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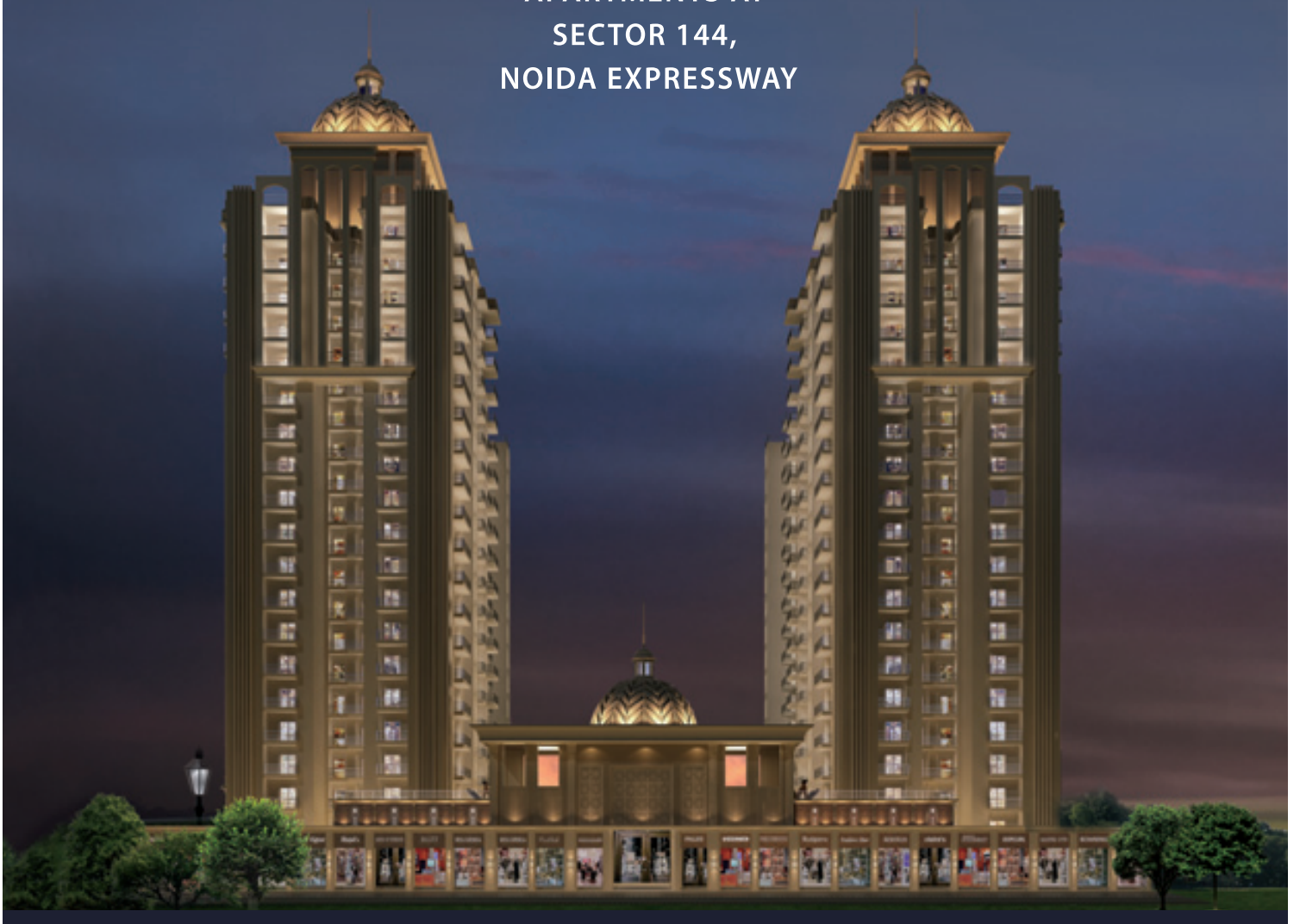

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Gautam Gaurav, Abhinav Kumar
Email:sales@doublehelical.com

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Contact us : dhelical@gmail.com
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New National Medical Commission Bill, 2017: Cripple the Medical Profession

Dear readers,

Wish you very happy New Year 2018. Thank you for providing your continuous support and encouragement to us as we bring out informative and thought-provoking content for you every month.

Our cover story this month is on much talked new National Medical Commission Bill, 2017. An aim to repeal the Indian Medical Council Act, 1956 and provide for a medical education system which ensures like availability of adequate and high quality medical professionals, adoption of the latest medical research by medical professionals, periodic assessment of medical institutions, and an effective grievance redressal mechanism, the Minister of Health and Family Welfare, Govt of India has already introduced the National Medical Commission(NMC) Bill, 2017 in Lok Sabha on December 29, 2017.

But Indian Medical Association (IMA) has strongly opposed the draft bill that seeks to replace the Medical Council of India with a new body, claiming it will cripple the medical profession. IMA appealed to the Prime Minister to revise the draft bill in the larger interest of the medical profession.

According to doctors, replacing MCI with another body could have made sense only after it was analyzed as to why was MCI not working and what makes one believe that the new body will not be "corrupt".

It is very interesting that MCI was suspended and replaced by handpicked professionals with integrity for three long years from 2010 to 2013. Was any improvement perceived? None to the eyes of many and that was the reason it was not continued with. Replacing one body with another will NOT serve any purpose unless we do a brainstorming about the underlying reasons as to why even the Government appointed Board could not redeem the image of MCI.

A number of medical colleges are being owned by political masters and they have been having indirect control over MCI and now in the new proposed body they can have more effective control!! Unless this conflict of interest is identified and neutralized no "institution" is likely to be effective.

The story on EXERCISE A WAY TO HEALTHY LONG LIFE is very informative. There are a variety of exercise or physical activities one can choose from, including in a hobby for eg- gardening , enrolling yourself in a sport activity like- badminton, golf etc. or picking up one or the other form of following aerobic exercises- swimming, brisk walk, cycling, skipping rope, hiking, dance etc.

It's important to remember that we have evolved from nomadic ancestors who spent all their time moving around in search of food and shelter, travelling large distances on a daily basis. Our bodies are designed and have evolved to be regularly active.

Over time people to develop problems if they sit down all day at a desk or in front of the TV and minimize the amount of exercise they do. These are many benefits of regular exercise and maintaining fitness.

And very interesting story on "Why worry about Hepatitis B" explains about the high prices of new medicines are a major barrier to access to treatment in most countries. Treatment for chronic hepatitis B virus infection is life-long for most people. About 2.7 million people of the 36.7 million living with HIV are also infected with HBV. The global prevalence of HBV infection in HIV-infected persons is 7.4%.

Viral hepatitis is a systemic infection affecting predominantly the liver and causing its inflammation. It is caused by infection with one of the five known viruses, namely hepatitis A, B, C, D and E viruses. These viruses vary with respect to their structure, epidemiology, routes of transmission, clinical presentations and other features. Hepatitis B virus is spread by contact with blood or body fluids of an infected person. It is 50 to 100 times more infectious than HIV.

An estimated 257 million people are living with hepatitis B virus infection. In Asia, especially Southeast Asian countries, 8-15% of the population is affected by Hepatitis B virus infection. Almost one-third of the carriers of this disease develop chronic liver diseases, including chronic hepatitis, cirrhosis and hepato- cellular carcinoma.

Hepatitis B is highly endemic in developing regions with large population such as South East Asia, China, sub-Saharan Africa and the Amazon Basin, where at least 8% of the population are HBV chronic carriers. In these areas, 70–95% of the population shows past or present evidence of HBV infection. Most infections occur during infancy or childhood.

There are many more interesting and insightful stories, based on intensive research and analysis. So, happy reading to all of you!

Warm regards,
Amresh K Tiwary,
Editor-in-Chief

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Food Safety and Nutrition

J P Nadda, Union Minister of Health and Family Welfare as he presided over the 'First Health Ministers Roundtable on Food Safety and Nutrition' organized by FSSAI, recently. Ashwini Kumar Choubey, MoS (Health) along with the Health Ministers of Uttar Pradesh, Gujarat, Uttarakhand, Telangana, Puducherry, Jharkhand and Delhi were also present at the roundtable.

"Central Government is providing support to the tune of Rs. 482 crore for the States. As many as 45 State labs are to be strengthened. I request the States to come forward with the proposals or give us the plan for strengthening the laboratories.," J P Nadda, said.

J P Nadda further stated that finance will not be a constraint and each State should have at least one government food laboratory of high quality with bigger States having at least two. Citing the example of Pradhan Mantri Dialysis Program, the Health Minister said that initially states expressed some apprehensions about this initiative however today the programme is a huge success. "More than 1.76 lakhs patients have availed free services from 539 Dialysis Units across the country, he, added.

Speaking on the enforcement of food standards, Nadda said that there should be fairness and transparency in enforcement. "We must safeguard public health by ensuring all food businesses are licensed and follow standards. At the same time, we should be careful that it does not put unnecessary regulatory burden on the food businesses", Nadda said. Emphasizing on generating awareness, Nadda said that sensitization is a major area to work for and FSSAI can provide support in this so that people opt for self-regulation.

J P Nadda further mentioned that the focus should shift from disease and treatment centred healthcare to preventive and promotive healthcare. Moving towards this, the Government has announced transforming 1.5 lakh sub health centres to 'Health and Wellness' centres. Nadda further stated that in a step towards provision of comprehensive primary care, the Government has initiated universal screening of common NCDssuch as diabetes, hypertension and common cancers at the sub-centre and Primary Health Centre."This will enable the strengthening of preventive and

promotive health, improve patient referral and access to secondary care services, Nadda added.

Speaking at the function, Ashwini Kumar Choubey, MoS (Health) stated that promoting and building the mechanisms for availability and consumption of Safe & Nutritious Food is central to attainment of the goals laid out in the National Health Policy 2017 which focuses on "promotive and preventive health care" and targets to reduce disease burden and premature mortality through Non-Communicable Disease like Diabetes, Cardiovascular Diseases among others. He further said that carrying out IEC and outreach efforts to create awareness in people about safe food & nutrition at schools, workplace, etc is central to avoiding food borne disease related morbidity & mortality and consequent savings in healthcare.

Preeti Sudan, Secretary (Health) assured support to the States through NHM. She further stated that we all aware of the rising incidence of non-communicable diseases in our country. Promoting healthy dietary habits amongst citizens is a key step to address it. "We must work together to inspire greater public confidence about food and nudge people to eat safe and eat right so that we can a healthier nation", she stated.

The Union Health Minister also released framework for 'Clean Street Food Hubs' and 'Safe and Hygienic Food Festivals'. These two initiatives would help to build capacities of street food vendors and will go a long way to inspire citizens' trust in unorganized street food vending. The Minister also released FSSAI's 'Healthy India Food Calendar'. First of its kind, this calendar covers India's main festivals, the food associated with them and their nutritional benefits. FSSAI's new look website with focus on its key stakeholders was also launched today.

During the round table, a team of researchers, who have carried out a rapid assessment of economic costs of food borne diseases in India, shared their findings. According to them, food borne diseases impose a huge economic burden on India. As per their estimates, this would amount to as much as 0.5 percent of India's GDP or about 28 billion USD.

During the Round table, the State Health Ministers assured to work towards creating a culture of self-compliance amongst food businesses by helping them build internal capacities, focus on third party audit, making enforcement transparent, standardized, predictable and fair by adopting a digital compliance platform, encouraging rating and fair competition amongst food businesses. States agreed to strengthen the food safety machinery and the state food lab system in their respective States.

During the Round table, the State Health Ministers adopted a joint resolution with a seven-point charter. This includes – 1) supporting development of robust food standards and code of practices for safe food; 2) creating a positive regulatory environment; 3) establishing a credible and robust national food testing system; 4) addressing micronutrient deficiencies and promoting healthy dietary habits; 5) bringing about large-scale social and behavioral change in citizens on safe and nutritious food; 6) building a culture of self-compliance in food businesses; and 7) developing effective institutions and institutional arrangements backed with competent human resources and adequate financial resources.

Also present at the Roundtable were State Health Secretaries and Food Safety Commissioners from the States, Senior officials from Ministry of HRD, Health and Family Welfare and Women and Child Development, FSSAI, industry associations, World Bank, WHO and World Food Programme, and development partners such as Tata Trusts, GAIN and PATH participated.

Anupriya Patel, Minister of State for Health and Family Welfare reviewed the activities of National Centre for Disease Control at New Delhi

Anupriya Patel reviews the activities of National Centre for Disease Control

Anupriya Patel, Minister of State for Health and Family Welfare reviewed the activities of National Centre for Disease Control and issued necessary directions for disease surveillance, monitoring of health status, educating the public, providing evidence for public health action and enforcing public health regulations.

She also visited the Epidemiology and Disease Control Complex and interacted with India Epidemic Intelligence Service (EIS) officers undergoing two years training at NCDC in collaboration with CDC Atlanta under Global Health Security Agenda (GHSA). During her visit at the Strategic Health Operations Centre (SHOC), the MoS (Health) reviewed the Seasonal Influenza (H1N1) status through video conferencing with the States of Rajasthan, Gujarat and Uttar Pradesh.

In her address at NCDC, the MoS (Health) appreciated the work being carried out at NCDC. She was impressed to visit the Institute and was glad to see the achievements and growth of the Institute. She further mentioned that Ministry the Ministry has high expectations from the Institute and the intent is reflected by the allocation of budget of Rs.382 Cr for up-gradation of NCDC campus.

Anupriya Patelalso mentioned about the NITI AYOG's vision document (2017-18 to 2019-20) that suggests that NCDC can act as a focal point with greater authority and resources for disease surveillance, monitoring of health status, educating the public, providing evidence for public health action and enforcing public health regulations. The MoS (Health) further said that the National Health Policy 2017 envisages for greater role of preventive and promotive aspects than curative and NCDC could play a pivotal role in this aspect.

Mentioning about Hon'ble Prime Minister's vision regarding Resurgent India, she ensured all the support from the Ministry. She instructed NCDC faculty to be in touch with State Health Authorities and make field visits to monitor the working of NCDC branches and other field activities.

The President of India Appreciates Mission Indradhanush

The Hon'ble President of India, Ram Nath Kovind delivering the Convocation Address at the 45th Convocation of the All India Institute of Medical Sciences (AIIMS), at New Delhi recently said, "the name "AIIMS" has become a byword for quality, commitment and rich experience. The faculty and doctors, as well as the students, are the pride of our medical fraternity and our nation." The Hon'ble President further stated that patients and their families have great trust in the doctors. "It is upon you to ensure that the trust is given due respect and that you treat them with care and compassion," the Hon'ble President added. Shri J P Nadda, Union Minister of Health and Family Welfare, and President of AIIMS, New Delhi was also present at the occasion, and awarded degrees to 572 graduating students.

Appreciating the efforts of the Health Ministry, the Hon'ble President said that by launching programmes like Mission Indradhanush, the Health Ministry is urgently trying to fill the immunisation gap and protecting all children from killer diseases. As a word of caution, the Hon'ble President stated that in our country, both obesity and malnutrition are substantial public health issues. "And in our country, we have a very large child population as well as one of the world's largest populations of senior people. Both these groups pose very different but very real challenges to our healthcare system and our doctors and nurses", he stated.

The Union Health Minister J P Nadda congratulated all the students and said innovation for low cost effective and affordable healthcare is the need of the day. To take up all these challenge AIIMS is strengthening and expanding its facilities and Government of India is fully supporting this. He further said that the brand of AIIMS is recognized and respected the world over and every student educated at AIIMS has the potential to become a leader in their chosen area. A considerable number of AIIMS alumni have already demonstrated leadership in making our world a better place, he stated.

Speaking at the function, Nadda said that in order to protect each and every child in the country from vaccine preventable diseases, the government has launched 'Mission Indradhanush' special immunization drives in 2014, to fully immunize all children and pregnant women across the country. "So far, more than 3.2 crore beneficiaries have been immunized. From 1% annual increase in full immunization, 'Mission Indradhanush' has resulted in 6.7% of annual expansion. Recently released SRS data has indicated a steep decline in Under 5 Mortality Rate (U5MR) from 49 in 2013 to 39 in 2016," Nadda added.

Nadda said that it's a great challenge to produce high quality healthcare providers at all levels. We need the teachers and academicians to develop such human resources in health. In this regard, the country has a lot of expectation from all of you. "To address these challenges we have undertaken reforms like setting up of more medical and nursing schools, introduction of National Eligibility cum Entrance Test (NEET) to get rid of multiple entrance exam and ensure greater transparency & better standard, reforms in MCI and DNB regulations have helped in taking the total number of PG & DNB seats to more than 37,000, to name a few", the Health Minister stated.

