



राष्ट्रीय आयुर्विज्ञान आयोग
National Medical Commission

NMC Compendium 2024
-Administration-



Volume 2

Publication Division, National Medical Commission
Pocket- 14 , Sector - 8, Dwarka Phase -1, New Delhi - 110077, INDIA

Volume 02:

Administration

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राष्ट्रीयआयुर्विज्ञानआयोग
National Medical Commission
(Establishment Section)

सेक्टर-8, द्वारका, नईदिल्ली- 110077
Sector- 8, Dwarka, New Delhi-110077
दूरभाष/ Phone : 5367033/35/36/37/41
5366650, 1800111154
ई-मेल/ E-mail : admin@nmc.org.in
वेबसाइट/ Website : www.nmc.org.in

F.No.D-13011/01/2023/NMC/GA(Computer No.8255519) Dated the January 2023

PUBLIC NOTICE

It has come to our attention that an individual with the mobile number **+919062719187** is impersonating as Dr. B. N. Gangadhar, Chairman of the National Medical Commission (NMC).

2. It is to be informed that this mobile number does not belong to Dr. B. N. Gangadhar, Chairman, NMC.
3. The public is advised not to engage in any conversation with the person using the mobile number **+919062719187**, claiming to be Dr. B. N. Gangadhar. Any individual taking cognizance or acting on such conversations does so at their own risk.
4. This notice is issued to safeguard the public from any misinformation and to prevent any unauthorized activities carried out by the impersonator.

By and with the order of Chairman, NMC

N-16021/24/2023-IT-NMC (8250552)
Government of India
National Medical Commission
(IT Section)

Sector-8, Dwarka
New Delhi-110075

Dated the 18th January, 2024

ADVISORY

Reference to this Commission's correspondences:

- i. No. D-130024/07/2022/NMC/DMMP/028293 dated 1.8.2022.
- ii. No. D-130024/07(01)/2022/NMC/DMMP dated 12.8.2022.
- iii. No. D-130024/07(02)/2022/NMC/DMMP dated 20.8.2022.
- iv. No. D-130024/07(03)/2022/NMC/DMMP dated 27.8.2022.
- v. No. D-130024/07/2022/NMC/DMMP dated 04.10.2022.
- vi. No. D-130024/07/2021/NMC/DMMP dated 18.10.2022.
- vii. No. D-130024/07/2022/NMC/DMMP-02558 dated 25.01.2023.
- viii. No. D-130024/07/2022/NMC/DMMP-002659 dated 30.01.2023.
- ix. N. D-130024/07/2022/NMC/DMMP/828293 dated 10.05.2023.

Subject: Clarifications/ directions regarding implementation of Adhaar Enabled Biometric Attendance System (AEBAS) in all government and private medical colleges.

In continuation to the above referred letters/ circulars/ advisories etc, issued regarding implementation of Adhaar Enabled Biometric Attendance System (AEBAS) in all government and private medical colleges, the following clarifications/ directions are issued hereby for information and compliance:

i. **AEBAS MACHINE-**

It is reiterated that NMC has not mandated the purchase of attendance machines from any specific vendor. The responsibility for procuring AEBAS compliant machines lies with the respective medical colleges, allowing them to choose a reliable vendor independently. The colleges must ensure the purchase of an adequate number of machines to guarantee the daily attendance of all users. NMC will not entertain any communication regarding maintenance issues related to biometric attendance machines. Additionally, colleges are required to ensure proper internet connectivity maintenance.

ii. FACE AEBAS-

As communicated earlier also all users, including those who are facing issues with fingerprint recognition, can utilize the face-based Biometric Attendance System (BAS). To facilitate whitelisting, NMC has introduced a portal accessible at **it.nmc.org.in**. All colleges are urged to submit whitelisting requests through this portal. If any earlier requests are pending whitelisting, please resubmit them through the portal. Please note that alternative forms of communication regarding this matter will not be considered.

iii. AEBAS ID transfer -

NMC has received requests/complaints regarding users facing difficulties in transferring their AEBAS IDs during job transfers. Therefore, all medical colleges are directed to promptly transfer the AEBAS ID of a user upon their resignation or transfer from one organization to another. If the destination is unknown, the AEBAS ID should be transferred to the "Free Pool" instead of being blocked.

Those users finding difficulty in getting AEBAS ID transferred /blocked AEBAS ID active from nodal officer such users can approach NMC by sending request on the portal **it.nmc.org.in** through AEBAS attendance ID transfer form. Earlier requests may also be sent once again.

iv. Error Code

Furthermore, colleges are informed that a comprehensive list of error codes and their resolutions is already available on central.nmcindia.ac.in in the FAQ section. Additionally, the detailed information has been re-uploaded on **it.nmc.org.in**.

v. Shift Option-

Nodal officers in medical colleges can activate the shift option for AEBAS directly on the portal. Therefore, they are encouraged to utilize this feature for enhanced monitoring of attendance for faculty/staff working on a shift basis.

2. This issues with the concurrence of competent authority.

Pankaj Agrawal

Director IT



F.No.20011/16/2024/Coordination.NMC
Government of India
National Medical Commission
Policy & Coordination Division



वसुधैव कुटुम्बकम्
ONE EARTH • ONE FAMILY • ONE

Pocket- 14, Sector- 8,
Dwarka, Phase-1, New Delhi-77
19-01-2024

CIRCULAR

Sub: Arrangements for viewing "Pariksha Pe Charcha 2024" - Hon'ble Prime Minister's interaction with students, teachers and parents on 29.01.2024-reg

All Medical Colleges are informed that Hon'ble Prime Minister will be interacting with students, teachers and parents for another edition of "Pariksha Pe Charcha 2024" at Bharat Mandapam, Pragati Maidan, New Delhi on 29th January, 2024. About 1200 students will be participating in the programme and the same will be broadcast live by Doordarshan through DD National, DD News and DD India. The programme will also be available through live airing on radio channels & Live Web streaming on websites of PMO, MOE, Doordarshan, MyGov.in and YouTube, Facebook and Swayamprabha channels of Ministry of Education.

2. All Medical Colleges are requested to give wide publicity for the programme and make necessary arrangements for viewing the programme by their students. The Exact timing of the programme will be available through TV channels, News Papers, web-site of PMO and Ministry of Education, etc.

3. A copy of letter dated 17th January received from Ministry of Education in the matter is enclosed.

4. This issues with the approval of the Secretary, NMC.

Signed by

Srinidhi Kari

K SRINIDHI
UNDER SECRETARY
ksrinidhi.kari@gov.in

Date: 19-01-2024 17:55:41

Deans/Principals
All Medical Colleges

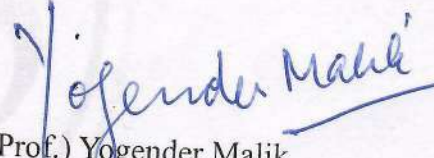


राष्ट्रीय आयुर्विज्ञान आयोग
National Medical Commission
ETHICS & MEDICAL REGISTRATION BOARD

New Delhi, 29th January, 2024

Addendum to Public Notice dated 23.01.2024 regarding the issue of live surgeries broadcast by private hospitals

All stakeholders and members of the public are hereby informed to provide comments on the issue of live surgery broadcast by private hospitals to Ethics and Medical Registration Board through an E-mail at ethics@nmc.org.in, within 10 days of the publication of this notice.


Dr. (Prof.) Yogender Malik
Member (EMRB)

File No.: M-19011/01/2024-MARB/NMC (e-ID8257886)

राष्ट्रीय आयुर्विज्ञान आयोग
National Medical Commission
Medical Assessment & Rating Board (MARB)

पॉकेट-14, सेक्टर-8, द्वारका, फेस- 1, नईदिल्ली-77
Pocket- 14, Sector- 8, Dwarka,
Phase – 1, New Delhi-77

Dated : 1st February, 2024

PUBLIC NOTICE

Subject: Return of Expired Bank Guarantees- Request therefor-Regarding.

It has been observed that a large number of expired Bank Guarantees(BGs), submitted by the various medical Colleges/Institutions in connection with the UG/PG medical courses, are lying in the National Medical Commission. It has,therefore, been decided to return those BGs on a formal request of the Colleges/Institutions subject to the fulfilling of the following conditions:

- (i) The validity period of Bank Guarantee has expired ,which is three-years for PG Courses and five-years for UG Courses;
- (ii) At least one Batch of PG students has passed out after completing the course; and
- (iii) At least one Batch of UG students has passed out after completing the course.

2. All medical Colleges/Institutions concerned are accordingly informed to make a formal request for return of expired BGs immediately on the authorised e-mails of MARB, NMC available on the following links :

[https://www.nmc.org.in/MCIRest/open/getDocument?
path=/Documents/Public/Portal/LatestNews/17-1.pdf](https://www.nmc.org.in/MCIRest/open/getDocument?path=/Documents/Public/Portal/LatestNews/17-1.pdf)

3. This issue with the approval of the Competent Authority,NMC.

Signed by Jitlal
Ramprasad Meena
Date: 01-02-2024 10:37:56

(J.L.Meena)
Member (MARB)
National Medical Commission

To

The Dean/Principal of Medical College/Institution concerned.

N-16014(18)/2/2024-IT-NMC (8263771)
Government of India
National Medical Commission
(IT Section)

Sector-8, Dwarka
New Delhi-110075

Dated the 2nd February, 2024

ADVISORY

Sub: - Installation of CCTV and connecting cameras feeds to NMC.

This Commission in receipt of issues/ queries raised by medical colleges and institutions in reference to the previous correspondences regarding CCTV installation & monitoring by NMC. In this direction, the following points may be noted for clarification and compliance:

- i. NMC will not store any camera feed, hence all the medical colleges must have NVR (Network Video Recorder) with a camera feed storage capacity of at least thirty (30) days.
- ii. All the medical colleges will share login credentials of such NVR on support.cctv@nmc.org.in. NMC must be given access to playback of any recording of last 30 days and downloading the same. Under no circumstances, such privilege given to the NMC would be withdrawn.
- iii. Based on the service availability, performance and reliability, colleges must have a dedicated MPLS/ILL connection of at least 100 MBPS speed.
- iv. All colleges can purchase, by following their own procurement rules, any make & model of camera in adherence to the directive of at least 2k cameras at all places except in lecture hall where 4K cameras need to be installed.
- v. Medical colleges need to configure all cameras with their own IP pool; NMC will not provide any IP pool henceforth.
- vi. Medical colleges can install any number of additional cameras in such a way that the objective of proper monitoring of the functioning of colleges can be achieved.
- vii. Colleges can purchase any make/model of router/switches depending on the suggestion of their internet service provider.
- viii. If colleges are having multiple NVR, then login credentials of all such NVR have to be shared with NMC.
- ix. NMC will not be responsible for maintenance related issues of CCTV, Router, Switches, or any other associated infrastructure.
- x. Medical colleges are advised that the nomenclature of camera should clearly indicate the location of cameras.

2. In case of any other technical queries apart from those addressed above, please reach out on the e-mail ID: support.cctv@nmc.org.in.

(Pankaj Agrawal)
Director

File No. M-19011/01/2024-MARB/NMC (e-ID8257886)

राष्ट्रीय आयुर्विज्ञान आयोग

National Medical Commission

Medical Assessment & Rating Board (MARB)

पॉकेट-14, सेक्टर-8, द्वारका, फेस- 1, नई दिल्ली-77

Pocket- 14, Sector- 8, Dwarka,

Phase – 1, New Delhi-77

Date:- 7th February 2024

PUBLIC NOTICE

In continuation of MARB's Public Notice of even number dated 01.02.2024 regarding returning of expired Bank Guarantees (BGs) to the concerned Medical College/Institutions wherein it was ,inter-alia, conveyed to the Medical Colleges/Institutions concerned to apply for return of expired Bank Guarantees so that they can approach the banks to revoke the BGs. Now, in order to speed up the matter of revoking the BGs, it has been decided that the Medical Colleges/Institutions whose name figure in the attached list may approach the Bank for getting their BGs revoked.

2. Accordingly, a list of expired BGs available with National Medical Commission (NMC) is attached with this public notice. The Banks concerned are requested to revoke the expired BGs mentioned in the attached list immediately to concerned Medical Colleges/Institutions under intimation to the MARB, NMC.

3. If any medical College/Institution/Bank face any issue in the matter, they may get it clarified by sending their requests on the authorised e-mails of MARB available at the following URL of the website of this Commission:
- <https://www.nmc.org.in/MCIRest/open/getDocument?path=/Documents/Public/Portal/LatestNews/17-1.pdf>

4. Before revoking the BGs, Bank concerned may cross check the list attached with this public notice available on the website of NMC.

5. This issue with the approval of the Competent Authority of this Commission.

Signed by Jitlal

Ramprasad Meena

Date: 07-02-2024 15:28:42

(J. L. Meena)

Member (MARB)

List of College with Expired Bank Guarantee					
Sr. No.	College/ Instt. Name	BG. No./ Date	Amount	Expiry date	Claim date/Remarks
1	Academy of Libral Education, Sullia	09714BG000002 21-05-2009	75 Lakh	24/02/2023	
2	Academy of Libral Education, Sullia	09714BG000003 21-05-2009	75 Lakh	24/02/2023	
3	Academy of Libral Education, Sullia	09714BG000005 21-05-2009	75 Lakh	24/02/2023	
4	Academy of Libral Education, Sullia	17714BG000002 27-02-2017	85 LAKH	26/02/2023	
5	Academy of Libral Education, Sullia	17714BG000003 27-02-2017	5 LAKH	26/02/2023	
6	Academy of Libral Education, Sullia	09714BG000002 21-05-2009	10 LAKH	13/03/2023	
7	ANIL NEERUKONDA EDUCATION SOCIETY	OGT0004190039408 27-12-2019	85 LAKH	30/06/2022	30/06/2023
8	ANIL NEERUKONDA EDUCATION SOCIETY	OGT0004190039403 27-12-2019	85 LAKH	30/06/2022	30/06/2023
9	ANIL NEERUKONDA EDUCATION SOCIETY	OGT0004190039404 27-12-2017	85 LAKH	30/06/2022	30/06/2023
10	SRI AUROBINDO INSTT. OF MEDICAL SCI., INDORE	036GT02192280002 16-08-2019	25 LAKH	13/08/2023	
11	SRI AUROBINDO INSTT. OF MEDICAL SCI., INDORE	036GT02192280012 16-08-2019	35 LAKH	13/08/2023	
12	SRI AUROBINDO INSTT. OF MEDICAL SCI., INDORE	036GT02192280006 16-08-2019	10 LAKH	13/08/2023	
13	SRI AUROBINDO INSTT. OF MEDICAL SCI., INDORE	036GT02192280007 16-08-2019	40 LAKH	13/08/2023	
14	SRI AUROBINDO INSTT. OF MEDICAL SCI., INDORE	036GT02192280009 16-08-2019	5 LAKH	13/08/2023	
15	SRI AUROBINDO INSTT. OF MEDICAL SCI., INDORE	036GT02192280011 16-08-2019	30 LAKH	13/08/2023	
16	SRI AUROBINDO INSTT. OF MEDICAL SCI., INDORE	036GT02192280013 16-08-2019	10 LAKH	13/08/2023	
17	SRI AUROBINDO INSTT. OF MEDICAL SCI., INDORE	036GT02192280005 16-08-2019	20 LAKH	13/08/2023	
18	SRI AUROBINDO INSTT. OF MEDICAL SCI., INDORE	036GT02192280003 16-08-2019	35 LAKH	13/08/2023	

List of College with Expired Bank Guarantee					
Sr. No.	College/ Instt. Name	BG. No./ Date	Amount	Expiry date	Claim date/Remarks
19	SRI AUROBINDO INSTT. OF MEDICAL SCI., INDORE	036GT02192280010 16-08-2019	30 LAKH	13/08/2023	
20	SRI AUROBINDO INSTT. OF MEDICAL SCI., INDORE	036GT02192280008 16-08-2019	25 LAKH	13/08/2023	
21	APOLLO HOSPITAL EDUCATIONAL AND RESEARCH, CHENNAI	OGT0007190036182 21-09-2019	85 LAKH	31/03/2023	
22	APOLLO HOSPITAL EDUCATIONAL AND RESEARCH, CHENNAI	OGT0007190036186 21-09-2019	85 LAKH	31/03/2023	
23	APOLLO HOSPITAL EDUCATIONAL AND RESEARCH, CHENNAI	OGT0007190036185 21-09-2019	85 LAKH	31/03/2023	
24	APOLLO HOSPITAL EDUCATIONAL AND RESEARCH, CHENNAI	OGT0007190036178 21-09-2019	85 LAKH	31/03/2023	
25	APOLLO HOSPITAL EDUCATIONAL AND RESEARCH, CHENNAI	OGT0007190035552 04-09-2019	85 LAKH	31/03/2023	
26	APOLLO HOSPITAL EDUCATIONAL AND RESEARCH, CHENNAI	OGT0007190035554 04-09-2019	85 LAKH	31/03/2023	
27	AL-AMEEN MEDICAL COLLEGE CAMPUS, VIJAYAPURA	SLBBGFN200915013 28-01-2020	25 LAKH	28/01/2023	
28	AL-AMEEN MEDICAL COLLEGE CAMPUS, VIJAYAPURA	SLBBGFN200915002 28-01-2020	30 LAKH	28/01/2023	
29	AL-AMEEN MEDICAL COLLEGE CAMPUS, VIJAYAPURA	SLBBGFN200915012 22-01-2020	25 LAKH	20/01/2023	
30	ASHWINI RURAL MEDICAL COLLEGE HOSPITAL AND RESEARCH CENTRE, SOLAPUR (M M PATEL PUBLIC HERITABLE TRUST)	PRO084BG2911819 24-01-2019	85 LAKH	23/01/2022	
31	ASHWINI RURAL MEDICAL COLLEGE HOSPITAL AND RESEARCH CENTRE, SOLAPUR (M M PATEL PUBLIC HERITABLE TRUST)	PRO084BG2921819 24-01-2019	85 LAKH	23/01/2022	
32	ASHWINI RURAL MEDICAL COLLEGE HOSPITAL AND RESEARCH CENTRE, SOLAPUR (M M PATEL PUBLIC HERITABLE TRUST)	PRO084BG2931819 24-01-2019	85 LAKH	23/01/2022	
33	ASHWINI RURAL MEDICAL COLLEGE HOSPITAL AND RESEARCH CENTRE, SOLAPUR (M M PATEL PUBLIC HERITABLE TRUST)	PRO084BG2941819 24-01-2019	85 LAKH	23/01/2022	
34	ASHWINI RURAL MEDICAL COLLEGE HOSPITAL AND RESEARCH CENTRE, SOLAPUR (M M PATEL PUBLIC HERITABLE TRUST)	PRO084BG2951819 24-01-2019	85 LAKH	23/01/2022	

