. is of Rs 17,00,000 in Harjyot Sing Ahluwalia vs Spring Meadows hospital, New Delhi.' And was the figure also awarded in 3 more cases later. However, of late, the highest compensation awarded is Rs 1Crore in Sukumar v Nileufer Govt. hospital in AP in2011 & being against the AP Govt., state government has to settle that claim—fortunate for the doctor who was an employee) and over 11.2 crores in Amri Hospital, (Dr. S. Mukharjee and others) v Kunal Saha case in 2013, but we do not have details of Insurance settlements.

Insurance coverage and systems for PIP are in a developing stage in India and we feel that they will be more **doctor-friendly** in near future. There is an urgent need for developing 'no fault liability insurance' to cover medical accidents or unexplained happenings. A few private companies have floated comprehensive policies for doctors giving door step services all the 24 hrs and giving medico-legal help even in criminal cases, stone throwing, and additionally other covers like riot insurance, vehicle insurance etc.

Now, even private companies like Bajaj Allianz, Tata AIG etc are competing in the field of these insurance systems but experience is limited as of this time.

PPP-Personal Protection Scheme of IMA MS and IMA HQ

To avoid all the hurdles posed by Insurance companies, IMAMS came out with this scheme which is doctor-friendly. The head office is at IMA Nagpur. Once you become member of the scheme, you have to send information regarding any trouble to the scheme, which will take care of answering notices, representing in consumer forums and courts, give you timely and honest guidance in any legal matter and so on. Of late, PPP has tied up with such scheme from Centre run from Kochi and the coverage is much extended and expertise shared. You have to be a life member of IMA but to get membership number from IMA HQ requires 3-4months and till you get this number, you cannot become PPP member, so enroll yourself at the earliest.

With these days of increasing litigations even from mofussil areas, it is essential that each doctor has Indemnity Insurance of any appropriate amount and continue uninterrupted till you practice and beyond…

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Updated August 2018

Table 4: Summary of WHO Position Papers – Immunization of Health Care Workers[A]

The information below is provided to assist countries to develop national policies for the vaccination of health care workers (HCWs). It is expected that HCWs are fully vaccinated per the national vaccination schedule in use in their country.

Antigen	Vaccination of Health Care Workers Recommended
BCG[1]	BCG vaccination is recommended for unvaccinated TST- or IGRA-negative persons at risk of occupational exposure in low and high TB incidence areas (e.g. health-care workers, laboratory workers, medical students, prison workers, other individuals with occupational exposure)
Hepatitis B[2]	Immunization is suggested for groups at risk of acquiring infection who have not been vaccinated previously (for example HCWs who may be exposed to blood and blood products at work).
Polio[3]	All HCWs should have completed a full course of primary vaccination against polio.
Diphtheria[4]	Particular attention should be given to revaccination of HCWs with diphtheria boosters every 10 years. Special attention should be paid to immunizing HCWs who may have occupational exposure to *C. diphtheriae*.
Measles[5]	All HCWs should be immune to measles and proof/documentation of immunity or immunization should be required as a condition of enrollment into training and employment.
Rubella[6]	If rubella vaccine has been introduced into the national programme, all HCWs should be immune to rubella and proof/documentation of immunity or immunization should be required as a condition of enrollment into training and employment.
Meningococcal[7]	One booster dose 3-5 years after the primary dose may be given to persons considered to be at continued risk of exposure, including HCWs.
Infuenza [8]	HCWs are an important group for infuenza vaccination. Annual immunization with a single dose is recommended.
Varicella[9]	Countries should consider vaccination of potentially susceptible health-care workers (i.e. unvaccinated and with no history of varicella) with 2 doses of varicella vaccine
Pertussis[10]	HWCs should be prioritized as a group to receive pertussis vaccine.
Antigen	**No current recommendation for vaccination of Health Care Workers**
Tetanus[11]	There is currently no recommendation regarding HCWs.
***Haemophilus infuenzae* type b[12]**	The main burden of disease lies in infants under 5 years of age. Work in a health care setting is not indicated as a factor for increased risk. There is currently no recommendation regarding HCWs.
Pneumococcal[13]	The main burden of disease lies in infants under 5 years of age. Immunocompetent adults are not at increased risk for serious pneumococcal disease. HCWs are not indicated as a group at increased risk of pneumococcal disease.
Rotavirus[14]	Children are the target group for rotavirus vaccination as they have the greatest burden of disease. Adults including HCWs are not at increased risk of severe disease.
HPV[15]	HCWs are not at increased risk of HPV. The primary target group for vaccination is girls aged 9-14.
Japanese Encephalitis[16]	Health-care workers are generally not at special risk of contracting JE. Workers at high-risk in endemic areas, such as those involved in vector control, should be vaccinated.
Yellow Fever[17]	Individuals in endemic countries and travelers to these countries should receive a single dose of yellow fever vaccine. Work in a health care setting is not indicated as a factor for increased risk. There is currently no recommendation regarding HCWs.
Tick-borne Encephalitis[18]	Health-care workers are generally not at special risk of contracting JE. Workers at high-risk in endemic areas, such as those involved in vector control, should be vaccinated.
Typhoid[19]	Typhoid vaccines should be employed as part of comprehensive control strategies in areas where the disease is endemic. Work in a health care setting is not indicated as a factor for increased risk. There is currently no recommendation regarding HCWs.
Cholera[20]	Cholera vaccines may be employed as part of comprehensive control strategies in areas where the disease is endemic as well as to prevent and respond to cholera outbreaks[B]. There is currently no recommendation regarding HCWs.
Hepatitis A[21]	Hepatitis A is transmitted through contaminated food and water or direct contact with an infectious person. HCWs are not indicated as a group at increased risk of hepatitis A infection.
Rabies[22]	PrEP may be considered for medical professionals who regularly provide care to persons with rabies.
Mumps[23]	Routine mumps vaccination is recommended in countries with a well-established, effective childhood vaccination programme and the capacity to maintain high level vaccination coverage with measles and rubella vaccination. HCWs are not indicated as a group at increased risk.
Dengue (CYD-TDV)[24]	HCWs are not at increased risk of dengue

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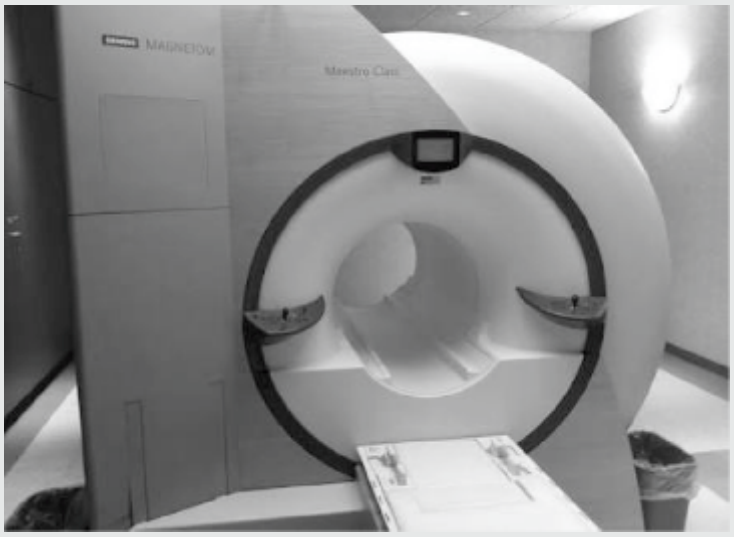

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[Published in the Gazette of India, Extraordinary, Part II, Section 3, Sub-section (i)]

GOVERNMENT OF INDIA
MINISTRY OF ENVIRONMENT, FOREST AND CLIMATE CHANGE

NOTIFICATION

New Delhi, the 28th March, 2016

G.S.R. 343(E).-Whereas the Bio-Medical Waste (Management and Handling) Rules, 1998 was published *vide* notification number S.O. 630 (E) dated the 20th July, 1998, by the Government of India in the erstwhile Ministry of Environment and Forests, provided a regulatory frame work for management of bio-medical waste generated in the country;

And whereas, to implement these rules more effectively and to improve the collection, segregation, processing, treatment and disposal of these bio-medical wastes in an environmentally sound management thereby, reducing the bio- medical waste generation and its impact on the environment, the Central Government reviewed the existing rules;

And whereas, in exercise of the powers conferred by sections 6, 8 and 25 of the Environment (Protection) Act, 1986 (29 of 1986), the Central Government published the draft rules in the Gazette vide number G.S.R. 450 (E), dated the 3rd June, 2015 inviting objections or suggestions from the public within sixty days from the date on which copies of the Gazette containing the said notification were made available to the public;

And whereas, the copies of the Gazette containing the said draft rules were made available to the public on the 3rd June, 2015;

And whereas, the objections or comments received within the specified period from the public in respect of the said draft rules have been duly considered by the Central Government;

Now, therefore, in exercise of the powers conferred by section 6, 8 and 25 of the Environment (Protection) Act, 1986 (29 of 1986), and in supersession of the Bio-Medical Waste (Management and Handling) Rules, 1998, except as respects things done or omitted to be done before such suppression, the Central Government hereby makes the following rules, namely:-

1. **Short title and commencement.-** (1) these rules may be called the Bio-Medical Waste Management Rules, 2016.

(2) They shall come into force on the date of their publication in the Official Gazette.

2. **Application.-**

(1) These rules shall apply to all persons who generate, collect, receive, store, transport, treat, dispose, or handle bio medical waste in any form including hospitals, nursing homes, clinics, dispensaries, veterinary institutions, animal houses, pathological laboratories, blood banks, ayush

hospitals, clinical establishments, research or educational institutions, health camps, medical or surgical camps, vaccination camps, blood donation camps, first aid rooms of schools, forensic laboratories and research labs.

(2). These rules shall not apply to,-

(a) radioactive wastes as covered under the provisions of the Atomic Energy Act, 1962(33 of 1962) and the rules made there under;

(b) hazardous chemicals covered under the Manufacture, Storage and Import of Hazardous Chemicals Rules, 1989 made under the Act;

(c) solid wastes covered under the Municipal Solid Waste (Management and Handling) Rules, 2000 made under the Act;

(d) the lead acid batteries covered under the Batteries (Management and Handling) Rules, 2001 made under the Act;

(e) hazardous wastes covered under the Hazardous Wastes (Management, Handling and Transboundary Movement) Rules, 2008 made under the Act;

(f) waste covered under the e-Waste (Management and Handling) Rules, 2011 made under the Act; and

(g) hazardous micro organisms, genetically engineered micro organisms and cells covered under the Manufacture, Use, Import, Export and Storage of Hazardous Microorganisms, Genetically Engineered Micro organisms or Cells Rules, 1989 made under the Act.

3. **Definitions.-** In these rules, unless the context otherwise requires, -

(a) "Act" means the Environment (Protection) Act, 1986 (29 of 1986);

(b) "animal house" means a place where animals are reared or kept for the purpose of experiments or testing;

(c) "authorisation" means permission granted by the prescribed authority for the generation, collection, reception, storage, transportation, treatment, processing, disposal or any other form of handling of bio-medical waste in accordance with these rules and guidelines issued by the Central Government or Central Pollution Control Board as the case may be;

(d) "authorised person" means an occupier or operator authorised by the prescribed authority to generate, collect, receive, store, transport, treat, process, dispose or handle bio-medical waste in accordance with these rules and the guidelines issued by the Central Government or the Central Pollution Control Board, as the case may be;

(e) "biological" means any preparation made from organisms or micro-organisms or product of metabolism and biochemical reactions intended for use in the diagnosis, immunisation or the treatment of human beings or animals or in research activities pertaining thereto;

(f) "bio-medical waste" means any waste, which is generated during the diagnosis, treatment or immunisation of human beings or animals or research activities pertaining thereto or in the production or testing of biological or in health camps, including the categories mentioned in Schedule I appended to these rules;

(g) "bio-medical waste treatment and disposal facility" means any facility wherein treatment, disposal of bio-medical waste or processes incidental to such treatment and disposal is carried out, and includes common bio-medical waste treatment facilities;

(h) “Form” means the Form appended to these rules;

(i) “handling” in relation to bio-medical waste includes the generation, sorting, segregation, collection, use, storage, packaging, loading, transportation, unloading, processing, treatment, destruction, conversion, or offering for sale, transfer, disposal of such waste;

(j) “health care facility” means a place where diagnosis, treatment or immunisation of human beings or animals is provided irrespective of type and size of health treatment system, and research activity pertaining thereto;

(k) “major accident” means accident occurring while handling of bio-medical waste having potential to affect large masses of public and includes toppling of the truck carrying bio-medical waste, accidental release of bio-medical waste in any water body but exclude accidents like needle prick injuries, mercury spills;

(l) “management” includes all steps required to ensure that bio- medical waste is managed in such a manner as to protect health and environment against any adverse effects due to handling of such waste;

(m) "occupier" means a person having administrative control over the institution and the premises generating bio-medical waste, which includes a hospital, nursing home, clinic, dispensary, veterinary institution, animal house, pathological laboratory, blood bank, health care facility and clinical establishment, irrespective of their system of medicine and by whatever name they are called;

(n) "operator of a common bio-medical waste treatment facility" means a person who owns or controls a Common Bio-medical Waste Treatment Facility (CBMWTF) for the collection, reception, storage, transport, treatment, disposal or any other form of handling of bio-medical waste;

(o) “prescribed authority” means the State Pollution Control Board in respect of a State and Pollution Control Committees in respect of an Union territory;

(p) "Schedule" means the Schedule appended to these rules.