J P Nadda also presented lifetime achievement awards to eminent professionals in the field of medical science, and medals and prizes to meritorious students. The recipients of lifetime achievement award for 45th Annual Convocation are Dr. Purushottam Upadhyaya, Prof. Lalit Mohan Nath, Prof. Usha Nayar, Dr. Meharban Singh, Prof. Indira Nath and Prof. M C Maheshwari..

Mission Indradhanush

JP Nadda, Union Minister of Health and Family Welfare expressed happiness over the just released SRS bulletin (2016) as India registered a significant decline inunder-five child mortality.

According to the bulletin, under-five child mortality (U5MR) of India showed an impressive decline by 9%, a 4 points decline from 43 per 1000 in 2015 to 39 in 2016. The rate of decline has doubled over the last year.Not only this, number of under-five deaths for the first time in the country have come down to below 1 million with nearly 120,000 fewer under-five deaths in 2016 as compared to 2015. Most of the states have shown good progress in reduction of under-five child mortality from the previous year, except Chattisgarh, Delhi and Uttarakhand, which have shown a slight increase over the previous year and Telangana, which has shown no change in 2016.

Congratulating all those associated with this remarkable featNadda stated thatthe results signify that the strategic approach of the Government is yielding dividends and the efforts of focusing on low performing states is paying off. He stated that India with the current rate of decline of U5MR is on track to meet the SDG target for under-five child mortality of 25 by 2030.

The Health Minister further said that under the visionary leadership and guidance of the Hon. Prime Minister ShriNarendraModiji, the government is committedto advancing the agenda of Universal Health Coverage in the countryand its initiatives like Mission Indradhanush and Intensified Mission Indradhanush, with their focused approach, are significantly turning the tide in favour of India.

Nadda said that these remarkable achievements in merely one year are the result of countrywide efforts to increase the health service coverage through various initiatives of the Government that include strengthening of service delivery; quality assurance; RMNCH+A interventions; strengthening human resources and community processes; information and knowledge; drugs and diagnostics, and supply chain management, etc.

According to the SRS Bulletin, the gender gap in India for child survival is reducingsteadily;the gender difference between female and male under-five mortality rates has now reduced to 11% which was as high as 17% in 2014. The current under-five mortality for male child is 37 per 1000, while for female child is 41 per 1000 live births. Amongst the bigger states, seven states (Chattisgarh, Delhi, Gujarat, MP, Odisha, Tamil Nadu Telangana) have reversed the gender gap in survival of female child, while four of these have reversed the gender gap for under-five survival. These are Madhya Pradesh, Chhattisgarh, Gujarat and Tamil Nadu.

Telangana, West Bengal, Odisha, Punjab and Delhi have depicted less than 5% gap in mortality of female child and are within striking distance to reverse the gender gap. The maximum gender gap in survival of under-five for female child is in Bihar (46% higher mortality for female child), followed by Haryana (23%), Kerala (20%), Assam, Karnataka (19%) and Rajasthan (17%).

Further, the SRS Bulletin also shows that the neonatal mortality rate has reduced by 1 point from 25 per 1000 live births to 24 per 1000.

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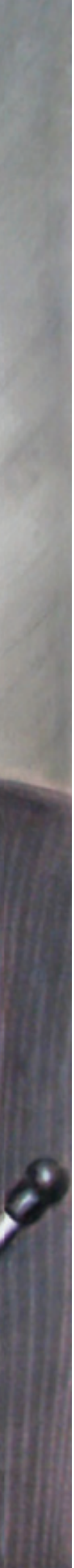

The unforgettable **Icon of Medical Fraternity**

Recipient of Padma Shri, Vishwa Hindi Samman, Dr B C Roy National Award and National Science Communication Award Dr K K Aggarwal is a Limca Book of Record Holder for the maximum number of people trained in the lifesaving technique of hands only CPR in one go, Gold Medallist and recipient of FICCI Healthy Care Personality of the Year Award 2016.

A renowned physician cardiologist, spiritual writer and motivational speaker, Dr K K Aggarwal is the Founding Trustee and President of Heart Care Foundation of India.

In addition to he is also the Immediate Past National President of Indian Medical Association, 1st Vice President Confederation of Medical Association of Asia and Oceana and **Advisor Ethics Committee World Medical Association**. He is also Editor in Chief of the IJCP Group.

A doctor and social worker par excellence, Dr Aggarwal is also IMA UNESCO Chair in Bioethics.

In the past, Dr Aggarwal has served as the Member Ethics Committee of the Medical Council of India (2014), Chairman Ethics Committee of the Delhi Medical Council (2009-2015), Member Delhi Medical Council (2004-09), Honorary Secretary General IMA (2014-16), Senior National Vice President IMA (2013-14), Chairman IMA Academy of Medical Specialties (06-07), National Honorary Finance Secretary IMA (07-08), Director IMA AKN Sinha Institute (08-09), President Delhi Medical Association (05-06), President IMA New Delhi Branch (94-95, 02-03-04) and Chairman of the Delhi Chapter of the International Medical Sciences Academy (10-13). He has also served as avisiting Professor of Clinical Research at DIPSAR and of Muzaffarnagar Medical College.

An advocator of preventive and universal healthcare, Dr Aggarwal has pioneered leading health initiatives in the country such as starting clot-dissolving therapy for acute heart attacks in 1984 and bringing the technique of Colour Doppler Echocardiography to North India in 1988. He has also been instrumental in conceptualizing and organizing unique consumer driven health awareness platforms such as The Perfect Health Mela and the Run for your Heart annual run. In recognition of both these initiatives, the Government of India released National Postal Commemorative Stamps (INR 6.50 & 1) respectively.

In 2012 he organized the first ever mega Telemedicine camp at Ajmer and again the government of Rajasthan ear marked the event by releasing a postal cancellation stamp. He is again the only doctor in the country to have three postal stamps to his credit.

Dr Aggarwal did his MBBS from MGIMS Sevagram under Nagpur University where he was awarded s the best graduate of MGIMS in 1979. He was topper throughout and receive the MGIMS gold medal for topping all the three professionals. He also received distinctions in Physiology, Ophthalmology and Forensic Medicine.

He also received two Nagpur University Gold Medals for topping all the three MBBS professions together and topping amongst the males in the final MBBS.

In addition to be a doctor par excellence, Dr Aggarwal is also a writer and has contributed to several books such as the International Textbook on Echocardiography, Journals including the Indian Heart Journal and newspapers

HIS CONTRIBUTION TO IMA

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Welcome the Girl Child Wing, IMA Doctor's Day Awards, IMA Dr Ketan Desai Oration, IMA Kishore Taori Oration, Dr VCP Pillai Oration, IMA Elders Day Awards, IMA Women Day Awards, IMA Teachers Day Awards, IMA Founder Day Oration, IMA Honour to Past National President at death,

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The success which will be remembered for long time in IMA

IMA Premises Flag, IMA Building Renovation, Inaugural plaques at IMA Building, Revised IMA Prayer, IMA Professors, IMA Faculty, IMA Credit Hours, IMA Grievance Redressal Cell, Me taking over as National President immediately after the HSG, Pension Scheme,

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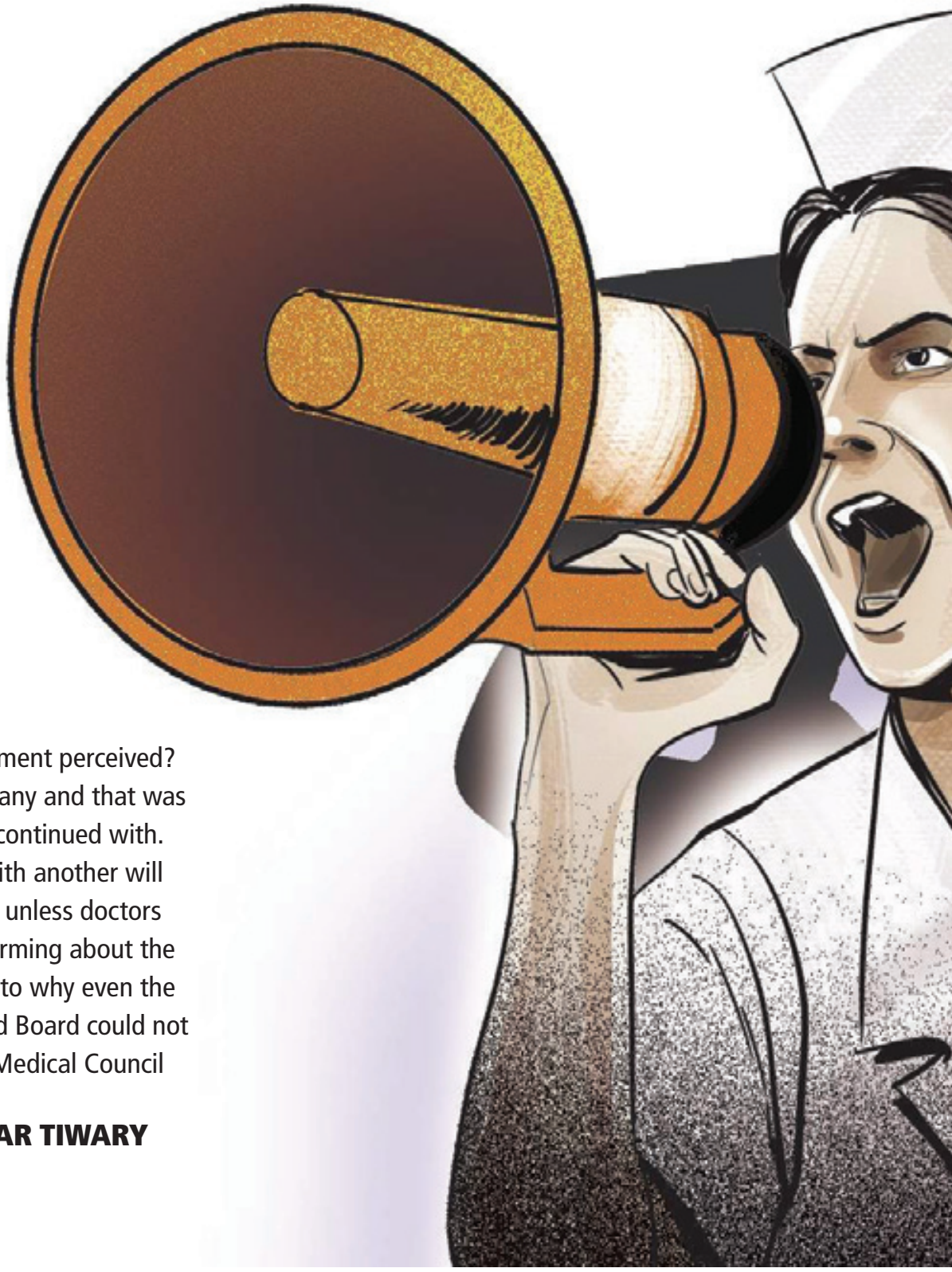
Face Book live twice over one lakh views, IMA You Tube Channel, IMA Blog, IMA Campaigns, IMA Noise Project, IMA Diabetic Blindness Prevention project, Doctors Day Slogan, IMA Digital TV, Cure in India,

EXCLUSIVE: NATIONAL MEDICAL COMMISSION BILL

Fight For Right



The much talked National Medical Commission Bill provides for the constitution of four autonomous boards entrusted with conducting undergraduate and postgraduate education, accreditation of medical institutions and registration of practitioners under the National Medical Commission. But with was any improvement perceived? None to the eyes of many and that was the reason it was not continued with. Replacing one body with another will not serve any purpose unless doctors faternity do a brainstorming about the underlying reasons as to why even the Government appointed Board could not redeem the image of Medical Council of India...

BY AMRESH KUMAR TIWARY

An aim to repeal the Indian Medical Council Act, 1956 and provide for a medical education system which ensures like availability of adequate and high quality medical professionals, adoption of the latest medical research by medical professionals, periodic assessment of medical institutions, and an effective grievance redressal mechanism, the Minister of Health and Family Welfare, Govt of India has already introduced the National Medical Commission(NMC) Bill, 2017 in Lok Sabha on December 29, 2017.

But Indian Medical Association (IMA) has strongly opposed the draft bill that seeks to replace the Medical Council of India with a new body, claiming it will cripple the medical profession. IMA appealed to the Prime Minister to revise the draft bill in the larger interest of the medical profession.

Key features of the Bill include **Constitution of the National Medical Commission:** The Bill sets up the National Medical Commission (NMC). Within three years of the passage of the Bill, state governments will establish State Medical Councils at the state level. The NMC will consist of 25 members, appointed by the central government. A Search Committee will recommend names to the central government for the post of Chairperson, and the part time members. These posts will have a maximum term of four years. The Search Committee will consist of seven members including the Cabinet Secretary and three experts nominated by the central government (of which two will have experience in the medical field).

Members of the NMC will include: (i) the Chairperson, (ii) the President of the Under-Graduate Medical Education Board, (iii) the President of the Post-Graduate Medical Education Board, (iv) the Director General of Health Services, Directorate General of Health Services, (v) the Director General, Indian Council of Medical Research, and (vi) five members (part-

Dr. Ravi Wankhedkar, National President, IMA,

time) to be elected by the registered medical practitioners from amongst themselves from the prescribed regional constituencies under the Bill.

Functions of the National Medical Commission: Functions of the NMC include: (i) framing policies for regulating medical institutions and medical professionals, (ii) assessing the requirements of healthcare related human resources and infrastructure, (iii) ensuring compliance by the State Medical Councils of the regulations made under the Bill, (iv) framing guidelines for determination of fees for up to 40% of the seats in the private medical institutions and deemed universities which are regulated as per the Bill.

Medical Advisory Council: Under the Bill, the central government will constitute a Medical Advisory Council. The Council will be the primary platform through which the states/ union territories can put forth their views and concerns before the NMC. Further, the Council will advise the NMC on measures to enable equitable access to medical education.

Autonomous boards: The Bill sets up certain autonomous boards under the supervision of the NMC. Each autonomous board will consist of a President and two members, appointed by the central government. These boards are: (i) the Under-Graduate Medical Education Board (UGMEB) and the Post-Graduate Medical Education Board (PGMEB): These Boards will be responsible for formulating standards, curriculum, guidelines, and granting recognition to medical qualifications at the undergraduate and post graduate levels respectively, (ii) the Medical Assessment and Rating Board (MARB):

The MARB will have the power to levy monetary penalties on medical institutions which fail to maintain the minimum standards as laid down by the UGMEB and the PGMEB. The MARB will also grant permission for establishing a new medical college, and (iii) the Ethics and Medical Registration Board: This Board will maintain a National Register of all

Dr Shishir Narayan, Shroff Eye Hospital

licensed medical practitioners, and regulate professional conduct. Only those included in the Register will be allowed to practice medicine.

Dr Shishir Narayan, Shroff Eye Hospital, New Delhi, said, "There will be a uniform National Eligibility-cum-Entrance Test for admission to under-graduate medical education in all medical institutions regulated by the Bill. The NMC will specify the manner of conducting common counselling for admission in all such medical institutions".

"There will be a National Licentiate Examination for the students graduating from medical institutions to obtain the license for practice. The National Licentiate Examination will also serve as the basis for admission into post-graduate courses at medical institutions", he added.

The draft National Medical Commission Bill provides for the constitution of four autonomous boards entrusted with conducting undergraduate and postgraduate education, accreditation of medical institutions and registration of practitioners under the National Medical Commission.

According to Ravi Wankhadkhe, National President, IMA, the NMC will "cripple" the functioning of the medical profession by making it completely answerable to the bureaucracy and non-medical administrators.

Regulators need to have autonomy and be independent of the administrators. The National Medical Commission will be a regulator appointed by the administrators under their direct control.

It abolishes the Medical Council of India and "possibly" Section 15 of the IMC Act, which says that the basic qualification to practice modern medicine is MBBS.

It takes away the voting right of every doctor in India to elect their medical council. The Medical Council of India is a representative body of the medical profession in India. Any registered medical practitioner in the country can contest the election and every qualified doctor can vote. Abolishing a democratic institution and replacing it by a body in which majority are nominated by the government is certainly a retrograde step.