List of College with Expired Bank Guarantee					
Sr. No.	College/ Instt. Name	BG. No./ Date	Amount	Expiry date	Claim date/Remarks
35	ASHWINI RURAL MEDICAL COLLEGE HOSPITAL AND RESEARCH CENTRE, SOLAPUR (M M PATEL PUBLIC HERITABLE TRUST)	PRO084BG2961819 24-01-2019	85 LAKH	23/01/2022	
36	ASHWINI RURAL MEDICAL COLLEGE HOSPITAL AND RESEARCH CENTRE, SOLAPUR (M M PATEL PUBLIC HERITABLE TRUST)	PRO084BG2971819 24-01-2019	85 LAKH	23/01/2022	
37	ASHWINI RURAL MEDICAL COLLEGE HOSPITAL AND RESEARCH CENTRE, SOLAPUR (M M PATEL PUBLIC HERITABLE TRUST)	PRO084BG2981819 24-01-2019	85 LAKH	23/01/2022	
38	ASHWINI RURAL MEDICAL COLLEGE HOSPITAL AND RESEARCH CENTRE, SOLAPUR (M M PATEL PUBLIC HERITABLE TRUST)	OBRO30BG0531920 11-09-2019	85 LAKH	10/09/2022	
39	ASHWINI RURAL MEDICAL COLLEGE HOSPITAL AND RESEARCH CENTRE, SOLAPUR (M M PATEL PUBLIC HERITABLE TRUST)	OBRO30BG0521920 11-09-2019	85 LAKH	10/09/2022	BG NUMBERS OF BOTH THE COURSES ARE SAME AS MENTIONED IN THE LETTER
40	ASHWINI RURAL MEDICAL COLLEGE HOSPITAL AND RESEARCH CENTRE, SOLAPUR (M M PATEL PUBLIC HERITABLE TRUST)	OBRO30BG0521920 22-10-2019	85 LAKH	21/10/2022	
41	AMALA CENCER HOSPITAL SOCIETY, THRISSUR	0462BG000012019 11-06-2019	128 LAKH	10/06/2022	
42	AMALA CENCER HOSPITAL SOCIETY, THRISSUR	0462BG000022019 20-08-2019	10 LAKH	19/08/2022	
43	AMALA CENCER HOSPITAL SOCIETY, THRISSUR	0462BG000032019 20-08-2019	85 LAKH	19/08/2022	
44	AYAAN EDUCATIONAL SOCIETY HYDERABAD	T91GPGE180750003 16-03-2018	75 Lakh	15/03/2023	
45	AYAAN EDUCATIONAL SOCIETY HYDERABAD	T91GPGE180750005 16-03-2018	20 LAKH	15/03/2023	
46	AMMA CHANDRAVATI EDUCATIONAL AND HERITABLE	01790015316 15-04-2023		21/08/2021	THERE ARE DISCRIPENCY IN DATES, AND AMOUNT IS ALSO NOT MENTIONED
47	AMMA CHANDRAVATI EDUCATIONAL AND HERITABLE	01790015416 15-04-2023		21/08/2021	
48	BELEIVERS CHURCH MEDICAL COLLEGE AND HOSPITAL, KUTTAPUZHA, THIRUVALLA	38930IGL0000121 04-08-2021	550 LAKH	03/08/2022	03/08/2023
49	BELEIVERS CHURCH MEDICAL COLLEGE AND HOSPITAL, KUTTAPUZHA, THIRUVALLA	38930IGL0000221 04-08-2021	150 LAKH	03/08/2022	03/08/2023

List of College with Expired Bank Guarantee					
Sr. No.	College/ Instt. Name	BG. No./ Date	Amount	Expiry date	Claim date/Remarks
50	BHASKAR MEDICAL COLLEGE HYDERABAD	S2VBBDP192730002 04-09-2019	25 LAKH	03/09/2023	A99BGDP192730002 (TWO BG NUMBER ARE MENTIONED IN THE LETTER)
51	CHARUTAR AROGYA MANDAL, KARAMSAD	50990000120		22/04/2023	
52	ST. JOHNS MEDICAL COLLEGE BENGALORE (CBCI SOCIETY FOR MEDICAL EDUCATION)	0416BG000052019 08-2019	10 LAKH	07/08/2022	07/08/2023
53	ST. JOHNS MEDICAL COLLEGE BENGALORE (CBCI SOCIETY FOR MEDICAL EDUCATION)	0416BG000062019 08-2019	5 LAKH	07/08/2022	07/08/2023
54	ST. JOHNS MEDICAL COLLEGE BENGALORE (CBCI SOCIETY FOR MEDICAL EDUCATION)	0416BG000072019 08-2019	30 LAKH	07/08/2022	07/08/2023
55	ST. JOHNS MEDICAL COLLEGE BENGALORE (CBCI SOCIETY FOR MEDICAL EDUCATION)	0416BG000082019 10-2019	10 LAKH	18/10/2022	18/10/2023
56	ST. JOHNS MEDICAL COLLEGE BENGALORE (CBCI SOCIETY FOR MEDICAL EDUCATION)	0416BG000092019 11-2019	10 LAKH	03/11/2022	03/11/2023
57	ST. JOHNS MEDICAL COLLEGE BENGALORE (CBCI SOCIETY FOR MEDICAL EDUCATION)	0416BG000102019 11-2019	25 LAKH	13/11/2022	13/11/2023
58	CMC, VELLORE	0161818BG0000009 03-2018	10 LAKH	01/03/2021	
59	CMC, VELLORE	0161816BG0000019 08-2016	20 LAKH	23/08/2021	
60	CMC, VELLORE	0161816BG0000017 08-2016	40 LAKH	23/08/2021	
61	CMC, VELLORE	0161816BG0000018 08-2016	40 LAKH	23/08/2021	
62	CMC, VELLORE	0161819BG0000002 03-2019	20 LAKH	24/03/2022	
63	CMC, VELLORE	0161819BG0000006 05-2019	128 LAKH	13/05/2022	
64	CMC, VELLORE	0161819BG0000007 05-2019	30 LAKH	13/05/2022	
65	CMC, VELLORE	0161819BG0000004 05-2019	128 LAKH	13/05/2022	
66	CMC, VELLORE	0161819BG0000005 05-2019	128 LAKH	13/05/2022	
67	CMC, VELLORE	0161819BG0000008 08-2019	70 LAKH	25/08/2022	

List of College with Expired Bank Guarantee					
Sr. No.	College/ Instt. Name	BG. No./ Date	Amount	Expiry date	Claim date/Remarks
68	CMC, VELLORE	0161819BG0000015 24-09-2019	5 LAKH	23/09/2022	
69	CMC, VELLORE	0161817BG0000003 21-02-2017	10 LAKH	21/02/2023	
70	CMC, VELLORE	0161817BG0000001 25-01-2017	25 LAKH	24/04/2023	
71	CMC, VELLORE	0161817BG0000004 21-02-2017	10 LAKH	21/02/2023	
72	CMC, VELLORE	0161817BG0000002 21-02-2017	85 LAKH	21/02/2023	
73	CMC, VELLORE	0161822BG0000002 17-03-2022	10 LAKH	16/03/2025	
74	CMC, VELLORE	0161819BG0000003 26-03-2019	128 LAKH	24/03/2022	
75	CMC, VELLORE	0161819BG0000009 26-03-2019	85 LAKH	25/08/2022	
76	CMC, VELLORE	0161819BG0000010 26-03-2019	20 LAKH	25/08/2022	
77	CMC, VELLORE	0161819BG0000012 05-09-2019	5 LAKH	04/09/2022	
78	CMC, VELLORE	0161820BG0000009 11-02-2020	40 LAKH	10/02/2023	
79	CMC, VELLORE	0161820BG0000011 11-02-2020	40 LAKH	10/02/2023	
80	CMC, VELLORE	0161820BG0000013 11-02-2020	20 LAKH	10/02/2023	
81	CMC, VELLORE	0161820BG0000008 11-02-2020	128 LAKH	10/02/2023	
82	CMC, VELLORE	0161820BG0000012 11-02-2020	30 LAKH	10/02/2023	
83	CMC, VELLORE	0161820BG0000010 11-02-2020	128 LAKH	10/02/2023	
84	CMC, VELLORE	0161820BG0000014 14-02-2020	128 LAKH	13/02/2023	
85	CMC, VELLORE	0161820BG0000017 25-02-2020	20 LAKH	24/02/2023	

List of College with Expired Bank Guarantee					
Sr. No.	College/ Instt. Name	BG. No./ Date	Amount	Expiry date	Claim date/Remarks
86	CHETTINAD HOSPITAL AND RE. INSTT.T.N.	004GT02190100001 10-01-2019	15 LAKH	06/01/2022	06-01-2025 EXT
87	CHETTINAD HOSPITAL AND RE. INSTT.T.N.	004GT02123520006 17-12-2012	85 LAKH	16/12/2015	17-12-2018, 17-12-2021 EXT
88	CHETTINAD HOSPITAL AND RE. INSTT.T.N.	004GT02170200001 20-01-2017	10 LAKH	20/01/2020	20-01-2023 EXT
89	CHETTINAD HOSPITAL AND RE. INSTT.T.N.	004GT02170200002 20-01-2017	5 LAKH	20/01/2020	20-01-2023 EXT
90	CHETTINAD HOSPITAL AND RE. INSTT.T.N.	0004913FBG039086 02-04-2013	128 LAKH	01/10/2022	
91	CHETTINAD HOSPITAL AND RE. INSTT.T.N.	004GT02190100009 10-01-2019	35 LAKH	06/01/2022	06-01-2025 EXT
92	CHETTINAD HOSPITAL AND RE. INSTT.T.N.	004GT02190100010 10-01-2019	45 LAKH	06/01/2022	06-01-2025 EXT
93	CHETTINAD HOSPITAL AND RE. INSTT.T.N.	004GT02190100005 10-01-2019	15 LAKH	06/01/2022	06-01-2025 EXT
94	CHETTINAD HOSPITAL AND RE. INSTT.T.N.	004GT02190100004 10-01-2019	35 LAKH	06/01/2022	06-01-2025 EXT
95	CHETTINAD HOSPITAL AND RE. INSTT.T.N.	0004919PBG011448 15-02-2019	45 LAKH	20/02/2022	20-02-2025 EXT
96	CHETTINAD HOSPITAL AND RE. INSTT.T.N.	39086 02-04-2013	128 LAKH	01/10/2016	01-10-2019, 01-10-2022 EXT
97	DEO MANGAL MEMORIAL TRUST (SASARAM)	2169ILG004018 07-05-2018	100 LAKH	06/05/2023	
98	DAYANANAD MEDICAL COLLEGE AND HOSPITAL, LUDHIYANA	034GT01190310002 31-01-2019	10 LAKH	30/01/2024	
99	DAYANANAD MEDICAL COLLEGE AND HOSPITAL, LUDHIYANA	034GT01190310003 31-01-2019	10 LAKH	30/01/2024	
100	DAYANANAD MEDICAL COLLEGE AND HOSPITAL, LUDHIYANA	034GT01190310004 31-01-2019	20 LAKH	30/01/2024	
101	DAYANANAD MEDICAL COLLEGE AND HOSPITAL, LUDHIYANA	034GT01190310005 31-01-2019	10 LAKH	30/01/2024	
102	DAYANANAD MEDICAL COLLEGE AND HOSPITAL, LUDHIYANA	034GT01190310006 31-01-2019	128 LAKH	30/01/2024	
103	DAYANANAD MEDICAL COLLEGE AND HOSPITAL, LUDHIYANA	034GT01190310007 31-01-2019	128 LAKH	30/01/2024	
104	D Y PATIL MEDICAL COLLEGE AND HOSPITAL.PUNE	111719IGPER0009	128 LAKH	16/05/2022	
105	D Y PATIL MEDICAL COLLEGE AND HOSPITAL.PUNE	111717IGPER0004	20 LAKH	02/04/2020	

List of College with Expired Bank Guarantee

Sr. No.	College/ Instt. Name	BG. No./ Date	Amount	Expiry date	Claim date/Remarks
106	D Y PATIL MEDICAL COLLEGE AND HOSPITAL.PUNE	111719IGFIN0010	15 LAKH	05/02/2022	
107	D Y PATIL MEDICAL COLLEGE AND HOSPITAL.PUNE	111719IGFIN0005	10 LAKH	05/02/2022	
108	D Y PATIL MEDICAL COLLEGE AND HOSPITAL.PUNE	111719IGFIN0008	10 LAKH	05/02/2022	
109	D Y PATIL MEDICAL COLLEGE AND HOSPITAL.PUNE	111719IGFIN0004	10 LAKH	05/02/2022	
110	D Y PATIL MEDICAL COLLEGE AND HOSPITAL.PUNE	111719IGFIN0009	5 LAKH	05/02/2022	
111	D Y PATIL MEDICAL COLLEGE AND HOSPITAL.PUNE	111719IGFIN0003	5 LAKH	24/02/2022	SAME
112	D Y PATIL MEDICAL COLLEGE AND HOSPITAL.PUNE	111719IGFIN0004	5 LAKH	25/02/2022	
113	D Y PATIL MEDICAL COLLEGE AND HOSPITAL.PUNE	111719IGFIN0007	10 LAKH	05/02/2022	
114	D Y PATIL MEDICAL COLLEGE AND HOSPITAL.PUNE	111719IGFIN0003	10 LAKH	05/02/2022	SAME
115	D Y PATIL MEDICAL COLLEGE AND HOSPITAL.PUNE	111717IGPER0002	128 LAKH	02/04/2020	
116	D Y PATIL MEDICAL COLLEGE AND HOSPITAL.PUNE	111718IGPER0014	10 LAKH	17/05/2021	
117	D Y PATIL MEDICAL COLLEGE AND HOSPITAL.PUNE	111718IGFIN0004	10 LAKH	08/02/2021	
118	D Y PATIL MEDICAL COLLEGE AND HOSPITAL.PUNE	111710IGPER0013	30 LAKH	28/08/2020	
119	D Y PATIL MEDICAL COLLEGE AND HOSPITAL.PUNE	111710IGPER0014	30 LAKH	28/08/2020	
120	D Y PATIL MEDICAL COLLEGE AND HOSPITAL.PUNE	111718IGPER0004	128 LAKH	02/03/2021	
121	D Y PATIL MEDICAL COLLEGE AND HOSPITAL.PUNE	111718IGFIN0006	10 LAKH	08/02/2021	
122	D Y PATIL MEDICAL COLLEGE AND HOSPITAL.PUNE	111719IGFIN0011	15 LAKH	02/05/2022	
123	D Y PATIL MEDICAL COLLEGE AND HOSPITAL.PUNE	111710IGPER0001	20 LAKH	02/04/2020	
124	D Y PATIL MEDICAL COLLEGE AND HOSPITAL.PUNE	2741IGPER003419	15 LAKH	18/09/2019	
125	D Y PATIL MEDICAL COLLEGE AND HOSPITAL.PUNE	2741IGPER003319	40 LAKH	17/12/2022	
126	D Y PATIL MEDICAL COLLEGE AND HOSPITAL.PUNE	2741IGPER003519	45 LAKH	17/09/2022	
127	D Y PATIL MEDICAL COLLEGE AND HOSPITAL.PUNE	2741IGPER003219	25 LAKH	17/09/2022	
128	D Y PATIL MEDICAL COLLEGE AND HOSPITAL.PUNE	2741IGPER003019	10 LAKH	17/09/2022	
129	D Y PATIL MEDICAL COLLEGE AND HOSPITAL.PUNE	2741IGPER003619	5 LAKH	17/09/2022	
130	D Y PATIL MEDICAL COLLEGE AND HOSPITAL.PUNE	2741IGPER002619	5 LAKH	27/11/2022	
131	D Y PATIL MEDICAL COLLEGE AND HOSPITAL.PUNE	2741IGPER001720	128 LAKH	26/05/2023	
132	D Y PATIL MEDICAL COLLEGE AND HOSPITAL.PUNE	2741IGPER001620	10 LAKH	27/05/2023	
133	D Y PATIL MEDICAL COLLEGE AND HOSPITAL.PUNE	2741IGPER002919	5 LAKH	17/12/2022	
134	D Y PATIL MEDICAL COLLEGE AND HOSPITAL.PUNE	2741IGPER000920	20 LAKH	22/04/2023	
135	D Y PATIL MEDICAL COLLEGE AND HOSPITAL.PUNE	2741IGPER000820	20 LAKH	22/04/2023	
136	D Y PATIL MEDICAL COLLEGE AND HOSPITAL.PUNE	2741IGP000498620	128 LAKH	27/11/2023	
137	D Y PATIL MEDICAL COLLEGE AND HOSPITAL.PUNE	2741IGPER002120	20 LAKH	08/03/2023	
138	DESHMESH EDUCATIONAL TRUST	4196ILG006320	100 LAKH	21/04/2023	
139	GEETANJALI UNIVERSITY, UDAIPUR	00615IG180000017	128 LAKH	22/05/2023	
140	GSL EDUCATIONAL SOCIETY	BG-01070100000137	35 LAKH	30/09/2021	
141	GSL EDUCATIONAL SOCIETY	BG-01070100000133	20 LAKH	30/09/2021	
142	GCS MEDICAL COLLEGE AND HOSPITAL, AHMEDABAD	31280IGL0001418	85 LAKH	06/02/2021	

List of College with Expired Bank Guarantee					
Sr. No.	College/ Instt. Name	BG. No./ Date	Amount	Expiry date	Claim date/Remarks
143	GCS MEDICAL COLLEGE AND HOSPITAL, AHMEDABAD	31280IGL0001518	85 LAKH	06/02/2021	
144	GCS MEDICAL COLLEGE AND HOSPITAL, AHMEDABAD	31280IGL0001718	85 LAKH	06/02/2021	
145	GCS MEDICAL COLLEGE AND HOSPITAL, AHMEDABAD	31280IGL0001618	85 LAKH	06/02/2021	
146	GCS MEDICAL COLLEGE AND HOSPITAL, AHMEDABAD	31280IGL0005719	85 LAKH	08/09/2022	
147	GCS MEDICAL COLLEGE AND HOSPITAL, AHMEDABAD	31280IGL0006119	85 LAKH	03/10/2022	
148	HAKIM ABDUL HAMID CENTENARY HOSPITAL	0387IPBG2002001	85 LAKH	04/02/2023	
149	HAKIM ABDUL HAMID CENTENARY HOSPITAL	0387IPBG2002002	85 LAKH	04/02/2023	
150	HAKIM ABDUL HAMID CENTENARY HOSPITAL	0387IPBG1911002	85 LAKH	10/11/2022	
151	HAKIM ABDUL HAMID CENTENARY HOSPITAL	0387IPBG1911003	85 LAKH	10/11/2022	
152	HAKIM ABDUL HAMID CENTENARY HOSPITAL	0387IPBG1911004	85 LAKH	10/11/2022	
153	HAKIM ABDUL HAMID CENTENARY HOSPITAL	0387IPBG1911005	85 LAKH	10/11/2022	
154	HAKIM ABDUL HAMID CENTENARY HOSPITAL	0387IPBG1909004	85 LAKH	13/09/2019	
155	HAKIM ABDUL HAMID CENTENARY HOSPITAL	0387IPBG2002004	85 LAKH	14/02/2023	
156	HAKIM ABDUL HAMID CENTENARY HOSPITAL	0387IPBG2002005	85 LAKH	14/02/2023	
157	HIND CHARITABLE TRUST	594GT02193200001	85 LAKH	15/11/2023	
158	HIND CHARITABLE TRUST	594GT02193200002	85 LAKH	15/11/2023	
159	HIND CHARITABLE TRUST	594GT02193260002	85 LAKH	15/11/2023	
160	HIND CHARITABLE TRUST	594GT02193200003	85 LAKH	15/11/2023	
161	HIND CHARITABLE TRUST	594GT02193200004	85 LAKH	15/11/2023	
162	HIND CHARITABLE TRUST	594GT02193230004	85 LAKH	15/11/2023	
163	HIND CHARITABLE TRUST	594GT02193200005	85 LAKH	15/11/2023	
164	HIND CHARITABLE TRUST	594GT02193230005	85 LAKH	18/11/2023	
165	HIND CHARITABLE TRUST	594GT02193200006	85 LAKH	18/11/2023	
166	HIND CHARITABLE TRUST	594GT02193150012	85 LAKH	10/11/2023	
167	HIND CHARITABLE TRUST	594GT02193150013	85 LAKH	10/11/2023	
168	HIND CHARITABLE TRUST	594GT02190180004	85 LAKH	17/01/2023	
169	HIND CHARITABLE TRUST	594GT02190180003	85 LAKH	17/01/2023	
170	HIND CHARITABLE TRUST	594GT02190180005	85 LAKH	17/01/2023	
171	I Q CITY MEDICCAL COLLEGE , DURGAPUR	0006BGFD029119	70 LAKH	N/A	
172	I Q CITY MEDICCAL COLLEGE , DURGAPUR	0006BGFD029019	15 LAKH	N/A	
173	K J SOMAIYA MEDICAL COLLEGE, MUMBAI	0658IGP210011043	85 LAKH	14-09-223	
174	KMCT CALICUT	4258ILG000920	85 LAKH	23/02/2023	
175	KMCT CALICUT	4258ILG001020	85 LAKH	23/02/2023	