4. **Duties of the Occupier.-** It shall be the duty of every occupier to-

(a) take all necessary steps to ensure that bio-medical waste is handled without any adverse effect to human health and the environment and in accordance with these rules;

(b) make a provision within the premises for a safe, ventilated and secured location for storage of segregated biomedical waste in colored bags or containers in the manner as specified in Schedule I, to ensure that there shall be no secondary handling, pilferage of recyclables or inadvertent scattering or spillage by animals and the bio-medical waste from such place or premises shall be directly transported in the manner as prescribed in these rules to the common bio-medical waste treatment facility or for the appropriate treatment and disposal, as the case may be, in the manner as prescribed in Schedule I;

(c) pre-treat the laboratory waste, microbiological waste, blood samples and blood bags through disinfection or sterilisation on-site in the manner as prescribed by the World Health Organisation (WHO) or National AIDs Control Organisation (NACO) guidelines and then sent to the common bio-medical waste treatment facility for final disposal;

(d) phase out use of chlorinated plastic bags, gloves and blood bags within two years from the date of notification of these rules;

(e) dispose of solid waste other than bio-medical waste in accordance with the provisions of respective waste management rules made under the relevant laws and amended from time to time;

(f) not to give treated bio-medical waste with municipal solid waste;

(g) provide training to all its health care workers and others, involved in handling of bio medical waste at the time of induction and thereafter at least once every year and the details of training programmes conducted, number of personnel trained and number of personnel not undergone any training shall be provided in the Annual Report;

(h) immunise all its health care workers and others, involved in handling of bio-medical waste for protection against diseases including Hepatitis B and Tetanus that are likely to be transmitted by handling of bio-medical waste, in the manner as prescribed in the National Immunisation Policy or the guidelines of the Ministry of Health and Family Welfare issued from time to time;

(i) establish a Bar- Code System for bags or containers containing bio-medical waste to be sent out of the premises or place for any purpose within one year from the date of the notification of these rules;

(j) ensure segregation of liquid chemical waste at source and ensure pre-treatment or neutralisation prior to mixing with other effluent generated from health care facilities;

(k) ensure treatment and disposal of liquid waste in accordance with the Water (Prevention and Control of Pollution) Act, 1974 (6 of 1974);

(l) ensure occupational safety of all its health care workers and others involved in handling of bio-medical waste by providing appropriate and adequate personal protective equipments;

(m) conduct health check up at the time of induction and at least once in a year for all its health care workers and others involved in handling of bio- medical waste and maintain the records for the same;

(n) maintain and update on day to day basis the bio-medical waste management register and display the monthly record on its website according to the bio-medical waste generated in terms of category and colour coding as specified in Schedule I;

(o) report major accidents including accidents caused by fire hazards, blasts during handling of bio-medical waste and the remedial action taken and the records relevant thereto, (including nil report) in Form I to the prescribed authority **and also** along with the annual report;

(p) make available the annual report on its web-site and all the health care facilities shall make own website within two years from the date of notification of these rules;

(q) inform the prescribed authority immediately in case the operator of a facility does not collect the bio-medical waste within the intended time or as per the agreed time;

(r) establish a system to review and monitor the activities related to bio-medical waste management, either through an existing committee or by forming a new committee and the Committee shall meet once in every six months and the record of the minutes of the meetings of this committee shall be submitted along with the annual report to the prescribed authority and the healthcare establishments having less than thirty beds shall designate a qualified person to review and monitor the activities relating to bio-medical waste management within that establishment and submit the annual report;

(s) maintain all record for operation of incineration, hydro or autoclaving etc., for a period of five years;

(t) existing incinerators to achieve the standards for treatment and disposal of bio-medical waste as specified in Schedule II for retention time in secondary chamber and Dioxin and Furans within two years from the date of this notification.

5. **Duties of the operator of a common bio-medical waste treatment and disposal facility.-**It shall be the duty of every operator to -

(a) take all necessary steps to ensure that the bio-medical waste collected from the occupier is transported, handled, stored, treated and disposed of, without any adverse effect to the human health and the environment, in accordance with these rules and guidelines issued by the Central Government or, as the case may be, the central pollution control board from time to time;

(b) ensure timely collection of bio-medical waste from the occupier as prescribed under these rules;

(c) establish bar coding and global positioning system for handling of bio- medical waste within one year;

(d) inform the prescribed authority immediately regarding the occupiers which are not handing over the segregated bio-medical waste in accordance with these rules;

(e) provide training for all its workers involved in handling of bio-medical waste at the time of induction and at least once a year thereafter;

(f) assist the occupier in training conducted by them for bio-medical waste management;

(g) undertake appropriate medical examination at the time of induction and at least once in a year and immunise all its workers involved in handling of bio-medical waste for protection against diseases, including Hepatitis B and Tetanus, that are likely to be transmitted while handling bio-medical waste and maintain the records for the same;

(h) ensure occupational safety of all its workers involved in handling of bio-medical waste by providing appropriate and adequate personal protective equipment;

(i) report major accidents including accidents caused by fire hazards, blasts during handling of bio-medical waste and the remedial action taken and the records relevant thereto, (including nil report) in Form I to the prescribed authority **and also** along with the annual report;

(i) maintain a log book for each of its treatment equipment according to weight of batch; categories of waste treated; time, date and duration of treatment cycle and total hours of operation;

(k) allow occupier , who are giving waste for treatment to the operator, to see whether the treatment is carried out as per the rules;

(l) shall display details of authorisation, treatment, annual report etc on its web-site;

(m) after ensuring treatment by autoclaving or microwaving followed by mutilation or shredding, whichever is applicable, the recyclables from the treated bio-medical wastes such as plastics and glass, shall be given to recyclers having valid consent or authorisation or registration from the respective State Pollution Control Board or Pollution Control Committee;

(n) supply non-chlorinated plastic coloured bags to the occupier on chargeable basis, if required;

(o) common bio-medical waste treatment facility shall ensure collection of biomedical waste on holidays also;

(p) maintain all record for operation of incineration, hydroor autoclaving for a period of five years; and

(q) upgrade existing incinerators to achieve the standards for retention time in secondary chamber and Dioxin and Furans within two years from the date of this notification.

6. **Duties of authorities.-**The Authority specified in column (2) of Schedule-III shall perform the duties as specified in column (3) thereof in accordance with the provisions of these rules.

7. Treatment and disposal.- (1) Bio-medical waste shall be treated and disposed of in accordance with Schedule I, and in compliance with the standards provided in Schedule-II by the health care facilities and common bio-medical waste treatment facility.

(2) Occupier shall hand over segregated waste as per the Schedule-I to common bio-medical waste treatment facility for treatment, processing and final disposal:

Provided that the lab and highly infectious bio-medical waste generated shall be pre-treated by equipment like autoclave or microwave.

(3) No occupier shall establish on-site treatment and disposal facility, if a service of `common bio-medical waste treatment facility is available at a distance of seventy-five kilometer.

(4) In cases where service of the common bio-medical waste treatment facility is not available, the Occupiers shall set up requisite biomedical waste treatment equipment like incinerator, autoclave or microwave, shredder prior to commencement of its operation, as per the authorisation given by the prescribed authority.

(5) Any person including an occupier or operator of a common bio medical waste treatment facility, intending to use new technologies for treatment of bio medical waste other than those listed in Schedule I shall request the Central Government for laying down the standards or operating parameters.

(6) On receipt of a request referred to in sub-rule (5), the Central Government may determine the standards and operating parameters for new technology which may be published in Gazette by the Central Government.

(7) Every operator of common bio-medical waste treatment facility shall set up requisite biomedical waste treatment equipments like incinerator, autoclave or microwave, shredder and effluent treatment plant as a part of treatment, prior to commencement of its operation.

(8) Every occupier shall phase out use of non-chlorinated plastic bags within two years from the date of publication of these rules and after two years from such publication of these rules, the chlorinated plastic bags shall not be used for storing and transporting of bio-medical waste and the occupier or operator of a common bio-medical waste treatment facility shall not dispose of such plastics by incineration and the bags used for storing and transporting biomedical waste shall be in compliance with the Bureau of Indian Standards. Till the Standards are published, the carry bags shall be as per the Plastic Waste Management Rules, 2011.

(9) After ensuring treatment by autoclaving or microwaving followed by mutilation or shredding, whichever is applicable, the recyclables from the treated bio-medical wastes such as plastics and glass shall be given to such recyclers having valid authorisation or registration from the respective prescribed authority.

(10) The Occupier or Operator of a common bio-medical waste treatment facility shall maintain a record of recyclable wastes referred to in sub-rule (9) which are auctioned or sold and the same shall be submitted to the prescribed authority as part of its annual report. The record shall be open for inspection by the prescribed authorities.

(11) The handling and disposal of all the mercury waste and lead waste shall be in accordance with the respective rules and regulations.

8. Segregation, packaging, transportation and storage.-(1) No untreated bio medical waste shall be mixed with other wastes.

(2) The bio-medical waste shall be segregated into containers or bags at the point of generation in accordance with Schedule I prior to its storage, transportation, treatment and disposal.

(3) The containers or bags referred to in sub-rule (2) shall be labeled as specified in Schedule IV.

(4) Bar code and global positioning system shall be added by the Occupier and common bio-medical waste treatment facility in one year time.

(5) The operator of common bio-medical waste treatment facility shall transport the bio-medical waste from the premises of an occupier to any off-site bio-medical waste treatment facility only in the vehicles having label as provided in part 'A' of the Schedule IV along with necessary information as specified in part 'B' of the Schedule IV.

(6) The vehicles used for transportation of bio-medical waste shall comply with the conditions if any stipulated by the State Pollution Control Board or Pollution Control Committee in addition to the requirement contained in the Motor Vehicles Act, 1988 (59 of 1988), if any or the rules made there under for transportation of such infectious waste.

(7) Untreated human anatomical waste, animal anatomical waste, soiled waste and, biotechnology waste shall not be stored beyond a period of forty –eight hours:

Provided that in case for any reason it becomes necessary to store such waste beyond such a period, the occupier shall take appropriate measures to ensure that the waste does not adversely affect human health and the environment and inform the prescribed authority along with the reasons for doing so.

(8) Microbiology waste and all other clinical laboratory waste shall be pre-treated by sterilisation to Log 6 or disinfection to Log 4, as per the World Health Organisation guidelines before packing and sending to the common bio-medical waste treatment facility.

9. **Prescribed authority.-**(1) The prescribed authority for implementation of the provisions of these rules shall be the State Pollution Control Boards in respect of States and Pollution Control Committees in respect of Union territories.

(2) The prescribed authority for enforcement of the provisions of these rules in respect of all health care establishments including hospitals, nursing homes, clinics, dispensaries, veterinary institutions, animal houses, pathological laboratories and blood banks of the Armed Forces under the Ministry of Defence shall be the Director General, Armed Forces Medical Services, who shall function under the supervision and control of the Ministry of Defence.

(3) The prescribed authorities shall comply with the responsibilities as stipulated in Schedule III of these rules.

10. Procedure for authorisation.-Every occupier or operator handling bio-medical waste, irrespective of the quantity shall make an application in Form II to the prescribed authority i.e. State Pollution Control Board and Pollution Control Committee, as the case may be, for grant of authorisation and the prescribed authority shall grant the provisional authorisation in Form III and the validity of such authorisation for bedded health care facility and operator of a common facility shall be synchronised with the validity of the consents.

(1) The authorisation shall be one time for non-bedded occupiers and the authorisation in such cases shall be deemed to have been granted, if not objected by the prescribed authority within a period of ninety days from the date of receipt of duly completed application along with such necessary documents.

(2) In case of refusal of renewal, cancellation or suspension of the authorisation by the prescribed authority, the reasons shall be recorded in writing:

Provided that the prescribed authority shall give an opportunity of being heard to the applicant before such refusal of the authorisation.

(3) Every application for authorisation shall be disposed of by the prescribed authority within a period of ninety days from the date of receipt of duly completed application along with such necessary documents, failing which it shall be deemed that the authorisation is granted under these rules.

(4) In case of any change in the bio-medical waste generation, handling, treatment and disposal for which authorisation was earlier granted, the occupier or operator shall intimate to the prescribed authority about the change or variation in the activity and shall submit a fresh application in Form II for modification of the conditions of authorisation.

11. **Advisory Committee**.-(1) Every State Government or Union territory Administration shall constitute an Advisory Committee for the respective State or Union territory under the chairmanship of the respective health secretary to oversee the implementation of the rules in the respective state and to advice any improvements and the Advisory Committee shall include representatives from the Departments of Health, Environment, Urban Development, Animal Husbandry and Veterinary Sciences of that State Government or Union territory Administration, State Pollution Control Board or Pollution Control Committee, urban local bodies or local bodies or Municipal Corporation, representatives from Indian Medical Association, common bio-medical waste treatment facility and non-governmental organisation.

(2) Notwithstanding anything contained in sub-rule (1), the Ministry of Defence shall constitute the Advisory Committee (Defence) under the chairmanship of Director General of Health Services of Armed Forces consisting of representatives from the Ministry of Defence, Ministry of Environment, Forest and Climate Change, Central Pollution Control Board, Ministry of Health and Family Welfare, Armed Forces Medical College or Command Hospital.

(3) The Advisory Committee constituted under sub-rule (1) and (2) shall meet at least once in six months and review all matters related to implementation of the provisions of these rules in the State and Armed Forces Health Care Facilities, as the case may be.

(4) The Ministry of Health and Defence may co-opt representatives from the other Governmental and non-governmental organisations having expertise in the field of bio-medical waste management.

12. **Monitoring of implementation of the rules in health care facilities.-** (1) The Ministry of Environment, Forest and Climate Change shall review the implementation of the rules in the country once in a year through the State Health Secretaries and Chairmen or Member Secretary of State Pollution Control Boards and Central Pollution Control Board and the Ministry may also invite experts in the field of bio-medical waste management, if required.

(2) The Central Pollution Control Board shall monitor the implementation of these rules in respect of all the Armed Forces health care establishments under the Ministry of Defence.

(3) The Central Pollution Control Board along with one or more representatives of the Advisory Committee constituted under sub-rule (2) of rule 11, may inspect any Armed Forces health care establishments after prior intimation to the Director General Armed Forces Medical Services.

(4) Every State Government or Union territory Administration shall constitute District Level Monitoring Committee in the districts under the chairmanship of District Collector or District Magistrate or Deputy Commissioner or Additional District Magistrate to monitor the compliance of the provisions of these rules in the health care facilities generating bio-medical waste and in the common bio-medical waste treatment and disposal facilities, where the bio-medical waste is treated and disposed of.