Dr. Ravi Wankhedkar, National President, IMA, said, "The draft bill, in its current form allows the private medical colleges to charge at will, nullifying whatever solace the NEET brought. The government can fix the fee for only 40% of the seats in private medical colleges. Also, it inducts non-medical people into the highest body of medical governance changing its perspective and character forever and introduces schedule IV to allow the AYUSH graduates to get registration in modern medicine."

Dr K K Aggarwal, Ex National President, said, "We already appeal to our Prime Minister Narendra Modi to recall the bill and rectify these anomalies. Parliament has a larger role to protect the interest of the medical profession of the country."

According to the draft bill, the

Dr K K Aggarwal, Ex National President,

commission will have government-nominated chairman and members, and the board members will be selected by a search committee under the Cabinet Secretary. There will five elected and 12 ex-officio members in the commission.

The draft bill also proposes a common entrance exam and licentiate exam which all medical graduates will have to clear to get practising licences. As per the provisions of the draft bill, no permission would be needed to add new seats or to start post-graduate courses.

National Medical Commission Bill 2017 sparks pan-India strike by doctors

Doctors in India recently went on a nationwide strike to protest against the draft National Medical Commission (NMC) Bill 2017. Indian Medical Association (IMA) has strongly opposed the bill.

The NMC bill seeks to replace the apex medical education regulator, the Medical Council of India (MCI), with a new body National Medical Commission (NMC). It is against this bill that doctors have decided to go on strike, leaving the fate of patients requiring urgent treatment hanging in the balance. Around 2.9 lakh doctors have come onto the streets in protest.

Here is what National Medical Commission (NMC) Bill is:

1) The bill seeks to replace the Medical Council of India with National Medical Commission as top regulator of medical education in India.

2) The bill also seeks to put in place a common entrance exam and licentiate exam, which all medical graduates will have to clear to get practicing licenses.

3) It would also put in place a four-tier structure for the regulation of medical education. The 20 members National Medical Commission will be at the top of this structure.

4) NMC will be a 20 member body comprising a Chairperson, a member secretary, eight ex-officio members and 10 part-time members.

5) Out of the 8 ex-officio members, four shall be presidents of the boards constituted under the act and remaining four shall be nominees from three ministries viz. Health, Pharmaceuticals, HRD and one from Director General of Health Services.

6) The bill also has a provision for a common entrance exam and licentiate (exit) exam that medical graduates have to pass before practicing or pursuing PG courses. For MBBS, students have to clear NEET, and before they step into practice, they must pass the exit exam.

7) The NMC can permit a medical professional to perform surgery or practice medicine without qualifying the National Licentiate Examination, in circumstances that may be specified in regulations.

8) According to the NMC Bill, the Ethics and Medical Registration Board can maintain a separate national register that would have the names of licensed AYUSH practitioners. The names of graduates of Bachelor of Ayurvedic Medicine and Surgery and Bachelor of Homeopathic Medicine

Dr Vinay Aggarwal, Ex National President,

and Surgery are already registered with their respective councils and on taking the bridge course they would be incorporated in a separate register maintained by the NMC, resulting in dual registration with two councils, which is neither open nor permissible.

9) The government, under the National Medical Commission (NMC), can dictate guidelines for fees up to 40% of seats in private medical colleges. This is aimed at giving students relief from the exorbitant fees charged by these colleges and is a standout feature of the bill.

Suggestions of IMA on National Medical Commission Bill, 2017

-Bill number 279 of 2017, introduced in lower house(Lok Sabha), The National Medical Commission Bill

-Ninety Second report of department related Parliamentary Standing Committee on Health and Family Welfare

-Ranjit Roy Chaudhary Expert Committee report submitted in February 2015.

-Opinion of IMA submitted to NITI Ayog on NMC

According to **A K Agarwal, Professor of Excelence and Medical Advisor, Apollo Group of Hospitals**, the Parliamentary Standing Committee, in its report submitted to the Parliament on 8th March 2015 had highlighted the challenges faced by the health sector in India. The most important concerns of the Committee were large gaps in health care and universal health care goals, shortage of qualified doctors, specialists, super specialists, geographical mal-distribution of medical colleges, disconnect between medical education system and health care system and inadequate in self regulatory process.

Prof. Ranjit Roy Chaudhary Committee constituted in 2014 by Government of India submitted its report and suggested a new regulatory structure for modern medicine.

Dr. Ravi Wankhedkar National President, IMA, said, "We are concerned to note that most of the recommendations of the Parliamentary Standing Committee or Prof. Ranjit Roy Chaudhary Committee do not find a place in the NMC Bill. On the other hand NMC Bill contains many clauses that are not as per the recommendation of the above committee. There are also contradictions between the objectives of the Bill and the clauses there under, eg. The Parliamentary Standing Committee did not mention about separate registration for AYUSH with bridge course which is included in the NMC Bill. Fixing fees is not within in the purview and powers of NMC."

Basically the objectives of the NMC Bill is to provide for a medical

A K Agarwal, Professor of Excelence and Medical Advisor, Apollo Group of Hospitals

education system that ensures availability of adequate and high quality professionals that encourages medical professionals to adopt latest medical research work and to contribute to research.

The various clauses in NMC Bill, like single inspections of medical college, provision for increasing the seats of under graduates, freedom to start PG courses without inspection and increase the seats at the discretion of the medical colleges will definitely dilute the maintenance of the highest standards of medical educations and against the objective of NMC.

Section 31(8) of the NMC Bill is also contradictory to the definition of modern medicine. Section 31(8 EMR Board shall maintain a separate National Register including the names of licensed Ayush Practitioners who qualifies the bridge course referred in Section 49(4) in such manner as may be specialized by Regulators. By an explanation, Ayush it has been defined as a person who is a practitioner of Homeopathy or a practitioner of Indian Medicine as defined in clause(e) of Subsection 1 of the section 2 of the Indian Medicine Central Council Act, 1970 and is contradictory to the definition of Modern Medicine.

Ayush Bridge Course

The Parliamentary Standing Committee on health has never mentioned Ayush Bridge Course NMC in its chapter V clause 49(3),(4): clause 54(O) has suggested Ayush Bridge Course and separate National register for practioners who qualify the bridge course. It has to be noted that the systems are naturally contradictory and non complimentary.

National Medical Commission is a regulatory body for modern medical practitioners. It can contain only one type of registration that is those who have passed MBBS. Having a separate register for Ayush practitioners with bridge course to practice modern medicine amounts to legalisation of quackery.

Dr Mangesh Pate, Joint Secrtary, IMA New Delhi, said, "We demand the deletion of separate register for AYUSH. Ethics and Medical Registration Board shall contain only one register that too only for MBBS.

To solve the issue of non availability of doctors in PHC after internship one year compulsory posting in rural area to be mandatory or special packages to attract MBBS doctors should be provided.

The PHC's are to be classified as very difficult rural area, difficult rural area and rural area. For very difficult and difficult rural area a special package should be made to attract MBBS doctors. Those who opt for these PHC's should have higher salary accommodation, transport facility nurseries, day care facility, allowance

for attending CME's and access to journals and books and 15-20% mark for PG admission. The PHC should have adequate investigation facilities, medicines and required staff. To ensure the availability of MBBS doctors, and Indian National Medical Services can be formed to enlist a panel of MBBS doctors who will work in rural areas at least for one or two years on a package basis.

Indian National Medical Services

Will have a panel of MBBS doctors who can be posted in very difficult and difficult PHCs. They should have a package with higher pay, Doctors' quarters, transportation facility, allowance for attending CMEs, availability of e-journals and books to prepare for PG , Nursery and Day Care Centre for children and 15-20% additional marks for PG Entrance. They can serve the rural PHC for one or two years. They will be posted in any PHC where there is a vacancy.

As a long term solution District Hospitals are to be upgraded into Medical Colleges to address the need for more MBBS doctors.

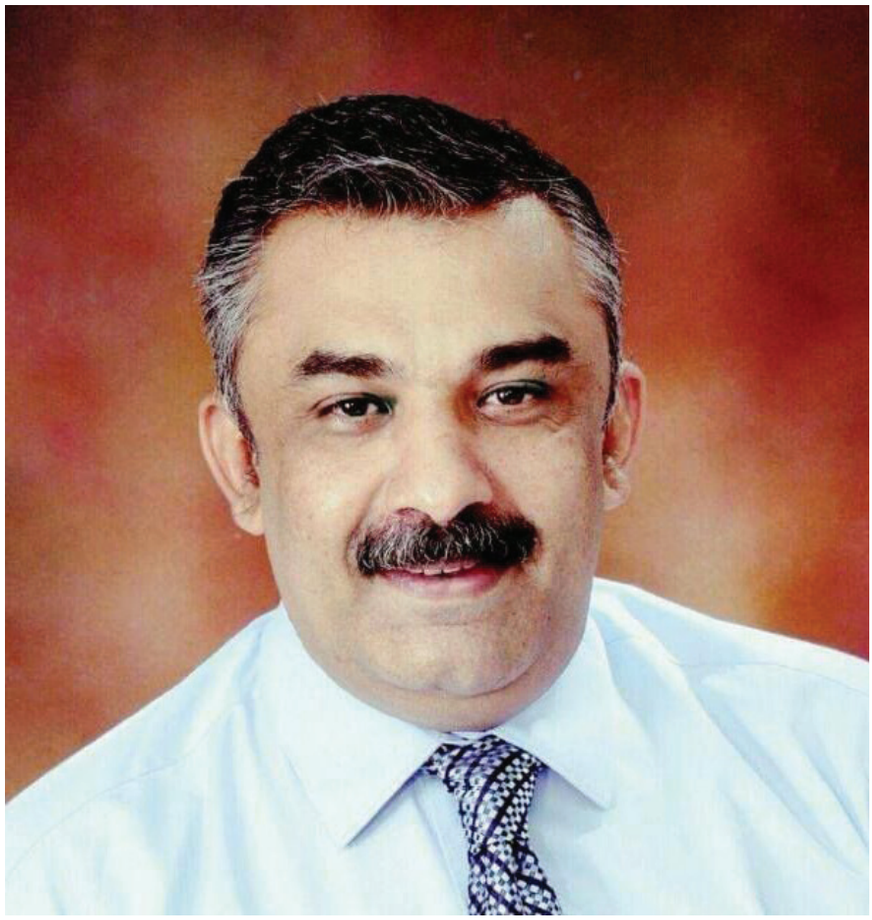
New Medical Colleges should be started in Public Sector particularly in regions where Medical College are not present to correct the geographical mal-distribution of Medical college

Licentiate examination

The national medical commission bill in Chapter IV clause 15 (1), (2), (3), (4), (5) mention about Uniform national licentiate examination for granting licence to practice modern medicine.

Dr Vinay Aggarwal, Ex President, IMA, said, " Qualifying licentiate examination no MBBS person will be enrolled in the National register and will not be entitled to practice or do further post graduate courses. Further the standard and backward communities would find it great difficulty to clear the exam. This would cause a great harm to them because they would neither be able to practice not would be able to take admission to PG courses"

" In addition even the students learning in medical colleges situated in remote areas as well as backward areas will also suffer in a similar manner. The net result would be that thousands of students passing their MBBS examination belonging to socio economically backward communities and from backward areas including north-east region would not be able to practice or seek admission to PG courses for want of clearance of the licentiate examination because of its higher standards," he added.



Dr Mangesh Pate, Joint Secrtary, IMA

It is worthwhile to note the neither the Parliamentary standing committee nor the Ranjit Roy Chaudhaury Committee had recommended such a licentiate exam n their respective reports.

The Hon'ble Parliamentary Standing Committee in its report in Page 94 submits:

"The committee takes note of the submission that today's graduate doctor after doing his internship is to confident of practicing because his entire period of one year internship goes into studying for PG entrance examination. The committee observes that skill training which is very important for a medical professional is not being acquired during internship. The committee therefore recommends that the PG entrance exam should be held immediately after final MBBS examination so that the graduate doctor could concentrate on practical skills during internship."

The Ranjit Roy Chaudhury Committee, in its report regarding UG Board, in point no. 15 of UG Board HAS SPECIFICALLY MENTIONED THAT THE FINAL ECAM WILL BE CONDUCTED BY RESPECTIVE UNIVERSITIES and the board will work in close collaboration with the universities to ensure that the assessment norms are being followed. (Page no. 118 of Hon'ble Parliamentary Standing Committee report; Appendix Ranjit Roy Chaudhurty Committee Report)

Dr R N Tandon, Secretary General, IMA, said, "Hence the PG NEET and

Exam for Government recruitment may be conducted immediately after the final MBBS examination, before commencement of internship, but it should not be linked to licence to practice.."

Indian Medical Association (IMA) requests the Hon'ble Parliamentary Standing Committee to make necessary changes in Chapter IV, Clause clause 15 (1), (2), (3), (4), (5), so that the concept of National Licentiate Exam is dropped.

To address the concern about the lack of uniform standard of MBBS graduates, The final year MBBS examination can be conducted as a common examination.

All common examinations including NEET and PG NEET should be under an examination board outside NMC except final year MBBS common examination.

Lack of representative character:

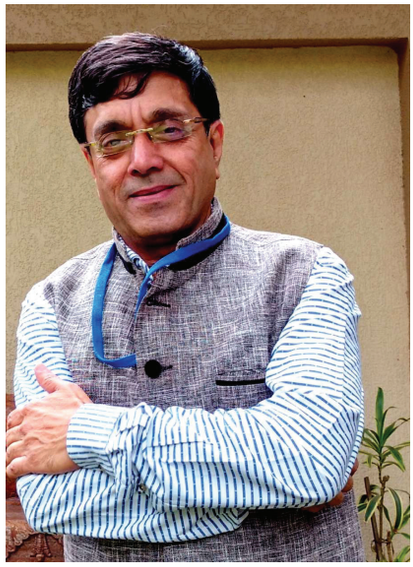
The Bill seeks to introduce a bureaucratic setup in the National Medical Commission with most of the members nominated by the central government, There are only 5 elected members from the registered Modern Medical practitioners from the state register

Dr K K Aggarwal, Ex President, IMA, said, "Instead of Five elected members one each should be elected from each state/ Union Territory from amongst the registered medical practitioners of Modern Medicine. IMA proposes one elected member from registered practitioners of Modern Medicine from each State. 50% of the elected members should be members of the autonomous Boards instead of having all nominated members. Board should consist of at least 6-8 members in total instead of only 3 members as suggested in the NMC Bill."

Representation for IMA in NMC:

IMA has been a member of both MCI and NBE, hence National President of IMA (or his nominee) should be included among the Ex Officio Members, by virtue of being the president of 206 lakhs modern medicine doctors.

Clause 11. (1) The Central Government shall constitute an advisory body to be



known as the Medical Advisory Council.

(2) The Council shall consist of a Chairperson and the following Members, namely:-

a)The Chairperson of the Commission shall be the ex officio Chairperson of the Council;

b)Every Member of the Commission shall be the ex officio Members of the Council;

c)One Member to represent each State, who is the Vice-chancellor of a health University in the State, to be nominated by that State Government;

d)One Member to represent each Union territory, who is the Vice-Chancellor of a health University in that Union territory, to be nominated by the Ministry of Home Affairs in the Government of India;

e)The Chairman, University Grants Commission;

f)The Director, National Assessment and Accreditation Council;

g)For Members to be nominated by the Central Government from amongst persons holding the post of Director in the Indian Institutes of Technology, Indian Institutes of Management and the Indian Institute of Science:

Provided that if there is no health University in any State or Union Territory, the Vice-Chancellor of a University within that State or Union territory having the largest number of medical colleges affiliated to it shall be nominated by the State Government or by the Ministry of Home Affairs in the Government of India. Provided further that if there is no University in any Union territory, the Ministry of Home Affairs shall nominate a Member who possesses such medical qualification and experience as may be prescribed.