List of College with Expired Bank Guarantee

Sr. No.	College/ Instt. Name	BG. No./ Date	Amount	Expiry date	Claim date/Remarks
176	KMCT CALICUT	4258ILG001120	85 LAKH	23/02/2023	
177	KMCT CALICUT	4258ILG001220	85 LAKH	23/02/2023	
178	KMCT CALICUT	4258ILG003119	85 LAKH	25/11/2023	
179	KMCT CALICUT	4258ILG003219	85 LAKH	25/11/2023	
180	KMCT CALICUT	4258ILG003319	85 LAKH	25/11/2023	
181	KMCT CALICUT	4258ILG003519	85 LAKH	25/11/2023	
182	KMCT CALICUT	4258ILG003419	85 LAKH	25/11/2023	
183	KMCT CALICUT	4258ILG003919	85 LAKH	19/12/2023	
184	KMCT CALICUT	4258ILG000420	85 LAKH	10/02/2024	
185	KAMINENI HOSPITAL	OBR030BG161920	85 LAKH	17/05/2022	17-05-2023 CLAIM
186	KAMINENI HOSPITAL	OBR030BG0662223	30 LAKH	15/03/2026	15-03-2027 EXT
187	KAMINENI HOSPITAL	OBR030BG1071819	85 LAKH	04/12/2021	
188	KAMINENI HOSPITAL	OBR030BG1081819	85 LAKH	04/12/2021	
189	KAMINENI HOSPITAL	OBR030BG1091819	85 LAKH	04/12/2021	
190	KAMINENI HOSPITAL	OBR030BG1251819	85 LAKH	09/01/2022	09/04/2022
191	KAMINENI HOSPITAL	OBR030BG1261819	85 LAKH	09/01/2022	09/04/2022
192	KAMINENI HOSPITAL	OBR030BG1271819	85 LAKH	09/01/2022	09/04/2022
193	KAMINENI HOSPITAL	OBR030BG1281819	85 LAKH	09/01/2022	09/04/2022
194	KAMINENI HOSPITAL	OBR030BG1291819	85 LAKH	09/01/2022	09/04/2022
195	KAMINENI HOSPITAL	OBR030BG0611920	85 LAKH	10/10/2022	10/10/2023
196	KAMINENI HOSPITAL	OBR030BG0601920	85 LAKH	10/10/2022	10/10/2023
197	KAMINENI HOSPITAL	OBR030BG0821920	85 LAKH	28-11-202	28/11/2023
198	KONASEEMA INSTT. OF MEDICDAL SCIENCES, A.P.	035118IGFIN0009	25 LAKH	N/A	
199	KONASEEMA INSTT. OF MEDICDAL SCIENCES, A.P.	BG4489/BGT/2018-02	85 LAKH	N/A	
200	KONASEEMA INSTT. OF MEDICDAL SCIENCES, A.P.	035118IGFIN0008	10 LAKH	N/A	
201	KRISHNA INSTT. OF MEDICAL SCIENCES,KARAD	KRD/VVS/BG/41/2015-16	128 LAKH	25/05/2022	
202	KUNHITHARUVAI MEMORIAL CHERITABLE TRUST,	009716IGPER0011	1000 lakh	25/09/2023	
203	KIRUPANANDA VARIYAR MEDICAL COLLEGE AND HOSPITAL, TAMIL NADU, SALEM	04/2018-19	10 LAKH	16/02/2022	
204	KIRUPANANDA VARIYAR MEDICAL COLLEGE AND HOSPITAL, TAMIL NADU, SALEM	CSB/SLM/295/02/2018-19	10 LAKH	15/02/2023	
205	KARPAGE VINAYA GAR EDUCATIONAL TRUST	0004015PBG001601	85 LAKH	27/07/2020	
206	KARPAGE VINAYA GAR EDUCATIONAL TRUST	0004015PBG001602	85 LAKH	27/07/2020	
207	KARPAGE VINAYA GAR EDUCATIONAL TRUST	0004015PBG001600	85 LAKH	27/07/2020	
208	KARPAGE VINAYA GAR EDUCATIONAL TRUST	0004016PBG003515	85 LAKH	31/07/2020	
209	KARPAGE VINAYA GAR EDUCATIONAL TRUST	0004015PBG001603	85 LAKH	27/07/2020	
210	KARPAGE VINAYA GAR EDUCATIONAL TRUST	0004019FBG022284	85 LAKH	31/08/2023	
211	KARPAGE VINAYA GAR EDUCATIONAL TRUST	0004019FBG022283	85 LAKH	31/08/2023	

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Sr. No.	College/ Instt. Name	BG. No./ Date	Amount	Expiry date	Claim date/Remarks
212	KARPAGE VINAYA GAR EDUCATIONAL TRUST	BG= 0040282000531972	85 LAKH	31/08/2023	
213	LORD BUDDHA EDUCATIONAL SOCEITY, RAIPUR	003GT02162460015	750 LAKH	N/A	
214	LORD BUDDHA EDUCATIONAL SOCEITY, RAIPUR	003GT02162460018	200 LAKH	N/A	
215	LAXMI MEMORIAL EDUCATION TRUST MENGLURU	IPBG01291900013	10 LAKH	24/01/2023	
216	LAXMI MEMORIAL EDUCATION TRUST MENGLURU	IPBG01291900050	30 LAKH	25/03/2023	
217	LAXMI MEMORIAL EDUCATION TRUST MENGLURU	IPBG01291900051	30 LAKH	25/03/2023	
218	LAXMI MEMORIAL EDUCATION TRUST MENGLURU	IPBG01291900052	30 LAKH	25/03/2023	
219	MAHA ACADEMY OF ENGG AND EDUCATION	0540IPEBG190439	100 LAKH	11/07/2022	11/07/2023
220	MAHA ACADEMY OF ENGG AND EDUCATION	0540IPEBG170140	85 LAKH	10/10/2020	10/10/2021
221	MAHA ACADEMY OF ENGG AND EDUCATION	0540IPEBG180071	10 LAKH	16/02/2020	16/02/2021
222	MAYANK WELFARE SOCIETY	0119022OFF009603	10 LAKH	20/01/2022	
223	MAYANK WELFARE SOCIETY	0119022OFF009606	20 LAKH	24/07/2022	
224	MAYANK WELFARE SOCIETY	0119022OFF009601	15 LAKH	20/01/2022	
225	MAYANK WELFARE SOCIETY	0119022OFF009604	40 LAKH	20/01/2022	
226	MAYANK WELFARE SOCIETY	0119022OFF009599	40 LAKH	20/01/2022	
227	MAYANK WELFARE SOCIETY	0119022OFF009600	30 LAKH	20/01/2022	
228	MAYANK WELFARE SOCIETY	0119022OFF009602	30 LAKH	20/01/2022	
229	MAYANK WELFARE SOCIETY	0119022OFF009605	15 LAKH	24/07/2022	
230	MANIPAL ACADEMY OF HIGHER EDUCATION	0002BGR0034720	128 LAKH	12/05/2022	
231	MANAKULA VINAYAGAR MEDICAL COLLEGE AND HOSPITAL	BG= 09/2018	5 LAKH	27/09/2021	
232	MANAKULA VINAYAGAR MEDICAL COLLEGE AND HOSPITAL	BG= 06/2017	15 LAKH	19/09/2021	
233	MANAKULA VINAYAGAR MEDICAL COLLEGE AND HOSPITAL	BG= 08/2018	10 LAKH	27/09/2021	
234	MANAKULA VINAYAGAR MEDICAL COLLEGE AND HOSPITAL	BG= 19/24	5 LAKH	16/10/2022	
235	MALAKARA ORTHODOX SYRIAL CHURCH MEDICAL MISSION KOLENCHERY	BG= KLY/IBG85620	85 LAKH	31/12/2023	
236	THE MUSLIM EDUCATIONAL WALEFARE SOCIETY	127GT02193110001	85 LAKH	06/11/2023	
237	MR MEDICAL COLLEGE, KARNATAKA	SQIBGDP193185001	35 LAKH	06/11/2023	
238	MAHARISHI MARKANDA TRUST	0246820BG0000055	85 LAKH	N/A	
239	MAHATMA GANDHI UNIVEERSITY OF MEDICAL SCIENCES AND TECHNELOGY, JAIPUR	URXBGPR192925001	25 LAKH	12/01/2021	BG WITH SAME NO. FOUND BUT WITH EXPIRY DATE 13-10-2023
240	MAHATMA GANDHI UNIVEERSITY OF MEDICAL SCIENCES AND TECHNELOGY, JAIPUR	URXBGPR192925002	15 LAKH	12/01/2021	BG WITH SAME NO. FOUND BUT WITH EXPIRY DATE 13-10-2023

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241	MAHATMA GANDHI UNIVEERSITY OF MEDICAL SCIENCES AND TECHNELOGY, JAIPUR	URXBGPR193045001	15 LAKH	30/01/2024	BG WITH SAME NO. FOUND BUT WITH EXPIRY DATE 30-10-2023
242	MAHATMA GANDHI UNIVEERSITY OF MEDICAL SCIENCES AND TECHNELOGY, JAIPUR	URXBGPR193045004	15 LAKH	30/01/2024	BG WITH SAME NO. FOUND BUT WITH EXPIRY DATE 30-10-2023
243	MAHATMA GANDHI UNIVEERSITY OF MEDICAL SCIENCES AND TECHNELOGY, JAIPUR	URXBGPR200375001	20 LAKH	05/02/2024	
244	MAHATMA GANDHI UNIVEERSITY OF MEDICAL SCIENCES AND TECHNELOGY, JAIPUR	URXBGPR200375002	30 LAKH	05/02/2024	
245	MAHATMA GANDHI UNIVEERSITY OF MEDICAL SCIENCES AND TECHNELOGY, JAIPUR	URXBGPR192760003	85 LAKH	31/12/2023	BG WITH SAME NO. FOUND BUT WITH EXPIRY DATE 30-09-2023
246	MAHATMA GANDHI UNIVEERSITY OF MEDICAL SCIENCES AND TECHNELOGY, JAIPUR	URXBGPR192760001	35 LAKH	31/12/2023	BG WITH SAME NO. FOUND BUT WITH EXPIRY DATE 30-09-2023
247	MAHATMA GANDHI UNIVEERSITY OF MEDICAL SCIENCES AND TECHNELOGY, JAIPUR	610000618	85 LAKH	24/01/2023	
248	M. M. PATEL PUBLIC HERITABLE TRUST	OBR030BG0661920	85 LAKH	21/10/2022	21/10/2023
249	M. M. PATEL PUBLIC HERITABLE TRUST	OBR030BG0531920	85 LAKH	10/09/2022	10/09/2023
250	M. M. PATEL PUBLIC HERITABLE TRUST	OBR030BG0521920	85 LAKH	10/09/2022	10/09/2023
251	MEDICITY INSTT. OF MEDICAL SCI.	2661IGPER0003019	20 LAKH	13/11/2022	
252	MEDICITY INSTT. OF MEDICAL SCI.	2661IGPER0002919	10 LAKH	13/11/2022	
253	MEDICITY INSTT. OF MEDICAL SCI.	2661IGPER0002819	15 LAKH	13/11/2022	
254	MEDICITY INSTT. OF MEDICAL SCI.	2661IGPER0002319	10 LAKH	18/10/2022	
255	MEDICITY INSTT. OF MEDICAL SCI.	2661IGPER0002019	30 LAKH	04/10/2022	
256	MAHAVIR INSTT. OF MEDICAL SCI,	OBR1957/2016	200 LAKH	13/08/2021	13/08/2022
257	MAHAVIR INSTT. OF MEDICAL SCI,	OBR1958/2016	200 LAKH	19/08/2022	19/08/2023
258	MAHAVIR INSTT. OF MEDICAL SCI,	OBR1959/2016	750 LAKH	19/08/2022	19/08/2023
259	NAVODAYA MEDICAL COLLEGE, RAICHUR	BG/25/2018-19	10 LAKH	N/A	
260	NAVODAYA MEDICAL COLLEGE, RAICHUR	BG/30/2018-19	15 LAKH	N/A	
261	NAVODAYA MEDICAL COLLEGE, RAICHUR	BG/31/2018-19	15 LAKH	N/A	
262	NAVODAYA MEDICAL COLLEGE, RAICHUR	BG/32/2018-19	25 LAKH	N/A	
263	NAVODAYA MEDICAL COLLEGE, RAICHUR	BG/26/2018-19	10 LAKH	N/A	
264	NAVODAYA MEDICAL COLLEGE, RAICHUR	BG/27/2018-19	10 LAKH	N/A	
265	NAVODAYA MEDICAL COLLEGE, RAICHUR	BG/36/2018-19	20 LAKH	N/A	
266	NAVODAYA MEDICAL COLLEGE, RAICHUR	BG/28/2018-19	10 LAKH	N/A	

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Sr. No.	College/ Instt. Name	BG. No./ Date	Amount	Expiry date	Claim date/Remarks
267	NAVODAYA MEDICAL COLLEGE, RAICHUR	BG/29/2018-19	10 LAKH	N/A	
268	NIMS RAJASTHAN	0649BGFD002620	20 LAKH	23/08/2023	
269	NIMS RAJASTHAN	0649BGFD002820	20 LAKH	23/08/2023	
270	NIMS RAJASTHAN	0649BGFD002720	20 LAKH	23/08/2023	
271	NIMS RAJASTHAN	0649BGFD002520	128 LAKH	23/08/2023	
272	NIMS RAJASTHAN	0649BGFD002420	128 LAKH	23/08/2023	
273	NARAYANA MEDICAL COLLEGE, NELLORE	OGT0004210058323	30 LAKH	08/09/2022	08/09/2023
274	NARAYANA MEDICAL COLLEGE, NELLORE	OGT0004210058334	25 LAKH	08/09/2022	08/09/2023
275	NARAYANA MEDICAL COLLEGE, NELLORE	0552OBG18017050	5 LAKH	03/09/2023	
276	NARAYANA MEDICAL COLLEGE, NELLORE	OGT0004210058327	20 LAKH	21/02/2021	08/09/2022
277	NARAYANA MEDICAL COLLEGE, NELLORE	OGT0004210058331	10 LAKH	21/02/2021	08/09/2022
278	NARAYANA MEDICAL COLLEGE, NELLORE	OGT0004210058336	20 LAKH	07/09/2021	08/09/2022
279	NARAYANA MEDICAL COLLEGE, NELLORE	OGT0004210058337	15 LAKH	07/09/2021	08/09/2022
280	NARAYANA MEDICAL COLLEGE, NELLORE	0552OBG18017056	30 LAKH	03/09/2022	
281	NARAYANA MEDICAL COLLEGE, NELLORE	0552OBG18010134	10 LAKH	23/05/2021	
282	NARAYANA MEDICAL COLLEGE, NELLORE	0552OBG18010594	10 LAKH	30/05/2021	
283	NARAYANA MEDICAL COLLEGE, NELLORE	0552OBG18010138	10 LAKH	23/05/2021	
284	NARAYANA MEDICAL COLLEGE, NELLORE	0552OBG18010597	10 LAKH	30/05/2021	
285	KS HEGDE MEDICAL ACADEMY , MANGALORE	SA8BGDP192560002	25 LAKH	12/09/2023	
286	KS HEGDE MEDICAL ACADEMY , MANGALORE	SA8BGDP192685002	10 LAKH	21/09/2023	21/12/2023
287	KS HEGDE MEDICAL ACADEMY , MANGALORE	SA8BGDP192945003	10 LAKH	11/10/2023	
288	KS HEGDE MEDICAL ACADEMY , MANGALORE	SA8BGDP192945002	10 LAKH	07/10/2023	
289	SVS MEDICAL COLLEGE, YENOGONDA	152419IGPER0004	40 LAKH	15/07/2023	
290	SVS MEDICAL COLLEGE, YENOGONDA	152419IGPER0008	65 LAKH	12/07/2023	
291	SVS MEDICAL COLLEGE, YENOGONDA	152419IGPER0007	50 LAKH	12/07/2023	
292	SVS MEDICAL COLLEGE, YENOGONDA	152419IGPER0010	40 LAKH	12/07/2023	
293	SVS MEDICAL COLLEGE, YENOGONDA	152419IGPER0005	10 LAKH	12/07/2023	
294	SVS MEDICAL COLLEGE, YENOGONDA	152419IGPER0009	10 LAKH	12/07/2023	
295	SVS MEDICAL COLLEGE, YENOGONDA	152419IGPER0006	10 LAKH	12/07/2023	
296	SHRI MURTI SMARAK TRUST	52240000619	N/A	31/10/2023	
297	SHRI MURTI SMARAK TRUST	52240000519	N/A	17/10/2023	
298	SHRI MURTI SMARAK TRUST	52240000719	N/A	31/10/2023	
299	SANTOSH TRUST	00401IG200000019	30 LAKH	31/05/2023	
300	SANTOSH TRUST	00401IG200000016	10 LAKH	31/05/2023	
301	SANTOSH TRUST	00401IG200000018	10 LAKH	31/05/2023	
302	SANTOSH TRUST	00401IG200000020	85 LAKH	31/05/2023	
303	SANTOSH TRUST	00401IG200000017	20 LAKH	31/05/2023	
304	SAVEETHA INSTT. OF MEDICAL SCI,	00102IG200000011	128 LAKH	17/02/2023	

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305	SAVEETHA INSTT. OF MEDICAL SCI,	00102IG160000037	128 LAKH	01/09/2022	
306	SAVEETHA INSTT. OF MEDICAL SCI,	00102IG160000039	128 LAKH	30/08/2021	
307	SAVEETHA INSTT. OF MEDICAL SCI,	00102IG160000044	128 LAKH	01/09/2021	
308	SAVEETHA INSTT. OF MEDICAL SCI,	00102IG190000056	55 LAKH	21/11/2022	
309	SAVEETHA INSTT. OF MEDICAL SCI,	00102IG190000057	45 LAKH	20/11/2022	
310	SAVEETHA INSTT. OF MEDICAL SCI,	00102IG190000058	35 LAKH	20/11/2022	
311	SAVEETHA INSTT. OF MEDICAL SCI,	00102IG190000059	50 LAKH	20/11/2022	
312	SAVEETHA INSTT. OF MEDICAL SCI,	00102IG190000060	30 LAKH	20/11/2022	
313	SAVEETHA INSTT. OF MEDICAL SCI,	00102IG190000061	35 LAKH	20/11/2022	
314	SAVEETHA INSTT. OF MEDICAL SCI,	00102IG190000062	15 LAKH	20/11/2022	
315	SAVEETHA INSTT. OF MEDICAL SCI,	00102IG190000063	10 LAKH	20/11/2022	
316	SAVEETHA INSTT. OF MEDICAL SCI,	00102IG190000064	40 LAKH	21/11/2022	
317	SAVEETHA INSTT. OF MEDICAL SCI,	00102IG190000065	15 LAKH	21/11/2022	
318	SAVEETHA INSTT. OF MEDICAL SCI,	00102IG190000066	35 LAKH	20/11/2022	
319	SAVEETHA INSTT. OF MEDICAL SCI,	00102IG190000067	30 LAKH	20/11/2022	
320	SAVEETHA INSTT. OF MEDICAL SCI,	00102IG190000068	10 LAKH	21/11/2022	
321	SAVEETHA INSTT. OF MEDICAL SCI,	00102IG190000069	15 LAKH	21/11/2022	
322	SRINIVASA TRUST	0384IPBG1911001	N/A	04/11/2022	
323	SRINIVASA TRUST	0384IPBG1911002	N/A	04/11/2022	
324	SRINIVASA TRUST	0384IPBG1911005	N/A	07/11/2022	
325	SRINIVASA TRUST	0384IPBG2002001	N/A	17/02/2023	
326	SRINIVASA TRUST	0384IPBG2002002	N/A	17/02/2023	
327	SRINIVASA TRUST	0384IPBG2002003	N/A	17/02/2023	
328	SRINIVASAN HERITABLE AND EDUCATIONAL TRUST	0457ILG000719	85 LAKH	14/10/2022	
329	SRINIVASAN HERITABLE AND EDUCATIONAL TRUST	0457ILG000619	85 LAKH	10/10/2022	
330	SRINIVASAN HERITABLE AND EDUCATIONAL TRUST	0457ILG000519	85 LAKH	03/10/2022	
331	SRINIVASAN HERITABLE AND EDUCATIONAL TRUST	0457ILG000219	85 LAKH	19/09/2022	
332	SRINIVASAN HERITABLE AND EDUCATIONAL TRUST	0457ILG000819	85 LAKH	15/10/2022	
333	SRINIVASAN HERITABLE AND EDUCATIONAL TRUST	0457ILG000319	85 LAKH	19/09/2022	
334	SRINIVASAN HERITABLE AND EDUCATIONAL TRUST	0457ILG001219	85 LAKH	11/11/2022	