(5) The District Level Monitoring Committee constituted under sub-rule (4) shall submit its report once in six months to the State Advisory Committee and a copy thereof shall also be forwarded to State Pollution Control Board or Pollution Control Committee concerned for taking further necessary action.

(6) The District Level Monitoring Committee shall comprise of District Medical Officer or District Health Officer, representatives from State Pollution Control Board or Pollution Control Committee, Public Health Engineering Department, local bodies or municipal corporation, Indian Medical Association, common bio-medical waste treatment facility and registered non-governmental organisations working in the field of bio-medical waste management and the Committee may co-opt other members and experts, if necessary and the District Medical Officer shall be the Member Secretary of this Committee.

13. **Annual report.-**(1) Every occupier or operator of common bio-medical waste treatment facility shall submit an annual report to the prescribed authority in Form-IV, on or before the 30th June of every year.

(2) The prescribed authority shall compile, review and analyse the information received and send this information to the Central Pollution Control Board on or before the 31st July of every year.

(3) The Central Pollution Control Board shall compile, review and analyse the information received and send this information, along with its comments or suggestions or observations to the Ministry of Environment, Forest and Climate Change on or before 31st August every year.

(4) The Annual Reports shall also be available online on the websites of Occupiers, State Pollution Control Boards and Central Pollution Control Board.

14. Maintenance of records.- (1) Every authorised person shall maintain records related to the generation, collection, reception, storage, transportation, treatment, disposal or any other form of handling of bio-medical waste, for a period of five years, in accordance with these rules and guidelines issued by the Central Government or the Central Pollution Control Board or the prescribed authority as the case may be.

(2) All records shall be subject to inspection and verification by the prescribed authority or the Ministry of Environment, Forest and Climate Change at any time.

15. **Accident reporting.-** (1) In case of any major accident at any institution or facility or any other site while handling bio-medical waste, the authorised person shall intimate immediately to the prescribed authority about such accident and forward a report within twenty-four hours in writing regarding the remedial steps taken in Form I.

(2) Information regarding all other accidents and remedial steps taken shall be provided in the annual report in accordance with rule 13 by the occupier.

16. **Appeal.-**(1) Any person aggrieved by an order made by the prescribed authority under these rules may, within a period of thirty days from the date on which the order is communicated to him, prefer an appeal in Form V to the Secretary (Environment) of the State Government or Union territory administration .

(2) Any person aggrieved by an order of the Director General Armed Forces Medical Services under these rules may, within thirty days from the date on which the order is communicated to him, prefer an appeal in Form V to the Secretary, Ministry of Environment, Forest and Climate Change.

(3) The authority referred to in sub-para (1) and (2) as the case may be, may entertain the appeal after the expiry of the said period of thirty days, if it is satisfied that the appellant was prevented by sufficient cause from filing the appeal in time.

(4) The appeal shall be disposed of within a period of ninety days from the date of its filing.

17. **Site for common bio-medical waste treatment and disposal facility**.-(1) Without prejudice to rule 5 of these rules, the department in the business allocation of land assignment shall be responsible for providing suitable site for setting up of common biomedical waste treatment and disposal facility in the State Government or Union territory Administration.

(2) The selection of site for setting up of such facility shall be made in consultation with the prescribed authority, other stakeholders and in accordance with guidelines published by the Ministry of Environment, Forest and Climate Change or Central Pollution Control Board.

18. **Liability of the occupier, operator of a facility**.- (1) The occupier or an operator of a common bio-medical waste treatment facility shall be liable for all the damages caused to the environment or the public due to improper handling of bio- medical wastes.

(2) The occupier or operator of common bio-medical waste treatment facility shall be liable for action under section 5 and section 15 of the Act, in case of any violation.

SCHEDULE I
[See rules 3 (e), 4(b), 7(1), 7(2), 7(5), 7 (6) and 8(2)]
Part-1

Biomedical wastes categories and their segregation, collection, treatment, processing and disposal options

Category	Type of Waste	Type of Bag or Container to be used	Treatment and Disposal options
(1)	(2)	(3)	(4)
Yellow	**(a) Human Anatomical Waste:** Human tissues, organs, body parts and fetus below the viability period (as per the Medical Termination of Pregnancy Act 1971, amended from time to time).	Yellow coloured non-chlorinated plastic bags	Incineration or Plasma Pyrolysis or deep burial*
	(b)Animal Anatomical Waste : Experimental animal carcasses, body parts, organs, tissues, including the waste generated from animals used in experiments or testing in veterinary hospitals or colleges or animal houses.		
	(c) Soiled Waste: Items contaminated with blood, body fluids like dressings, plaster casts, cotton swabs and		Incineration or Plasma Pyrolysis or deep burial* In absence of above facilities, autoclaving or micro-waving/

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	bags containing residual or discarded blood and blood components.		hydroclaving followed by shredding or mutilation or combination of sterilization and shredding. Treated waste to be sent for energy recovery.
	(d) Expired or Discarded Medicines: Pharmaceutical waste like antibiotics, cytotoxic drugs including all items contaminated with cytotoxic drugs along with glass or plastic ampoules, vials etc.	Yellow coloured non-chlorinated plastic bags or containers	Expired `cytotoxic drugs and items contaminated with cytotoxic drugs to be returned back to the manufacturer or supplier for incineration at temperature >1200 ^{0}C or to common bio-medical waste treatment facility or hazardous waste treatment, storage and disposal facility for incineration at >1200^{0}C Or Encapsulation or Plasma Pyrolysis at >1200^{0}C. All other discarded medicines shall be either sent back to manufacturer or disposed by incineration.
	(e) Chemical Waste: Chemicals used in production of biological and used or discarded disinfectants.	Yellow coloured containers or non-chlorinated plastic bags	Disposed of by incineration or Plasma Pyrolysis or Encapsulation in hazardous waste treatment, storage and disposal facility.
	(f) Chemical Liquid Waste : Liquid waste generated due to use of chemicals in production of biological and used or discarded disinfectants, Silver X-ray film developing liquid, discarded Formalin, infected secretions, aspirated body fluids**,** liquid from laboratories and floor washings, cleaning, house-keeping and disinfecting activities etc.	Separate collection system leading to effluent treatment system	After resource recovery, the chemical liquid waste shall be pre-treated before mixing with other wastewater. The combined discharge shall conform to the discharge norms given in Schedule-III.
	(g) Discarded linen, mattresses, beddings contaminated with blood or body fluid.	Non-chlorinated yellow plastic bags or suitable packing material	Non- chlorinated chemical disinfection followed by incineration or Plazma Pyrolysis or for energy recovery. In absence of above facilities, shredding or mutilation or combination of sterilization and shredding. Treated waste to be sent for energy recovery or incineration or Plazma Pyrolysis.

	(h) Microbiology, Biotechnology and other clinical laboratory waste: Blood bags, Laboratory cultures, stocks or specimens of micro-organisms, live or attenuated vaccines, human and animal cell cultures used in research, industrial laboratories, production of biological, residual toxins, dishes and devices used for cultures.	Autoclave safe plastic bags or containers	Pre-treat to sterilize with non-chlorinated chemicals on-site as per National AIDS Control Organisation or World Health Organisation guidelines thereafter for Incineration.
Red	**Contaminated Waste (Recyclable)** (a) Wastes generated from disposable items such as tubing, bottles, intravenous tubes and sets, catheters, urine bags, syringes (without needles and *fixed needle syringes*) and vaccutainers with their needles cut) and gloves.	Red coloured non-chlorinated plastic bags or containers	Autoclaving or micro-waving/ hydroclaving followed by shredding or mutilation or combination of sterilization and shredding. Treated waste to be sent to registered or authorized recyclers or for energy recovery or plastics to diesel or fuel oil or for road making, whichever is possible. Plastic waste should not be sent to landfill sites.
White (Translucent)	**Waste sharps including Metals:** Needles, syringes with fixed needles, needles from needle tip cutter or burner, scalpels, blades, or any other contaminated sharp object that may cause puncture and cuts. This includes both used, discarded and contaminated metal sharps	Puncture proof, Leak proof, tamper proof containers	Autoclaving or Dry Heat Sterilization followed by shredding or mutilation or encapsulation in metal container or cement concrete; combination of shredding cum autoclaving; and sent for final disposal to iron foundries (having consent to operate from the State Pollution Control Boards or Pollution Control Committees) or sanitary landfill or designated concrete waste sharp pit.
Blue	**(a) Glassware:** Broken or discarded and contaminated glass including medicine vials and ampoules except those contaminated with cytotoxic wastes.	Cardboard boxes with blue colored marking	Disinfection (by soaking the washed glass waste after cleaning with detergent and Sodium Hypochlorite treatment) or through autoclaving or microwaving or hydroclaving and then sent for recycling.

	(b) Metallic Body Implants	Cardboard boxes with blue colored marking	

[*]**Disposal by deep burial is permitted only in rural or remote areas where there is no access to common bio-medical waste treatment facility. This will be carried out with prior approval from the prescribed authority and as per the Standards specified in Schedule-III. The deep burial facility shall be located as per the provisions and guidelines issued by Central Pollution Control Board from time to time.**

Part -2

(1) All plastic bags shall be as per BIS standards as and when published, till then the prevailing Plastic Waste Management Rules shall be applicable.

(2) Chemical treatment using at least 10% Sodium Hypochlorite having 30% residual chlorine for twenty minutesor any other equivalent chemical reagent that should demonstrate $Log_{10}4$ reduction efficiency for microorganisms as given in Schedule- III.

(3) Mutilation or shredding must be to an extent to prevent unauthorized reuse.

(4) There will be no chemical pretreatment before incineration, except for microbiological, lab and highly infectious waste.

(5) Incineration ash (ash from incineration of any bio-medical waste) shall be disposed through hazardous waste treatment, storage and disposal facility, if toxic or hazardous constituents are present beyond the prescribed limits as given in the Hazardous Waste (Management, Handling and Transboundary Movement) Rules, 2008 or as revised from time to time.

(6) Dead Fetus below the viability period (as per the Medical Termination of Pregnancy Act 1971, amended from time to time) can be considered as human anatomical waste. Such waste should be handed over to the operator of common bio-medical waste treatment and disposal facility in yellow bag with a copy of the official Medical Termination of Pregnancy certificate from the Obstetrician or the Medical Superintendent of hospital or healthcare establishment.

(7) Cytotoxic drug vials shall not be handed over to unauthorised person under any circumstances. These shall be sent back to the manufactures for necessary disposal at a single point. As a second option, these may be sent for incineration at common bio-medical waste treatment and disposal facility or TSDFs or plasma pyrolys is at temperature >1200 ^{0}C.

(8) Residual or discarded chemical wastes, used or discarded disinfectants and chemical sludge can be disposed at hazardous waste treatment, storage and disposal facility. In such case, the waste should be sent to hazardous waste treatment, storage and disposal facility through operator of common bio-medical waste treatment and disposal facility only.

(9) On-site pre-treatment of laboratory waste, microbiological waste, blood samples, blood bags should be disinfected or sterilized as per the Guidelines of World Health Organisation or National AIDS Control Organisation and then given to the common bio-medical waste treatment and disposal facility.

(10) Installation of in-house incinerator is not allowed. However in case there is no common biomedical facility nearby, the same may be installed by the occupier after taking authorisation from the State Pollution Control Board.

(11) Syringes should be either mutilated or needles should be cut and or stored in tamper proof, leak proof and puncture proof containers for sharps storage. Wherever the occupier is not linked to a disposal facility it shall be the responsibility of the occupier to sterilize and dispose in the manner prescribed.

(12) Bio-medical waste generated in households during healthcare activities shall be segregated as per these rules and handed over in separate bags or containers to municipal waste collectors. Urban Local Bodies shall have tie up with the common bio-medical waste treatment and disposal facility to pickup this waste from the Material Recovery Facility (MRF) or from the house hold directly, for final disposal in the manner as prescribed in this Schedule.

SCHEDULE II
[See rule 4(t), 7(1) and 7(6)]

STANDARDS FOR TREATMENT AND DISPOSAL OF BIO-MEDICALWASTES

1. STANDARDS FOR INCINERATION.-

All incinerators shall meet the following operating and emission standards-

A. Operating Standards

1). Combustion efficiency (CE) shall be at least 99.00%.

2). The Combustion efficiency is computed as follows:

$$C.E. = \frac{\%CO_2}{\%CO_2 + \%\ CO} \times 100$$

3). The temperature of the primary chamber shall be a minimum of 800 ^{0}C and the secondary chamber shall be minimum of 1050^{0}C + or - 50^{0}C.

4). The secondary chamber gas residence time shall be at least two seconds.

B. Emission Standards

Sl. No.	Parameter	Standards	
(1)	(2)	(3)	(4)
		Limiting concentration in mg Nm^3 unless stated	**Sampling Duration in minutes, unless stated**
1.	Particulate matter	50	30 or $1NM^3$ of sample volume, whichever is more
2.	Nitrogen Oxides NO and NO_2 expressed asNO_2	400	30 for online sampling or grab sample
3.	HCl	50	30 or $1NM^3$ of sample volume, whichever is more
4.	Total Dioxins and Furans	0.1ngTEQ/Nm^3 (at 11% O2)	8 hours or $5NM^3$ of sample volume, whichever is more
5.	Hg and its compounds	0.05	2 hours or $1NM^3$ of sample volume, whichever is more

C. Stack Height: Minimum stack height shall be 30 meters above the ground and shall be attached with the necessary monitoring facilities as per requirement of monitoring of 'general parameters' as notified under the Environment (Protection) Act, 1986 and in accordance with the Central Pollution Control Board Guidelines of Emission Regulation Part-III.

Note:

(a) The existing incinerators shall comply with the above within a period of two years from the date of the notification.

(b) The existing incinerators shall comply with the standards for Dioxins and Furans of 0.1ngTEQ/Nm^3, as given below within two years from the date of commencement of these rules.