Dr. Ravi Wankhedkar, said, "IMA demands that the National Medical Commission should not have non medical persons as members. The services of non medical experts and be utilized as part time consultants. "

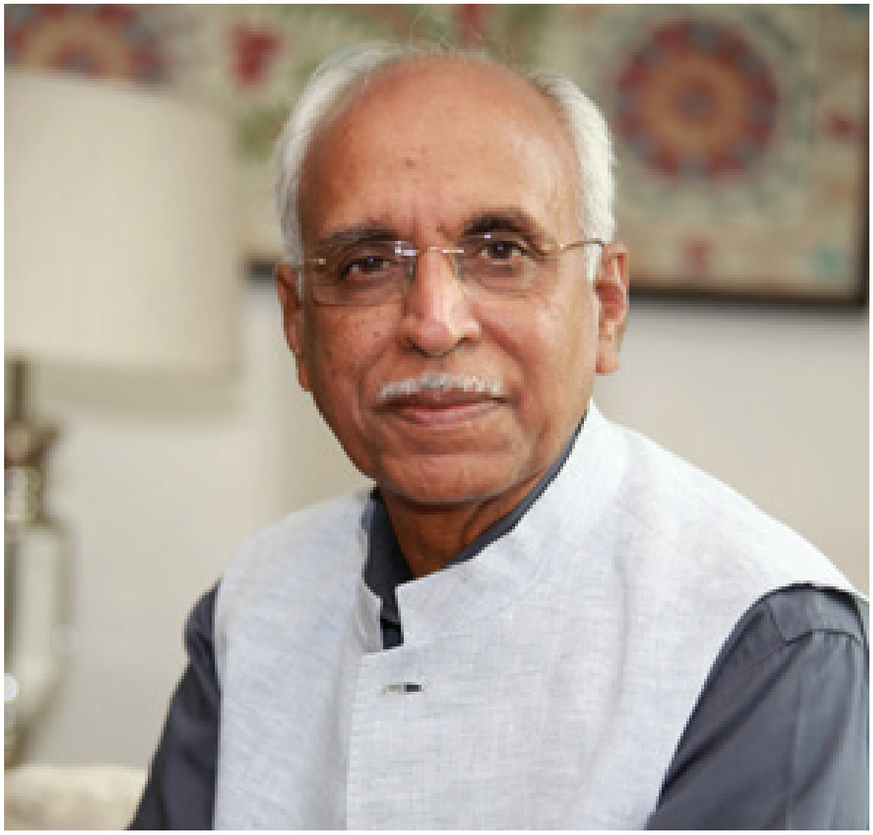
Directions to State Medical Councils:

The proposed Bill at section 10(1)(f) authorizes the commission to take such measures as may be necessary to ensure compliance by the State Medical Councils of the guidelines framed and regulations made under this Act for their effective functioning under this Act

The proposed Bill under section 30(2) entitles that Central Govt. to give direction to the State Medical Council for dispensation of task under their jurisdiction. All these provisions shall take away the autonomy vested with the State Medical Council and make them subservient to the Central Govt and NMC. This would be a great prejudice caused to the State Medical Councils and violation of principles of FEDERAL STSTEM.

Dr Manglesh Pate, Joint Secretary, said," IMA demands the autonomy of the State Medical Council should be retained." Composition of Medical Advisory Council Under section 11(1) of the proposed Bill the Central Govt. is required to constitute an Advisory Body to be known as the Medical Advisory Council.

The composition of the said Council stipulated at section 11(2) at its sub section (c) provides for that one member to represent each State who is the Vice Chancellor of a health University in that State to be nominated by that State Govt. However, at a proviso it brings out that "if there is no health university in any state or Union Territory the Vice Chancellor of a university within that state or Union Territory having the largest number of medical college affiliated to it shall be nominated by the



Dr. Vijay Agarwal, President, Consortium of Accredited Healthcare Organization (CAHO)

State Govt. or the ministry of home affairs in the Govt. of India.

A health sciences university apart form including medical colleges has under its ambit colleges of other stream of health sciences as well. The vice Chancellor of a health sciences university of a State therefore necessarily would not be a person possessing qualification in modern medicine.

Further, in case of non-health sciences universities, where under apart from medicine faculty there are several other faculties, the Vice Chancellor of such a university to which maximum number of medical colleges would be affiliated in the State could be a person who may not be even from the stream for health science. As such, the said proviso opens doors for representation of people as Vice Chancellor not only from non-medical faculty amongst health sciences but form the non-health sciences faculty as well.

"IMA demands that instead of VC of the university, a Modern Medical Doctor who should be elected form among the syndicate members of the university should represent the university," Dr Manglesh, said.

Accreditation Council and National Medical Grants Commission IMA also demands the formation of Accreditation Council and Medical Grants Commission outside NMC ACCREDITATION COUNCIL- as is in existence even for art and science colleges should be added to NMC. The inspection at the time of starting a medical college will be assessing only infrastructural facilities and manpower. But the accreditation council assess the standards of medical teachings, pass percentage and student performance which in effect will assure uniform minimum standards in medical education and there will be no need for NEXT (National Exit Exam). NATIONAL MEDICAL GRANTS COMMISSION also should be added in NMC to encourage research, teachers' career advancement, and funding teachers training programs Penalty for non-compliance should be fixed:

The penalty for non compliance varies from 5 crores to 100 crores which again opens the gates for corruption. The penalty should be fixed.

Fee Fixation:

In 60% medical seats, fees fixation is left the management which will make medical education unaffordable to socio economically weaker sections of the society. The Management seats should be limited to 15%. The proposed Medical Grants Commission can support private medical colleges even financially.

MCI ACT CAN BE AMENDED

These proposed amendments can be incorporated in the present MCI Act or through NMC. Indian medical Association request the Parliamentary Standing Committee to consider the above mentioned facts and modify the bill to achieve its aim of providing a medical education system that ensues availability of adequate and high quality medical professionals with zeal in research, orientation in health needs of the country with high ethical standards.

Dr. Vijay Agarwal, President, Consortium of Accredited Healthcare Organization (CAHO) and Advisor to Max Healthcare, Replacing MCI with another body could have made sense only after it was analyzed as to why was MCI not working and what makes one believe that the new body will not be "corrupt". It is very interesting that MCI was suspended and replaced by handpicked professionals with integrity for three long years from 2010 to 2013.

Was any improvement perceived? None to the eyes of many and that was the reason it was not continued with. Replacing one body with another will NOT serve any purpose unless we do a brainstorming about the underlying reasons as to why even the Government appointed Board could not redeem the image of MCI.

A number of medical colleges are being owned by political masters and they have been having indirect control over MCI and now in the new proposed body they can have more effective control!! Unless this conflict of interest is identified and neutralized no "institution" is likely to be effective…

Observations of the National Medical Commission Bill 2017

1. Composition of the National Medical Commission:

It is a three tier composition:

a) As per section (4) of the Bill, Composition of the National Medical Commission, which will have an effective membership of 25 of which only 5 members (Part Time) will be elected.

b) As per section (11) of the Bill, Composition of an Advisory Body to be known as the Medical Advisory Council. Totally Medical advisory council shall consists of about 60 members. All are nominated members.

c) As per section (16) of the Bill, Composition of 4 autonomous boards to be known as the UGME Board, PGME Board, MAR(Medical Assessment and Rating) Board and EMR(Ethics and Medical Registration) Board. Each board consists of 3 members only and all these members will be nominated by Central Government. Totally these four boards shall consists of 12 members. They will constitute further sub committees to assist them.

As such it is evident that the proposed commission will have 10% elected members (part time) and 90% nominated members. It is for this reason it will not have a desired 'representative character' with reference to 'elected and nominated / appointed members' whereas present Medical council of India has 75% elected members and 25% nominated members.

Further, a National Medical Commission ought to have a National character meaning thereby that it ought to have representation from across the country from amongst the relevant stakeholders. The present Indian Medical Council Act, 1956, vide its section 3 ensures that it had representation from all the States and Union Territories, all the Universities, from the Govt. of India through eight nominees and each State having a representation from amongst the registered medical graduates thus providing it the much desired National character. As against the proposed National Medical Commission Bill contemplates appointed members who by the very nature broadly would turn out to be 'capital based' than rendering a national character.

The composition of the various autonomous boards prescribed under the Bill does not include any elected member there under. As such, the relevance of elected members vis-a-vis their authority and jurisdiction is a big question mark left unanswered.

2. Un-wielding numbers in the name of spurning

One of the concerns raised was that the existing Indian Medical Council Act, 1956, provided for the composition of Medical Council of India, which has an exceptional large membership unwielding in character. However, the present proposed Bill contemplates a National Commission of 25 Members, a National Advisory Council which will include 25 members of the commission plus nearly 30 representatives of the State Govts. and Union Territories, Chairman University Grants Commission and Director National Accreditation and Assessment Council as Ex-officio members, four members nominated by the Central Govt. taking the overall number to well over 60.

In addition there will be four autonomous boards with three members including the Chairman taking it to 12, thus taking the number to a tally of 72.

Further at Section 8(7) it is provided that the Commission may engage, in accordance with the procedures specified by a regulation, such number of experts and professionals who have special knowledge of and experience in such fields including medical education, public health management, health economics, quality assurance, patient advocacy, health research, science and technology, administration, finance, accounts and law as it deems necessary to assist the commission in discharge of its function under this Act.

At Section 10(4) it is further prescribed that the commission may constitute sub-committees and delicate such of its power to such committees as may be necessary to enable them to accomplish specific task.

Further there is a provision to section 20(1) whereby each autonomous Board except the EMR board shall be assisted by such Advisory committees of experts as may be constituted by the commission for the efficient discharge of the functions of such boards under this Act.

Further at section 20(2) it is stipulated that the EMR board shall be assisted by such ethics committees of experts as may be constituted by the Commission for the efficient discharge of its functions. Thus, the number could be open ended.

Thus in the name of spurning the membership the provisions bring out inclusions in an open ended manner turning out to be an antithesis to the very aim and objective that came to be postulated.

3. Term of Membership of Commission:

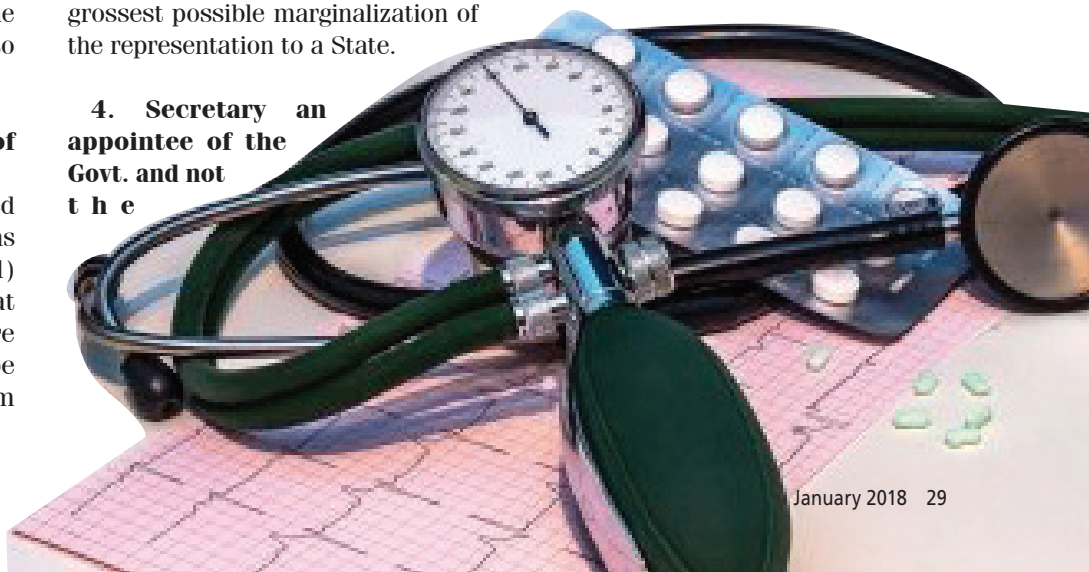
The term of membership stipulated in the proposed Bill is 4 years in terms of Provisions included at section 6(1) of the proposed Bill. However, at Section 4(b) it is stated that "there shall be three members to be appointed on rotational basis from amongst the nominees of the States and Union Territories in the Medical Advisory Council for the term of two years in such manner as may be prescribed. This is discriminatory in as much as, as against a stipulated term of four years to all other members, a set of State Govt. nominees as members would have a term of two years only.

Further, as against the present provision in the existing Indian Medical Council Act, every State is represented by its member on the council for the full term of five years without any discrimination of any type. But in the present stipulation, each State apart from getting a restricted term of two years on a rotational basis, its next turn would come only after a gap of 10 years on rotation basis construing the total rotational strength of the states to be 30. This definitely has resulted in grossest possible marginalization of the representation to a State.

4. Secretary an appointee of the Govt. and not the commission :

The proposed Bill at its section 8(1) provides for that there shall be a secretariat for the commission to be headed by a Secretary to be appointed by the Central Govt. As such, the Secretary would be appointed by the Govt. of India and not by the Commission, which speaks as to how the Central Govt. has caught hold of the autonomy of the commission which is just a namesake with real authority vested in the Central Govt. in an exclusive manner.

Further, at section 8(2) it is stipulated that the Secretary of the commission shall be a person of outstanding ability and integrity possessing a postgraduate qualification in such areas as may be prescribed, paving a way that the Secretary of the National Medical Commission could be a person without possessing modern medicine



qualification as the provision contemplates the incumbent to possess PG qualifications in such areas as may be prescribed.

5. Directions to State Medical Councils:

The proposed Bill at section 10(1)(f) authorises the commission to take such measures as may be necessary to ensure compliance by the State Medical Councils of the guidelines framed and regulations made under this Act for their effective functioning under this Act.

Further the proposed Bill at proviso to section27 (b) brings out that 'provided that the EMR board shall ensure compliance of the Code of Professional and Ethical Conduct through the State Medical Council in a case were such medical council has been conferred power to take disciplinary actions in respect of professional or ethical misconduct by medical practitioners under respective State Acts.

The proposed Bill under section 30(2) entitles the Central Govt. to give direction to the State Medical Council for dispensation of task under their jurisdiction. All these provisions shall take away the autonomy vested with the State Medical Council and make them subservient to the Central Govt. This would be a great prejudice caused to the State Medical Councils.

6. Composition of Medical Advisory Council:

Under section 11(1) of the proposed Bill the Central Govt. is required to constitute an Advisory Body to be known as the Medical Advisory Council.

The composition of the said Council stipulated at section 11(2) at its sub section (c) provides for that one member to represent to each State who is the Vice Chancellor of a health University in that State to be nominated by that State Govt. However, at a proviso it brings out that 'if there is no health university in any state or Union Territory the Vice

Chancellor of a university within that state or Union Territory having the largest number of medical colleges affiliated to it shall be nominated by the State Govt. or the ministry of home affairs in the Govt. of India.

A health sciences university apart from including medical colleges has under its ambit colleges of other streams of health sciences as well. The Vice Chancellor of a health sciences university of a State therefore necessarily would not be a person possessing qualifications in modern medicine.

Further, in case of non-health sciences universities, whereunder apart from medicine faculty there are several other faculties, the Vice Chancellor of such a university to which maximum number of medical colleges would be affiliated in the State could be person who may not be even from the stream of health sciences. As such, the said proviso opens doors for representation of people as Vice Chancellor not only from non-medical faculty amongst health sciences but from the non-health sciences faculty as well.

7. Separate National Register :

Under section 31(8) the EMR Board shall maintain a separate National Register including the names of licensed Ayush Practitioners who qualifies the bridge course referred in Section 49(4) in such manner as may be specified by Regulations. By an explanation, Ayush Practitioner has been defined as a person who is a practitioner of Homeopathy or a practitioner of Indian Medicine as defined in Clause (e) of Sub-section 1 of section 2 of the Indian Medicine Central Council Act, 1970.

Section 49(4) contemplates bridge courses even for the practitioners of homeopathy to enable them to prescribe such modern medicines at such level as may be prescribed. This is materially inconsistent with the definition of the word 'medicine' as depicted at section 2(j) wherein it is defined as 'medicine means modern scientific medicine in all its branches and include surgery and obstetrics but does not include veterinary medicine and surgery'.

It is worthwhile to note that the names of the BAMS and BHMS graduates are already registered with their respective councils. On availing the bridge course they would be incorporated in a separate register, which would mean that they would be having duel registrations with two registering councils, which is neither open nor permissible. Further, the disciplinary jurisdiction with reference to breach of ethics is not indicated as they have duel registrations to their credit. In a way a classical privileged group would stand created by virtue of the proposed Bill.

As such these are the flood gates that have been opened up in terms of the statutory provisions for backdoor entry into medical profession entitling practicing modern medicine.