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Sr. No.	College/ Instt. Name	BG. No./ Date	Amount	Expiry date	Claim date/Remarks
335	SRINIVASAN CHERITABLE AND EDUCATIONAL TRUST	0457ILG000919	85 LAKH	15/10/2022	
336	SRINIVASAN CHERITABLE AND EDUCATIONAL TRUST	0457ILG001119	85 LAKH	07/11/2022	
337	SRIDEVI INSTITUTE. TUMKUR	HC9GOPG223425001	85 LAKH	07/06/2023	
338	SRIDEVI INSTITUTE. TUMKUR	HC9GOPG223425002	85 LAKH	07/06/2023	
339	SRIDEVI INSTITUTE. TUMKUR	HC9GOPG223425003	85 LAKH	07/06/2023	
340	SRIDEVI INSTITUTE. TUMKUR	HC9GOPG223425004	85 LAKH	07/06/2023	
341	SRIDEVI INSTITUTE. TUMKUR	HC9GOPG223425005	85 LAKH	07/06/2023	
342	SRIDEVI INSTITUTE. TUMKUR	HC9GOPG223425006	85 LAKH	07/06/2023	
343	SRIDEVI INSTITUTE. TUMKUR	HC9GOPG223425007	85 LAKH	07/06/2023	
344	SRIDEVI INSTITUTE. TUMKUR	HC9GOPG223425009	85 LAKH	07/06/2023	
345	SRIDEVI INSTITUTE. TUMKUR	HC9GOPG223425010	85 LAKH	07/06/2023	
346	SRIDEVI INSTITUTE. TUMKUR	HC9GOPG223425011	85 LAKH	07/06/2023	
347	SRIDEVI INSTITUTE. TUMKUR	HC9GOPG223425013	85 LAKH	07/06/2023	
348	SRIDEVI INSTITUTE. TUMKUR	HC9GOPG223425014	85 LAKH	07/06/2023	
349	VIGNAN EDUCATIONAL FOUNDATION	172BG01191630001	128 LAKH	11/06/2022	11/06/2023
350	VIGNAN EDUCATIONAL FOUNDATION	172BG01191420001	128 LAKH	21/05/2022	22/05/2023
351	VYDEHI INSTT. OF MEDICAL SCI.	0384IPBG1702001	20 LAKH	N/A	
352	VYDEHI INSTT. OF MEDICAL SCI.	0384IPBG1702002	20 LAKH	N/A	
353	VYDEHI INSTT. OF MEDICAL SCI.	0384IPBG1801006	20 LAKH	N/A	
354	VSPM ACADEMY OF HIGHER EDUCATION, NAGPUR	BG/02/100	50 LAKH	05/11/2023	
355	VSPM ACADEMY OF HIGHER EDUCATION, NAGPUR	BG/02/99	25 LAKH	05/11/2023	
356	VSPM ACADEMY OF HIGHER EDUCATION, NAGPUR	BG/02/103	15 LAKH	21/11/2023	
357	VSPM ACADEMY OF HIGHER EDUCATION, NAGPUR	BG/02/104	15 LAKH	21/11/2023	
358	VSPM ACADEMY OF HIGHER EDUCATION, NAGPUR	BG/02/102	10 LAKH	21/11/2023	
359	VSPM ACADEMY OF HIGHER EDUCATION, NAGPUR	BG/02/101	20 LAKH	21/11/2023	
360	VELAMMAL MEDICAL COLLEGE	BG= 169571119000019	N/A	31/10/2023	
361	VELAMMAL MEDICAL COLLEGE	BG= 169571119000020	N/A	31/10/2023	
362	VELAMMAL MEDICAL COLLEGE	BG= 169571219000027	N/A	31-11-2022	30/11/2023
363	VELAMMAL MEDICAL COLLEGE	BG= 169571219000028	N/A	31-11-2022	30/11/2023
364	VELAMMAL MEDICAL COLLEGE	BG= 169571219000029	N/A	31-11-2022	30/11/2023
365	VELAMMAL MEDICAL COLLEGE	BG= 169571219000030	N/A	31-11-2022	30/11/2023
366	VELAMMAL MEDICAL COLLEGE	BG= 169571219000031	N/A	31-11-2022	30/11/2023
367	VIGNAN EDUCATIONAL FOUNDATION	172BG011182410001	155 LAKH	26/08/2022	22-08-2023 SAME COLLEGE AS MENTIONED AT 349
368	VISHWA BHARTI EDUCATIONAL SOCIETY, KURNOOR	4050IBGISS200001	85 LAKH	10/02/2023	
369	VISHWA BHARTI EDUCATIONAL SOCIETY, KURNOOR	4050IBGISS200002	85 LAKH	10/02/2023	

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Sr. No.	College/ Instt. Name	BG. No./ Date	Amount	Expiry date	Claim date/Remarks
370	VISHWA BHARTI EDUCATIONAL SOCIETY, KURNOOR	4050IBGISS200003	85 LAKH	10/02/2023	
371	VISHWA BHARTI EDUCATIONAL SOCIETY, KURNOOR	4050IBGISS200004	85 LAKH	10/02/2023	
372	VISHWA BHARTI EDUCATIONAL SOCIETY, KURNOOR	4050IBGISS200005	85 LAKH	25/02/2023	
373	VISHWA BHARTI EDUCATIONAL SOCIETY, KURNOOR	4050IBGISS200006	85 LAKH	25/02/2023	
374	VISHWA BHARTI EDUCATIONAL SOCIETY, KURNOOR	4050IBGISS200007	85 LAKH	25/02/2023	
375	VISHWA BHARTI EDUCATIONAL SOCIETY, KURNOOR	4050IBGISS200008	85 LAKH	26/02/2023	
376	VISHWA BHARTI EDUCATIONAL SOCIETY, KURNOOR	4050IBGISS200009	85 LAKH	01/03/2023	
377	VISHWA BHARTI EDUCATIONAL SOCIETY, KURNOOR	4050IBGISS200010	85 LAKH	01/03/2023	
378	VISHWA BHARTI EDUCATIONAL SOCIETY, KURNOOR	4050IBGISS200011	85 LAKH	01/03/2023	
379	YENEPOYA, MANGALORE	1132IGISS200003	20 LAKH	25/02/2023	
380	YENEPOYA, MANGALORE	1132IGISS190008	128 LAKH	19/11/2022	
381	ZYDUS LIFE SCIENCES LTD.	0849IGPER011218	750 LAKH	19/07/2023	
382	ZYDUS LIFE SCIENCES LTD.	0849IGPER011318	200 LAKH	19/07/2023	
383	Prakash Shikshan Mandal	OBR1919/2016	750 LAKH	12.06.2022	12.06.2023
384	Prakash Shikshan Mandal	OBR1920/2016	200 LAKH	12.06.2022	12.06.2023
385	M/s PES Institute of Medical Science and Research	00564IG200000001	10 LAKH	30.06.2023	
386	M/s PES Institute of Medical Science and Research	INBG03820000021	10 LAKH	31.12.2023	
387	M/s PES Institute of Medical Science and Research	INBG03820000022	15 LAKH	31.12.2023	
388	M/s PES Institute of Medical Science and Research	INBG03820000023	20 LAKH	31.12.2023	
389	M/s PES Institute of Medical Science and Research	INBG03820000024	25 LAKH	31.12.2023	
390	M/s PES Institute of Medical Science and Research	02279IG200000003	25 LAKH	30.06.2023	
391	M/s PES Institute of Medical Science and Research	02279IG200000004	5 LAKH	30.06.2023	
392	Prathima Education Society	OBR1743/2015	100 LAKH	11.06.2020	
393	Prathima Education Society	OBR030BG0691819	60 LAKH	18.08.2022	18.08.2023
394	Prathima Education Society	OBR030BG0661819	25 LAKH	18.08.2022	18.08.2023
395	Prathima Education Society	OBR030BG0711819	45 LAKH	18.08.2022	18.08.2023
396	Prathima Education Society	OBR030BG0651819	10 LAKH	18.08.2022	18.08.2023
397	Prathima Education Society	OBR030BG0681819	60 LAKH	18.08.2022	18.08.2023
398	Prathima Education Society	OBR030BG0671819	20 LAKH	18.08.2022	18.08.2023
399	Prathima Education Society	OBR030BG0701819	15 LAKH	18.08.2022	18.08.2023
400	Prathima Education Society	OBR030BG1461819	15 LAKH	14.02.2022	
401	Parul Aarogya Seva Mandal	0676IGPER021016	400 LAKH	27.12.2022	27.12.2022
402	Parul Aarogya Seva Mandal	0676IGP002397121	200 LAKH	22.09.2022	22.09.2022
403	Parul Aarogya Seva Mandal	0676IGP002397821	750 LAKH	22.09.2022	22.09.2022
404	M/s Pushpagiri Medical Society	0079BG000022019	128 LAKH	11.06.2022	
405	Oxford Medical College Hospital & Research	LW7GOPG193180003	85 LAKH	14.11.2022	14.11.2022
406	Oxford Medical College Hospital & Research	LW7GOPG193180001	85 LAKH	14.11.2023	14.11.2023

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407	Oxford Medical College Hospital & Research	LW7GOPG193180003	85 LAKH	14.11.2023	BG NO SAME FOUND BUT EXIPRY DATE IS DIFFERENT
408	Oxford Medical College Hospital & Research	LW7GOPG193180004	85 LAKH	14.11.2023	14.11.2023
409	Oxford Medical College Hospital & Research	LW7GOPG193180006	85 LAKH	14.11.2023	14.11.2023
410	Oxford Medical College Hospital & Research	LW7GOPG193180007	85 LAKH	14.11.2023	14.11.2023
411	Oxford Medical College Hospital & Research	LW7GOPG193180008	85 LAKH	14.11.2023	14.11.2023
412	Oxford Medical College Hospital & Research	LW7GOPG193240002	85 LAKH	20.11.2023	20.11.2023
413	Oxford Medical College Hospital & Research	LW7GOPG200360001	85 LAKH	05.02.2023	05.02.2023
414	Oxford Medical College Hospital & Research	LW7GOPG193180004	85 LAKH	14.11.2022	BG NO SAME FOUND BUT EXIPRY DATE IS DIFFERENT
415	Oxford Medical College Hospital & Research	LW7GOPG193240002	85 LAKH	20.11.2022	BG NO SAME FOUND BUT EXIPRY DATE IS DIFFERENT
416	Oxford Medical College Hospital & Research	LW7GOPG193180008	85 LAKH	14.11.2022	BG NO SAME FOUND BUT EXIPRY DATE IS DIFFERENT
417	Oxford Medical College Hospital & Research	LW7GOPG200200001	85 LAKH	20.01.2023	
418	Oxford Medical College Hospital & Research	LW7GOPG193180007	85 LAKH	14.11.2022	BG NO SAME FOUND BUT EXIPRY DATE IS DIFFERENT
419	Oxford Medical College Hospital & Research	LW7GOPG193240003	85 LAKH	20.11.2022	BG NO SAME FOUND BUT EXIPRY DATE IS DIFFERENT
420	Oxford Medical College Hospital & Research	LW7GOPG193180006	85 LAKH	14.11.2022	BG NO SAME FOUND BUT EXIPRY DATE IS DIFFERENT
421	Oxford Medical College Hospital & Research	LW7GOPG192960001	85 LAKH	23.10.2022	
422	Oxford Medical College Hospital & Research	LW7GOPG192960001	85 LAKH	23.10.2023	BG NO SAME FOUND BUT EXIPRY DATE IS DIFFERENT
423	Oxford Medical College Hospital & Research	LW7GOPG193180001	85 LAKH	14.11.2022	BG NO SAME FOUND BUT EXIPRY DATE IS DIFFERENT
424	SMT. KASHIBAI NAWALE MEDICAL COLLEGE & GENERAL HOSPITAL, NARHE,PUNE	017/46/22/BG/33/01	85 LAKH	23/02/2021	
425	SMT. KASHIBAI NAWALE MEDICAL COLLEGE & GENERAL HOSPITAL, NARHE,PUNE	017/46/26/BG/33/05	85 LAKH	23/02/2021	
426	SMT. KASHIBAI NAWALE MEDICAL COLLEGE & GENERAL HOSPITAL, NARHE,PUNE	017/46/23/BG/33/02	85 LAKH	23/02/2021	
427	SMT. KASHIBAI NAWALE MEDICAL COLLEGE & GENERAL HOSPITAL, NARHE,PUNE	017/46/32/BG/33/11	85 LAKH	23/02/2021	
428	SMT. KASHIBAI NAWALE MEDICAL COLLEGE & GENERAL HOSPITAL, NARHE,PUNE	017/46/25/BG/33/04	85 LAKH	23/02/2021	

List of College with Expired Bank Guarantee					
Sr. No.	College/ Instt. Name	BG. No./ Date	Amount	Expiry date	Claim date/Remarks
429	SMT. KASHIBAI NAWALE MEDICAL COLLEGE & GENERAL HOSPITAL, NARHE,PUNE	017/46/30/BG/33/09	85 LAKH	23/02/2021	
430	SMT. KASHIBAI NAWALE MEDICAL COLLEGE & GENERAL HOSPITAL, NARHE,PUNE	017/46/27/BG/33/06	85 LAKH	23/02/2021	
431	SMT. KASHIBAI NAWALE MEDICAL COLLEGE & GENERAL HOSPITAL, NARHE,PUNE	017/46/24/BG/33/03	85 LAKH	23/02/2021	
432	SMT. KASHIBAI NAWALE MEDICAL COLLEGE & GENERAL HOSPITAL, NARHE,PUNE	DGK/44/21/BG/10/18	05 LAKH	21/02/2018	
433	SMT. KASHIBAI NAWALE MEDICAL COLLEGE & GENERAL HOSPITAL, NARHE,PUNE	DGK/44/22/BG/10/19	05 LAKH	21/02/2018	
434	SMT. KASHIBAI NAWALE MEDICAL COLLEGE & GENERAL HOSPITAL, NARHE,PUNE	DGK/44/23/BG/10/20	05 LAKH	21/02/2018	
435	SMT. KASHIBAI NAWALE MEDICAL COLLEGE & GENERAL HOSPITAL, NARHE,PUNE	017/46/17/BG/10/21	05 LAKH	30/01/2020	
436	SMT. KASHIBAI NAWALE MEDICAL COLLEGE & GENERAL HOSPITAL, NARHE,PUNE	017/46/18/BG/10/22	25 LAKH	23/02/2020	
437	SMT. KASHIBAI NAWALE MEDICAL COLLEGE & GENERAL HOSPITAL, NARHE,PUNE	017/46/20/BG/10/24	10 LAKH	23/02/2020	
438	SMT. KASHIBAI NAWALE MEDICAL COLLEGE & GENERAL HOSPITAL, NARHE,PUNE	017/46/21/BG/10/25	10 LAKH	23/02/2020	
439	SMT. KASHIBAI NAWALE MEDICAL COLLEGE & GENERAL HOSPITAL, NARHE,PUNE	017/46/19/BG/10/23	10 LAKH	23/02/2020	
440	SMT. KASHIBAI NAWALE MEDICAL COLLEGE & GENERAL HOSPITAL, NARHE,PUNE	017/47/5/BG/10/30	15 LAKH	16/04/2020	
441	SMT. KASHIBAI NAWALE MEDICAL COLLEGE & GENERAL HOSPITAL, NARHE,PUNE	017/47/2/BG/10/27	10 LAKH	16/04/2020	
442	SMT. KASHIBAI NAWALE MEDICAL COLLEGE & GENERAL HOSPITAL, NARHE,PUNE	017/47/3/BG/10/28	40 LAKH	16/04/2020	
443	SMT. KASHIBAI NAWALE MEDICAL COLLEGE & GENERAL HOSPITAL, NARHE,PUNE	017/47/6/BG/10/31	10 LAKH	16/04/2020	
444	SMT. KASHIBAI NAWALE MEDICAL COLLEGE & GENERAL HOSPITAL, NARHE,PUNE	017/47/4/BG/10/29	25 LAKH	16/04/2020	
445	SMT. KASHIBAI NAWALE MEDICAL COLLEGE & GENERAL HOSPITAL, NARHE,PUNE	017/48/4/BG/10/33	05 LAKH	15/04/2021	
446	SMT. KASHIBAI NAWALE MEDICAL COLLEGE & GENERAL HOSPITAL, NARHE,PUNE	DGK/48/3/BG/10/32	05 LAKH	15/04/2021	

List of College with Expired Bank Guarantee					
Sr. No.	College/ Instt. Name	BG. No./ Date	Amount	Expiry date	Claim date/Remarks
447	SMT. KASHIBAI NAWALE MEDICAL COLLEGE & GENERAL HOSPITAL, NARHE,PUNE	017/48/5/BG/10/34	05 LAKH	15/04/2021	
448	SMT. KASHIBAI NAWALE MEDICAL COLLEGE & GENERAL HOSPITAL, NARHE,PUNE	017/46/17/BG/10/21	05 LAKH	30/01/2021	DUPLICATE BUT EXPIRY DATE CHANGED
449	SMT. KASHIBAI NAWALE MEDICAL COLLEGE & GENERAL HOSPITAL, NARHE,PUNE	017/46/17/BG/10/21	05 LAKH	31/07/2021	DUPLICATE BUT EXPIRY DATE CHANGED
450	SMT. KASHIBAI NAWALE MEDICAL COLLEGE & GENERAL HOSPITAL, NARHE,PUNE	017/46/18/BG/10/22	25 LAKH	23/02/2021	DUPLICATE BUT EXPIRY DATE CHANGED
451	SMT. KASHIBAI NAWALE MEDICAL COLLEGE & GENERAL HOSPITAL, NARHE,PUNE	017/46/18/BG/10/23	10 LAKH	23/02/2021	DUPLICATE BUT EXPIRY DATE CHANGED
452	SMT. KASHIBAI NAWALE MEDICAL COLLEGE & GENERAL HOSPITAL, NARHE,PUNE	017/46/18/BG/10/24	10 LAKH	23/02/2021	
453	SMT. KASHIBAI NAWALE MEDICAL COLLEGE & GENERAL HOSPITAL, NARHE,PUNE	017/46/18/BG/10/25	10 LAKH	23/02/2021	
454	M/S SRM INSTITUTE OF SCIENCE AND TECHNOLOGY	0051719PBG013582	85 LAKH	31/10/2022	31/10/2022
455	M/S SRM INSTITUTE OF SCIENCE AND TECHNOLOGY	0051719PBG013668	85 LAKH	13/11/2022	13/11/2022
456	M/S SRM INSTITUTE OF SCIENCE AND TECHNOLOGY	0051719PBG013666	85 LAKH	13/11/2022	13/11/2022
457	M/S SRM INSTITUTE OF SCIENCE AND TECHNOLOGY	0051719PBG013669	85 LAKH	13/11/2022	13/11/2022
458	M/S SRM INSTITUTE OF SCIENCE AND TECHNOLOGY	0051719PBG013701	85 LAKH	19/11/2022	19/11/2022
459	M/S SRM INSTITUTE OF SCIENCE AND TECHNOLOGY	0051719PBG013699	85 LAKH	19/11/2022	19/11/2022
460	M/S SRM INSTITUTE OF SCIENCE AND TECHNOLOGY	0051719PBG013700	85 LAKH	19/11/2022	19/11/2022
461	M/S SRM INSTITUTE OF SCIENCE AND TECHNOLOGY	0051719PBG013740	85 LAKH	26/11/2022	26/11/2022
462	M/S SRM INSTITUTE OF SCIENCE AND TECHNOLOGY	0051719PBG013739	85 LAKH	26/11/2022	26/11/2022
463	M/S SRM INSTITUTE OF SCIENCE AND TECHNOLOGY	0051719PBG013735	85 LAKH	26/11/2022	26/11/2022
464	M/S SRM INSTITUTE OF SCIENCE AND TECHNOLOGY	0051719PBG013738	85 LAKH	26/11/2022	26/11/2022
465	M/S SRM INSTITUTE OF SCIENCE AND TECHNOLOGY	0051719PBG013741	85 LAKH	26/11/2022	26/11/2022
466	M/S SRM INSTITUTE OF SCIENCE AND TECHNOLOGY	0051719PBG013736	85 LAKH	26/11/2022	26/11/2022
467	M/S SRM INSTITUTE OF SCIENCE AND TECHNOLOGY	594BG07200420001	15 LAKH	07/02/2023	07/02/2024
468	M/S SRM INSTITUTE OF SCIENCE AND TECHNOLOGY	PBG201500002	05 LAKH	17/02/2021	
469	M/S SRM INSTITUTE OF SCIENCE AND TECHNOLOGY	PBG201500003	05 LAKH	17/02/2021	
470	M/S SRM INSTITUTE OF SCIENCE AND TECHNOLOGY	PBG201500004	10 LAKH	17/02/2021	
471	M/S SRM INSTITUTE OF SCIENCE AND TECHNOLOGY	PBG201500005	05 LAKH	17/02/2021	
472	M/S SRM INSTITUTE OF SCIENCE AND TECHNOLOGY	PBG201500006	10 LAKH	17/02/2021	
473	SIDDHARTHA ACADEMY	TD0BGDP192490003 (536BGDP192490003	85 LAKH	03/09/2023	
474	SIDDHARTHA ACADEMY	TD0BGDP192550002 536BGDP192550002	85 LAKH	10/09/2023	