(c) All upcoming common bio-medical waste treatment facilities having incineration facility or captive incinerator shall comply with standards for Dioxins and Furans.

(d) The existing secondary combustion chambers of the incinerator and the pollution control devices shall be suitably retrofitted, if necessary, to achieve the emission limits.

(e) Wastes to be incinerated shall not be chemically treated with any chlorinated disinfectants.

(f) Ash from incineration of biomedical waste shall be disposed of at common hazardous waste treatment and disposal facility. However, it may be disposed of in municipal landfill, if the toxic metals in incineration ash are within the regulatory quantities as defined under the Hazardous Waste (Management and Handling and Transboundary Movement) Rules, 2008 as amended from time to time.

(g) Only low Sulphur fuel like Light Diesel Oil or Low Sulphur Heavy Stock or Diesel, Compressed Natural Gas, Liquefied Natural Gas or Liquefied Petroleum Gas shall be used as fuel in the incinerator.

(h) The occupier or operator of a common bio-medical waste treatment facility shall monitor the stack gaseous emissions (under optimum capacity of the incinerator) once in three months through a laboratory approved under the Environment (Protection) Act, 1986 and record of such analysis results shall be maintained and submitted to the prescribed authority. In case of dioxins and furans, monitoring should be done once in a year.

(i) The occupier or operator of the common bio-medical waste treatment facility shall install continuous emission monitoring system for the parameters as stipulated by State Pollution Control Board or Pollution Control Committees in authorisation and transmit the data real time to the servers at State Pollution Control Board or Pollution Control Committees and Central Pollution Control Board.

(j) All monitored values shall be corrected to 11% Oxygen on dry basis.

(k) Incinerators (combustion chambers) shall be operated with such temperature, retention time and turbulence, as to achieve Total Organic Carbon content in the slag and bottom ashes less than 3% or their loss on ignition shall be less than 5% of the dry weight.

(l) The occupier or operator of a common bio-medical waste incinerator shall use combustion gas analyzer to measure CO_2, CO and O_2.

2. **Operating and Emission Standards for Disposal by Plasma Pyrolysis or Gasification:**

A. Operating Standards:

All the operators of the Plasma Pyrolysis or Gasification **s**hall meet the following operating and emission standards:

1) Combustion Efficiency (CE) shall be at least 99.99%.

2) The Combustion Efficiency is computed as follows.

$$C.E = \frac{\%\ CO_2}{(\%\ CO_2 + \%\ CO)} \times 100$$

3) The temperature of the combustion chamber after plasma gasification shall be $1050 \pm 50\ ^{o}C$ with gas residence time of at least 2(two) second, with minimum 3 % Oxygen in the stack gas.

4) The Stack height should be minimum of 30 m above ground level and shall be attached with the necessary monitoring facilities as per requirement of monitoring of 'general parameters' as notified under the Environment (Protection) Act, 1986 and in accordance with the CPCB Guidelines of Emission Regulation Part-III.

B. Air Emission Standards and Air Pollution Control Measures

(i) Emission standards for incinerator, notified at Sl No.1 above in this Schedule, and revised from time to time, shall be applicable for the Plasma Pyrolysis or Gasification also.

(ii) Suitably designed air pollution control devices shall be installed or retrofitted with the 'Plasma Pyrolysis or Gasification to achieve the above emission limits, if necessary.

(iii) Wastes to be treated using Plasma Pyrolysis or Gasification shall not be chemically treated with any chlorinated disinfectants and chlorinated plastics shall not be treated in the system.

C. Disposal of Ash Vitrified Material: The ash or vitrified material generated from the 'Plasma Pyrolysis or Gasification shall be disposed off in accordance with the Hazardous Waste (Management, Handling and Transboundary Movement) Rules 2008 and revisions made thereafter in case the constituents exceed the limits prescribed under Schedule II of the said Rules or else in accordance with the provisions of the Environment (Protection) Act, 1986, whichever is applicable.

3. STANDARDS FOR AUTOCLAVING OF BIO-MEDICAL WASTE.-

The autoclave should be dedicated for the purposes of disinfecting and treating bio-medical waste.

(1) When operating a gravity flow autoclave, medical waste shall be subjected to:

(i) a temperature of not less than 121° C and pressure of 15 pounds per square inch (psi) for an autoclave residence time of not less than 60 minutes; or

(ii) a temperature of not less than 135° C and a pressure of 31 psi for an autoclave residence time of not less than 45 minutes; or

(iii) a temperature of not less than 149° C and a pressure of 52 psi for an autoclave residence time of not less than 30 minutes.

(2) When operating a vacuum autoclave, medical waste shall be subjected to a minimum of three pre-vacuum pulse to purge the autoclave of all air. The air removed during the pre-vacuum, cycle should be decontaminated by means of HEPA and activated carbon filtration, steam treatment, or any other method to prevent release of pathogen. The waste shall be subjected to the following:

(i) a temperature of not less than 121°C and pressure of 15 psi per an autoclave residence time of not less than 45 minutes; or

(ii) a temperature of not less than 135°C and a pressure of 31 psi for an autoclave residence time of not less than 30 minutes;

(3) Medical waste shall not be considered as properly treated unless the time, temperature and pressure indicators indicate that the required time, temperature and pressure were reached during the autoclave process. If for any reasons, time temperature or pressure indicator indicates that the required temperature, pressure or residence time was not reached, the entire load of medical waste must be autoclaved again until the proper temperature, pressure and residence time were achieved.

(4) **Recording of operational parameters:** Each autoclave shall have graphic or computer recording devices which will automatically and continuously monitor and record dates, time of day, load identification number and operating parameters throughout the entire length of the autoclave cycle.

(5) **Validation test for autoclave:** The validation test shall use four biological indicator strips, one shall be used as a control and left at room temperature, and three shall be placed in the approximate center of three containers with the waste. Personal protective equipment (gloves, face mask and coveralls) shall be used when opening containers for the purpose of placing the biological indicators. At least one of the containers with a biological indicator should be placed in the most difficult location for steam to penetrate, generally the bottom center of the waste pile. The occupier or operator shall conduct this test three consecutive times to define the minimum operating conditions. The temperature, pressure and residence time at which all biological indicator vials or strips for three consecutive tests show complete inactivation of the spores shall define the minimum operating conditions for the autoclave. After determining the minimum temperature, pressure and residence time, the occupier or operator of a common biomedical waste treatment facility shall conduct this test once in three months and records in this regard shall be maintained.

(6) **Routine Test:** A chemical indicator strip or tape that changes colour when a certain temperature is reached can be used to verify that a specific temperature has been achieved. It may be necessary to use more than one strip over the waste package at different locations to ensure that the inner content of the package has been adequately autoclaved. The occupier or operator of a common bio medical waste treatment facility shall conduct this test during autoclaving of each batch and records in this regard shall be maintained.

(7) Spore testing: The autoclave should completely and consistently kill the approved biological indicator at the maximum design capacity of each autoclave unit. Biological indicator for autoclave shall be Geobacillusstearothermophilus spores using vials or spore Strips; with at least $1X10^6$ spores. Under no circumstances will an autoclave have minimum operating parameters less than a residence time of 30 minutes, a temperature less than 121^o C or a pressure less than 15 psi. The occupier or operator of a common bio medical waste treatment and disposal facility shall conduct this test at least once in every week and records in this regard shall be maintained.

4. **STANDARDS OF MICROWAVING.-**

(1) Microwave treatment shall not be used for cytotoxic, hazardous or radioactive wastes, contaminated animal carcasses, body parts and large metal items.

(2) The microwave system shall comply with the efficacy test or routine tests and a performance guarantee may be provided by the supplier before operation of the limit.

(3) The microwave should completely and consistently kill the bacteria and other pathogenic organisms that are ensured by approved biological indicator at the maximum design capacity of each microwave unit. Biological indicators for microwave shall be Bacillus atrophaeusspores using vials or spore strips with at least 1×10^4sporesper detachable strip. The biological indicator shall be placed with waste and exposed to same conditions as the waste during a normal treatment cycle.

5. **STANDARDS FOR DEEP BURIAL.-** (1) A pit or trench should be dug about two meters deep. It should be half filled with waste, then covered with lime within 50 cm of the surface, before filling the rest of the pit with soil.

(2) It must be ensured that animals do not have any access to burial sites. Covers of galvanised iron or wire meshes may be used.

(3) On each occasion, when wastes are added to the pit, a layer of 10 cm of soil shall be added to cover the wastes.

(4) Burial must be performed under close and dedicated supervision.

(5) The deep burial site should be relatively impermeable and no shallow well should be close to the site.

(6) The pits should be distant from habitation, and located so as to ensure that no contamination occurs to surface water or ground water. The area should not be prone to flooding or erosion.

(7) The location of the deep burial site shall be authorised by the prescribed authority.

(8) The institution shall maintain a record of all pits used for deep burial.

(9) The ground water table level should be a minimum of six meters below the lower level of deep burial pit.

6. STANDARDS FOR EFFICACY OF CHEMICAL DISINFECTION

Microbial inactivation efficacy is equated to "Log10 kill" which is defined as the difference between the logarithms of number of test microorganisms before and after chemical treatment. Chemical disinfection methods shall demonstrate a 4 Log10 reduction or greater for Bacillus Subtilis (ATCC 19659) in chemical treatment systems.

7. STANDARDS FOR DRY HEAT STERILIZATION

Waste sharps can be treated by dry heat sterilization at a temperature not less than 185^0C, at least for a residence period of 150 minutes in each cycle, which sterilization period of 90 minutes. There should be automatic recording system to monitor operating parameters.

(i) Validation test for Shaprs sterilization unit

Waste shaprs sterilization unit should completely and consistently kill the biological indicator GeobacillusStearothermophillus or Bacillus Atropheausspoers using vials with at least $\log_{10} 6$ spores per ml. The test shall be carried out once in three months

(ii) Routine test

A chemical indicator strip or tape that changes colour when a certain temperature is reached can be used to verify that a specific temperature has been achieved. It may be necessary to use more than one strip over the waste to ensure that the inner content of the sharps has been adequately disinfected. This test shall be performed once in week and records in this regard shall be maintained.

8. **STANDARDS FOR LIQUID WASTE.-**

(1) The effluent generated or treated from the premises of occupier or operator of a common bio medical waste treatment and disposal facility, before discharge into the sewer should conform to the following limits-

PARAMETERS	PERMISSIBLE LIMITS
pH	6.5-9.0
Suspended solids	100 mg/l
Oil and grease	10 mg/l
BOD	30 mg/l
COD	250 mg/l
Bio-assay test	90% survival of fish after 96 hours in 100% effluent.

(2) Sludge from Effluent Treatment Plant shall be given to common bio-medical waste treatment facility for incineration or to hazardous waste treatment, storage and disposal facility for disposal.

MINISTRY OF ENVIRONMENT, FOREST AND CLIMATE CHANGE

NOTIFICATION

New Delhi, the 16th March, 2018

G.S.R. 234 (E).– In exercise of the powers conferred by sub-section (1) and clause (v) of sub-section (2) of section 3 of the Environment (Protection) Act, 1986 (29 of 1986) read with sub-rule (4) of rule 5 of the Environment (Protection) Rules, 1986, the Central Government hereby makes the following rules to amend the Bio-Medical Waste Management Rules, 2016, published in the Gazette of India, Extraordinary, vide G.S.R. 343(E), dated the 28th March, 2016, after having dispensed with the requirement of notice under clause (a) of sub-rule (3) of rule 5 of the said rules in public interest, namely:-

1. (1) These rules may be called the Bio-Medical Waste Management (Amendment) Rules, 2018.

(2) They shall come into force on the date of their publication in the Official Gazette.

2. In the Bio-Medical Waste Management Rules, 2016 (hereinafter referred to as the principal rules), in rule 2, in sub-rule (2),–

(i) in clause (c), for the words, brackets and figures "Municipal Solid Waste (Management and Handling) Rules, 2000", the words and figures "Solid Waste Management Rules, 2016" shall be substituted;

(ii) in clause (e), for the words, brackets and figures "Hazardous Wastes (Management, Handling and Transboundary Movement) Rules, 2008", the words, brackets and figures "Hazardous and Other Wastes (Management and Transboundary Movement) Rules, 2016", shall be substituted; and

(iii) in clause (f), for the words, brackets and figures "E-Waste (Management and Handling) Rules, 2011", the words, brackets and figures "E-Waste (Management) Rules, 2016", shall be substituted.

3. In the principal rules, in rule 4,–

(i) in clause (c), for the portion beginning with "or National and ending with final disposal", the following shall be substituted, namely:–

"(c), guidelines on Safe management of wastes from health care activities and WHO Blue Book, 2014 and then sent to the Common bio-medical waste treatment facility for final disposal;".

(ii) for clause (d), the following clause shall be substituted, namely:–

"(d) phase out use of chlorinated plastic bags (excluding blood bags) and gloves by the 27th March, 2019;".

(iii) in clause (i), for the words "place for any purpose within one year from the date of the notification of these rules", the words and figures "for the further treatment and disposal in accordance with the guidelines issued by the Central Pollution Control Board by 27th March, 2019" shall be substituted;

(iv) for clause (p), the following clause shall be substituted, namely:–

"(p) ,all the health care facilities (any number of beds) shall make available the annual report on its web-site within a period of two years from the date of publication of Bio-Medical Waste Management (Amendment) Rules, 2018;".

4. In the principal rules, in rule (5), in clause (c), for the words "within one year", the words, letters and figures "in accordance with the guidelines issued by the Central Pollution Control Board by 27th March, 2019" shall be substituted.

5. In the principal rules, in rule 7, in clause (8),–

(a) for the words "phase out use of non-chlorinated plastic bags", the words "phase out use of chlorinated plastic bags" shall be substituted;

(b) for the words and figures "the Plastic Waste Management Rules, 2011", the words and figures "the Plastic Waste Management Rules, 2016" shall be substituted.