8. licenciate examination

As per section (15) of the Bill, provision is made for introduction of licenciate examination mandatory after acquiring MBBS qualification. Without qualifying licenciate examination no person will be enrolled in the National register and would be entitled to practise and do further post graduate courses. Further the standard and level of licenciate examination would be such that the students belonging to backward communities would find it great difficulty to clear the same easily and handily. This would cause a great harm to them because they would neither be able to practice nor would be able to take admission to PG courses. In addition even the students learning in medical colleges situated in remote areas as well as backward areas/states they will also suffer in a similar manner. This handicap would be equally applicable to the students passing out from north-east region as well. The net result would be that thousands of students passing their MBBS examination belonging to backward communities learning from backward areas including north-east region would not be able to practice timely and also seek admission to PG courses for want of clearance of the licenciate examination because of its higher standards.

As per provisio to section33(1)(d) of the Bill, it stipulates that 'the commission may permit a medical professional to perform surgery or practice medicine without qualifying the National Licenciate Examination, in such circumstances and for such period as may be specified by regulations'. This operationally means that without ascertaining of the required levels and certification thereto the commission would be permitting people to practice surgery and medicine in an open ended manner is nothing less than legalizing quackery in an operational sense and playing with lives of the people at large. Such sweeping powers are not only illegal but will give ample scope of manipulation and corruption.

What Association of Healthcare Providers India says on National Medical Commission Bill 2017?

According to **Dr Gridhar Gyani, Director General, Association of Healthcare Providers India**, the Honorable Parliamentary Standing Committee in its report submitted to the parliament on March 8 2016, highlighted the challenges being faced by the health sector in India. There are huge gaps in availability of qualified doctors, specialist, and super specialist. There is huge geographical mal-distribution of medical colleges under which 2/3 medical colleges are located in the regions representing 1/3 population. The medical education regulatory framework is grossly inadequate and in-effective on ground. There is total disconnect between medical education system and needs of healthcare delivery system in the country.

Dr Alexander Thomas, President, Association of Healthcare Providers India, said, "Keeping above in view there has been long pressing need to reform medical education. Accordingly Government of India came up with the draft National Medical Commission bill 2017, aimed at creating of robust medical education regulatory system. Considering that reforms in health systems of nation are closely linked with nation's medical education system, it is important that new system by way of NMC should be able to meet the challenges as mentioned above and take our health system to next level and make universal health coverage (UHC) a reality in near future."

However there are areas of concern in the draft bill that need to be addressed if the objectives of having world class regulatory framework are to be fulfilled. These are as follows;

1. The proportion of elected representatives from medical fraternity in the proposed NMC 2017 is to the extent of 20% which is grossly inadequate and undermines the principles of democracy. This needs to

be enhanced appropriately.

2. The founding principles of modern medicine are evidence-based and are rooted in standard treatment protocols, which have nothing in common with the traditional systems of medicine (AYUSH). Therefore, mixing up of these systems of medicine through bridge courses will in no way be appropriate. On the contrary it will undermine the patient safety and pave the way for promoting quackery.

3. Following successful completion of the MBBS examination enforcing another National Licentiate Examination is superfluous. However, those aspiring to do post-graduate courses can be made to appear for common PG-entrance examination.

The NMC Bill will once and for all resolve the issue of equivalence between MD/MS & NBE degrees and there will be no disparity. The new bill gives great importance to monitoring quality of Institutions which will in turn produce quality medical professionals.

"The medical fraternity needs to stand united and support the IMA in voicing the concerns of doctors"

Dr Vinay Aggarwal, former National President, Indian Medical Association (IMA) and Founder Member of IMA-East Delhi is all for a relationship of deep trust between patients and doctors. Towards this end, he believes the doctor has to go an extra mile in extending healthcare with a healing touch and the society too has to develop an understanding of the complexities involved in medical care and treatment. Dr Aggarwal has been closely involved with various welfare measures adopted for the betterment of patients and doctors.

He founded Pushpanjali Medical Centre, a 60-bedded secondary care hospital and then started Pushpanjali Crosslay Hospital, a 300-bedded tertiary care centre of excellence (now Max Super Specialty Hospital, Vaishali). He started a social initiative under the scheme Beti Padaho Yojana as he believes that educating a girl child means educating an entire family and society. His initiative provides monthly financial assistance to the minor girl children as decided from time to time.

The multifaceted Dr Vinay with an ever-present winning smile on his face, spoke at length to **Amresh K Tiwari, Editor-in-Chief, Double Helical** on a wide range of issues.

Excerpts of the interview…

Can you please take us along your long journey as a medico-social activist and leader?

I started my medico-social activist journey in 1970 as a rebel medical student against the urban health programme run by the Preventive and Social Medicine (PSM) department of Maulana Azad Medical College, where students were not made to actively participate. We collected funds and started our own dispensary at Seelampur. It grew from strength to strength from a few eager medical students trying to help the well-known NSS Seelampur Health Centre to the one which fulfilled the medical needs of a large minority population of the area. As a medical intern in 1974, I took an active part in the historical national strike to increase the meager spend provided to doctors by medical colleges, which successfully culminated in the government taking note and including doctors salaries under the National Pay Commission. This is how the residency program was started. At an early stage, I realized the potential of Medical Associations, and the need for doctors to stand united. So, in 1978-82 I became the youngest secretary of Delhi Medical Association (DMA). From an elite eminent club of handful senior doctors, I strived hard and increased its membership to include hundreds of young doctors. As DMA Secretary and president of ESI Medical officersAssociation, I successfully achieved the regularizing of more than 500 ad hoc doctors through DPC. By this time I was a recognized state medico political leader. I worked for the revival of IMA East Delhi Branch (EDB) along with Dr S N Mishra, Dr Harsh Vardhan and Dr Sudarshan Vaid.

How did you achieve excellence in the medical field?

I studied in Government Boys' Higher Secondary School, Krishna Nagar and was the first student from my school to be selected at the prestigious Maulana Azad Medical College. I come from a humble background and paid for my college education by selling anatomy dissection boxes to fellow classmates. I went from a shy awe-struck boy among a batch of 140 to later being recognized by my alma mater with the "Best Alumnus" award. I started a small clinic in Krishna Nagar, and like most doctors, I was the neighbourhood 'Family doctor'. With the goodwill of my parents and friends, I established Pushpanjali Medical Centre, a 60-bedded secondary care hospital and then started Pushpanjali Crosslay Hospital, a 300-bedded tertiary care centre of excellence (now Max Super Specialty Hospital, Vaishali).

We would like to know more about some community health programmes you have been a part of…

Some of the projects I have been actively involved with and played a leadership role include the following:

Save the Girl Child & Stop Female Foeticide, Anemia Free India; Stop Child Abuse; Prevention of Blindness Programme; Programme for Prevention and Control of Water and Vector Borne Diseases; Leprosy Control Program; HIV/AIDS programme (in close association with the Clinton Foundation); amongst many others. I spearheaded the 'Aao Gaon Chalen' project under the aegis of IMA, with adoption of a village by each branch of IMA. I was honoured by the President of India with the BC ROY Award (2005), by FICCI as the Healthcare Personality of the Year award (2014) and by the Global Association of Physicians of Indian Origin with the Lifetime Achievement Award (2014) for my medico-social work besides many others.

What is your opinion about the current medical scenario in the country?

These are hard times to be a doctor. The medical profession today is under attack on various front – bureaucrats, media and dissatisfied relatives of patients. The tradional issues of wages and working conditions for doctors that the IMA has always fought for remain unresolved and yet we have additional demons to deal with such as violence against doctors, Clinical Establishment Act, criminalizaon of Pre-Natal Diagnostic Techniques (PCPNDT) Act, Cross-pathy, quackery, the need for capping of compensation in medical negligence, generic medicine, and the NMC bill. I think now more than ever the medical fraternity needs to stand united and support the IMA in voicing the concerns of doctors.

This IMA EDB Election, you were a strong proponent of having a female leader, why?

Shouldn't everyone be a proponent of a hard working and dedicated female leader!? Over the years women's membership and participation in IMA activists has been increasing but unfortunately they are grossly underrepresented in leadership positions in the medical fraternity. Dr Neelam Lekhi has been working for the benefit of IMA, peculiarly EDB for several years now. It was a natural choice and one that I assumed would be unanimous. Anyway she came out stronger by winning the election with a thumping majority. I think IMA EDB Branch is in good hands and I wish her and her team all the success.

What are your main socio-medical achievements?

With efficient leadership skills and an aim for greater social benefit, I initiated and significantly contributed to the following projects:

Aao Gaon Chalen – a Dream Project

As Secretary General of Indian Medical

Association (IMA), initiated the project to improve rural health as envisaged in the National Health Policy.

Anemia Free India

On Doctor's Day on 1st July 2005, a National Project – "Anemia Free India" – was initiated with the aim to create public awareness regarding the ill effects of anemia, to promote better nutrition and promote vitamin, iron and folic acid supplementation.

Physician's Training Initiative - Bill Clinton Foundation

An ambitious project of sensitizing 1.5 lakh members of IMA to HIV/AIDS and anti-retroviral therapy has been undertaken with NACO and Clinton Foundation. The project is accredited by the Medical Council of India launched on 26th May, 2005 by former president Bill Clinton himself in Delhi.

Iodised Salt

Convened a country-wide campaign along with UNICEF, Department of Nutrition and All India Institute of Medical Sciences, explaining the importance of iodization of salt. Five regional meetings were organized in various cities on this issue.

Integrated Disease Surveillance Programme

Worked on a National Project along with NICD and the World Bank. A workshop of seven states was organized in November 2005 along with representatives of NICD and World Bank in this regard.

Family through the Child

"Family through the Child", a Balwadi-oriented health project, was started with the assistance of Delhi Social Welfare Advisory Board in 1980. A health survey of 2000 children and their families was conducted in this scheme. Proper health facilities were provided to the families of these children of the Balwadis. Also organized a reorientation course for Bal-Sevikas in DMA during the project.

Save the Girl Child Campaign

The main goal of Beti Bachao Beti Padhao launched by Prime Minister Narender Modi, is to generate awareness and improve the efficiency of welfare services meant the girl child across the whole country.

The scheme is being implemented in almost 100 districts with low Child Sex Ratio (CSR). The major fundamentals of this Yojna include Enforcement of PC & PNDT Act, nation-wide consciousness and encouragement campaign and multi-sectoral action in choose 100 districts in the first stage.

The main objective of the Beti Bachao Beti Padhao Yojana is to prevent gender biased sex selective elimination, survival and protection of the girl child and her education.

The issue of falling sex ratio and female foeticide was effectively highlighted by IMA by various Campaigns during my tenure as President, MAMCOS.

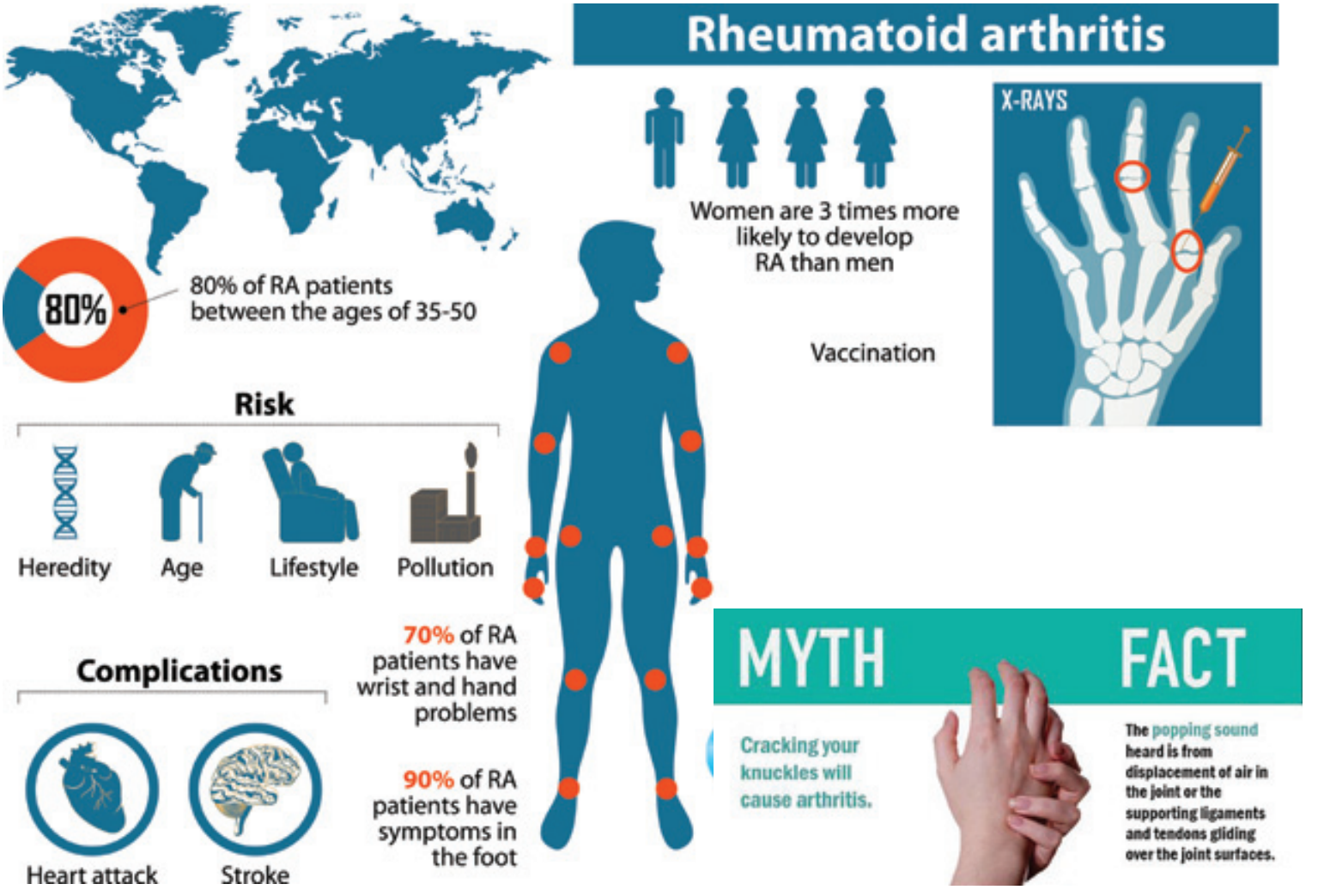
"No Tobacco Day" and "Smoking or Health Choice is Yours"

Launched a massive Anti-Tobacco Campaign during my tenure as the secretary of DMA on the WHO Day on 7th April, 1980 on the theme of "Smoking or Health - Choice is Yours". Public awareness lectures were organized at various places in Delhi.

ARTHRITIS : Myths And Facts

The Dangerous (Autoimmune) Type Of Arthritis Is Not Restricted To The Joints And Can Virtually Affect Any Or Multiple Organs Like Lungs,Kidneys,Eyes,And Sometimes Even The Brain. Without Prompt Early Diagnosis And Treatment It Can Be Severly Damaging To The Organs Can Cause Deformities Of The Joints Or Damage The Lungs,Kidneys,Eyes,Brain Etc.and Sometimes Even Lead To Death.....

BY DR P D RATH



Myth: arthritis is a simple disease which affects only elderly people.

Fact: arthritis is a broad term used as an umbrella for many diseases which lead to pain and swelling of joints. It is very similiar to saying that some one has fever.

Fever can be due to various causes some very simple and short lasting like viral,typhoid,malaria and some more sinister and life threatening like cancer .

Similiarly arthritis are also of various types and there are over a 100 or more types of arthritis but for simplicity we can divide them into two broad categories:

The simple/common type and the dangerous(autoimmune) type

The former is what is often commonly reffered to as arthritis- it is primarily a degenerative process mainly affecting the knees commonly seen in late middle age and elderly.

It leads to pain that worsens on movement and improves with rest . It is restricted mainly to the joints involved (e.G knees). It is not a life threatening disease.(E.G osteoarthritis)

The latter group(dangerous type) though less common is very important as it can affect people of any age groups starting from small children to young adults,males and females alike. (E.G rheumatoid arthritis,spondyloar thritis,lupus,gout etc.)

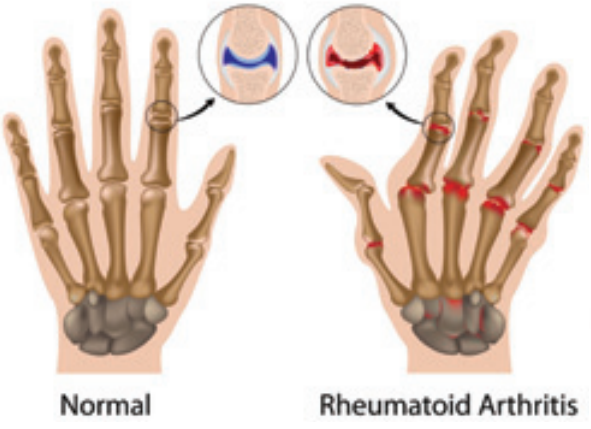
It often affects multiple joints both small and large including the back. In the early stages there is significant stiffness and pain in early morning which gradually improves as the day progresses and again worsens at night .There are associated symptoms like fatigue,tiredness, feverishness,loss of appetite etc.