List of College with Expired Bank Guarantee					
Sr. No.	College/ Instt. Name	BG. No./ Date	Amount	Expiry date	Claim date/Remarks
475	SIDDHARTHA ACADEMY	TD0BGDP192550003 536BGDP192550003	85 LAKH	10/09/2023	
476	M/S SIKSHA O ANUSANDHAN	4077ILG001815	NA	20/12/2023	
477	M/S SIKSHA O ANUSANDHAN	4077ILG001915	NA	20/12/2023	
478	M/S SIKSHA O ANUSANDHAN	4077ILG002115	NA	20/12/2023	
479	SREE GOKULAM MEDICAL COLLEGE HOSPITAL	020GT02193470001	85 LAKH	10/12/2023	
480	SHREE ASTHA FOUNDATION FOR EDUCATION SOCIETY	8801IPEBG160001	200 LAKH	31/08/2018	
481	M/S SHRI BANKEY BIHARI EDUCATIONAL & WELFARE	0717-BG0093-16	NA	22/09/2023	22/09/2023
482	M/S SHRI BANKEY BIHARI EDUCATIONAL & WELFARE	0717-BG0094-16	NA	22/09/2023	22/09/2023
483	SRI RANGA MEDICAL COLLEGE HOSPITAL & KUNIGAL RESEARCH INSTITUTE	0182323IPG000021	750 LAKH	24/11/2023	
484	SRI RANGA MEDICAL COLLEGE HOSPITAL & KUNIGAL RESEARCH INSTITUTE	0182323IPG000023	200 LAKH	24/11/2023	
485	S J M VIDHYAPEETHA	PBG201700003	85 LAKH	26/08/2023	
486	SRI ALLURI SITARAMARAJU EDUCATIONAL SOCIETY	8440100000034	15 LAKH	25/02/2022	25/02/2022
487	SRI RAMACHANDRA MEDICAL COLLEGE AND RESEARCH INSTITUTE	00333IGL90000116	10 LAKH	13/11/2022	
488	SRI RAMACHANDRA MEDICAL COLLEGE AND RESEARCH INSTITUTE	00333IGL90000118	40 LAKH	13/11/2022	
489	SRI RAMACHANDRA MEDICAL COLLEGE AND RESEARCH INSTITUTE	00333IGL90000110	85 LAKH	30/10/2022	
490	SRI RAMACHANDRA MEDICAL COLLEGE AND RESEARCH INSTITUTE	00333IGL90000117	10 LAKH	13/11/2022	
491	M/S RAJ SHREE EDUCATIONAL TRUST	36470ILG000919	85 LAKH	16/10/2023	16/10/2023
492	M/S RAJ SHREE EDUCATIONAL TRUST	36470ILG001119	85 LAKH	16/10/2023	16/10/2023
493	M/S RAJ SHREE EDUCATIONAL TRUST	36470ILG001019	85 LAKH	16/10/2023	16/10/2023
494	M/S RAJ SHREE EDUCATIONAL TRUST	36470ILG001219	85 LAKH	30/10/2023	30/10/2023
495	M/S RAJ SHREE EDUCATIONAL TRUST	36470ILG001319	85 LAKH	30/10/2023	30/10/2023
496	M/S RAJ SHREE EDUCATIONAL TRUST	36470ILG001419	85 LAKH	30/10/2023	30/10/2023
497	M/S RAJ SHREE EDUCATIONAL TRUST	36470ILG001519	85 LAKH	30/10/2023	30/10/2023
498	M/S RAJ SHREE EDUCATIONAL TRUST	36470ILG001919	85 LAKH	29/11/2023	29/11/2023
499	M/S RAJ SHREE EDUCATIONAL TRUST	36470ILG001819	85 LAKH	29/11/2023	29/11/2023
500	RAJALAKSHMI MEDICAL EDUCATION & RESEARCH FOUNDATION	1384ILG000916	NA	31/08/2023	
501	RAJALAKSHMI MEDICAL EDUCATION & RESEARCH FOUNDATION	1384ILG001016	NA	31/08/2023	
502	RUXMANIBEN DEEPCHAND GARDI MEDICAL	OGT0766200040293	05 LAKH	21/01/2023	21/01/2023

List of College with Expired Bank Guarantee					
Sr. No.	College/ Instt. Name	BG. No./ Date	Amount	Expiry date	Claim date/Remarks
503	RUXMANIBEN DEEPCHAND GARDI MEDICAL	OGT0766200040291	30 LAKH	21/01/2023	21/01/2023
504	Ayaan Instt. Of Medical Sci. Kanakamamudi , Moinabad Mandal, Ranga Reddy Distt. Telangana (Ayaan Educational Society)	BG NO. 01/2018	750 LAKH	16/03/2023	
505	Ayaan Instt. Of Medical Sci. Kanakamamudi , Moinabad Mandal, Ranga Reddy Distt. Telangana (Ayaan Educational Society)	BG NO. 02/2018	200 LAKH	16/03/2023	
506	Kanachur Instt. Of Medical Sci, Mangaluru	161117IBGP00002	750 LAKH	N/A	
507	Kanachur Instt. Of Medical Sci, Mangaluru	161117IBGP00003	200 LAKH	N/A	
508	Raja Rajeshwari Medical College, Bangalore (Moogambigai Charitable & Educational Trust)	594GM07170230002	20 LAKH	22/01/2022	
509	Raja Rajeshwari Medical College, Bangalore (Moogambigai Charitable & Educational Trust)	594GM07170340001	15 LAKH	02/02/2022	
510	Raja Rajeshwari Medical College, Bangalore (Moogambigai Charitable & Educational Trust)	594GM07190310001	128 LAKH	31/01/2021	
511	Raja Rajeshwari Medical College, Bangalore (Moogambigai Charitable & Educational Trust)	594GM07170370001	5 LAKH	05/02/2022	
512	Raja Rajeshwari Medical College, Bangalore (Moogambigai Charitable & Educational Trust)	594GM07170530001	5 LAKH	20/02/2022	
513	Raja Rajeshwari Medical College, Bangalore (Moogambigai Charitable & Educational Trust)	594GM07171140001	200 LAKH	20/04/2022	
514	Raja Rajeshwari Medical College, Bangalore (Moogambigai Charitable & Educational Trust)	594GM07172490001	25 LAKH	05/02/2022	
515	Raja Rajeshwari Medical College, Bangalore (Moogambigai Charitable & Educational Trust)	594GM07180320001	10 LAKH	20/01/2023	
516	Vinayaka Mission Medical College and Hospital, puducherry	02/2018-19	15 LAKH	20/02/2019	extended till 15-02-2023 and 15-02-2024
517	Vinayaka Mission Medical College and Hospital, puducherry	03/2018-19	85 LAKH	19/02/2022	extended till 15-02-2023 and 15-02-2024
518	Aarupadai veedu Medical College, Puducheery	87810BG19003733	85 LAKH	19/02/2022	extended till 18-02-2023
519	Aarupadai veedu Medical College, Puducheery	00075IG180000001	5 LAKH	19/02/2021	extended till 19-02-2022
520	D Y PATIL MEDICAL COLLEGE AND HOSPITAL.PUNE	111719IGFIN0006	15 LAKH	05/02/2022	
521	D Y PATIL MEDICAL COLLEGE AND HOSPITAL.PUNE	111718IGFIN0005	40 LAKH	08/02/2021	
522	Sri Devaraj Urs Med. College, Kolar	402LG0657/12 dt. 26/9/12	100.00 Lakh	24/09/2017	
523	Khaja Edn. Society, Gulbarga	04/2014-15 dt:12/04/2014	85.00 Lakh	12/04/2017	
524	Khaja Edn. Society, Gulbarga	07/2015-16 dt.19/02/2015	5.10 crore (85.00)	19/02/2018	
525	NKP Salve Instt. Of Med. Sc., Nagpur	066/02/73 dt.19/04/2014	5.00 Lakh	18/04/2017	

List of College with Expired Bank Guarantee

Sr. No.	College/ Instt. Name	BG. No./ Date	Amount	Expiry date	Claim date/Remarks
526	NKP Salve Instt. Of Med. Sc., Nagpur	066/02/76 dt.19/04/2014	10.00 Lakh	18/04/2017	
527	Sri Siddhartha Med. College, Tumkur	8/2010 dt. 3/4/2010	21.00 lakh	03/04/2013	
528	Sri Siddhartha Med. College, Tumkur	6/2010 dt. 30/3/2010	33.00 lakh	03/04/2013	
529	Sri Siddhartha Med. College, Tumkur	4/2011 dt. 25/3/2011	5.00 Lakh	24/03/2017	
530	Sri Guru Ram Das Instt. Of Med. Sc., Sri Amritsar	07/06-07 dt. 02/03/2007	100.00 Lakh	10/07/2012	
531	Sri Guru Ram Das Instt. Of Med. Sc., Sri Amritsar	3/2010-11 dt. 5/3/2011	10.00 Lakh	04/03/2014	
532	Sri Guru Ram Das Instt. Of Med. Sc., Sri Amritsar	2/2010-11 dt. 3/3/2011	10.00 Lakh	02/03/2014	
533	Sri Guru Ram Das Instt. Of Med. Sc., Sri Amritsar	1/2010-11 dt. 22/2/2011	15.00 Lakh	21/02/2014	
534	Sri Guru Ram Das Instt. Of Med. Sc., Sri Amritsar	5/2010-11 dt. 16/3/2011	5.00 Lakh	15/03/2014	
535	Sri Guru Ram Das Instt. Of Med. Sc., Sri Amritsar	4/2010-11 dt. 16/3/2011	5.00 Lakh	15/03/2014	
536	Sri Guru Ram Das Instt. Of Med. Sc., Sri Amritsar	6/2010-11 dt. 31/3/2011	5.00 Lakh	30/03/2014	
537	Sri Guru Ram Das Instt. Of Med. Sc., Sri Amritsar	BG No. 01510000313 dt. 08/04/11	5.00 Lakh	07/10/2016	
538	Sri Guru Ram Das Instt. Of Med. Sc., Sri Amritsar	BG No. 01510000113 dt. 08/04/11	5.00 Lakh	07/10/2016	
539	Sri Guru Ram Das Instt. Of Med. Sc., Sri Amritsar	BG No. 01510000213 dt. 08/04/11	5.00 Lakh	07/10/2016	
540	Sri Guru Ram Das Instt. Of Med. Sc., Sri Amritsar	BG No. AB/DAV/BG/MCI/01 dt. 04/10/2010	100.00 Lakh	03/10/2017	
541	Sri Guru Ram Das Instt. Of Med. Sc., Sri Amritsar	AB/DAV/BG/MCI/08 dt:04/10/2010	85.00 Lakh	03/10/2017	
542	Sri Guru Ram Das Instt. Of Med. Sc., Sri Amritsar	AB/DAV/BG/MCI/07 dt:04/10/2010	85.00 Lakh	03/10/2017	
543	Sri Guru Ram Das Instt. Of Med. Sc., Sri Amritsar	AB/DAV/BG/MCI/11 dt:23/23/2010	10.00 Lakh	22/04/2017	
544	Fr. Muller Med. College, Mangalore	7/2010 dt. 29/3/2010	15.00 Lakh	30/08/2014	
545	Fr. Muller Med. College, Mangalore	2/2010 dt. 22/2/2010	20.00 Lakh	30/08/2014	
546	Fr. Muller Med. College, Mangalore	1/2010 dt. 9/2/2010	50.00 Lakh	30/08/2014	
547	Fr. Muller Med. College, Mangalore	6/2012 dt. 3/4/12	10.00 Lakh	30/04/2018	
548	Fr. Muller Med. College, Mangalore	02/2014 dt:10/04/2014	15.00 Lakh	30/04/2018	
549	Fr. Muller Med. College, Mangalore	04/2014 dt:10/04/2014	15.00 Lakh	30/04/2018	
550	Fr. Muller Med. College, Mangalore	05/2014 dt:10/04/2014	10.00 Lakh	30/04/2018	
551	Fr. Muller Med. College, Mangalore	Sep-13	10.00 Lakh	22/05/2016	
552	Bharti Vidyapeeth Med. College, Pune	BSB/HO/16/09-10 dt. 9/4/2009	5.00 Lakh	08/04/2012	
553	K.J. Somaiya Med. College, Mumbai	05300005012 dt.15/11/10	5.00 Lakh	14/11/2015	
554	Mahadevappa Rampure Medical College, Gulbarga	1/2011 dt.25/3/2011	5.00 Lakh	24/03/2016	
555	Mahadevappa Rampure Medical College, Gulbarga	BG NO.02/2012 dt.26/03/2012	10.00 Lakh	25/03/2016	
556	K.S. Hegde Med. College, Bangalore (Nitte Education Trust)	184BGPG102920001 dt. 19/10/2015	10.00 Lakh	19/10/2015	
557	K.S. Hegde Med. College, Bangalore (Nitte Education Trust)	184BGPG103290001/03-10 dt.25/11/2015	15.00 Lakh	25/11/2015	
558	K.S. Hegde Med. College, Bangalore (Nitte Education Trust)	184BGPG103290004/06-10 dt.25/11/2015	20.00 lakh	25/11/2015	
559	K.S. Hegde Med. College, Bangalore (Nitte Education Trust)	184BGPG103290003/05-10 dt.25/11/2015	20.00 lakh	25/11/2015	
560	K.S. Hegde Med. College, Bangalore (Nitte Education Trust)	184BGPG103290002/04-10 dt.25/11/2015	5.00 Lakh	25/11/2015	
561	K.S. Hegde Med. College, Bangalore (Nitte Education Trust)	02/2011 dt. 21/1/11	5.00 Lakh	21/01/2016	
562	K.S. Hegde Med. College, Bangalore (Nitte Education Trust)	03/2011 dt. 21/1/11	10.00 Lakh	21/01/2016	
563	K.S. Hegde Med. College, Bangalore (Nitte Education Trust)	04/2011 dt. 17/2/11	85.00 Lakh	17/02/2015	

List of College with Expired Bank Guarantee

Sr. No.	College/ Instt. Name	BG. No./ Date	Amount	Expiry date	Claim date/Remarks
564	K.S. Hegde Med. College, Bangalore (Nitte Education Trust)	05/2011 dt. 24/2/11	5.00 Lakh	24/02/2015	
565	K.S. Hegde Med. College, Bangalore (Nitte Education Trust)	06/2011 dt. 11/3/11	5.00 Lakh	11/03/2015	
566	K.S. Hegde Med. College, Bangalore (Nitte Education Trust)	184/BGPG/102920001 dt. 22/6/2	100.00 Lakh	22/06/2016	
567	K.S. Hegde Med. College, Bangalore (Nitte Education Trust)	PG 07/2012 dt. 16/3/2012	10.00 Lakh	16/03/2015	
568	K.S. Hegde Med. College, Bangalore (Nitte Education Trust)	PG 06/2012 dt. 16/3/2012	30.00 Lakh	16/03/2015	
569	K.S. Hegde Med. College, Bangalore (Nitte Education Trust)	PG 05/2012 dt. 16/3/2012	10.00 Lakh	16/03/2015	
570	K.S. Hegde Med. College, Bangalore (Nitte Education Trust)	14/2013 dt. 03/10/2013	5.00 Lakh	03/10/2016	
571	K.S. Hegde Med. College, Bangalore (Nitte Education Trust)	23/2012 dt. 22/11/2012	10.00 Lakh	22/11/2015	
572	K.S. Hegde Med. College, Bangalore (Nitte Education Trust)	24/2012 dt. 22/11/2012	20.00 lakh	22/11/2015	
573	K.S. Hegde Med. College, Bangalore (Nitte Education Trust)	15/2013 dt. 03/10/2013	5.00 Lakh	03/10/2016	
574	K.S. Hegde Med. College, Bangalore (Nitte Education Trust)	13/2013 dt. 03/10/2013	5.00 Lakh	03/10/2016	
575	K.S. Hegde Med. College, Bangalore (Nitte Education Trust)	16/2013 dt. 03/10/2013	5.00 Lakh	03/10/2016	
576	K.S. Hegde Med. College, Bangalore (Nitte Education Trust)	12/2013 dt. 03/10/2013	5.00 Lakh	03/10/2016	
577	K.S. Hegde Med. College, Bangalore (Nitte Education Trust)	17/2013 dt. 03/10/2013	5.00 Lakh	03/10/2016	
578	K.S. Hegde Med. College, Bangalore (Nitte Education Trust)	04/2014 dt:04/04/2014	30.00 Lakh	03/04/2017	
579	K.S. Hegde Med. College, Bangalore (Nitte Education Trust)	03/2014 dt:04/04/2014	15.00 Lakh	03/04/2017	
580	K.S. Hegde Med. College, Bangalore (Nitte Education Trust)	05/2014 dt:04/04/2014	30.00 Lakh	03/04/2017	
581	CMC, Vellore	0161808BG0000019 dt. 15/2/20	25.00 Lakh	14/02/2017	
582	CMC, Vellore	0161808BG0000027 dt. 23/2/20	20.00 lakh	22/02/2017	
583	CMC, Vellore	0161808BG0000025 dt. 23/2/20	30.00 Lakh	22/02/2017	
584	CMC, Vellore	0161811BG0000030 dt. 01/3/20	5.00 Lakh	28/02/2017	
585	Himalayan Instt. Of Med. Sc., Dehradun	2010-11/4 dt.5/3/11	5.00 Lakh	04/03/2014	
586	Himalayan Instt. Of Med. Sc., Dehradun	2010-11/5 dt.5/3/11	5.00 Lakh	04/03/2014	
587	Himalayan Instt. Of Med. Sc., Dehradun	2010-11/3 dt.5/3/11	10.00 Lakh	04/03/2014	
588	Himalayan Instt. Of Med. Sc., Dehradun	2010-11/6 dt.7/3/11	5.00 Lakh	06/03/2014	
589	Himalayan Instt. Of Med. Sc., Dehradun	BG/10580/2012-13/021	85.00 Lakh	12/09/2016	
590	Himalayan Instt. Of Med. Sc., Dehradun	BG/10580/2012-13/022 dt. 13/03	5.00 Lakh	12/09/2016	
591	Himalayan Instt. Of Med. Sc., Dehradun	BG/10580/2012-13/023 dt. 13/03	5.00 Lakh	12/09/2016	
592	Himalayan Instt. Of Med. Sc., Dehradun	2012-13/015 dt. 27/02/2013	100.00 Lakh	21/02/2018	
593	Himalayan Instt. Of Med. Sc., Dehradun	2012-13/25 dt. 30/03/2013	85.00 Lakh	29/09/2016	
594	Himalayan Instt. Of Med. Sc., Dehradun	BG/2014-15/05 dt.13/04/2014	85.00 Lakh	12/05/2017	
595	Himalayan Instt. Of Med. Sc., Dehradun	PG/2014-15/01 dt.17/04/2014	15.00 Lakh	16/04/2017	
596	Era's Lucknow Medical College & Hospital, Lucknow	0294ILG000411 dt. 9/5/11	100.00 Lakh	09/05/2016	
597	Era's Lucknow Medical College & Hospital, Lucknow	7177ILG001812 dt. 4/4/12	5.00 Lakh	03/04/2015	
598	Era's Lucknow Medical College & Hospital, Lucknow	7177ILG001512 dt. 4/4/12	10.00 Lakh	03/04/2015	
599	Era's Lucknow Medical College & Hospital, Lucknow	7177ILG002012 dt. 4/4/12	5.00 Lakh	03/04/2015	
600	Era's Lucknow Medical College & Hospital, Lucknow	7177ILG001712 dt. 4/4/12	5.00 Lakh	03/04/2015	
601	Era's Lucknow Medical College & Hospital, Lucknow	7177ILG001912 dt. 4/4/12	5.00 Lakh	03/04/2015	