6. In the principal rules, in rule 13, in sub-rule (2), for the words "Central Pollution Control Board on or before", the words, figures, brackets and letter "Central Pollution Control Board in Form IVA before" shall be substituted.

7. In the Schedule I to the principal rules,–

(a) in the Table under part 1–

(i) against the category yellow,–

(A) in item (g) under column (2), after the words "body fluid", the words ", routine mask and gown" shall be inserted;

(B) against item (h), for the entry under column (3), the following entry shall be substituted, namely:-

"Autoclave or Microwave or Hydroclave safe plastic bags or containers";

(C) against item (h), in the entry under column (4), for the portion beginning with "as per National AIDS Control Organisation", and ending with "for incineration", the following shall be substituted, namely:–

"as per World Health Organisation guidelines on Safe management of wastes from health care activities and WHO Blue Book, 2014 and thereafter sent for incineration";

(ii) against the category blue–

(A) against item (a), for the entry under column (3), the following item shall be substituted, namely:–

"(a) Puncture proof and leak proof boxes or containers with blue colored marking";

(B) against item (b) for the entry under column (3), the following item shall be substituted, namely:–

"(b) Puncture proof and leak proof boxes or containers with blue colored marking";

(iii) in the Note, for the word and figures "Schedule - III", the word and figures "Schedule – II" shall be substituted;

(b) in Part – 2, in item (2), for the figures "10 %", the figures "1% to 2%" shall be substituted;

8. In Schedule II to the principal rules,–

(i) in serial number 1, in the Table under Part B relating to "Emission Standards", in column heading under (3), for the letters and figure "$mgNm^3$" the letters and figure "mg/Nm^3" shall be substituted;

(ii) in serial number 8, in item (1), the following Note shall be inserted, namely:–

"Note–

1. Above limits are applicable to the occupiers of Health Care Facilities (bedded) which are either connected with sewerage network without terminal sewage treatment plant or not connected to public sewers.

2. For discharge into public sewers with terminal facilities, the general standards as notified under the Environment (Protection) Act, 1986 (29 of 1986) shall be applicable.

3 Health Care Facilities having less than ten beds shall have to install Sewage Treatment Plant by the 31 st December, 2019.

4 Non-bedded occupiers shall dispose infectious liquid wastes only after treatment by disinfection as per Schedule – II (6) of the principal rules.".

9. In Schedule - III to the principal rules,–

(i) against serial number 3, in item (i) under column (3), for the brackets, word and figure "(Rule 9)", the brackets, word and figure "(Rule 10)" shall be substituted;

(ii) against serial number 4, in item (viii) under column (3), for the brackets, word and figure "(Rule 9)", the brackets, word and figure "(Rule 12)" shall be substituted.

Fire Safety in Hospitals

1. Are Hospitals more prone to Fire Hazard?

Fire safety is a very vital component of risk management or patient safety management program in any hospital. As such, the hospitals are more prone to fire hazard because of concentration of a lot of electrical equipment some of it working on high voltage, concentration of chemicals and gases being used, DG sets, Transformers, UPS, overloaded switches and sockets and loose temporary connections, the problem is further compounded because a sizable percentage of people inside the hospital are, partly or completely incapacitated, vulnerable and at the mercy of others.

2. Why fire safety is much more important for the Hospitals?

The Most dangerous aspect of fire hazard is that once it starts, it is difficult to control. It spreads very fast. In less than 30 seconds, a small flame can get completely out of control and within minutes, an entire house can be engulfed in flames. There is only time to escape. Within minutes, the temperature can shoot up igniting everything in the room, spontaneously. The thick black smoke can quickly engulf the room in complete darkness. It uses up all the oxygen and produces smoke and poisonous gases that kill more people that the flames do. The odorless, colorless fumes can lull people into adeep sleep before the flames even reach the door.

3. How do you classify fire in the Hospitals?

Fire can be classified into four categories :

Class A : Produced by combustion of solid combustible materials that are not metal, such aswood, paper, cloth, trash, plastics.

Class B : Oil or Gas fires caused by ignition of any nonmetal in a liquid state such as Flammable liquids: Gasoline, oil, grease, acetone or flammable gases.

Class C : Electrical fire caused by energized electrical equipment.

Class D : Fire caused by combustion of metals such as potassium, sodium, aluminum, magnesium(in a laboratory or industry that uses these) materials. It requires special extinguishing agents (Metal-X, foam) to fight such fires.

4. What are the common causes of fire in the Hospitals ?

I) Smoking, naked lighting in hazard prone areas, heating appliances, static current, andexplosive gases in the OT, and diagnostic areas, other areas with heavy power load ofequipment.

ii.) Electrical short circuiting / sparks in any area of the hospital.

iii.) Chemical fire in the Pathology Lab. Stores area.

iv.) Battery charging, spray painting.

v.) Welding and cutting activities.

vi.) Spontaneous combustion.

5. What are the areas more prone to fire in hospital?

All areas of the hospital with heavy electrical activity / equipment usage or storage of inflammable / explosive items (OT, ICU, cath. Lab, path lab, radiotherapy, radio diagnosis, generator room, maintenance workshop, battery banks, medical stores, manifold room, diesel storage etc.) are specially prone to fire hazards and special care must be taken to prevent firein these areas.

6. What are the Exit Requirements?

In buildings or sections occupied by bed-ridden patients where the floor area is over 280 m2, facilities shall be provided to move patients in hospital beds to the other side of a smoke barrier from any part of such building or section not directly served by approved horizontal exits or exits from the first floor (floor 2) of a building to the outside.

Not less than two exits of one or more of the following types shall be provided for every floor, including basement, of every building or section:

a) Doors leading directly outside the building;

b) Stairways

c) Ramps

d) Horizontal exits; and

e) Fire tower.

All required exits that serve as egress from hospital or infirmary sections shall be not less than 2 m in clear width including patient bedroom doors to permit transportation of patients on beds, litters, or mattresses. The minimum width of corridors serving patients bedrooms in buildings shall be 2400mm.

Elevators constitute a desirable supplementary facility, but are not counted as required exits. Patient lifts shall also

be provided with enough room for transporting a stretcher trolley.

Any area exceeding 500 m2 shall be divided into compartments by fire resistant walls. Doors in fire resistant walls shall be so installed that these may normally be kept in open position, but will close automatically. Corridor door openings in smoke barriers shall be not less than 2000 mm in width.Provision shall also be made for double swing single/double leaf type door.

Additional Precautions:

N o combustible material of any kind shall be stored or used in any building or section thereof used for institutional occupancy, except as necessary to normal occupancy and use of the building.

Bare minimum quantities of flammable material such as chloroform, ethyl alcohol, spirit, etc shall be allowed to be stored and handled. The handling of such liquids shall not be permitted by un-authorized persons. Bulk storage of these items, will be governed by relevant rules and safe practices.

Exceptions and Deviations:

It is recognized that in institutions or part of buildings housing various types of psychiatric patients, or used as penal and mental institutions, it is necessary to maintain locked doors and barred windows; and to such extent the necessary provision in other sections of the Code requiring the keeping of exits unlocked may be waived. It is also recognized that certain type of psychiatric patients are not capable of seeking safety without adequate guidance. In buildings where this situation prevails, reliable means for the rapid release of occupants shall be provided, such as remote control of locks, or by keying all locks to keys commonly used by attendants.

7. What are the requirements about ramps, corridors & staircase?

Internal Staircases

- Internal staircases shall be constructed with non-combustible materials
- Internal stairs shall be constructed as self-contained units along an external wall of the building constituting at least one of its sides and shall be completely closed
- A staircase shall not be arranged around a Lift shaft.
- Hollow combustible construction shall not be permitted
- The construction material shall have 02 hrs fire resistances.
- Minimum width of stairs shall be 2 mtrs.
- Width of the tread shall not be less than 300 mm.
- The height of the riser shall not be less than 150 mm and the number of stairs per flight shall not exceed 15
- Handrails shall be provided at a height of 1000 mm, which is to be measured from the base of the middle of the treads to the top of the handrails.
- Banisters or railings shall be provided such that the width of staircase is not reduced.
- Minimum head room in a passage under the landing of a staircase and under the Staircase shall be 2.2 mtrs.
- The staircase shall be continuous from ground floor to the terrace and the exit door at the ground level shall open directly to the open spaces or a large lobby.
- The number of people in between floor landings of staircases shall not be less than the population on each floor for the purpose of the design of the staircase.
- Fire/Smoke check doors shall be provided for a minimum of 2 hrs fire resistance rating.
- Lift openings and any other openings shall not be permitted.
- No electrical shaft and panel, AC ducts or gas pipelines, etc. shall pass through or open onto the staircases.
- No combustible material shall be used for decoration/wall paneling in the staircases.

Protected Staircases

Provisions given for internal staircases shall apply to protected staircases. Also, additional safeguards shall be provided as under:

- The staircases shall be enclosed by walls having 02 hrs fire resistance
- The external exit doors at ground floor shall open directly onto open spaces or a lobby and Fire & Smoke check doors shall be provided.
- Protected staircases shall be pressurized. Under no circumstances shall they be connected to a corridor, lobby and staircase which is unpressurized.
- Pressurization systems shall be incorporated in protected staircases where the floor area is more than 500 sq. mtr. The difference in pressurization levels

between staircase and lobby/corridor shall not be greater than 5 Pa. Where 2 stage pressurization system is in use the pressure difference shall be as under:

- In normal conditions - Minimum 8Pa to 15 Pa.
- In emergency conditions - 50 Pa.

- The pressurization system shall be interconnected with the automatic/manual fire alarm system for actuation.

External Staircases

- External staircases serving as a required means of egress shall be of permanent fixed construction.
- External staircases shall be protected by a railing or guard. The height of such a guard/ railing shall not be less than 1200 mm.
- External staircases shall be separated from the interior of the building by walls that are fire resistant and have fixed or self-closing opening protective', as required for enclosed stairs. External staircases shall extend vertically from the ground to a point 3 meters above the topmost landing of the stairway or the roof line whichever is lower, and at least 3 meters horizontally.
- All openings below and outside the external staircases shall be protected with requisite fire resistance rating.
- External staircases shall be so arranged to avoid any discomfort/obstruction for persons with a fear of heights, from using them.
- External staircases shall be so arranged to ensure a clear direction of egress to the street.
- External staircases shall be continuous from the ground floor to the terrace level
- The entrance to the external staircases shall be separate and remote from internal staircases.
- External staircases shall have a straight flight with a width not less than 2 mtrs, a tread not less than 300 mm, a riser not more than 150 mm and the number of risers shall be limited to 15 per flight.
- The handrail shall have a height not less than 1000 mm and not exceeding 1200 mm. Banisters shall be provided with a maximum gap of 150 mm
- Stair treads shall be uniformly slip resistant and shall be free of projections or lips that could trip stair users
- External staircases used as fire escapes shall not be inclined at an angle greater than 450 from the horizontal
- Unprotected steel frame staircases shall not be acceptable means of egress; however steel
- staircases in an enclosed compartment with a fire resistance of 2 hrs will be accepted as means of escape.
- Elevators constitute a desirable supplementary facility though they are not counted as required exits. Patient's lifts shall have sufficient space for Stretcher trolley.

Horizontal Exits

A horizontal exit implies that the occupants will be transferred from one side of a partition to the other. Essential fire safety provisions for horizontal exits are as follows:

- Width of the horizontal exits shall be same as the exit doorways.
- A horizontal exit shall be equipped with at least one fire/smoke door of minimum 2 hrs fire resistance of self-closing type. Further they shall have direct access to the fire escape staircase for evacuation.
- A refuge area of 15 Sq. Mtr. or an area equivalent to 0.3 Sq Mtr. per person for the number of occupants in two consecutive floors, whichever is more, shall be provided on the periphery of the floor or preferably on an open air cantilever projection with at least
- One side protected with suitable railings/guards with a height not less than 1 mtr.
- Within the aggregated area of corridors, patient rooms, treatment rooms, lounges, dining area and other low hazards areas on each side of the horizontal exit, a single door may be used in a horizontal exit given that the exit serves one direction only. Such doors shall be swinging doors or a horizontal sliding door.
- Where there is a difference in the level between areas connected by a horizontal exit, ramps not more than 1 in 10 mtr slope shall be provided. The steps shall not be used.
- Doors shall be accessible at all times from both sides.
- A horizontal exit involving a corridor 8 ft or more in width serving as a means of egress from both sides of the doorway shall have the opening protected by a pair of swinging doors arranged to swing in the opposite direction from each other.

Corridors and Passageways

- The minimum width and height of corridors and

passage ways shall be 2.4 mtr. The exit corridor and passage ways shall have a width not less than the aggregate required width of Exit doorways leading from them in the direction of travel to the exterior. Corridors shall be adequately ventilated.

- Corridor walls shall form a barrier to limit the transfer of smoke, toxic gases and heat.
- Transfer grills, regardless of whether protected by fusible link operated dampers, shall not be used in corridor walls or doors.
- Openings if required in corridor walls for specific use, shall be suitably protected.
- Fixed wired glass opening vision panel shall be permitted in corridor walls, provided they don"t exceed 0.84 Sq Mtr in area and are mounted in steel or other approved metal frames.

Ramps

- All ramps shall comply with the applicable requirements for stairways regarding enclosure, capacity and limiting dimensions except in certain cases where steeper slopes may be permitted with inclination less than 1 in 8 (under no condition shall the slopes greater than 1 in 8 be used).
- Ramps shall be surfaced with approved nonskid & non slippery material.
- Average width should be 2 meters.