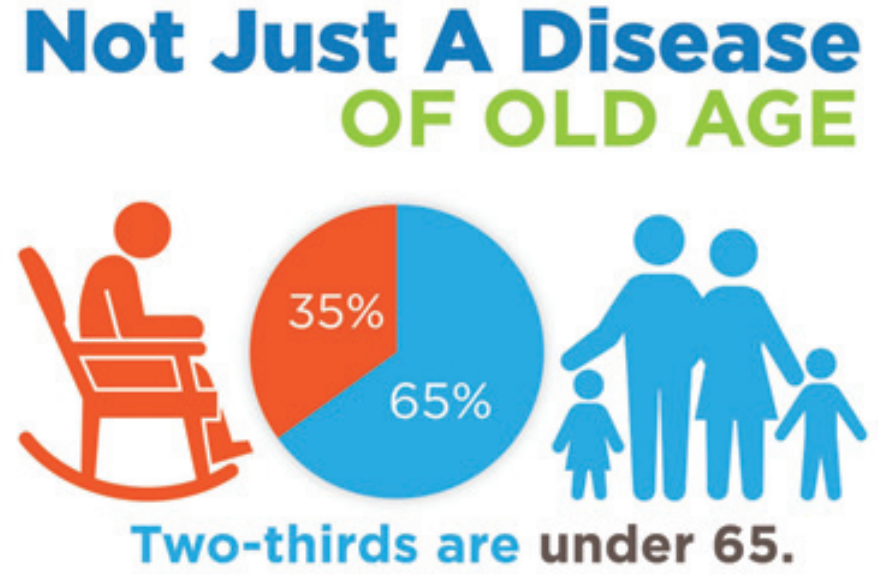
Myth:arthritis is not a life threatening disease

Fact: the dangerous (autoimmune) type of arthritis is not restricted to the joints and can virtually affect any or multiple organs like lungs,kidneys,eyes,and sometimes even the brain. Without prompt early diagnosis and treatment it can be severly damaging to the organs can cause deformities of the joints or damage the lungs,kidneys,eyes,brain etc.And sometimes even lead to death.

Myth: there is no cure for arthritis

Fact: there is no cure for common conditions like diabetes,hypothyroid and hypertension however all of them are treatable. Likewise all types of





arthritis are treatable.

Rheumatologists are a group of highly specialised doctors who diagnose and treat these various type of dangerous(autoimmune) arthritis with highly specialised drugs which if used early and appropriately are life saving and transform the life of patients and help them lead a near normal life.

Joints that are permanently damaged are replaced by orthopaedic surgeons.

Myth: arthritis can be diagnosed by a single test

Fact: there is no single test to diagnose arthritis . They are diagnosed taking into account a detail history including family history,symptoms and clinical signs and lastly some blood tests which should be ordered only in individuals with high clinical suspicion. It is important to remember that some of these tests can be positive in normal individuals also therefore it is very important to consult a rheumatologist who understands these diseases and tests.

Myth: arthritis can be managed at home with pain killers and home remedies.

Fact: don't manage arthritis on your own with pain killers. Pain killers provide temporary relief and may not address the underlying disease. Specialy the dangerous(autoimmune type). It is important to consult a rheumatologist.

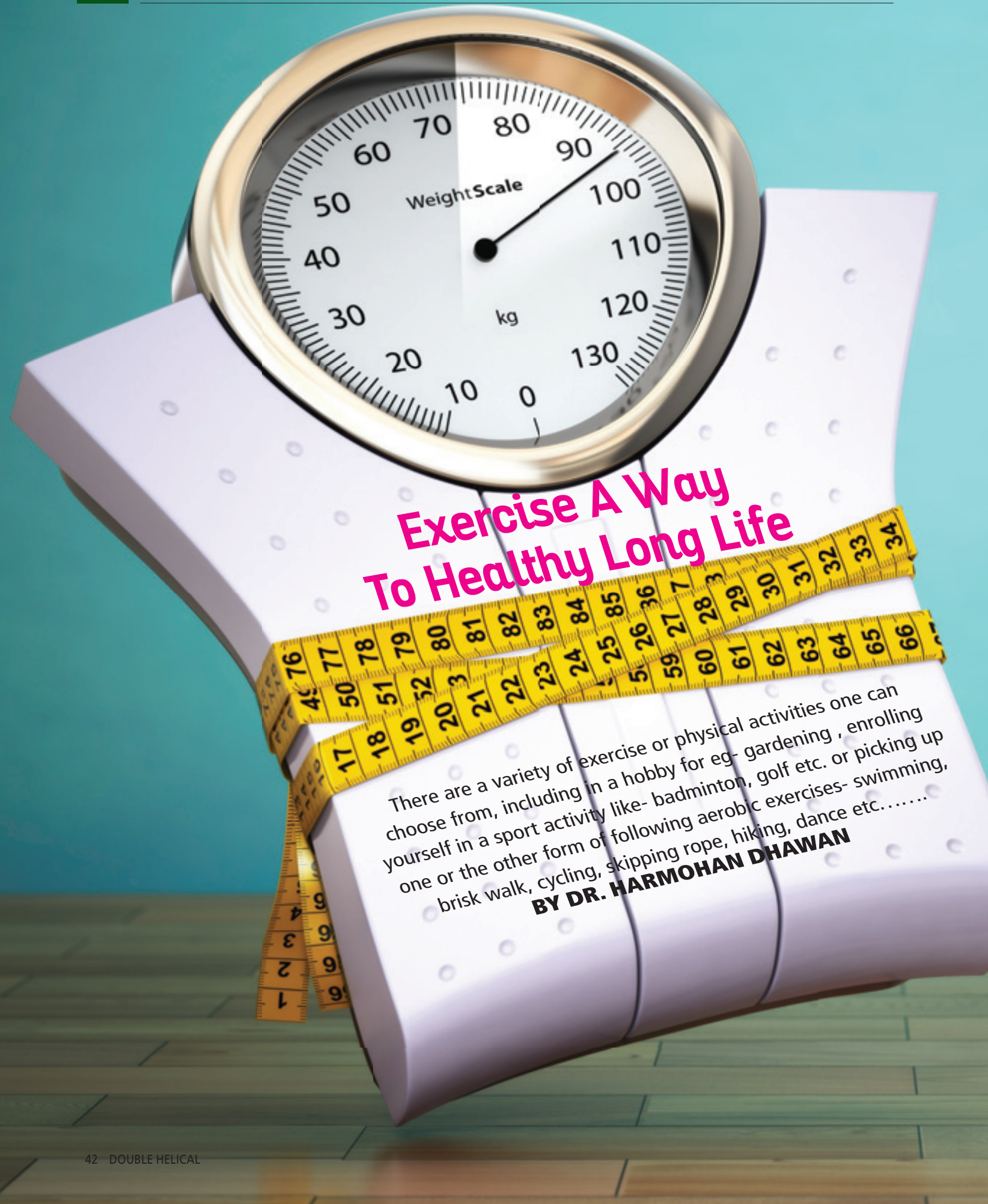
Myth: we can and should stop medications on our own as these are dangerous drugs.

Facts:no drugs are dangerous as long as they are taken under the supervision of a doctor with proper monitoring. Neither discontinue nor continue any medication on your own without routine follow up with your doctor.

Myth:arthritis is caused due to diet and can be treated by diet alone.

Facts:arthritis(dangerous type) is a multifactorial disease however a healthy life style with good exercise and a healthy balanced diet is an essential part of any treatment. Eating plenty of fresh fruits and green vegetables and certain foods rich in omega-3 fatty acids like fish and flaxseeds etc. Have been found to be beneficial.

(The author is Director and Head Of Deptt. Rheumatology, Max Super Speciality Hospital Saket, Smart, Panchsheel, New Delhi)



Exercise A Way To Healthy Long Life

There are a variety of exercise or physical activities one can choose from, including in a hobby for eg- gardening , enrolling yourself in a sport activity like- badminton, golf etc. or picking up one or the other form of following aerobic exercises- swimming, brisk walk, cycling, skipping rope, hiking, dance etc.....

BY DR. HARMOHAN DHAWAN

It's important to remember that we have evolved from nomadic ancestors who spent all their time moving around in search of food and shelter, travelling large distances on a daily basis. Our bodies are designed and have evolved to be regularly active.

Over time people to develop problems if they sit down all day at a desk or in front of the TV and minimize the amount of exercise they do.

These are many benefits of regular exercise and maintaining fitness and these include-

1. Exercise increases energy levels.
2. Exercise improves muscle strength.
3. Exercise improves brain function.
4. Exercise is good for your heart.
5. Regular exercise lowers your risk of developing type 2 diabetes.
6. Exercise enhances your immune system.
7. Staying active reduces the likelihood of developing some degenerative bone diseases.
8. Exercise may help to reduce the risk of certain cancers.
9. Active people tend to sleep better.
10. Exercise improves your mood and gives you an improved sense of well- being.
11. Exercise can help prevent and treat mental illnesses like depression.
12. Keeping fit can reduce some of the effects of aging.
13. Recover better from period of hospitalized or bed rest.
14. Improve your ability to do daily activities and prevent falls if you're an older adult.
15. Increase your chances of living longer.
16. Hip fracture is a serious health condition that can have life changing negative effects, especially if you're an older adult. But research shows that people who do 120 to 300 minutes of least moderate. Intensity aerobic activity each weak have a lower risk of hip fracture.
17. Regular physical activity helps with arthritis and other conditions affecting the joints.
18. Regular physical activity can help keep your thinking, learning and judgment skills sharp as you age.
19. It can also reduce your risk of depression and may help you sleep better.
20. When you are not physically active, you are more at risk for:-
    - High blood pressure
    - High blood cholesterol
    - Stroke
    - Type 2 diabetes
    - Heart disease
    - Cancer
21. Physical activity and nutrition work together for better health being active increases the amount of calories burned. As people age their metabolism slows so maintaining energy balance requires moving more and eating less.
22. Balance and stretching activities enhance physical stability and flexibility. This reduces risk of injuries. Eg are gentle stretching, dancing, yoga, martial arts etc.
23. Muscle- strengthening activities make your muscles stronger. These include activities like push-ups and lifting weights. It is important to work all the different parts of the body your legs, hips, back, chest, stomach, shoulders and arms.

These a variety of exercise or physical activities one can choose from, including in a hobby for eg- gardening , enrolling yourself in a sport activity like- badminton, golf etc. or picking up one or the other form of following aerobic exercises- swimming, brisk walk, cycling, skipping rope, hiking, dance etc.

Exercise is as important to health as proper nutrition. When exercising, it becomes even more important to have a good diet to ensure that the body is getting all the necessary.

(The author is Naturopathologist Ex Civil Aviation Minister, Govt of India)

Moving from Maternal Death Review to **Surveillance and Response**

Maternal Death Surveillance and Response (MDSR) is expected to be important to reduce the MMR further and eliminating preventable maternal mortality. MDSR is a form of continuous surveillance that links the health information system and quality improvement processes from local to national levels, which includes the routine identification, notification, quantification and determination of causes to avoid all maternal deaths, as well as the use of this information to respond with actions that will prevent future death……

BY DR SUNEELA GARG

Government of India is striving towards bringing down the maternal mortality ratio to less than 70/100,000 live births by 2030 in accordance to the Sustainable Development Goals (SDGs). India's commitment to reduce its MMR is reflected in National Health Policy 2017 which envisages reducing MMR to 100 by 2020.

Maternal death is defined as death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and the site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management but not from accidental or incidental causes. Maternal death is expressed as Maternal Mortality Ratio (MMR) which is an indicator of the quality of healthcare in a country.

India once had one of the highest maternal mortality ratios in the world – in 1990, it was 437 per 100000 live births. In 2005, the government launched the National Rural Health Mission "to provide accessible, affordable and quality health care to the rural sections especially the vulnerable populations". It did so by promoting institutional delivery and breastfeeding and post-natal care by integrating various conditional cash transfer schemes for pregnant and lactating women. The strategies adopted by the government worked and maternal deaths reduced to 167 deaths per 100000 live births in 2011-13, and decline in maternal mortality ratio (MMR) was much faster in India (4.5%) as compared to global rate (2.6%). As per historical trend, MMR is expected to reach the level of 140 maternal deaths by 2015, and India is likely to miss the MDG target of 109 per 100,000 live births.

In this scenario, where India has seen drastic reductions in the maternal mortality, a robust Maternal Death Surveillance and Response (MDSR) is expected to be important to reduce the MMR further and eliminating preventable maternal mortality. MDSR is a form of continuous surveillance that links the health information system and quality improvement processes from local to national levels, which includes the routine identification, notification, quantification and determination of causes to avoid all maternal deaths, as well as the use of this information to respond with actions that will prevent future deaths.

Based on the learnings and feedback from the states and in line with the recent WHO guidelines, the Government of India revised the MDSR guidelines with a focus on surveillance (for improving reporting) & response (for improving analysis and action planning) and incorporating a component of Confidential Review. Precise mechanisms for review of deaths of migrant population, use of ICD 10 instead of ICD 9 for classification of maternal deaths and Training of Medical officers on Medical Certification on cause of Death (MCCD) are few of the newer components in the guidelines. Most importantly, the guidelines reiterate that based on the findings of the maternal death reviews, no disciplinary action is to be initiated against any of the service providers. The key principle to be adopted during the entire process of reviewing is not to blame or find fault with anybody.

To achieve the SDG goal, the need of the hour is to identify, review and take actions to correct the causes and determinants of maternal death to prevent future deaths. The new guidelines adopt a health systems approach and the focus is on identifying gaps in the system and respond by taking action to address those gaps. The factor leading to maternal death are identified as per the "Three Delay Model".

The first delay is described as the delay in deciding to seek care. The reasons behind this delay may be social, cultural or economic. They may stem from lack of woman empowerment to make decisions regarding health, beliefs and cultural practices of the family or financial constraints. Lack of awareness regarding danger signs in pregnancy is also an important factor contributing to the first delay and indicates a deficiency in adequate antenatal care and advice. This delay is probably the most difficult to address as it requires long term action for improving socio-economic status of women in society. A short-term solution would be to ensure that the existing community level and primary level functionaries provide good quality antenatal services by periodic monitoring and supportive supervision.

The second delay is the delay in reaching care. Once the decision has been made to seek care, delay may be encountered on the way to the facility. Common reasons for this delay include long distances to hospitals, difficult terrain or unmaintained roads, unavailable or expensive ambulance services. This delay needs coordination and partnership with other

organizations working outside the health sector such as the Ministry of Road Transport and Highways.

The third delay is described as the delay in receiving care. This occurs when the mother reaches the facility but there is a delay due to lack of quality care at the facility level. Facility readiness is crucial to address this delay. The facilities should have documented standard operating procedures which should be adhered to. The services and supplies should be available at the facility as per norms.

The new MDSR guidelines provides various tools to identify the delays that lead to maternal death. Community-based MDSR incorporates a verbal autopsy format that can be effectively utilized to identify the causes and determinants of maternal death. Community-based review is especially useful to identify the first and second delay. The third delay can be identified by Facility-based MDSR which delves into the detail of patient management at the healthcare facility.

Confidential Review of maternal deaths has been introduced for the first time in these guidelines with the objective of checking adherence to protocols and line of management adopted in particular cases.. The principle of "No names, no blame" was adopted to find the reasons and learnings from maternal deaths. The provision of Confidential Review in the new guidelines provides an opportunity to have expert opinion on Maternal death which will provide important clues towards patient management. This becomes more important as a state moves towards lower MMR and indirect causes of maternal deaths become more important.

It is important to reiterate that data by itself is useless, data is useful only when it is applied. Data collection must be linked to action. Commitment to respond, i.e. to act on findings of the deaths reviewed, is essential for success. Taking action to reduce avoidable maternal deaths is the reason for conducting Maternal Death Surveillance and Response.