List of College with Expired Bank Guarantee

Sr. No.	College/ Instt. Name	BG. No./ Date	Amount	Expiry date	Claim date/Remarks
602	Era's Lucknow Medical College & Hospital, Lucknow	7177ILG00161912 dt. 4/4/12	5.00 Lakh	03/04/2015	
603	Era's Lucknow Medical College & Hospital, Lucknow	7177ILG004613 dt. 15/4/13	10.00 Lakh	14/04/2016	
604	Era's Lucknow Medical College & Hospital, Lucknow	7177ILG004713 dt. 15/4/13	10.00 Lakh	14/04/2016	
605	Era's Lucknow Medical College & Hospital, Lucknow	7177ILG004513 dt. 15/4/13	10.00 Lakh	14/04/2016	
606	Era's Lucknow Medical College & Hospital, Lucknow	7177ILG002514 dt.09/04/2014	20.00 Lakh	08/04/2017	
607	Era's Lucknow Medical College & Hospital, Lucknow	7177ILG002314 dt.09/04/2014	10.00 Lakh	08/04/2017	
608	Era's Lucknow Medical College & Hospital, Lucknow	7177ILG002115 dt.30/12/2015	10.00 Lakh	30/12/2018	
609	Era's Lucknow Medical College & Hospital, Lucknow	717700ILG000116 dt.10/02/201	5.00 Lakh	23/02/2018	
610	C.U. Shah Med. College, Surendranagar	101GT02150500002 dt.19/02/20	10.00 Lakh	18/05/2018	
611	Subharti Medical College, Meerut	00170002016 dt.03/09/2016	200.00 Lakh	02/09/2017	
612	R. M. Med. College, Annamalainagar	BG dt. 18/2/2011	15.00 Lakh	31/07/2014	
613	R. M. Med. College, Annamalainagar	BG dt.22/3/2011	10.00 Lakh	31/07/2014	
614	R. M. Med. College, Annamalainagar	BG dt. 22/3/2011	5.00 Lakh	31/07/2014	
615	SRMC & RI, Porur, Chennai	00333IG120000035 dt. 27/06/20	10.00 Lakh	26/09/2016	
616	SRMC & RI, Porur, Chennai	00333IG120000036 dt. 27/06/20	10.00 Lakh	26/09/2016	
617	SRMC & RI, Porur, Chennai	BG No. 00333IG140000037 dt. 0	40.00 Lakh	02/04/2017	
618	Academy of Med. Sc., Kannur	BG No. Nil Dated 17/2/2011	234.00 Lakh	31/05/2014	
619	Academy of Med. Sc., Kannur	BG No. Nil Dated 12/7/2011	128.00 Lakh	31/12/2014	
620	Dr. Somervell Memo. CSI Medical College & Hosp., Thiruv	734GOPG152110001 dt.30/07/2	85.00 Lakh	31/03/2016	
621	Dr. Somervell Memo. CSI Medical College & Hosp., Thiruv	734GOPG152110002 dt.30/07/2	85.00 Lakh	31/03/2016	
622	Dr. Somervell Memo. CSI Medical College & Hosp., Thiruv	734GOPG150840001 dt.24/03/2	85.00 Lakh	22/03/2016	
623	Dr. Somervell Memo. CSI Medical College & Hosp., Thiruv	734GOPG152110003 dt.30/07/2	85.00 Lakh	31/03/2016	
624	Dr. Somervell Memo. CSI Medical College & Hosp., Thiruv	734GOPG150840005 dt.24/03/2	85.00 Lakh	22/03/2016	
625	Dr. Somervell Memo. CSI Medical College & Hosp., Thiruv	734GOPG150840007 dt.24/03/2	85.00 Lakh	22/03/2016	
626	Dr. Somervell Memo. CSI Medical College & Hosp., Thiruv	734GOPG150840008 dt.24/03/2	85.00 Lakh	22/03/2016	
627	Dr. Somervell Memo. CSI Medical College & Hosp., Thiruv	734GOPG150840009 dt.24/03/2	85.00 Lakh	23/09/2015	
628	Dr. Somervell Memo. CSI Medical College & Hosp., Thiruv	057BG01131450004 dt. 25/05/2	5.00 Lakh	31/12/2016	
629	Dr. Somervell Memo. CSI Medical College & Hosp., Thiruv	057BG01130160004 dt. 16/01/2	75.00 Lakh & 10.0	31/12/2016	
630	Dr. Somervell Memo. CSI Medical College & Hosp., Thiruv	057BG01131450005 dt. 25/05/2	5.00 Lakh	31/12/2016	
631	Dr. Somervell Memo. CSI Medical College & Hosp., Thiruv	057BG01130160003 dt. 16/01/2	75.00 Lakh & 10.0	31/12/2016	
632	Dr. Somervell Memo. CSI Medical College & Hosp., Thiruv	1 BG 51888 dt.16/04/2014	5.00 Lakh	31/12/2017	
633	S.Nijalingappa Medical College, Bagalkot	CBG201200006 20/04/2015	3.00 Lakh	12/12/2015	
634	S.Nijalingappa Medical College, Bagalkot	09/2011 dt. 7/4/2011	5.00 Lakh	04/07/2014	
635	S.Nijalingappa Medical College, Bagalkot	15/2011 dt. 29/06/2011	100.00 Lakh	28/06/2016	
636	S.Nijalingappa Medical College, Bagalkot	CBG201200005 20/04/2015 FIN	10.00 Lakh	04/04/2016	
637	S.Nijalingappa Medical College, Bagalkot	2014-8 dt.16/04/2014	10.00 Lakh	15/04/2017	
638	S.Nijalingappa Medical College, Bagalkot	2014-7 dt.16/04/2014	10.00 Lakh	15/04/2017	
639	Amrita Instt. Of Med. Sc., Kochi	002BG01121770003 dt. 25/6/20	10.00 Lakh	31/12/2017	

List of College with Expired Bank Guarantee

Sr. No.	College/ Instt. Name	BG. No./ Date	Amount	Expiry date	Claim date/Remarks
640	Amrita Instt. Of Med. Sc., Kochi	002BG01162430002 dt. 23/02/2	2.00 Crore	28/08/2017	
641	Amrita Instt. Of Med. Sc., Kochi	002BG01162430001 dt. 29/08/2	2.00 Crore	28/08/2017	
642	Amrita Instt. Of Med. Sc., Kochi	002BG01162430003 dt. 29/08/2	2.00 Crore	28/08/2017	
643	Mahatma Gandhi Med. Coll., Pondicherry	17/2010 dt.25/3/10	5.00 Lakh	24/03/2013	
644	Mahatma Gandhi Med. Coll., Pondicherry	12/2011 dt.7/4/11	5.00 Lakh	06/04/2014	
645	Mahatma Gandhi Med. Coll., Pondicherry	13/2011 dt.7/4/11	5.00 Lakh	06/04/2014	
646	Mahatma Gandhi Med. Coll., Pondicherry	15/2011 dt.21/5/11	128.00 Lakh	20/05/2014	
647	MNR Med. College, Sangareddy	1081000911 dt. 30.3.2011	115.00 lakh	29/03/2017	
648	KVG Med. College, Sullia, Karnataka	4/10-11 dt. 16/3/2011	85.00 Lakh	30/12/2015	
649	Pushpagiri Med. Ollege, Tiruvalla	0079BG000082012 08/2012 dt.	5.00 Lakh	31/03/2017	
650	Vydehi Instt. Of Med. Sc., Bangalore	8498IPBG100002 dt. 20/01/20	5.00 Lakh	30/09/2013	
651	Vydehi Instt. Of Med. Sc., Bangalore	09/11 dt. 21/2/2011	10.00 Lakh	16/08/2018	
652	A J. Instt. Of Med. Sc., Mangalore	PBG-2015/8 dt:19/02/2015	5.00 Lakh	18/02/2018	
653	Navodaya Medical College, Raichur	17/2009 Dt. 02-11-2009	85.00 Lakh	10/04/2014	
654	Katuri Med. College Guntur	171BG01100890010 dt. 30/3/20	5.00 Lakh	31/03/2013	
655	Katuri Med. College Guntur	171BG01100890011 dt. 30/3/20	5.00 Lakh	31/03/2013	
656	Katuri Med. College Guntur	171BG01100890008 dt. 30/3/20	10.00 lakh	30/03/2013	
657	Katuri Med. College Guntur	171BG01100890007 dt. 30/3/20	10.00 lakh	30/03/2013	
658	Katuri Med. College Guntur	46/2010-11 dt. 28/3/11	5.00 Lakh	27/03/2014	
659	Katuri Med. College Guntur	47/2010-11 dt. 28/3/11	5.00 Lakh	27/03/2014	
660	MGM Med. College, Aurangabad	110376IBG0014 dt. 10/1/2011	5.00 Lakh	03/06/2016	
661	K.M. Shah Charitable Trust, Vadodara (SBKS, Vadodara)	61920IGL0001012 dt.12/3/12	10.00 lakh	31/03/2016	
662	Chalmeda Anandrao Instt. Of Med. Sc., Karimnagar (Arihant)	104816IGFIN0007 dt.29/08/2016	2.00 Crore	28/08/2017	
663	Deccan College of Medical Sc., Hyd.	17 dt. 9/2/2010	85.00 Lakh	08/02/2017	
664	Deccan College of Medical Sc., Hyd.	19/2010 dt. 5/3/2010	85.00 Lakh	04/03/2017	
665	Deccan College of Medical Sc., Hyd.	25 dt. 20/3/2012	10.00 lakh	20/03/2017	
666	Deccan College of Medical Sc., Hyd.	14 dt. 12/09/2012	5.00 Lakh	13/09/2017	
667	Deccan College of Medical Sc., Hyd.	13 dt. 12/09/2012	10.00 Lakh	13/09/2017	
668	Deccan College of Medical Sc., Hyd.	12 dt. 12/09/2012	85.00 Lakh	29/09/2016	
669	Dr. D.Y. Patil Med. College, Navi Mumbai	08IBG70 dt. 29/07/08 ((2741IGP	128.00 Lakh	08/11/2014	
670	Dr. D.Y. Patil Med. College, Navi Mumbai	111-09 dt. 30/6/2009	128.00 Lakh	29/06/2012	
671	Dr. D.Y. Patil Med. College, Navi Mumbai	065 dt. 8/3/ 2010	5.00 Lakh	07/03/2013	
672	Dr. D.Y. Patil Med. College, Navi Mumbai	011/11 dt. 13/1/2011	30.00 Lakh	12/01/2014	
673	Dr. D.Y. Patil Med. College, Navi Mumbai	016/11 dt. 13/1/2011	5.00 Lakh	12/01/2014	
674	Dr. D.Y. Patil Med. College, Navi Mumbai	039/11 dt. 10/2/2011	10.00 Lakh	09/02/2014	
675	Dr. D.Y. Patil Med. College, Kolhapur	BG No. 2/2012-13 dt. 24/09/2012	5.00 Lakh	31/12/2017	
676	Dr. D.Y. Patil Med. College, Kolhapur	BG No. 4/2012-13 dt. 24/09/2012	85.00 Lakh	31/12/2017	
677	Vinayaka Mission's Med. College, Salem	ILG 01/12 dt. 24/04/2012	10.00 Lakh	23/04/2015	

List of College with Expired Bank Guarantee

Sr. No.	College/ Instt. Name	BG. No./ Date	Amount	Expiry date	Claim date/Remarks
678	Vinayaka Mission's Med. College, Salem	011/2020-2021 dt. 05/10/2020	100.00 Lakh	10/04/2015	
679	Cancer Hospital, Chennai	149711IGFIN003 dt. 16/08/2017	10.00 Lakh	15/08/2017	
680	SDM Medical College, Dharwad	669BGP110120005 dt. 12/1/2016	64.00 Lakh	11/01/2016	
681	SDM Medical College, Dharwad	BG No. 669BGP121010002 dt. 04/09/2015	64.00 Lakh	04/09/2015	
682	Padmashri Dr. Vithalrao Vikhe Patil Foundation, Ahmednagar	BG No. nil dated 11/09/2012	85.00 Lakh	31/12/2016	
683	Sri Guru Ram Rai Instt. Of Med. Sc., Dehradun	1516ILG001814 dt.16/04/2014	5.00 lakh	15/04/2017	
684	Sikkim Manipal Instt. Of Med Sc., Gangtok	003GM07102700001	100.00 Lakh	24/09/2011	
685	National Institute of Medical Sciences & Research, Jaipur, R	0505711BG0055	40.00 Lakh	23/08/2014	
686	National Institute of Medical Sciences & Research, Jaipur, R	0505711BG00120	100.00 Lakh	11/05/2017	
687	Kannur Medical college, Kannur	67314356794 dt.28/02/2015	85.00 Lakh	28/02/2018	
688	Shadan Instt. Of Med. Sc., Hyd.	18/HYD/BG/109	85.00 Lakh	30/06/2016	
689	Dr. Panjabrao alias Bhausaheb Deshmukh Memo. Med. Co	AMT/BG/29	85.00 Lakh	29/03/2015	
690	Kasturba Med. College, Manipal	0002BGR0060718 dt.04/10/2018	5.00 Lakh	02/10/2018	
691	Kasturba Med. College, Manipal	0002BGR0060818 dt.04/10/2018	10.00 Lakh	02/10/2018	
692	Bharti Vidyapeeth Med. College, Sangli	HO/3185/2012-13	5.00 Lakh	24/03/2017	
693	Bharti Vidyapeeth Med. College, Sangli	HO/3187/2012-13	10.00 Lakh	24/03/2017	
694	Bharti Vidyapeeth Med. College, Sangli	HO/3188/2012-13	85.00 Lakh	24/03/2017	
695	Bharti Vidyapeeth Med. College, Sangli	HO/3189/2012-13	85.00 Lakh	24/03/2017	
696	Bharti Vidyapeeth Med. College, Sangli	HO/3190/2012-13	85.00 Lakh	24/03/2017	
697	Bharti Vidyapeeth Med. College, Sangli	HO/3191/2012-13	85.00 Lakh	24/03/2017	
698	Bharti Vidyapeeth Med. College, Sangli	2/2014-15	85.00 Lakh	09/10/2018	
699	Bharti Vidyapeeth Med. College, Sangli	3/2014-15	5.00 Lakh	09/10/2018	
700	Bombay Hospital Instt. of Med. Sc., Bombay	301/49/11	10.00 Lakh	23/04/2017	
701	Sree Gokulam Med. College, TVM, Kerala	03/11 dt. 31/3/2011	723.00 lakh	30/03/2017	
702	Sree Gokulam Med. College, TVM, Kerala	09/12 dt. 11/4/2012	42.00 lakh	31/03/2017	
703	Sree Gokulam Med. College, TVM, Kerala	10/12 dt. 10/5/2012	35.00 lakh	09/05/2017	
704	Sree Gokulam Med. College, TVM, Kerala	05/2015-1051 dt.22/06/25015	200.00 lakh	16/05/2017	
705	Sri Aurobindo Instt. Of Med.Sc, Indore	963211BG00257 dt. 13/5/2011	1.00 Crore	12/05/2016	
706	Sri Aurobindo Instt. Of Med.Sc, Indore	0963215BG00218 dt.04/07/2015	10.00 Lakh	30/06/2017	
707	Sri Aurobindo Instt. Of Med.Sc, Indore	0963215BG00221 and 963212E	30.00 Lakh	30/06/2017	
708	Sri Aurobindo Instt. Of Med.Sc, Indore	0963215BG00220 and 963212E	20.00 Lakh	30/06/2017	
709	Sri Aurobindo Instt. Of Med.Sc, Indore	0963215BG00219 and 963212E	20.00 Lakh	30/06/2017	
710	Sri Aurobindo Instt. Of Med.Sc, Indore	0963215BG00217 dt.04/07/2015 dt. 14/3/2012	10.00 Lakh	30/06/2017	
711	Sri Aurobindo Instt. Of Med.Sc, Indore	963212BG00282 dt. 23/6/2012	10.00 Lakh	21/06/2017	
712	Sri Aurobindo Instt. Of Med.Sc, Indore	963212BG00283dt. 23/6/2012	10.00 Lakh	21/06/2017	
713	Sri Aurobindo Instt. Of Med.Sc, Indore	036GT02122830002 dt. 09/10/2015	30.00 Lakh	07/10/2015	