8. What are the fixed firefighting installations?

Minimum Requirements for Fire Fighting Installations (NBC)

		Type of Installation									Water Supply (In liters)		Pump Capacity (in L/min)	
S.No.	Type of Building/ Occupancy	Fire Extinguisher	Hose Reel	Dry Riser	Wet Riser	Downcomer	Yard Hydrant	Automatic Sprinkler System	Manually operated Electric Fire Alarm System	Automatic Detection & Fire Alarm System	Underground static water storage tank	Terrace tank	Pump near underground static water storage tank with min pressure 3.5Kg/cm2 at terrace level	At the terrace tank level with min pressure 2 Kg/cm2
	INSTITUTION BUILDINGS													
a	Hospitals, Sanitoria & Nursing Homes (C-1)													
1	Less than 15 m in height with plot area up to 1000m2													
i	Up to ground plus one storey, with no beds	R	R	NR	NR	NR	NR	R (NOTE 1)	R	NR	NR	2500 (2500) SEE NOTE 2	NR	NR
ii	Up to ground plus one storey with beds	R	R	NR	NR	R	NR	R (NOTE 1)	R	NR	NR	5000 (5000) SEE NOTE 2	NR	450(450) SEE NOTE 2
iii	Ground plus 2 or more storeys, without beds	R	R	NR	NR	R	NR	R (NOTE 1)	R	R	NR	5000 (5000) SEE NOTE 2	NR	450 (450) SEE NOTE 2
iv	Ground plus 2 or more storeys, with beds	R	R	NR	R	NR	NR	R (NOTE 1)	R	R	50000	5000 (5000) SEE NOTE 2	NOTE 3	NR
2	Less than 15 m in height with plot area more than 1000m2	R	R	NR	R	NR	R	R (NOTE 1)	R	R	10000	10000	NOTE 3	NR
3	Above 15m height but not exceeding 24m in height	R	R	NR	R	NR	R	R (NOTE 6)	R	R	100000	20000	NOTE 4	NR
4	Above 15m height but not exceeding 30m in height	R	R	NR	R	NR	R	R (NOTE 6)	R	R	150000	20000	NOTE 5	NR
		R = Required			NR = Not required									
	Note 1	Required to be installed in basement if area of basement exceeds 200m2												
	Note 2	Additional value given in parenthesis shall be added if basement area exceeds 200m2												
	Note 3	One electric & one diesel pump of capacity 1620 lpm and one electric pump of capacity 180 lpm												
	Note 4	One electric & one diesel pump of capacity 2280 lpm and one electric pump of capacity 180 lpm												
	Note 5	One electric & one diesel pump of capacity 2280 lpm and one electric pump of capacity 180 lpm												
	Note 6	To be installed at all floors at appropriate places and in consultation with local fire authorities												

9. How does NABH survey on Fire Safety?

During its survey process the NABH auditors look into the following to ensure that the organization is compliant with Fire

Safety Regulations:

Fire Prevention and Control Infrastructure:

1. The organization has updated NOC from state Fire Department.
2. The organization has a multi-disciplinary safety committee with a senior person as the chairman of the safety committee. The safety committee meetings are held at least once in 3 months. The minutes of the meeting are recorded and put up to the senior management.
3. The organization has a formally appointed Fire Safety Officer in-charge of all concerns related to Fire Prevention & Safety. The Fire Safety Officer should be preferably from Security Staff and should be aware of all fire safety protocols.
4. The organization has a written plan for Fire Prevention and Safety and has a Fire Safety Manual approved by the safety committee.
5. The organization has an Emergency Command Centre that becomes functional immediately whenever there is an emergency. There is a written protocol and written constitution of the committee and the Fire Command Centre is update with the name of the members. A designated person has the responsibility of informing all the Emergency Command members.
6. The Fire Safety Manual has the following components:

- Plan for fire prevention & control.
- Systems for fire prevention & control.
- Maintenance Schedules/ SOPs for systems related to fire prevention & control
- Inspection protocols for fire safety installations.
- Codes for announcement of fire related emergency, procedures and communication protocols for the same.
- Responsibilities of different departments in case of fire.
- Procedures, frequency & protocols for mock drills.
- Constitution of Fire Fighting & Evacuation Teams.
- Evacuation Plan.
- Electrical Safety & System.

7. A multi-disciplinary committee, which has Fire Safety Officer as a member, holds facility rounds at least once a year for non-clinical areas & twice a year for clinical areas. Fire Safety requirements are on the checklist of the said committee and the reports are submitted in writing to the safety committee.
8. The safety committee has a system whereby all fire safety concerns are addressed.
9. The mock drills are conducted and the reports submitted to the safety committee. Necessary action is taken to address any issues that crop up during mock drills.
10. The fire exits are well defined and end on the ground floor or refuge area or any safe place decided by the management.
11. The Fire Signages are appropriate and placed at the right locations.
12. Emergency fire signages are glow in dark signages.
13. The Fire Signages are visible and are bilingual, with one local language.
14. The egress routes are free from any materials that would cause hindrance in evacuation.
15. The Fire Doors have a proper fire rating and open outside.
16. The Fire Doors preferably have panic bars.
17. The Fire Doors remain open at all times.
18. The Fire cabinets are open all the time.
19. The Manual Call Points have means to break the glass.
20. The Fire Alarm systems are properly tested and maintained and a record is kept for the same.
21. The Emergency Exit signs should be displayed prominently.
22. The stairwells used for evacuation are pressurized in case of fire emergency.
23. The lifts are not used in case of fire.
24. The HVAC system has appropriate fire dampers to prevent spread of fire that function properly in case of fire. The dampers are tested and have a regular preventive maintenance schedule.
25. All the equipments have an organized preventive maintenance schedule that is recorded and stickers put

on the equipments showing the date of preventive maintenance check and the next date for maintenance.

26. Appropriate type & number of fire extinguishers have been installed according to the type of fire that could take place.
27. The Fire Extinguishers have a regular preventive maintenance schedule and stickers are put showing the date of checking and the next scheduled date for checking.
28. 10% of Fire Extinguishers are used every year for checking the same.
29. The building has an approachable peripheral road around it for access by fire brigade.
30. The Fire Pump House is maintained properly and the pumps have pressure gauges that have been calibrated and appropriate pressures are maintained in the fire hydrant & sprinkler lines.
31. There is a proper training program for handling fire emergencies and training records are maintained. The entire staff is imparted fire safety training.
32. The staff is aware of the firefighting systems, responsibilities during fire emergencies, evacuation routes & techniques, conversant with the type of fire extinguishers and their area of use, trained to operate fire extinguishers, code announcements and assembly points in case of fire.
33. The organization has policies & protocols for storing, dispensing & use of flammable materials.
34. Electrical safeties are in place. Preventive maintenance & testing is done at regular pre decided intervals and are recorded and stickers affixed.
35. All electrical panels have a rubber mat in front of them.
36. The earthing system is tested regularly.
37. The UPS batteries are checked regularly by loading the same periodically to check any heating up etc.
38. There is proper ventilation in panel, UPS & equipment rooms to avoid overheating.
39. There is an approval from the Indian Explosives Department for bulk storage of Diesel & any other flammable material as per Indian Explosives Act, in case stored in bulk.
40. The pumps used for pumping fuel are of flame proof construction.
41. The Provisions are there to take care of fuel overflow.
42. Flues are properly insulated.

10. What are Types of Fire extinguisher?

Extinguisher	Fire Class	Fire Description
Water (PSW)	A	Ordinary combustibles only
Carbon Dioxide (CO_2)	B C	Fire caused by flammable liquids, gases, Electrical fire
Dry Chemical	ABC	Fires caused by ordinary combustibles; flammable liquids, gases and electrical fires.
Special Dry Chemical (MET-L-X)	D	Combustible metals only

11. Safety Rules for Operation of Lifts:

1. Installation and operation of lifts/escalators must be in full compliance with the rules/regulations applicable in the state. Any passenger lift installed in any building except the building maintained by Public Works Department and MES, can be operated only after obtaining a valid license which is issued after confirming the safety of electrical installation of lift, its layout, safety mechanisms and safety gears, etc. As per the standards laid down in relevant Bureau of India Standards. The license to operate the lift must be renewed well in time in r/o each and every lift.
2. **Inspection of Lifts:** The lifts are to be inspected regularly as per the prescribed frequency to check whether the same are being maintained properly and the safety provisions are being followed. The deficiencies detected must be attended to without any delay.
3. **Automatic Rescue Device:** Every lift in the hospital should have an automatic rescue device to rescue the passenger trapped in the lift in the event of breakdown of power supply, by bringing and stopping the lift at the nearest landing floor and keeping the landing and car door open.
4. **Mandatory Auxiliary or Alternate Power Supply System:** The owner of a lift shall provide for mandatory auxiliary or alternative automatic power (generator) supply system to ensure the functioning

of the lift in the event of breakdown of power supply within a time period of ten seconds.

5. **Intercom connection** for communication with the security as well as the lift (machine) room for assistance in case of emergency.

6. **Emergency Alarm System:** Every passenger lift must have an audio visual alarm system to alert the security/maintain staff for assistance in case of malfunctioning of the lift. The lift for transportation of stores, especially the biomedical waste should not be used for transportation of passengers, especially the patients.

7. **Maximum Carrying Capacity** display in every lift must be adhered to. There must be a documented and well-rehearsed drill for rescue of passengers trapped in the lift, in minimum possible time.

8. **Maintenance of Lifts:** Operational reliability and safety of every lift must be ensured through a program of planned preventive maintenance. Ideally, the hospital should have a regular Annual Maintenance contract with the manufacturer / supplier of the lift himself, who must issue an annual certificate confirming the safety of lifts.

9. **Reporting of Accidents:** Any accident in operation of any lift, resulting into or likely to result into injury to any person is required to be reported to the Inspector of Lifts. After that the lift installation cannot be interfered with/operated until written permission of the authorized officer is issued.

10. **Display of Information:** Every operating lift should have the following information display inside the lift for the information and safety of passengers:

a. A copy of the valid license.

b. Certificate of last inspection for fitness.

c. Maxim passenger load / capacity permitted for strict compliance

d. Instructions for passengers (Do‟s / Don‟ts) in case of lift getting stuck.

e. Actions to be taken in case of emergency.

12. **What are the fire safety plan & procedures?**

1. There should be a fire safety Manual covering the:

a.) Fire prevention, which includes all activities before the actual occurrence of fire-including identification, detection and correction of hazards, fire control planning, employee and patient education, equipment testing, drills and liaison with fire department. It must include a detailed layout plan of all the Fire points (major and minor) worked out after a detailed survey of the entire area of the hospital on all the floors.

b.) Fire Action plan, incorporating the emergency response plans for all kinds of fires in all the fire prone areas of the hospitals. The plan must include procedure for flashing the coded message for fast response of the staff, chronological sequence of action, the role and responsibility of each and every important official, the SOPs for quick and effective control of patients without disrupting their treatment.

2.) The hospital should have a safety management committee with a documented charter of duties and responsibilities. The committee must, during the periodic facility surveys far hazard identification, particularly identify the fire hazards in various areas for priority action by the management. A record of the hazards identified, the action recommended and the corrective action taken must be maintained.

3.) A regular program of Training of the staff of all categories (especially the nurses, the ward boys, the HK staff and technicians and the reception staff who are present round the clock) in fire prevention and firefighting techniques, as per a regular schedule and maintaining a roster/record of the staff trained.

Every staff member must be subjected to at least two training sessions every quarter and proficiency in fighting fire must be tested, periodically.

4.) The system must include a weekly roster of duties of various staff detailed for dire-fighting duties and the roster must be known all concerned.

5.) Availability of the phone numbers of the nearest 2-3 fire stations. Better still, the service people may be periodically invites to visit the hospital, get familiar and give give any suggestions for implementation.

6.) Every floor should have the location map of all fire-fighting equipment (including the smoke detectors, sprinklers, extinguishers) displayed prominently at a central place and the exact locations must be known to all the staff working on the floor.

7.) Exits/fire escapes must be inspected by the on duty security staff/fire supervisors every day during their tour of duty. Obstacles, if any must be removed and it should ensure that the keys to the exit doors are available at a designated nearby place.

8.) Evacuation routes (staircases, ramps, lifts) from various fire prone areas must be earmarked, kept free

of obstacles and the ward boys, security personnel/other rescue staff must be made to rehearse the drills of moving the patient on the stretcher/trolley through the stairs, ramps.

9.) Identification of the high risk areas such as OT, lab. Kitchen, stores and implementing all measures such as minimizing the hazards, special training of staff of those areas, providing all necessary equipment and regular check of the optimal functioning of the equipment.

10.) OT, Delivery suits and other high risk areas must be set off from the rest of the hospital by fire resistant doors. Sealing the space (unit concept) at one level can prevent the fire/smoke from spreading to the next bigger level. The plan should aim at contained of fire/smoke through five different units/levels, such as-the room-the first/smallest unit/level, the compartment-the next bigger unit/level, the floor-the third unit/level. The building block-the fourth unit/level, and the exits (the fifth level).

11.) Synthetic / woolen clothing / blankets should not be allowed in the OT or the delivery rooms.

12.) No smoking signs must be displayed all over the hospital, especially in the high risk areas and the administration should, by repeated surprise checks, ensure that the instructions are never violated. In fact cigarettes, match boxes/lighters should not be allowed in the hospital premises.

13.) A documented program of planned preventive maintenance of all the firefighting equipment and a system of monthly check and certification of serviceability by the engineering staff. Of special significance would be the regular maintenance of the rising mains-the Wet/Dry Risers Systems, as prescribed (BS 5306 Part 1 1976), to ensure the patency, integrity and operative reliability if this crucial component.

13. **What is the Plan for minor fire?**

A.) The information of fire may reach the security control room through:

- The individual who first detects the fire
- Through the fire indication detected at the fire control panel" located at the central control room
- Through the automatic fire alarm.

B.) The individual discovering the fire will take the following actions:

Inform the security control room giving the type and location of fire and his own name and department.

- Starts immediate action to fight the fire with the assistance of colleagues in the fire extinguishers available at the nearest fire point.

C.) Staff on duty at Fire Control Room will immediately flash a message, giving location of the fire, on walkie-talkie to:

- Fire safety supervisor
- The Security supervisor/security officer
- The AMS/DMS
- Engineering maintenance supervisor/CME.