(The Author is Director Professor & Head, Community Medicine Maulana Azad Medical College & Associated Hospitals, New Delhi)

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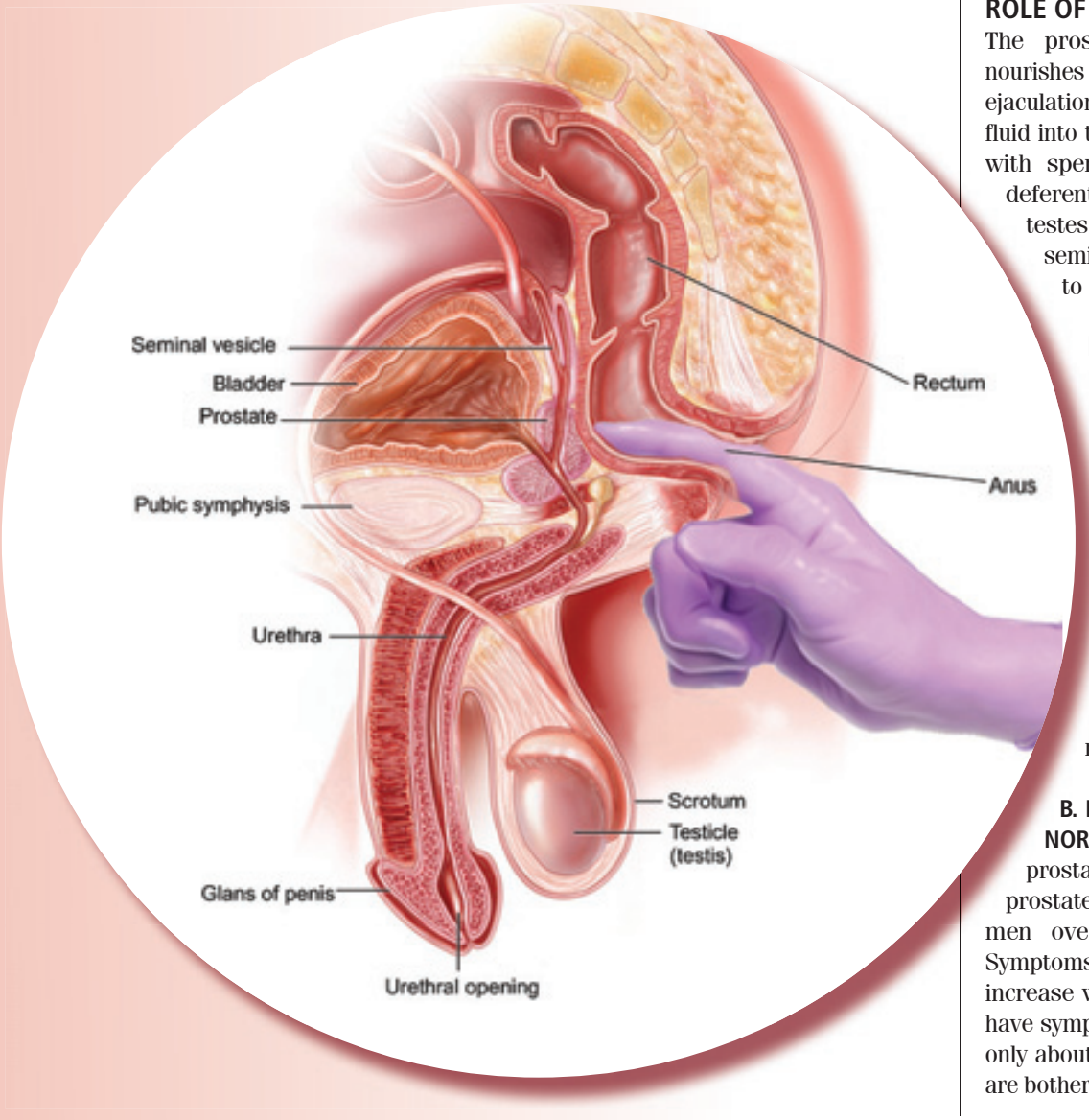
INCURABLE PROSTATE DISEASES

A DRUG-FREE CURE AT ALL STAGES

BY DR. R. K. TULI



The Prostate is a walnut-sized gland located between the urinary bladder just in front of the rectum. The urethra runs through the center of the prostate, from the bladder to the penis, letting urine flow out of the body.

ROLE OF PROSTATE:

The prostate secretes fluid that nourishes and protects sperms. During ejaculation, the prostate squeezes this fluid into the urethra and it's expelled with sperms as semen. The vasa deferentia bring sperms from the testes to the seminal vesicles. The seminal vesicles contribute fluid to semen during ejaculation.

PROSTATE DISORDERS:

A. PROSTATITIS: It's commonly caused by infection and treated by antibiotics. When not controlled adequately, the infection may spread in the region to infect testes, epididymis, seminal vesicles, urinary bladder, the urethra, prostate, etc., leading to miserable inflammation in the whole region.

B. ENLARGED PROSTATE WITH NORMAL PSA : It's called benign prostatic hypertrophy or BPH. The prostate growth affects virtually all men over the age of 50 years. Symptoms of difficult urination tend to increase with age, up to 90% of men have symptoms of BPH by age 85, but only about one-third of men with BPH are bothered by the symptoms. Usually

Alpha-blockers or 5-alpha-reductase inhibitor medicines are used as a first line of treatment to relieve symptoms of enlarged prostate. When drugs cease to help the urine flow freely some men require surgery to improve symptoms and prevent complications.

C. ENLARGED PROSTATE WITH RAISED PSA : This situation has to be closely observed to watch for malig- nancy.

D.PROSTATE CANCER : It's the most common form of cancer in men, but only one in 35 men die from prostate cancer. Surgery, radiation, hormone therapy, and chemotherapy can be used to treat prostate cancer. Some men choose to delay treatment, which is called watchful waiting.

E. POST-SURGICAL INCONTINENECE OF BLADDER: A few men after surgical resection of the prostate gland suffer life-long loss of control over their bladder due to irreversible damage to their sphincters, leading to embar- rassing and foul smelling 'leaky bladder' or dependence on 'diapers'.

Holistic Medicine Therapy For Incurable Prostate

Dr. R. K. Tuli, the global pioneer of Holistic
Medicine therapy expressed that in his clinical drug-free model of treatment experience the all inclusive has been highly efficient and reproduc- ible in all of the above Failed Prostate conditions. This fact is endorsed by his patients for each of the above men- tioned conditions with a message that the benefits of Holistic Medicine must be further explored and made available to all, especially when the conventional medical interventions have failed.

A. INCURABLE PROSTATIS

One of the greatest Indians and founder of world famous Hindustan Computers Limited (HCL), Padma Bhushan Awardee **Mr. Ajai Chowdhry** likes to share, "I was referred to Dr. Tuli by my neighbour as he had been cured of an incurable ailment. I had continued to suffer from Chronic Prostatitis & Orchitis for over10 years in spite of all possible and best of medical advice in the world; in addition I suffered from 'Uveitis'; Cervical & L-S Spondylosis with PA Shoulder and Osteoarthritis of Both T-M & Knee Joints; Bronchial Asthma & Sinusitis; Hypertension, Hyperlipedemia and CAD: DVD-PTCA over the last 20 years. I feel happy to an- nounce that I have been CURED at this "SOHAM" Clinic of all these problems concurrently over one year of spaced drug-free holistic medicare therapy. The cure has been so complete that I do not need any medicines, now. It's been a great experience to recover lost health and attain wellness. I strongly recommend to all those who are disappointed by their medications to come here, GET WELL, and Live Life all over again."

LEGACY OF HEALING JHALANI BROTHERS

B. PROSTATE HYPERTROPHY WITH NORMAL PSA Mr. Prakash C. Jhalani, in 80th year of his life has been an ardent practitioner of Vipassana Meditation for decades, and author of a book MEDITATE: He writes, "Observing dramatic improvement in the condition of my younger brother, I also decided to join Dr. Tuli's Centre for Holistic MediCare for my symptoms of BENIGN PROSTATE HYPER TROPHY, in spite of prescribed medical treatment. "In addition I, also, suffered from TREMORS in my both arms due to Parkinson's disease, Cervical & Lumbo-Sacral Spondylosis, and Uncontrolled Watering from Eyes, Hypertension, Chronic Bronchitis-DRY COUGH for over 20 years and DYSPEPSIA with poor state of health due to depletion of energy, etc. After undergoing spaced treatment at Dr. Tuli's Clinic without any medicines over the last six months, the symptoms due to Prostate are all gone, I feel more energetic and healthier, Dry Cough has been cured, Watering in the Eyes and Trembling of Hands has reduced substantially. Blood pressure is now under control without any medication." He likes to highlight, "The best part of treatment is the realization that existence of human beings is a composite one of spirit, mind and body, and not the body alone. Efforts are made during this treatment towards synchronization of the existence at all levels and to get and remain in touch with the omnipresent, omnipotent and omniscient universal consciousness or the higher power. The treatment done by Dr. Tuli is an exceptional service to the humanity. I hope and wish that many that qualified doctors will adopt the procedures done by Dr. Tuli in the service of suffering humanity."

C. PROSTATE HYPERTROPHY WITH RAISED PSA

Mr. Yogesh Jhalani states, "I arrived at Dr. Tuli's Clinic For Holistic HYPERTROPHY with doubtful Cancer due to raised PSA of 14.56 (Normal< 4.0); the Ultrasound revealed Rt. URTEROCELE. I had made up my mind to not to go to a hospital because of associated torment and limitations of medical care. In that situation Dr. Tuli's words were reassuring that his therapy should help me to overcome the problem comprehensively;

and at the same time even help to eliminate 8 years of medication for Hypertension. I like to share that I started improving in my health from day one, and realize as I look back 3-4 months, how it has helped me to eliminate all the symptoms of prostate enlargement, improve my all-round 'quality of life'. As a bonus my Blood Pressure, as forecast by Dr. Tuli, remains normal without any medication. I feel happy to share that I certainly feel10 years younger in my body and mind today, than the day I commenced this therapy!"

D. CONFIRMED PROSTATE CANCER:

Mr. Satish Bhatia, a 70 years old business entrepreneur from Delhi states, "My family was confused due to varying opinions on treatment of my ADENOCARCINOMA Grade II of my PROSTATE by the various leading specialist doctors. But, my son who lives in California, USA advised us to consult Dr. Ravi Tuli in New Delhi. After being fully convinced about his approach to drug-free, natural and harmless method of treatment, the family preferred to go for it. It turned out to be very interest- ing procedure whereby each successive session of therapy kindled a sense of well being and the symptoms starting regressing, gradually on to normalisa- tion of my gland to the extent that my Urologist declared me CANCER FREE and fully CURED! Successive follow-ups by doctors at the top NCR Delhi hospital over the last three years continue to endorse success of this therapy. I must add that Dr. Tuli's holistic medicine therapy has definitely made me feel much healthier and happier, and as an additional benefit, it has also helped me to improve my hypertension and coro- nary heart disease of over 25 years."

E. POST-SURGICAL INCONTINENCE OF BLADDER:

Dr. Pervez Ali Ahmed, a world renowned Cardiologist, son of a former President of India, and founder of Fakhruddin Ali Ahmed Medical College in Assam wishes to share, "I have known Ravi for five decades and have met him in various capacities. I'vve always heard of his exceptional work with Complementary Alternate Medicine. Now, I'vve experienced him at my personal level for my problem of 'Post-Operative Urinary Incontinence, following my surgery for Benign Prostate Hyperplasia'. The work he is doing is commendable. The results are outstanding, though anecdotal are obvious objectively. He has the knowledge, dedication and ability to harness the 'Universal Energy' and utilize it for wholesome benefits – that it helped me to overcome my other problems concurrently of 'Low Backache -Severe Coccydynia + Sciatica due to Prolapsed Inter-Vertebral Discs & L4 Radiculopathy; Arthralgia Lt Knee & Rt Ankle; Seasonal Bronchitis, and CAD-Post PTCA, etc. I promise him all the support in his mission to promote Holistic Medicare."

CONCLUSION: It's no wonder that Dr. Tuli is so passionate to share miracles of such wide spectrum of stories which prove the efficacy and versatility of Holistic Medicare. It reveals the potential to tremendously improve the way medicine is practiced today. The efficacy of modern medicine enhanced by CAM therapies brings out the best to offer to the humanity at large. After all, given an opportunity, nobody would like to suffer the process and misery of medical interventions which do not even assure a clean recovery.

At the same time Dr. Tuli, cautions that to establish its universal acceptability we need large scale multicentric scientific studies and develop evidence based protocols for the larger benefits of humanity that help in entire range of chronic and incurable medical conditions at a fraction of cost.

He stated that in the absence of medical profession extending benefits of CAM practices, a vast number of 'quacks' are exploiting their inherent goodness without scientific fervor and even mislead the society. Therefore, the medical profession must raise its level to complement the benefits of Holistic Medicine for "Health For All".

He appeals to his peers to open their minds and rise above to extend humane benefits of complementar alternate medicine (CAM) which has the infinite potential to enrich the 'science' of modern medicine with the 'art' of time honoured practices of traditional systems of health to restore the old glory of the profession.

PREDICTABILITY & REPRODUCIBILITY
ARE THE TWO INVINCIBLE MARKERS OF A SCIENTIFIC PHENOMENON

What is Holistic Medicine

Holistic Medicine is the wholesome approach to Health where each individual is treated as a whole ''Body, Mind & Spirit by an optimum synergy of the evidence based ''science'' of modern medicine with the highly complementary and reproducible time honoured ''art' of various harmonious drug-free modalities of officially recognised traditional systems of health to Eliminate All Sickness, promote Positive Health & Total Wellness to improve 'Quality-of-Life'.

Holistic Medicine = Modern Medicine + Alternate Medicine (CAM)(Alternate/CAM = Traditional Indian & Chinese + NewAge Medicine).

(The author is Professor: Indira Gandhi Technological And Medical Sciences University And Chief Consultant Holistic Medicine "SOHAM,"New Delhi)

Why worry about **Hepatitis B**

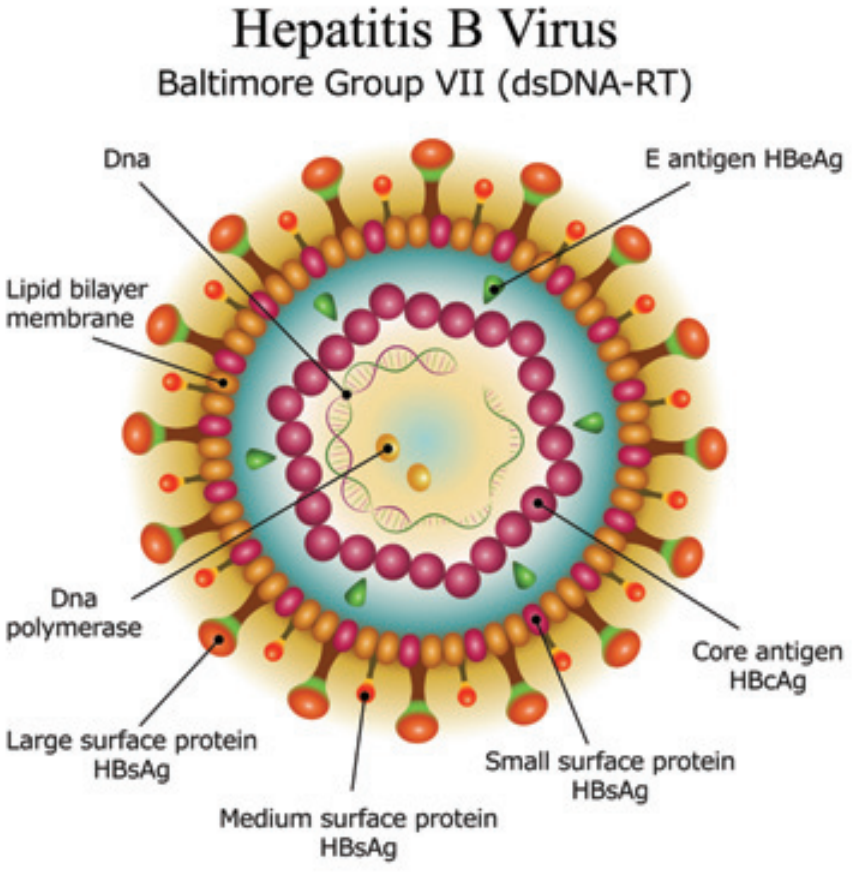
The high prices of new medicines are a major barrier to access to treatment in most countries. Treatment for chronic hepatitis B virus infection is life-long for most people. About 2.7 million people of the 36.7 million living with HIV are also infected with HBV. The global prevalence of HBV infection in HIV-infected persons is 7.4%.