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Sr. No.	College/ Instt. Name	BG. No./ Date	Amount	Expiry date	Claim date/Remarks
714	Sri Aurobindo Instt. Of Med.Sc, Indore	0963212BG0000488 dt. 18/11/15	15.00 lakh	18/11/2015	
715	Sri Aurobindo Instt. Of Med.Sc, Indore	0963212BG0000409 dt. 09/10/15	20.00 Lakh	07/10/2015	
716	Sri Aurobindo Instt. Of Med.Sc, Indore	0963216BG0000301 dt. 31/08/2017	200.00 lakh	30/08/2017	
717	Rajarajeshwari Med. College, Bangalore (Moogambigai Ch	0422OBG12003937 dt. 18/09/2017	5.00 Lakh	17/03/2017	
718	Rajarajeshwari Med. College, Bangalore (Moogambigai Ch	8037OBG15002632 dt.30/03/2017	5.00 Lakh	29/03/2017	
719	Instt of Medi Sci & Sum Hospital,Siksha 'O' Anusandhan, Bh	4077ILG000315 dt:21/02/2015	85.00 Lakh	20/08/2018	
720	Konaseema Instt. Of Med.Sc., Amalapuram, AP	B.G. No. 01/2013 dt. 12/01/2013	5.00 Lakh	11/10/2016	
721	Konaseema Instt. Of Med.Sc., Amalapuram, AP	448913BG0000015 dt:29/05/2017	5.00 Lakh	28/05/2017	
722	Konaseema Instt. Of Med.Sc., Amalapuram, AP	448913BG0000016 dt:29/05/2017	5.00 Lakh	28/05/2017	
723	S.S. Instt. Of Med. Sc. & Res., Davangere (Bapuji Edn. Trust	009GT02141830004 dt:02/07/2017	1.28 Crore	30/11/2017	
724	Rohilkhand Med. College, Bareilly	52260000213 dt. 22/03/13	5.00 Lakh	21/03/2016	
725	Geetanjali Med. College & Hospital, Udaipur (Geetanjali Fo	0045 BG 00004212 dt. 29/3/12	85.00 Lakh	09/06/2016	
726	Geetanjali Med. College & Hospital, Udaipur (Geetanjali Fo	00615IG150000004 dt.21/02/2018	10.00 Lakh	30/06/2018	
727	Shafa Educational Society, Hyd.	2007212BG 0000054 dt. 12/04/2015	85.00 Lakh	11/04/2015	
728	Shafa Educational Society, Hyd.	2007212BG 0000118 dt. 21/09/2015	85.00 Lakh	20/09/2015	
729	Regional Centre for Cancer Research & Treatment, Chenna	1497121GFIN0004 dt. 4/7/12	10.00 lakh	29/06/2017	
730	Regional Centre for Cancer Research & Treatment, Chenna	1497121GFIN0003 dt. 4/7/12	20.00 lakh	29/06/2017	
731	Chennai Medical College Hospital & Research Centre, Trich	BG No. 36491 dt. 06/09/2012	85.00 Lakh	05/09/2018	
732	Azeezia Instt of Medical Sciences & Research, Kerala	IBG58591 dt. 23/02/2015	85.00 Lakh	23/02/2018	
733	Azeezia Instt of Medical Sciences & Research, Kerala	IBG58593 dt. 23/02/2015	85.00 Lakh	23/02/2018	
734	Azeezia Instt of Medical Sciences & Research, Kerala	IBG58600 dt. 23/02/2015	85.00 Lakh	23/02/2018	
735	Khaja Edn. Society, Gulbarga	37556625303 dt. 23/02/2018	15.00 Lakh	22/02/2021	
736	Kamineni Academy of Med. Sci. & Res. Centre, Hyderabad	OBR2039/2016 dt.27/02/2017 Extn. 26/02/2020	85.00 Lakh	26/02/2021	
737	Kamineni Academy of Med. Sci. & Res. Centre, Hyderabad	OBG030BG1071819 dt.05/12/2018	85.00 Lakh	04/12/2021	
738	Kamineni Academy of Med. Sci. & Res. Centre, Hyderabad	OBG030BG1081819 dt.05/12/2018	85.00 Lakh	04/12/2021	
739	Kamineni Academy of Med. Sci. & Res. Centre, Hyderabad	OBG030BG1091819 dt.05/12/2018	85.00 Lakh	04/12/2021	
740	Pramukh Swami Med. College, Karamsad	50990000118 dt.16/01/2018	20.00 Lakh	15/01/2021	
741	CMC, Vellore	0161816BG0000019 dt:24/08/2016	20.00 lakh	23/08/2021	

List of College with Expired Bank Guarantee					
Sr. No.	College/ Instt. Name	BG. No./ Date	Amount	Expiry date	Claim date/Remarks
742	CMC, Vellore	0161816BG0000018 dt:23/08/2016	40.00 Lakh	23/08/2021	
743	CMC, Vellore	0161816BG0000017 dt:24/08/2016	40.00 Lakh	23/08/2021	
744	Himalayan Instt. Of Med. Sc., Dehradun	36491838773 BG-2016-17/06 dt.27/01/2017	20.00 Lakh	19/01/2021	
745	Dr. B.R. Ambedkar Med. College, BLR	IPBG-06561800002 dt.9/02/2018	15.00 Lakh	04/02/2021	
746	Dr. B.R. Ambedkar Med. College, BLR	IPBG-06561800003 dt.16/02/2018	15.00 Lakh	15/02/2021	
747	Dr. B.R. Ambedkar Med. College, BLR	IPBG-06561800004 dt.16/02/2018	15.00 Lakh	15/02/2021	
748	SRMC & RI, Porur, Chennai	003333IG180000026 dt.05/03/2018	10.00 Lakh	04/03/2021	
749	SRMC & RI, Porur, Chennai	003333IG180000052 dt.25/05/2018	128.00 lakh	23/05/2021	
750	SRMC & RI, Porur, Chennai	003333IG180000053 dt.25/05/2018	30.00 Lakh	23/11/2021	
751	Dr. D.Y. Patil Med. College, Pimpri, Pune	1117181GFIN0004 dt.09/02/2018	10.00 Lakh	08/02/2021	
752	Dr. D.Y. Patil Med. College, Pimpri, Pune	1117181GFIN0005 dt.09/02/2018	40.00 Lakh	08/02/2021	
753	Dr. D.Y. Patil Med. College, Pimpri, Pune	1117181GFIN0006 dt.09/02/2018	10.00 Lakh	08/02/2021	
754	Dr. D.Y. Patil Med. College, Pimpri, Pune	1117181GFIN0007 dt.09/02/2018	15.00 Lakh	08/02/2021	
755	Dr. D.Y. Patil Med. College, Pimpri, Pune	117181GPER0004 dt.03/03/2018	128.00 Lakh	02/03/2021	
756	Dr. D.Y. Patil Med. College, Pimpri, Pune	117181GPER0013 dt.18/05/2018	10.00 Lakh	17/05/2021	
757	Dr. D.Y. Patil Med. College, Pimpri, Pune	117181GPER0014 dt.18/05/2018	10.00 Lakh	17/05/2021	
758	S.Nijalingappa Medical College, Bagalkot	FINBG/2015/12 dt. 30/12/2015	85.00 Lakh	29/12/2021	
759	S.Nijalingappa Medical College, Bagalkot	FINBG/2015/01 dt.18/02/2015	5.00 Lakh	17/02/2021	
760	S.Nijalingappa Medical College, Bagalkot	IPBG0317180002 dt.22/02/2018	10.00 Lakh	22/02/2021	

List of College with Expired Bank Guarantee					
Sr. No.	College/ Instt. Name	BG. No./ Date	Amount	Expiry date	Claim date/Remarks
761	S.Nijalingappa Medical College, Bagalkot	IPBG0317180003 dt.22/02/2018	15.00 Lakh	22/02/2021	
762	S.Nijalingappa Medical College, Bagalkot	IPBG0317180004 dt.22/02/2018	20.00 Lakh	22/02/2021	
763	Amrita Instt. Of Med. Sc., Kochi	002BG01162430005 dt. 29/08/2016	128.00 Lakh	28/08/2021	
764	Amrita Instt. Of Med. Sc., Kochi	002BG01162430007 dt. 29/08/2016	128.00 Lakh	28/08/2021	
765	Amrita Instt. Of Med. Sc., Kochi	002BG01162430008 dt. 29/08/2016	20.00 Lakh	28/08/2021	
766	Amrita Instt. Of Med. Sc., Kochi	002BG01162430006 dt. 29/08/2016	128.00 Lakh	28/08/2021	
767	Mahatma Gandhi Med. Coll., Pondicherry	00284IG180000016 dt.13/02/2018	35.00 Lakh	12/02/2021	
768	Pushpagiri Med. Ollege, Tiruvalla	0079BG000012018 dt.19/02/2018	10.00 Lakh	18/02/2021	
769	Prathima Ednl. Society, Nagunur	BG No. 011/2016-17 dt.21/01/2017 Extn. BG No.OBR030BG0331718 Dt. 06/01/2020	20.00 Lakh	18/01/2021	
770	Prathima Ednl. Society, Nagunur	BG No. 017/2016-17 dt.23/02/2017 Extn. BG No.OBR030BG0371718 Dt. 19/02/2020	5.00 Lakh	22/02/2021	
771	Prathima Ednl. Society, Nagunur	BG No. 015/2016-17 dt.23/02/2017 Extn. BG No.OBR030BG0351718 Dt. 19/02/2020	10.00 Lakh	22/02/2021	
772	Prathima Ednl. Society, Nagunur	BG No. 016/2016-17 dt.23/02/2017 Extn. BG No.OBR030BG0361718 Dt. 19/02/2020	15.00 Lakh	22/02/2021	
773	Prathima Ednl. Society, Nagunur	BG No. 014/2016-17 dt.23/02/2017 Extn. BG No.OBR030BG0341718 Dt. 19/02/2020	5.00 Lakh	22/02/2021	

List of College with Expired Bank Guarantee					
Sr. No.	College/ Instt. Name	BG. No./ Date	Amount	Expiry date	Claim date/Remarks
774	Vydehi Instt. Of Med. Sc., Bangalore	8498IPEBG130003 dt. 31/05/2013	128.00 Lakh	29/01/2021	
		8498IPEBG190002			
		Extn. Dt. 24.02.2020			
775	Vydehi Instt. Of Med. Sc., Bangalore	8498IPEBG130002 dt. 31/05/2013	128.00 Lakh	29/01/2021	
776	Katuri Med. College Guntur	172BG01182410001 dt. 29/08/2018	155.00 Lakh	27/08/2021	
777	Maharishi Markandeshwar Med. College, Mullana, Ambala	51820001017 dt.07/11/2017	35.00 Lakh	06-Sep-21	
778	Maharishi Markandeshwar Med. College, Mullana, Ambala	51820001117 dt.07/11/2017	25.00 Lakh	06-Sep-21	
779	Maharishi Markandeshwar Med. College, Mullana, Ambala	51820001217 dt.07/11/2017	5.00 Lakh	06-Sep-21	
780	Maharishi Markandeshwar Med. College, Mullana, Ambala	51820001317 dt.07/11/2017	15.00 Lakh	06-Sep-21	
781	Maharishi Markandeshwar Med. College, Mullana, Ambala	51820001417 dt.07/11/2017	20.00 Lakh	06-Sep-21	
782	Maharishi Markandeshwar Med. College, Mullana, Ambala	51820001517 dt.07/11/2017	5.00 Lakh	06-Sep-21	
783	Maharishi Markandeshwar Med. College, Mullana, Ambala	51820001617 dt.07/11/2017	5.00 Lakh	06-Sep-21	
784	Maharishi Markandeshwar Med. College, Mullana, Ambala	51820001717 dt.07/11/2017	20.00 Lakh	06-Sep-21	
785	Maharishi Markandeshwar Med. College, Mullana, Ambala	51820001817 dt.07/11/2017	10.00 Lakh	06-Sep-21	
786	Maharishi Markandeshwar Med. College, Mullana, Ambala	51820001917 dt.07/11/2017	5.00 Lakh	06-Sep-21	
787	Maharishi Markandeshwar Med. College, Mullana, Ambala	51820000318 dt.09/02/2018	85.00 Lakh	31-Dec-21	
788	Maharishi Markandeshwar Med. College, Mullana, Ambala	51820000518 dt.09/02/2018	5.00 Lakh	31-Dec-21	
789	Maharishi Markandeshwar Med. College, Mullana, Ambala	51820000418 dt.09/02/2018	10.00 Lakh	31-Dec-21	
790	Maharishi Markandeshwar Med. College, Mullana, Ambala	51820000218 dt.16/01/2018	5.00 Lakh	31-Dec-21	

List of College with Expired Bank Guarantee					
Sr. No.	College/ Instt. Name	BG. No./ Date	Amount	Expiry date	Claim date/Remarks
791	NRI Medical College, Guntur	103BG01180470001 dt.16/02/2018	20.00 Lakh	15/02/2021	
792	KIMS, Karad	SVC/KRD/BG/60/2021-22 dt. 09/11/20221	5.00 Lakh	08/11/2021	
793	Dayanand Med. College, Ludhiana	02981LG001316 DT. 10/06/2016	100.00 Lakh	09/06/2021	
794	Cancer Hospital, Chennai	2005/20 dt. 18/01/2006	10.00 Lakh	17/01/2021	
795	Katihar Medical College, Katihar	187/16-17 dt.24/01/2017 Extn. 19/02/2020	85.00 Lakh	30/06/2021	
796	MIMSR, Latur	0540IPEBG180071 dt.17/02/2018	10.00 Lakh	16/02/2021	
797	SDM Medical College, Dharwad	669BGPR201700003 dt:20/11/2017	85.00 Lakh	19/05/2021	
798	SDM Medical College, Dharwad	669BGPR201700004 dt:20/11/2017	20.00 lakh	19/05/2021	
799	SDM Medical College, Dharwad	669BGPR201700005 dt:20/11/2017	20.00 lakh	19/05/2021	
800	SDM Medical College, Dharwad	669BGPR201700006 dt:20/11/2017	10.00 Lakh	19/05/2021	
801	SDM Medical College,	669BGPR201700007 dt:20/11/2017	5.00 Lakh	19/05/2021	
802	Smt. NHL Municipal Med. College, Ahmedabad	0024BGFD001017 dt. 09/06/2016	350.00 Lakh	07/06/2021	
803	Sri Guru Ram Rai Instt. Of Med. Sc., Dehradun	1516ILG001518 dt.16/02/2018	10.00 Lakh	31/08/2021	
804	Sri Guru Ram Rai Instt. Of Med. Sc., Dehradun	1516ILG001618 dt.16/02/2018	10.00 Lakh	31/08/2021	
805	Sri Guru Ram Rai Instt. Of Med. Sc., Dehradun	1516ILG000418 dt.17/02/2018	85.00 Lakh	17/06/2021	
806	Sri Guru Ram Rai Instt. Of Med. Sc., Dehradun	1516ILG005517 dt.15/11/2017	20.00 Lakh	30/06/2021	
807	GSL Medical College, Rajahmundry	01070100000137 dt.12/02/2018	35.00 Lakh	30/09/2021	
808	GSL Medical College, Rajahmundry	01070100000127 dt.07/10/2017	20.00 Lakh	30/09/2021	
809	GSL Medical College, Rajahmundry	01070100000128 dt.07/10/2017	10.00 Lakh	30/09/2021	
810	GSL Medical College, Rajahmundry	01070100000129 dt.07/10/2017	15.00 Lakh	30/09/2021	

List of College with Expired Bank Guarantee					
Sr. No.	College/ Instt. Name	BG. No./ Date	Amount	Expiry date	Claim date/Remarks
811	GSL Medical College, Rajahmundry	01070100000133 dt.30/01/2018	20.00 Lakh	30/09/2021	
812	GSL Medical College, Rajahmundry	01070100000134 dt.30/01/2018	5.00 lakh	30/09/2021	
813	GSL Medical College, Rajahmundry	01070100000135 dt.30/01/2018	15.00 Lakh	30/09/2021	
814	SRM Medical College Hospital & Research Centre, Tamilnadu	594GM07180540003 dt.23/02/2018	35.00 Lakh	21/02/2021	
815	SRM Medical College Hospital & Research Centre, Tamilnadu	594GM07181480001 dt.28/05/2018	20.00 Lakh	27/05/2021	
816	Smt. Kashibai Navale Med. College and Gen. Hospital, Pune (Singhad Tech. Edn., Pune)	017/47/5/BG/10/30 dt.17/04/2017	15.00 Lakh	16/04/2021	
817	Smt. Kashibai Navale Med. College and Gen. Hospital, Pune (Singhad Tech. Edn., Pune)	017/46/20/BG/10/24 dt.23/02/2017 Extn. 17/02/2020	10.00 Lakh	23/02/2021	
818	Kalinga Institute of Medical Sciences, Bhubaneswar	5566IPEBG180015 dt.12/01/2018	25.00 Lakh	12/01/2021	
819	Kalinga Institute of Medical Sciences, Bhubaneswar	5566IPEBG180005 dt.12/01/2018	10.00 Lakh	12/01/2021	
820	Kalinga Institute of Medical Sciences, Bhubaneswar	5566IPEBG180012 dt.12/01/2018	15.00 Lakh	12/01/2021	
821	Kalinga Institute of Medical Sciences, Bhubaneswar	5566IPEBG180006 dt.12/01/2018	10.00 Lakh	12/01/2021	
822	Kalinga Institute of Medical Sciences, Bhubaneswar	5566IPEBG180010 dt.12/01/2018	25.00 Lakh	12/01/2021	
823	Kalinga Institute of Medical Sciences, Bhubaneswar	5566IPEBG180009 dt.12/01/2018	10.00 Lakh	12/01/2021	
824	Kalinga Institute of Medical Sciences, Bhubaneswar	5566IPEBG180007 dt.12/01/2018	15.00 Lakh	12/01/2021	
825	Kalinga Institute of Medical Sciences, Bhubaneswar	5566IPEBG180013 dt.12/01/2018	10.00 Lakh	12/01/2021	
826	Kalinga Institute of Medical Sciences, Bhubaneswar	5566IPEBG180011 dt.12/01/2018	25.00 Lakh	12/01/2021	
827	Kalinga Institute of Medical Sciences, Bhubaneswar	5566IPEBG180008 dt.12/01/2018	5.00 Lakh	12/01/2021	
828	Kalinga Institute of Medical Sciences, Bhubaneswar	5566IPEBG180020 dt.13/02/2018	20.00 Lakh	12/02/2021	

List of College with Expired Bank Guarantee					
Sr. No.	College/ Instt. Name	BG. No./ Date	Amount	Expiry date	Claim date/Remarks
829	Kalinga Institute of Medical Sciences, Bhubaneswar	5566IPEBG180021 dt.13/02/2018	30.00 Lakh	12/02/2021	
830	Kalinga Institute of Medical Sciences, Bhubaneswar	5566IPEBG180014 dt.12/01/2018	30.00 Lakh	12/01/2021	
831	Dr. Panjabrao alias Bhausahab Deshmukh Memo. Med. College, Amravati	BG/56/2018 dt.22/02/2018	85.00 Lakh	21/02/2021	
832	Bharti Vidyapeeth Med. College, Sangli	BG No. 06/34 dt.03/02/2017	10.00 Lakh	02/02/2021	
833	Jubilee Mission Med. College , Thrissur	0368BG 000092021 dt. 09/11/2021	5.00 Lakh	08/11/2021	
834	Instt of Medi Sci & Sum Hospital,Siksha 'O' Anusandhan, Bhubaneswar	4077ILG001617 dt:15/11/2017	10.00 Lakh	31/05/2021	
835	Instt of Medi Sci & Sum Hospital,Siksha 'O' Anusandhan, Bhubaneswar	4077ILG001517 dt:15/11/2017	5.00 Lakh	31/05/2021	
836	Instt of Medi Sci & Sum Hospital,Siksha 'O' Anusandhan, Bhubaneswar	4077ILG000918 dt:18/01/2018	30.00 Lakh	31/05/2021	
837	Instt of Medi Sci & Sum Hospital,Siksha 'O' Anusandhan, Bhubaneswar	4077ILG000818 dt:18/01/2018	25.00 Lakh	31/05/2021	
838	Instt of Medi Sci & Sum Hospital,Siksha 'O' Anusandhan, Bhubaneswar	4077ILG001218 dt:18/01/2018	15.00 Lakh	31/05/2021	
839	Instt of Medi Sci & Sum Hospital,Siksha 'O' Anusandhan, Bhubaneswar	4077ILG001018 dt:18/01/2018	20.00 lakh	31/05/2021	
840	Instt of Medi Sci & Sum Hospital,Siksha 'O' Anusandhan, Bhubaneswar	4077ILG001118 dt:18/01/2018	35.00 Lakh	31/05/2021	
841	Instt of Medi Sci & Sum Hospital,Siksha 'O' Anusandhan, Bhubaneswar	4077ILG000718 dt:18/01/2018	5.00 Lakh	31/05/2021	
842	Instt of Medi Sci & Sum Hospital,Siksha 'O' Anusandhan, Bhubaneswar	4077ILG001318 dt:18/01/2018	10.00 Lakh	31/05/2021	
843	Instt of Medi Sci & Sum Hospital,Siksha 'O' Anusandhan, Bhubaneswar	4077ILG000618 dt:18/01/2018	15.00 Lakh	31/05/2021	
844	School of Medical Sc. & Research, Greater Noida	OGT0005180018830 dt.22/02/2018	85.00 Lakh	21/02/2021	
845	School of Medical Sc. & Research, Greater Noida	OGT0005180018838 dt.22/02/2018	85.00 Lakh	21/02/2021	
846	School of Medical Sc. & Research, Greater Noida	OGT0005180018839 dt.22/02/2018	85.00 Lakh	21/02/2021	
847	School of Medical Sc. & Research, Greater Noida	OGT0005180018851 dt.22/02/2018	85.00 Lakh	21/02/2021	