D.) Engineering supervisor /CME will ensure adequate water supply and also alert the engineering control room in case the oxygen/electric supply is to be switched off. It is important to remember that the security supervisor should carry a torch (during night hours) as well as the master keys of all the floors. Similarly, the engineering supervisor must carry the emergency elevator key with him.

When the fire is extinguished the AMS/Security Officer and the CME will assess the damage and submit a preliminary report to the MS.

14. **What is the plan for major fire without evacuation?**

After the quick initial assessment, the team of AMS/DMS, Security officer and the CME, (or the senior most official present in the spot) should be able to decide the extent of fire. If it appears to be a major fire they should inform the control room and the telephone operator to:

- Send more staff available on duty
- Activate the full fire plan by flashing Code Red and calling staff off duty
- Informing the MS and the NS
- Calling the Fire Brigade as well as police for help

All the staff responding to the emergency code will report to the Control room and will be organized into four groups:

- Firefighting party
- Cordon party
- Rescue party
- Salvage party

In case, the fire is in the patient care areas, a decision

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will have to be taken whether evacuation, partial or full, sound be carried out. Even, if the fire is containable / being contained, the evacuation may be necessary because of excessive smoke, heat and disruption of power supply, air conditioning services.

Evacuation may be required in case the fire is a major one, getting out of control spreading to other floors also and life of the patients/staff on the floors is in danger because of fire, smoke and disruption of essential services. Depending on the extent of spread of fire/smoke, it may be full evacuation (evacuation of all the floors in the block or even beyond) or it may be a partial evacuation (up to 02 floors above and 01 floor below the floor of fire) it would involve:

- Safe evacuation of patients along with their treatment records and belongings
- Preparing the records of new location of the patients transferred
- Informing the relatives of the patients evacuated and the concerned staff

After the fire is extinguished and patient treatment restored to normal, attention is paid towards assessment of the damage done by the fire and investigating the cause and mode of fire.

15. **What are the important lifesaving don'ts during fire?**

Some Life Saving „Don"ts"

- Never run cords under rugs or carpets where heat might build up or damage to a cord may go unnoticed
- Never connect generators to another power source such as power lines. The reverse flow of electricity or "back feed" can electrocute an unsuspecting utility worker
- Never overload electrical circuits by using multi-plug
- Do not wear loose and synthetic clothing while working with gas burner/electric heater
- Do not forget to turn-off gas cylinder before going to bed
- Smell and listen for leaky gas connections. If you believe there is a gas leak, immediately leave the room and leave the door(s) open
- Keep combustible liquids away from heat sources
- Do not park your vehicle or store any item to obstruct the access to firefighting facilities provided in your premises
- Do not hide any information concerning hazards in the premises make them known to all
- Do not temper with firefighting equipment in your premises
- Do not race with firefighting or any other emergency vehicle. Give them way to reach faster to the scene of accident
- Do not crowd the fire accident site, as it may hamper firefighting and rescue operations
- Do not ever hesitate to call the local Fire Service in times of emergency, however minor that may be.
- Don"t fail to report the fire incident to fire service. It is a cognizable offence.
- Never stand up in a fire, always crawl low under the smoke and try to keep your mouth covered
- Never go back into a burning building for any reason
- Do not open fire/smoke check door as they limit the spread of fire/smoke when in closed position
- Do not obstruct the fire escape routes with anything. Keep the passages clear
- Do not cover the fire hydrants or cutter the area so that they are easily visible/accessible
- In case of Fire, in your own interest:
- Do not use lift as a means of escape
- Do not should or run. This tends to cause panic
- Don"t park your cars/truck close to fire hydrants/underground static water tanks

16. **Do you know the Safety rules of Diesel Storage in the Hospital premises ?**

A large number of hospitals having diesel generators sets, other equipment / vehicles running on diesel, may require storage for diesel within the premises. As much as convenient it is, it is also the most hazard prone area in the hospital and requires total compliance with the safety rules as discussed below:

1. License on form XV for storage of diesel/petrol is a mandatory requirement
2. Fire precautions, as mentioned below, should be strictly implemented

a.) The area should be observed strictly as a "NO Smoking Zone" and there should be signage to that effect around the storage site.

b.) Carrying matches, fuses or other appliances capable

of producing ignition or explosion inside and in the vicinity of the area used for storage of petroleum, should be strictly prohibited.

c.) No fire, furnace or other source of heat or light capable of igniting inflammable vapor shall be allowed in the petroleum storage area.

d.) An adequate number of oil fire extinguishers should always be available and all staff should be fully trained in their use

3.) Supervision of operations should be by an experienced responsible supervisor and the staff should have proper safety training

4.) Prevention of unauthorized entry by a wall/fence 1.8 M high

5.) In the Petroleum storage shed, only petroleum is to be stored and nothing else.

6.) Tanks for the storage of petroleum shall be constructed of iron or steel in accordance with the ISI specification and tank capacity is to be marked on them. The tanks shall be protected against corrosion and tested by water pressure and certified by a competent person before usage

7.) Earthing of tank and testing of earth connections by a competent person at least once a year

17. **Safety of centralized gas and vacuum supply service ?**

Centralized Gas and vacuum supply service is a modern system of piped supply of medical gases (Oxygen, Nitrous oxide), Compressed Air and Clinical Vacuum Delivery from a central storage area called the Manifold Room, to all delivery points/patient areas in various wards, OT, labor room, etc.. in the hospital. The service is very crucial for the efficient treatment and survival of many patients in a hospital so much, so that even a couple of minutes break can lead to serious consequences including loss of lives.

The central supply station is among the most hazard prone areas in a hospital Because of the storage of gases, any safety violations can cause explosions which can be disastrous. Further, unless the distribution pipelines and the terminal unit are periodically inspected and their patency is maintained, there is always a chance of leakage and erratic supply the user and endangering thereby, the life and safety of patients, yet, it is a department often ignored. For safety of gas and vacuum supply service, the hospital management must pay attention to the following important aspects:

1. The department should have a documented SOP for all activities including the procedure for safe operations, the safety precautions to be taken, periodic inspection of distribution system and the actions to be taken in case a leakage is suspected/detected in the distribution system.
2. **Adequate staff:** The staff should be well trained and adequate to provide round the clock cover and emergency maintenance service.
3. **Quality of Equipment:** The source Equipment, the Distribution System and the Terminal Units must be as per the prescribed standards.
4. Color Coding: The color of gas cylinders and distribution pipelines should be strictly as per the prescribed Color Coding (IS 2379-1963-Indian standards Specifications and Codes) and all staff posted in the manifold room should be fully acquainted with it.
5. Separate enclosures for the compressor for compressed air, the gas supply and the vacuum pumps for vacuum supply.
6. There should be a documented procedure to ensure the supply of gases and vacuum at the desired pressures (4.22 Kg/sq. cm for oxygen). The pressure range should be displayed on the wall next to the particular equipment.
7. The cylinder banks should have adequate number of cylinders to ensure uninterrupted supply for at least 48 hours.
8. The gas cylinders must be in compliance with the Gas Cylinder Rules 1981. The important aspects to be ensured are:

- The cylinders are manufactured as per the rules
- The cylinders have the color coding as per the rules
- The cylinders are filled as per the rules governing the gaseous pressure
- The cylinders are filled by an authorized agency and as per the rules
- The cylinders are refilled correctly as per the color coding
- The cylinders are stacked and stored as per the rules prescribed
- They are kept in an area safe from the obvious hazards of explosion

- Repainting of cylinders should be done only by the suppliers and never by own staff.

9. Empty and full gas cylinders must be stored, separately. Full cylinders in use should be in a standing position chained to the wall so as to preclude any possibility of their falling down.

10. Adequate lighting and ventilation is to be ensured in all areas of manifold room.

11. Meticulous cleaning: No oil spills or grease on the floor or the equipment in the area.

12. The distribution pipelines should have stop valves at suitable intervals to disconnect the flow in case of any leakage or during repair work.

13. There should be a system of visual (green-normal, red-abnormal) and auditory alarms to indicate any fluctuations in the pressure beyond the acceptable range.

14. No Fire Hazards: There should be no fire hazards allowed in the vicinity of the manifold room andthe warning sign should be displayed prominently outside the facility.

15. Being an area prone to fire hazards/explosions, the manifold room must have a well-equipped and reliable system of fire prevention and safety.

16. Planned preventive maintenance, recalibration and observance of precautions including regular periodic check of the distribution pipelines for any leakages.

17. No unauthorized entry, no other activity and no other stores/equipment should be allowed inside the manifold room.

18. **Evacuation of Patients in case of fire?**

People designated for evacuation should know basic methods. They should be taught the following.

- 2 and 4 handed lifts.
- Fireman's lift from the bed.
- Human Crutch.
- Blanket removal.
- Wheel Chair.
- Pick a back.
- Fore and Aft method.
- Removal Downstairs.
- Removal by stretcher.

The details of rescue by the above methods are given below

Two handed seat method

Two rescuers face one another on either side of the casualty and stoop. Each rescuer passes his arm nearest the casualty‟s head under his back. Just below the shoulders and, if possible, grips his clothing. They raise the casualty‟s back and slip their other arms under the middle of his thighs. Rescuers join their hands with a hook grip. The rescuers rise together and step off with short paces. This seat is mostly used to carry a casualty who is unable to assist the bearers by using his arms

Four Handed Seat

This

This seat is used when the casualty can assist the bearer by using one or both arms.

This method should be used when the casualty is not too heavy for the bearer or rescuer. Help the casualty to rise to the upright position. Grasp his right wrist with left hand. Bend down with head under his extended right arm so that right shoulder is level with the lower part of his abdomen and place right arm between or round his legs.

Taking his weight on right shoulder rise to the erect position. Pull the casualty across both shoulders and transfer his right wrist to right hand so that having left hand free.

Human Crutch

Where the casualty can help himself the rescuer stands at his injured side and places the casualty‟s arm round his shoulder grasping the wrist His hand. At the same time he passes his other hand round the

casualty waist gripping his clothing at the hip and thus assists him by acting as crutch. Each person should step off with the outside foot, the rescuer using his nearest foot to the casualty as a propos in a three legged race.

A blanket is placed length wise on the ground in line with the casualty and rolled up half its width. The casualty is then carefully turned on his side. The rolled up portion of the blanket is then Placed close to the casualty and he is gently replaced on his back upon the unrolled position of the blanket. The rolled portion is then unrolled so that he lies in the center of the blanket. The two edges of the blanket are then rolled up against the casualty"s body grasped by two bearers on Each side of the casualty, thus supporting the head. Shoulders, legs and hips.

Pick a Back

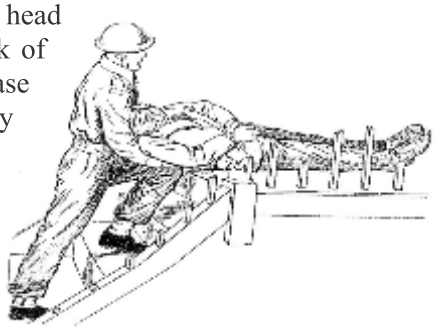
In this method the casualty is carried in the ordinary pick a back position. This is the best way if casualty is conscious able to hold on.

Fore and Aft Method

The casualty is placed on his back. One rescuer raises the shoulders and passes his hands under the arms from behind clasping them in-front of the chest. The other rescuer takes one leg under each arm and they carry him feet first. If the leg is broken both legs should be tied together, or put in splints and both carried under one arm.

Removal through Downstairs

To remove the casualty downstairs, lay him on his back, head downwards on the stairs, place your Hands under his armpits so that his head rests on the crook of your arm and ease him gently downstairs



No. Z.28015/1/2015-H
Government of India
Ministry of Health and Family Welfare
***

NirmanBhawan, New Delhi
Dated August 24, 2015

Subject: Guidelines for protection of Good Samaritans

Hon'ble Supreme Court passed an order on 29th October, 2014 in W.P. No.235 of 2012 directing the Union Government to frame guidelines for protection of good Samaritans. Accordingly, the Ministry of Road Transport and Highways issued notification No. 25035/101/2014-RS dated 12th May, 2015. In this regard, all the registered public and private hospitals need to ensure the following:

2. Mandatory display of the important points of the Gazette notification as stated above, at all prominent places of the respective hospitals including Casualty/Emergency Department, patients waiting areas, etc., indicating, *inter-alia*, the following:

(i) All registered public and private hospitals are not to detain bystander or good Samaritan or demand payment for registration and admission costs, unless the good Samaritan is a family member or relative of the injured and the injured is to be treated immediately in pursuance of the order of the hon'ble supreme court in Pt. Parmanand Katara vs Union of India & others [1989] 4 SCC 286. A bystander or Good Samaritan including an eye witness of a road accident may take an injured person to the nearest hospital, and the bystander or Good Samaritan should be allowed to leave immediately except after furnishing address by the eyewitness only and no question shall be asked to such bystander or good Samaritan.

(ii) The disclosure of personal information, such as name and contact details of the Good Samaritan shall be made voluntary and optional including in the Medico Legal Case (MLC) Form provided by hospitals.

(iii) Lack of response by a doctor in an emergency situation pertaining to road accidents, where he is expected to provide care, shall constitute "professional Misconduct" under Chapter 7 of the Indian Medical Council (Professional Conduct, Etiquette and Ethics) Regulation, 2002 and disciplinary action shall be taken against such doctors under Chapter 8 of the Said Regulations.

(iv) All Hospitals shall publish a charter in Hindi, English and the vernacular language of the State or Union Territory at their entrance to the effect that they shall not detain bystander or good Samaritan or ask depositing money from them for the treatment of a victim.

Anjuly Chib Duggal
Secretary

(v) In case a bystander or good Samaritan so desires, the hospital shall provide an acknowledgement to such good Samaritans, confirming that an injured person was brought to the hospital and the time and place of such occurrence. The acknowledgement may be prepared in a standard format by the State Government and disseminated to all hospitals in the State for incentivizing the bystander or Good Samaritan as deemed fit by the State Government/UTs.

3. An orientation training for all Staff members on the Gazette Notifications should be undertaken at the time of their joining. Refresher training should be done regularly for all staff members.