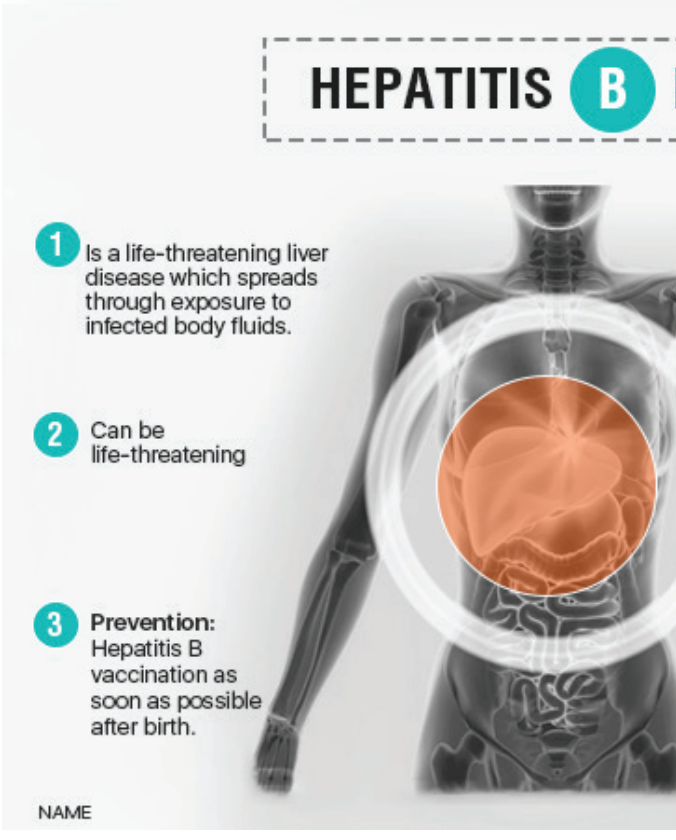
BY DR SUNEELA GARG / KAJOK ENGTIPI

Viral hepatitis is a systemic infection affecting predominantly the liver and causing its inflammation. It is caused by infection with one of the five known viruses, namely hepatitis A, B, C, D and E viruses. These viruses vary with respect to their structure, epidemiology, routes of transmission, clinical presentations and other features. Hepatitis B virus is spread by contact with blood or body fluids of an infected person. It is 50 to 100 times more infectious than HIV.

DISEASE BURDEN

An estimated 257 million people are living with hepatitis B virus infection. In Asia, especially Southeast Asian countries, 8-15% of





the carriers of this disease develop chronic liver diseases, including chronic hepatitis, cirrhosis and hepato- cellular carcinoma.

Hepatitis B is highly endemic in developing regions with large population such as South East Asia, China, sub-Saharan Africa and the Amazon Basin, where at least 8% of the population are HBV chronic carriers. In these areas, 70–95% of the population shows past or present evidence of HBV infection. Most infections occur during infancy or childhood.

WHAT IS HEPATITIS B VIRUS AND HOW DOES IT SPREAD?

HBV is a DNa virus which belongs to the the family Hepadnaviridae. HBV contains numerous antigenic components, including HBsAg, HBcAg, and hepatitis B e antigen (HBeAg). A person is said to be a chronic case of HBV infection if he/she has been HbsAg positive for more than six months.

One of the main causes of the transmission of Hepatitis B in India occurs due to transmission of the virus from the infected mother to the baby, during or soon after delivery, through direct contact of the infant with infectious mother's blood and other body fluids. Transmission of HBV from mother to child stays a serious public health problem.

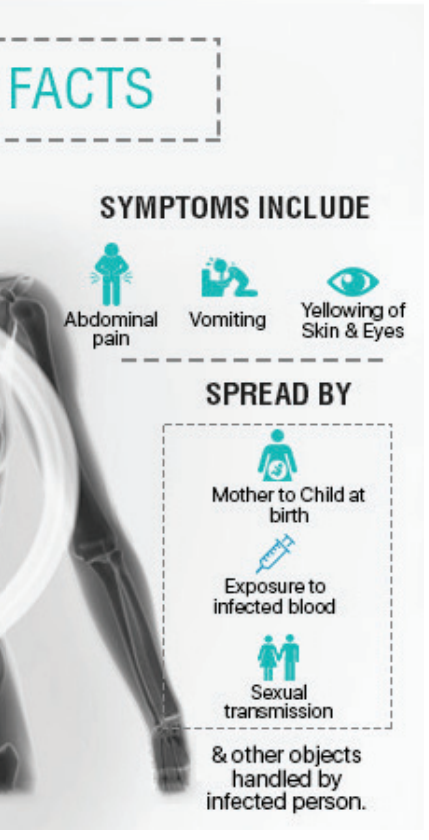
People who have a higher risk of getting exposed to hepatitis B virus infection and who require improved testing and treatment services are health care providers, persons who inject drugs, prisoners, migrants who have limited access to health care etc. Indigenous populations and minorities in many parts of the world have a high prevalence of HBV infection, including people of the Indian Ocean (in the Andaman and Nicobar Islands of India.

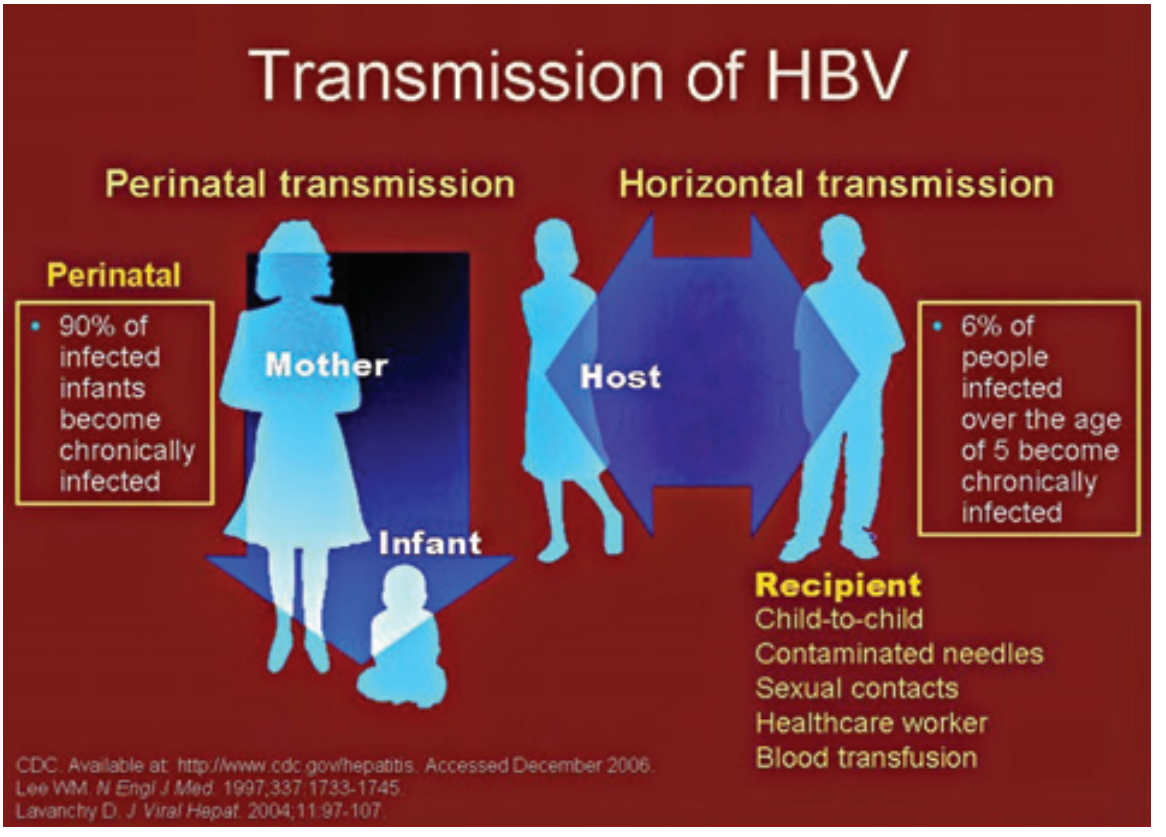
HEPATITIS B VACCINATION

In 2015, global coverage with the three doses of hepatitis B vaccine in infancy reached 84%. This has substantially reduced HBV transmission in the first five years of life, as reflected by the reduction in HBV prevalence among children to 1.3%. However, coverage with the initial birth dose vaccination is still low at 39%.

Hepatitis B vaccination decreases HBV infection and ultimately reduces the incidence of chronic liver disease or liver cancer. It was reported that incidence of hepatocellular carcinoma in children decreased by more than 50% after universal infant and childhood vaccination.

The key strategy for control of the HBV epidemic is vaccination at birth and infant vaccination. Additional measures include use of hepatitis B immunoglobulin (HBIG) and diagnosis of mothers at high risk of transmitting HBV and use of antiviral agents during





pregnancy to decrease the viral concentrations in the mother. Despite the substantial decrease in HBV cases since introduction of vaccination, implementation of birth dose vaccination in low-income and middle-income countries and vaccination of high-risk adults remains a moajor challenge.

TREATMENT

In 2015, WHO formulated a recommendation to include drugs such as tenofovir and entecavir for treatment of HBV infection. These drugs are nucleos(t)ide analogues and have a high barrier to resistance. They are easier to administer (one pill a day), more effective, have less side effects and induce less resistance. However, they seldom result in cure. Therefore, at present, long-term (potentially lifelong) therapy is required for the majority of patients.

A MAJOR PUBLIC HEALTH PROBLEM

Medical injections still account for an estimated 1.7 million new hepatitis B virus infections annually. Simple and effective hepatitis testing strategies and tools are unavailable in all settings, with less than 5% of people with chronic hepatitis infection knowing their status. Of those people with chronic viral hepatitis infection, it is estimated that less than 1% have access to effective antiviral therapy. The high prices of new medicines are a major barrier to access to treatment in most countries. Treatment for chronic hepatitis B virus infection is life-long for most people. About 2.7 million people of the 36.7 million living with HIV are also infected with HBV. The global prevalence of HBV infection in HIV-infected persons is 7.4%.

In May 2016, the World Health Assembly endorsed the Global Health Sector Strategy (GHSS) on viral hepatitis 2016–2021. The GHSS calls for the elimination of viral hepatitis as a public health threat by 2030 (reducing new infections by 90% and mortality by 65%).

CONCLUSION

In order to achieve elimination of viral hepatitis we need to overcome the various barriers and challenges discussed above. Improving hepatitis B vaccine coverage in children as well as in unimmunized adults at risk of infection remains one of the most crucial measures to fight the battle against hepatitis B infection. Also access to affordable treatment and diagnostic services and reduction in stigma and discrimination against hepatitis B patients through peer educators will help us in overcoming hepatitis B infection as a public health problem.

(The authors are Director Professor and Head/ Senior Resident, Department of Community Medicine, Maulana Azad Medical College, New Delhi)

Meets new National President, IMA: A perfect example of a modern times 'Polymath

Dr Ravi Wankhedkar recently took over the charge of new National President, New Delhi. After taking up charge he said, "In next six weeks doctors across the country should be united. We plan to sensitise all Member of Parliaments and citizen of India on why NMC Bill needs to be opposed. The IMA also plans to go on country wide strike if the government does not agree to its demand."

Dr Ravi Wankhedkar, MMBS, MS (Surgery) from 1980 batch of BJ Medical College, Pune, University of Poona is practicing surgeon and coloproctologist at Sitaram Hospital in Dhule. He is also Associate Prof of Surgery, SBH Govt Medical College, Duhule, and Chairman, Rural Health Committee.

Born on 21st, September, 1963 to Smt. Bhagirathibai Wankhedkar (A school teacher and headmistress) and Late Shri Sitaram Wankhedkar (A freedom fighter), Dr. Ravi Wankhedkar is a perfect example of a modern times 'Polymath '- a terminology coined to address persons, whose expertise or knowledge spans varied subjects. He completed his schooling from Canossa Convent, Dhule. Later on, he completed MBBS and MS (General Surgery) from the renowned BJ Medical College, Pune.

Before getting admission to BJ Medical College itself, Ravi had decided that his area of work will be his home town Dhule, as he had seen the poverty and related health problems. So, after becoming a General Surgeon, he joined the Shri Bhausaheb Hire Govt Medical College. As a lecturer in surgery, he was extremely popular amongst medical students and staff of Shri Bhausaheb Hire Medical College, Dhule, so much so that he was bestowed 'Teacher of the Decade Award' in 1999. Till date he continues his passion for teaching as Hon Professor in Surgery at the Govt Medical College.

Since 2003 onwards, he started taking pro active initiatives in the working of IMA Dhule. IMA Dhule Hall got renovated because of his extraordinary efforts. In 2010, the EVECON-State IMA Women conference was conceived and organized successfully under his leadership. And since then, many state level and national level programs like WEZ AMSCON HOSPEX, Unmesh, Yomedicon (Young Medico's convention), WIMALS- Women IMA Leaders Summit, SHABDANGAN- a Medicos' Literary Festival were organized under his leadership. As a result of his relentless efforts towards making IMA stronger, Ravi was chosen unopposed as the Presidential Candidate for IMA for the year 2017-18.

Apart from his Professional and Organizational activities, he finds solace in Nature. He has transformed a piece of barren land into a lush green, colourful farm 'Ravi Shrushti', which has become a destination for informal meetings and gatherings. Shared his experiences on different platform he is involved in many social activities apart from medical practise. He runs 'Sitaram Hospital' very successfully at Dhule, upgrading it with modern equipments and technology as required, the latest being "DYBSS "- a centre for laser anorectal.

Dr Ravi Wankhedkar witnessed the NATCON 2017 Conference in Mumbai recently where he saw the participation of 1,100 delegates from all over the world. The major issued discussed in the conference were Pre-Conception and Pre-Natal Diagnostic Techniques (PCPNDT) Act, violence against the doctors, capping of compensation and generic drugs. One of the key points discussed at the two day conclave has been about the action plan for the coming days where the IMA will be agitating and negotiating for National Medical Commission (NMC) Bill.

New President, IMA Noida

Dr Arvind Garg is one of the best Pediatric Neonatalogist is new President, IMA, Noida. Over 35 years of experience he ia also associated with Apollo Hospitals Noida.

After taking over as a new President, Indian Medical Association (IMA), Noida, he said, "I always believe in patient's first policy. The government should treat us as equal partners in a respectable manner to make people friendly policies. I am sure that after taking up new responsibility, there is more to look forward to both doctors and patients friendly environment."

He further emphasized that the doctors must be united in this tough time when the government is rigid over implementation of New Medical Commission Bill, 2017.

According to Dr Garg, IMA, Noida includes both Noida and Greater Noida region which have lot of potential to explore any body's expertise to do something unique in medical fraternity. The twin cities have very sound infrastructures and fast connectivity to its neighbouring areas like Ghaziabad, Faridabad and capital city Delhi. Number of top notched premier healthcare institutions and hospitals already cater their services here. So serve the healthcare services in an association with Noida IMA will be something amazing for any young and already established doctors.

Today, certain aspects of medical education are particularly dependent upon teaching by microscope using glass slides. As medical education moves into the 21st century, new tools and methodologies have evolved into an innovative learning technique referred to as Virtual Microscopy (VM) and the image produced called Virtual Image. Virtual images are being used worldwide for e-teaching and e-learning of morphological sciences like histology and pathology. It is not a replacement of regular teaching methods; instead it is a great addition for quality enhancement of education. Its value lies in the ways it is utilized within the context of a well-designed, well-integrated and well-delivered medical curriculum. Though it is customary to introduce students to microscopes and glass slides at the beginning of medical and dental education, virtual slide laboratory will provide a better way of learning histology and pathology.

He said, "As a President, IMA, Noida, I have already requested to our office bearers to update their contact information with National and State IMA. They are also requested to send the monthly activities photos and brief information by email to state office, so that they can be published in Journal of both National and State IMA. Regards

Dr. Arvind Garg also runs a Pediatrics clinic in Sector 19, Noida. The services like Vaccination/ Immunization are already being provided by the clinic. According to him, the department of Pediatrics revolves around care, well being and treatment of infants, juveniles, and adolescents. We provide specialized and subspecialty care even for the most complicated cases.

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