4. A Committee headed preferably by the Head of the Emergency Department should be constituted for ensuring that the guidelines are followed in the hospital for taking care of all issues related to the implementation of guidelines as contained in the Notification.

5. These guidelines shall be binding on all the hospitals including public and private hospitals and they shall implement these guidelines immediately. In case of non-compliance or violation of these guidelines, appropriate action shall be taken by the authorities concerned.

6. It shall be the responsibility of the State Government/UTs to ensure that these guidelines are followed by all the hospitals in the States/UTs as mentioned in paragraph 5 above in right earnest.

Sd/-
(Oma Nand)
Deputy Secretary to the Government of India
Telephone: 23062870

Secretary (Health) of All States/ UTs,

Secretary, MCI, New Delhi

Guidelines for protection of Good Samaritans (Ministry of Road Transport and Highways, GOI)

MINISTRY OF ROAD TRANSPORT AND HIGHWAYS
NOTIFICATION

New Delhi, the 12th May, 2015

No. 25035/101/2014-RS — Whereas the Hon'ble Supreme Court in the case of Savelife Foundation and another V/S, Union of India and another in Writ Petition (Civil) No.235 of 2012 *vide* its order dated 29th October, 2014, interalia, directed the Central Government to issue necessary directions with regard to the protection of Good Samaritans until appropriate legislation is made by the Union Legislature.

And whereas, the Central Government considers it necessary to protect the Good Samaritans from harassment of the actions being taken by them to save the life of the road accident victims and, therefore, the Central Government hereby issues the following guidelines to be followed by hospitals, police and all other authorities for the protection of Good Samaritans, namely:-

1. (1) A bystander or good Samaritan including an eyewitness of a road accident may take an injured person to the nearest hospital, and the bystander or good Samaritan should be allowed to leave immediately except after furnishing address by the eyewitness only and no question shall be asked to such bystander or good Samaritan.

(2) The bystander or good Samaritan shall be suitably rewarded or compensated to encourage other citizens to come forward to held the road accident victims by the authorities in the manner as may be specified by the State Governments.

(3) The bystander of good Samaritan shall not be liable for any civil and criminal liability.

(4) A bystander or good Samaritan, who makes a phone call to inform the police or emergency services for the person lying injured on the road, shall not be compelled to reveal his name and personal details on the phone or in person.

(5) The disclosure of personal information, such as name and contact details of the good Samaritan shall be made voluntary and optional including in the Medico Legal Case (MLC) Form provided by hospitals.

(6) The disciplinary or departmental action shall be initiated by the Government concerned against public officials who coerce or intimidate a bystander or good Samaritan for revealing his name or personal details.

(7) In case a bystander or good Samaritan, who has voluntarily stated that he is also an eye-witness to the accident and is required to be examined for the purposes of investigation by the police or during the trial, such bystander or good Samaritan shall be examined on a single occasion and the State Government shall develop standard operating procedures to ensure that bystander or good Samaritan is not harassed or intimated.

(8) The methods of examination may either be by way of a commission under section 284, of the Code of Criminal Procedure 1973 or formally on affidavit as per section 296, of the said Code and Standard Operating Procedure shall be developed within a period of thirty days from the date when this notification is issued.

(9) Video conferencing may be used extensively during examination of bystander or good Samaritan including the persons referred to in guideline (1) above, who are eye witness in order to prevent harassment and inconvenience to good Samaritans.

(10) The Ministry of Health and Family Welfare shall issue guidelines stating that all registered public and private hospitals are not to detain bystander or good Samaritan or demand payment for registration and admission costs, unless the good Samaritan is a family member or relative of the injured and the injured is to be treated immediately in pursuance of the order of the Hon'ble Supreme Court in Pt. Parmanand Katara Vs Union of India & Ors [1989] 4 SCC 286.

(11) Lack of response by a doctor in an emergency situation pertaining to road accidents, where he is expected to provide care, shall constitute "Professional Misconduct", under Chapter 7 of the Indian Medical Council (Professional Conduct, Etiquette and Ethics) Regulation, 2002 and disciplinary action shall be taken against such doctor under Chapter 8 of the said Regulations.

(12) All hospitals shall publish a charter in Hindi, English and the vernacular language of the State of Union territory at their entrance to the effect that they shall not detain bystander or good Samaritan or ask depositing money from them for the treatment of a victim.

(13) In case a bystander or good Samaritan so desires, the hospital shall provide and acknowledgement to such good Samaritan, confirming that an injured person was brought to the hospital and the time and place of such occurrence and the acknowledgement may be prepared in a standard format by the State Government and disseminated to all hospitals in the State for incentivising the bystander or good Samaritan as deemed fit by the State Government.

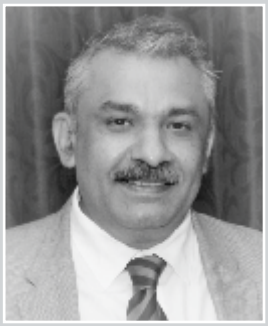
(14) All public and private hospitals shall implement these guidelines immediately and in case of noncompliance or violation of these guidelines appropriate action shall be taken by the concerned authorities.

(15) A letter containing these guidelines shall be issued by the Central Government and the State Government to all Hospitals and Institutes under their respective jurisdiction, enclosing a Gazette copy of the notification and ensure compliance and the Ministry of Health and Family Welfare and Ministry of Road Transport and Highways shall publish advertisements in all national and one regional newspaper indulging electronic media informing the general public of these guidelines.

2. The above guidelines in relation to protection of bystander or good Samaritan are without prejudice to the liability of the driver of a motor vehicle in the road accident, as specified under section 134 of the Motor Vehicles Act, 1988 (59 of 1988).

SANJAY BANDOPADHYAYA, Jt. Secy.

"Zero Tolerance for violence against Health Professionals & Clinical Establishments"



Dr. Mangesh Pate
National Jt. Secretary, IMA
Convener, IMA Committee for Healthcare Violence

"Any behaviour that is responsible for physical or emotional harm to the healthcare persons is violence".

Violence against doctors is seriously threatening. It is an effect of unwell, pathetically backed healthcare system. The hospitals cannot be allowed to become war zones as sick people need a peaceful environment and the Doctors also need a stable and peaceful ambience for delivering 100% sel quality care. Because of violence doctors have started practicing defensive medicine.

Finally, the stressful hospital environment is making doctors as well as patients suffer the brunt.

Healthcare violence is an act of aggression, erratic quarrelling behaviour, abusive threats to vandalize the hospitals, physical assault or any sort of threatening behaviour that occurs in hospitals.

The exposed cases of healthcare violence reach at various levels in the doors of law-keepers. The system with the pressures & presence of illiterate but politically powerful people around suppress the tame, intellectual medicos. The sufferers from healthcare fraternity get lost in the in the doors of law-keepers.

Violence against Doctors, Healthcare Professionals, Hospitals has become a routine The anger & anguish seen in many such incidences is actually misdirected towards doctors.

Lack of knowledge, literacy about healthcare, disease process, management, unreasonable expectations for compulsory positive outcomes, unaffordable healthcare expenses etc. Many such reasons play role in the violent episodes in hospitals. Besides these main reasons, negligence, lack of communication do have place as provocative factors.

The percentage of actual negligence or actual unethicality in the healthcare is very low. But the unwarranted spread of anguish over to the rest of the fraternity is making the violence as a big challenge to the entire healthcare of the country.

Principles :-

1. **REPORT :-**

Report to Authorities & IMA registry. Reporting of violence incidences is the most important. Not reporting makes it a vicious cycle. We must think in broad perspective and report the cases of any sort of violence to the authorities. Informing IMA helps to form violence registry. Local IMA branches are helping our affected doctors every time. To create & maintain the workable system reporting of all incidences to IMA is must.

2. **REACT :-**

Local IMA to urgently react through the Crisis Management Groups. Developing the local crisis management groups or IMA Defence Cell (IMADC) is the most important action while dealing with violence episodes. The IMADC should be formed through WhatsApp groups, Broadcast groups or local IMADC mobile app. The red alert should be sent by affected doctor or any trained staff of the hospital on group or app. Concerned members of IMADC should reach the site immediately without delay or fear. Remember, your unity is going to avert the mishap.

3. **REACHOUT :-**

Reach out to Community, Opinion Makers, Law makers, Media & fraternity. Involving community leaders, social workers, law makers, prominent persons, making them aware of situations, educating them to carry actual positive message to society is must in reducing the stress of violence. Social workers, prominent persons prove helpful in counselling too.

4. **REGULATE :-**

Strong Central Regulation & Self-Regulation. Self-regulation is the best regulation. IMA advocates ethical, safe, quality professional practice of medicine. The lucrative shortcut unethical practices are harmful to one and all. It is collective responsibility of all of us to maintain ethics in practice & lead by example.

5. **RETALIATE:-**

By Constitutional means, National Violence Registry. IMA shall form national violence registry & for the cause within the framework of constitution to sort out the strong solution for healthcare violence issue.

CAUSES OF HEALTHCARE VIOLENCE :

- Failure of Communication.
- Poor Public Image of the Profession.
- Mob Mentality
- Government Apathy
- Low Health Literacy
- Rising Healthcare Costs
- Poor Security for Hospitals and Doctors
- Role of Media

TYPES OF HEALTHCARE VIOLENCE :

- Verbal Abuse.
- Mobbing.
- Psychological Harassment.
- Threat.
- Physical Violence.
- Vandalism.
- Cyber Trolling.

SECURITY MEASURES... ACTUAL SCENARIO :

- 19 States have Medicare Act.
- No CRPC Code for Act.
- Not known to Police Stations.
- Not Executed or Applied.
- Not a Single Conviction Till Date.
- Culprits are Indirectly Helped, Not Arrested or Get Free with in 24 hours.
- No use of State Acts which is only on Paper..!

EFFECTS OF HEALTHCARE VIOLENCE :

- Impossible to Work Under Stress.
- Safe Practice Only.
- Doctors Losing Hope for Safety.
- Threat to Dignity, Self Respect.
- Families of Doctors Feel Threat.
- The Intellectual Fraternity is Supressed by Goons.
- Doctors Scared to Rise Up to Social or Political Platform; Prefer to Remain Subdued.

Action Plan: -

a) **CCTV cameras in all hospitals :**

Local branches to advocate the CCTV campaign in all hospitals in the area, make an affordable system for maintenance of the same. Mass orders of fitting new CCTV cameras and maintenance will lower the cost for all members. CCTV footage is the most important in the cases of violence and proves the actual happening which is always demanded by Police.

b) **Anti-violence Videos to display in all hospitals, Clinics.**

IMA Headquarters released the factual video of healthcare violence recently in New Delhi. This video and pictures shall be displayed in the reception areas for public viewing.

c) Demand Government to declare all hospitals a " Safe Zone".

d) Community Sensitization- NGOs programs locally highlighting hospital violence and its impact on healthcare. Public and community education will play most important role in diminishing the violence incidences. The factual education about the healthcare management, disease process, efforts of professionals & restrictions of medical sciences will help to reduce the violence over longer period.

e) SOP for formation of "Crisis Management Groups" in each branch should exist.

f) Extensive use of Social Media, Radio jingles, TV tickers etc.

IMA HQ RESOLVES TO FOLLOW THIS SERIOUS ISSUE TILL SATISFACTORY SOLUTION IS MET WITH.

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IMAFEST 2019

20TH Annual Conference of IMA Dombivli
30th November & 1st December 2019
Website:www.imadombivli.com Email Id:imafestdombivli@gmail.com

Dear Friends,

With immense pleasure and pride, IMA Dombivli announces its 20th Annual Conference - IMAFEST 2019, which will be held on 30th November & 1st December 2019, at Dombivli.

We vouch for a Scientific Feast, Fun starring Banquet Night and a Cultural Extravaganza beyond compare.

Do register at the earliest and avail the early bird offer, which is valid up to 31st March 2019.

Warm Regards,

Team IMAFEST 2019

Registration Charges in INR: (Inclusive of GST)

Category	Early Bird Offer Till 31st March 2019	Until 31st August 2019	Until 15th November 2019	Spot Registration
Delegate charges	2000	2500	3000	3500
Accompanying person	1800	2000	2000	2500
Medical students	1800	2000	2000	2500
Only Banquet	1000	1000	1000	1000

REGISTRATION Includes:
Breakfast, lunch, Delegate kit, Banquet.

PLEASE NOTE:

1) Children above 5 years have to be paid in full.
2) Please produce your payment receipt at Registration counter.
3) Please ensure to wear conference badge at the venue / banquet.
4) Delegate kits will be given to delegates registering on the spot only if available.
5) Charges once paid will not be refunded.

NAHAR

MULTI SPECIALITY HOSPITAL

I.C.U. & TRAUMA CENTRE

IN DOMBIVLI CITY

OUR FACILITIES

- I.C.U.
- X - RAY
- SONOGRAPHY
- PATHOLOGY
- IN HOUSE PHARMACY
- POLYCLINIC
- CASHLESS PAYMENT

OUR SERVICES

- CARDIAC CARE
- TRAUMA CENTRE
- KNEE & JOINT REPLACEMENT
- LAPAROSCOPY
- OBSTETRICS & GYNAECOLOGY
- DERMATOLOGY
- BRAIN & SPINE CARE
- KIDNEY CARE
- PAIN MANAGEMENT
- DIABETES CLINIC
- ENT
- CANCER CARE
- ZERO INTEREST LOAN AVAILABLE FOR INDOOR PATIENTS
- PSYCHIATRY
- PAEDIATRIC
- RESPIRATORY CARE
- PHYSIOTHERAPY
- 24 X 7 AMBULANCE SERVICE

Kasturi-Ashish, 2nd Floor, Near Vyankatesh Petrol Pump,
Kalyan-Shill Road, Dombivli (East) 421 203
Email : info@hospitalnahar.com, Web : www.hospitalnahar.com

7045280777 / 7045380007
9930850007 / 7045286777