List of College with Expired Bank Guarantee					
Sr. No.	College/ Instt. Name	BG. No./ Date	Amount	Expiry date	Claim date/Remarks
848	School of Medical Sc. & Research, Greater Noida	OGT0005180018845 dt.22/02/2018	85.00 Lakh	21/02/2021	
849	Rohilkhand Med. College, Bareilly	52260000118 dt.13/2/2018	30.00 Lakh	12/02/2021	
850	Rohilkhand Med. College, Bareilly	52260000218 dt.13/2/2018	20.00 Lakh	12/02/2021	
851	Rohilkhand Med. College, Bareilly	52260000318 dt.13/2/2018	15.00 Lakh	12/02/2021	
852	Geetanjali Med. College & Hospital, Udaipur (Geetanjali Foundation)	00615IG170000012 dt.09/11/2017	25.00 Lakh	09/08/2021	
853	Geetanjali Med. College & Hospital, Udaipur (Geetanjali Foundation)	00615IG170000015 dt.09/11/2017	10.00 Lakh	09/08/2021	
854	Geetanjali Med. College & Hospital, Udaipur (Geetanjali Foundation)	00615IG170000014 dt.09/11/2017	10.00 Lakh	09/08/2021	
855	Geetanjali Med. College & Hospital, Udaipur (Geetanjali Foundation)	00615IG170000013 dt.09/11/2017	25.00 Lakh	09/08/2021	
856	Geetanjali Med. College & Hospital, Udaipur (Geetanjali Foundation)	00615IG170000016 dt.09/11/2017	10.00 Lakh	09/08/2021	
857	Geetanjali Med. College & Hospital, Udaipur (Geetanjali Foundation)	00615IG180000017 dt.24/05/2018	128.00 Lakh	23/11/2021	
858	Adesh Institute of Medical Sciences & Research, Bathinda	2017-18/16 dt.26/02/2018	85.00 Lakh	25/02/2021	
859	Saveetha Medical College, Chennai	00102IG160000039 dt.24/05/2018	128.00 Lakh	30/08/2021	
860	L. N. Medical College & J. K. Hospital, Bhopal	062GT02193640002 dt.30/12/2019	85.00 Lakh	21/02/2021	
861	SGT Medical College, Hospital & Research Institute, Gurgaon	3092ILG000418 dt.08/02/2018	85.00 Lakh	07/02/2021	
862	SGT Medical College, Hospital & Research Institute, Gurgaon	3092ILG000518 dt.08/02/2018	85.00 Lakh	07/02/2021	
863	SGT Medical College, Hospital & Research Institute, Gurgaon	3092ILG000618 dt.08/02/2018	85.00 Lakh	07/02/2021	
864	SGT Medical College, Hospital & Research Institute, Gurgaon	3092ILG000718 dt.08/02/2018	85.00 Lakh	07/02/2021	
865	SGT Medical College, Hospital & Research Institute, Gurgaon	3092ILG000818 dt.08/02/2018	85.00 Lakh	07/02/2021	
866	SGT Medical College, Hospital & Research Institute, Gurgaon	3092ILG001118 dt.08/02/2018	85.00 Lakh	07/02/2021	
867	SGT Medical College, Hospital & Research Institute, Gurgaon	3092ILG001218 dt.08/02/2018	85.00 Lakh	07/02/2021	

List of College with Expired Bank Guarantee

Sr. No.	College/ Instt. Name	BG. No./ Date	Amount	Expiry date	Claim date/Remarks
868	SGT Medical College, Hospital & Research Institute, Gurgaon	3092ILG000318 dt.25/01/2018	85.00 Lakh	25/01/2021	
869	SGT Medical College, Hospital & Research Institute, Gurgaon	3092ILG000218 dt.25/01/2018	85.00 Lakh	25/01/2021	
870	SRINIVAS INSTT. OF MED. SCI. & RES. CENTRE, Mangaluru	BOM038/BG30/2014-15 dt. 19/02/2015	85.00 Lakh	18/02/2021	
871	GMERS Medical College, Sola, Ahmedabad	0505417BG0000254 dt.23/02/2017 Extension Dt.18.02.2020	85.00 Lakh	20/02/2021	
872	GMERS Medical College, Sola, Ahmedabad	0505417BG0000255 dt.23/02/2017 Extension Dt.18.02.2020	85.00 Lakh	20/02/2021	
873	GMERS Medical College, Sola, Ahmedabad	0505417BG0000250 dt.23/02/2017	85.00 Lakh	20/02/2021	
874	GMERS Medical College, Sola, Ahmedabad	0505417BG0000252 dt.23/02/2017 Extension Dt.18.02.2020	85.00 Lakh	20/02/2021	
875	GMERS Medical College, Sola, Ahmedabad	0505418BG0000212 dt.12/02/2018	85.00 Lakh	05/02/2021	
876	GMERS Medical College, Sola, Ahmedabad	0505418BG0000259 dt.22/02/2018	85.00 Lakh	20/02/2021	
877	GCS Medical College, Ahmedabad	31250IGL0001418 dt.07/02/2018	85.00 Lakh	06/02/2021	
878	GCS Medical College, Ahmedabad	31250IGL0001618 dt.06/02/2018	85.00 Lakh	06/02/2021	
879	GCS Medical College, Ahmedabad	31280IGL0001518 dt.06/02/2018	85.00 Lakh	06/02/2021	
880	GCS Medical College, Ahmedabad	31280IGL0001718 dt.06/02/2018	85.00 Lakh	06/02/2021	
881	Sapthagiri Institute of Medical Sciences & Research Centre, Bengaluru	1412518BG0000108 Dt.03/04/2018	85.00 Lakh	02/10/2021	
882	Sapthagiri Institute of Medical Sciences & Research Centre, Bengaluru	1412518BG0000098 Dt.03/04/2018	85.00 Lakh	02/10/2021	
883	Sapthagiri Institute of Medical Sciences & Research Centre, Bengaluru	1412518BG0000099 Dt.03/04/2018	85.00 Lakh	02/10/2021	
884	Sapthagiri Institute of Medical Sciences & Research Centre, Bengaluru	1412518BG0000100 Dt.03/04/2018	85.00 Lakh	02/10/2021	

List of College with Expired Bank Guarantee					
Sr. No.	College/ Instt. Name	BG. No./ Date	Amount	Expiry date	Claim date/Remarks
885	Sapthagiri Institute of Medical Sciences & Research Centre, Bengaluru	1412518BG0000101 Dt.03/04/2018	85.00 Lakh	02/10/2021	
886	Sapthagiri Institute of Medical Sciences & Research Centre, Bengaluru	1412518BG0000102 Dt.03/04/2018	85.00 Lakh	02/10/2021	
887	Sapthagiri Institute of Medical Sciences & Research Centre, Bengaluru	1412518BG0000103 Dt.03/04/2018	85.00 Lakh	02/10/2021	
888	Sapthagiri Institute of Medical Sciences & Research Centre, Bengaluru	1412518BG0000104 Dt.03/04/2018	85.00 Lakh	02/10/2021	
889	Sapthagiri Institute of Medical Sciences & Research Centre, Bengaluru	1412518BG0000105 Dt.03/04/2018	85.00 Lakh	02/10/2021	
890	Sapthagiri Institute of Medical Sciences & Research Centre, Bengaluru	1412518BG0000106 Dt.03/04/2018	85.00 Lakh	02/10/2021	
891	Sapthagiri Institute of Medical Sciences & Research Centre, Bengaluru	1412518BG0000107 Dt.03/04/2018	85.00 Lakh	02/10/2021	
892	Sapthagiri Institute of Medical Sciences & Research Centre, Bengaluru	1412518BG0000109 Dt.03/04/2018	85.00 Lakh	02/10/2021	
893	Great Eastern Medical School & Hospital, Srikakulam	006BG07183330007 dt.29/11/2018	85.00 Lakh	08/03/2021	
894	Satya Sai Medical College & Research Instt., Nellikuppam	00284IG180000010 dt.13/02/2018	15.00 Lakh	12/02/2021	
895	Satya Sai Medical College & Research Instt., Nellikuppam	00284IG180000011 dt.13/02/2018	20.00 Lakh	12/02/2021	
896	Satya Sai Medical College & Research Instt., Nellikuppam	00284IG180000012 dt.13/02/2018	25.00 Lakh	12/02/2021	
897	Satya Sai Medical College & Research Instt., Nellikuppam	00284IG180000013 dt.13/02/2018	15.00 Lakh	12/02/2021	
898	Satya Sai Medical College & Research Instt., Nellikuppam	00284IG180000014 dt.13/02/2018	15.00 Lakh	12/02/2021	
899	Satya Sai Medical College & Research Instt., Nellikuppam	0028IG180000015 dt.13/02/2018	5.00 Lakh	12/02/2021	
900	Narayan Medical College & Hospital, Sasaram, Rohtas, Bihar	2169ILG002118 dt.14/02/2018	85.00 Lakh	13/02/2021	
901	Narayan Medical College & Hospital, Sasaram, Rohtas, Bihar	2169ILG002218 dt.14/02/2018	85.00 Lakh	13/02/2021	
902	Narayan Medical College & Hospital, Sasaram, Rohtas, Bihar	2169ILG002318 dt.14/02/2018	85.00 Lakh	13/02/2021	

List of College with Expired Bank Guarantee					
Sr. No.	College/ Instt. Name	BG. No./ Date	Amount	Expiry date	Claim date/Remarks
903	Narayan Medical College & Hospital, Sasaram, Rohtas, Bihar	2169ILG002418 dt.14/02/2018	85.00 Lakh	13/02/2021	
904	Shri Shankaracharya Instt. Of Med. Sci., Junwani, Bhilai	OGT0005210059997 dt. 10/11/2021	85.00 Lakh	09/11/2021	
905	T.S.M. Medical College & Hospital, Lucknow	BG No. 30220IGL10000916 dt. 06/06/2016	200.00 Lakh	05/06/2021	
906	T.S.M. Medical College & Hospital, Lucknow	BG No. 30220IGL10001016 dt. 06/06/2016	750.00 Lakh	05/06/2021	
907	GCRG Instt. Of Medical Sciences, Lucknow	BG No. 43720ILGL0001016 dt. 29/08/2016	750.00 Lakh	28-Aug-21	
908	GCRG Instt. Of Medical Sciences, Lucknow	BG No. 43720ILGL0001116 dt. 29/08/2016	200.00 Lakh	28-Aug-21	
909	Raipur Instt. Of Medical Sciences, Raipur	BG No. 003GT02162460015 dt. 02/09/2016	750.00 Lakh	01-Sep-21	
910	Raipur Instt. Of Medical Sciences, Raipur	BG No. 003GT02162460018 dt. 02/09/2016	200.00 Lakh	01-Sep-21	
911	Kanachur Instt. Of Medical Sciences, Mangalore	BG No. 161117IBGP00002 dt. 29/08/2016	750.00 Lakh	28-Aug-21	
912	Kanachur Instt. Of Medical Sciences, Mangalore	BG No. 161117IBGP00003 dt. 29/08/2016	200.00 Lakh	28-Aug-21	
913	Kerala Medical College, Kerala	BG No. 05/2016 dt. 01/09/2016	750.00 Lakh	01-Sep-21	
914	Kerala Medical College, Kerala	BG No. 04/2016 dt. 01/09/2016	200.00 Lakh	01-Sep-21	
915	World College of Med. Sci. & Res., Jhajjar	BG No. 01790015416 dt. 02/09/2016	200.00 Lakh	31-Aug-21	
916	World College of Med. Sci. & Res., Jhajjar	BG No. 01790015316 dt. 02/09/2016	750.00 Lakh	31-Aug-21	
917	Maheshwara Medical College, Hyderabad	BG No. 00391IG160000012 dt. 24/08/2016	750.00 Lakh	23-Aug-21	
918	Glocal Super Speciality Hosp. & Res., Saharanpur	BG No. 3885ILG003716 dt. 30/08/2016	200.00 Lakh	29-Aug-21	
919	Glocal Super Speciality Hosp. & Res., Saharanpur	BG No. 3885ILG003816 dt. 30/08/2016	750.00 Lakh	29-Aug-21	
920	RVS Institute of Medical Sciences, Chittoor	BG No. 1384ILG000616 dt. 01/09/2016	200.00 Lakh	31-Aug-21	

List of College with Expired Bank Guarantee					
Sr. No.	College/ Instt. Name	BG. No./ Date	Amount	Expiry date	Claim date/Remarks
921	RVS Institute of Medical Sciences, Chittoor	BG No. 1384ILG000716 dt. 01/09/2016	750.00 Lakh	31-Aug-21	
922	Prasad Instt. Of Med. Sci., Lucknow	BG No. 53770IGL0000116 dt. 26/08/2016	750.00 Lakh	23-Aug-21	
923	Prasad Instt. Of Med. Sci., Lucknow	BG No. 53770IGL0000216 dt. 26/08/2016	200.00 Lakh	23-Aug-21	
924	Amaltas Instt. Of Medical Sciences, Dewas	BG No. 0176516BG00006 dt. 24/08/2016	750.00 Lakh	23-Aug-21	
925	Amaltas Instt. Of Medical Sciences, Dewas	BG No. 0176516BG00005 dt. 24/08/2016	200.00 Lakh	23-Aug-21	
926	Saraswati Medical College, Unnao	BG No. 53360IGL0002016 dt. 29/08/2016	200.00 Lakh	28-Aug-21	
927	Saraswati Medical College, Unnao	BG No. 53360IGL0001816 dt. 29/08/2016	750.00 Lakh	28-Aug-21	
928	Annaii Med. Coll. Hosp. & Res. Centre, T.N.	BG No. 1384ILG001016 dt. 01/09/2016	750.00 Lakh	31-Aug-21	
929	Annaii Med. Coll. Hosp. & Res. Centre, T.N.	BG No. 1384ILG000916 dt. 01/09/2016	200.00 Lakh	31-Aug-21	
930	S. R. Medical College & Res. Centre, Kerala	BG No. 0497BG000082016 dt. 01/09/2016	150.00 Lakh	01-Sep-21	
931	S. R. Medical College & Res. Centre, Kerala	BG No. 0497BG000072016 dt. 01/09/2016	550.00 Lakh	01-Sep-21	
932	Ananta Instt. Of Med. Sci. & Res., Nathdwara	1097316BG0000435 dt. 26/08/2016	750.00 Lakh	25-Aug-21	
933	Ananta Instt. Of Med. Sci. & Res., Nathdwara	1097316BG0000437 dt. 26/08/2016	200.00 Lakh	25-Aug-21	
934	Akash Instt. Of Med. Sci. & Res. Centre, Bangaloe	BG No. 08/2016-17 dt. 01/09/2016	750.00 Lakh	31-Aug-21	
935	Akash Instt. Of Med. Sci. & Res. Centre, Bangaloe	BG No. 06/2016-17 dt. 01/09/2016	200.00 Lakh	31-Aug-21	
936	American International Instt. Of Medical Sciences, Udaipur	003GMO1162660003 dt. 22/09/2016	750.00 Lakh	21-Sep-21	
937	American International Instt. Of Medical Sciences, Udaipur	003GMO1162660001 dt. 22/09/2016	200.00 Lakh	21-Sep-21	
938	Sambhram institute of Medical Sciences & Research KGF, Bangalore	BG No. 15410100007578 dt. 27/09/2016	200.00 Lakh	26-Sep-21	

List of College with Expired Bank Guarantee					
Sr. No.	College/ Instt. Name	BG. No./ Date	Amount	Expiry date	Claim date/Remarks
939	Sambhram institute of Medical Sciences & Research KGF, Bangalore	BG No. 15410100007582 dt. 27/09/2016	750.00 Lakh	26-Sep-21	
940	Venkateshwara Institute of Medical Sciences, Meerut	BG No. 0717-BG0094-16 dt. 23/09/2016	200.00 Lakh	22-Sep-21	
941	Varunarjun Medical College & Rohilkhand Hospital, Shahjahanpur, (U.P.)	BG No. 52260000416 dt. 15/09/2016	200.00 Lakh	14-Sep-21	
942	Varunarjun Medical College & Rohilkhand Hospital, Shahjahanpur, (U.P.)	BG No. 52260000516 dt. 15/09/2016	750.00 Lakh	14-Sep-21	
943	Maharashtra Instt. Of Med. Ed. & Res., Talegaon	0540IPEBG160220 dt.26/09/2016	100.00 Lakh	26-Sep-21	
944	Krishna Mohan Medical College & Hospital, Mathura	037271116000011 dt. 28/09/2016	750.00 Lakh	27-Sep-21	
945	Krishna Mohan Medical College & Hospital, Mathura	037271116000010 dt. 28/09/2016	200.00 Lakh	27-Sep-21	
946	Gouri Devi Institute of Medical Sciences & Hospital, Durgapur	4274IPEBG160001 dt. 01/09/2016	350.00 Lakh	31-Aug-21	
947	Gouri Devi Institute of Medical Sciences & Hospital, Durgapur	4274IPEBG160002 dt. 01/09/2016	200.00 Lakh	31-Aug-21	
948	Apollo Instt. of Med. Sc., Chittoor	11650100010400 dt. 14/09/2016	950.00 lakh	13-Sep-21	

दूरभाष/Phone : 25367033,

25367035, 25367036

फैक्स/Fax : 0091-11-

25367024

ई-मेल/E-mail :

pgmeb.recognition@nmc.org.in

पॉकेट -14, सेक्टर-8, द्वारका, फेस1-, नई
दिल्ली-77-

Pocket- 14,
Sector- 8, Dwarka,
Phase - 1, New Delhi-77

राष्ट्रीय आयुर्विज्ञान आयोग National Medical Commission

स्नातकोत्तर आयुर्विज्ञान शिक्षा बोर्ड

Post Graduate Medical Education Board (PGMEB)

F. No. NMC-23(1)(163)S-39/2022/Med/PG

Date: 08.02.2024

PUBLIC NOTICE

Subject:- Hostel accommodation for Post-graduate Medical Students - reg.

As per the regulation 5.6 of the Post Graduate Medical Education Regulation (PGMER), 2023, *"It will be mandatory for the college to provide appropriate residential accommodation to post-graduate students. However, it will not be mandatory for the post-graduate students to stay in the hostel."*

Similarly, there was no such provisions in the PGMER, 2000 for mandatory stay of the PG Medical Students in the hostel offered by the college .

2. However, numbers of complaints have been received from PG students alleging that the Medical Colleges/Institutions are compelling them to stay in the hostel offered by the Medical Colleges/ Institutions and hefty amount is being charged on this account. This is a violation of Regulation 5.6 of the PGMER, 2023.

3. Hence, all the Medical Colleges and Institutes are directed to take cognizance of the above-mentioned regulation, failing which NMC may take action as per Regulations 9.1 and 9.2 of the PGMER, 2023 which includes monetary penalty, reduction of seats, stoppage of admission etc.

4. This issues with the approval of competent Authority.

(Aujender Singh)
Deputy Secretary, PGMEB,

राष्ट्रीय आयुर्विज्ञान आयोग
NATIONAL MEDICAL COMMISSION
पॉकेट-14, सेक्टर-8, द्वारका, नई दिल्ली- 110077
Pocket- 14, Sector- 8, Dwarka, New Delhi- 110077

Memo No. D-16022/01/2023/NMC/Admn

DATE: 9th February 2024

A D D E N D U M

**EXPRESSION OF INTEREST (EOI) INVITING APPLICATIONS FOR
EMPANELMENT OF ADVOCATE(S) AS STANDING COUNSELS**

Attention is invited to the Expression of Interest (EoI) dated 23rd May 2023 (**copy enclosed**) issued by the National Medical Commission (NMC) for inviting applications for Empanelment of Advocates as Standing Counsels for this Commission on the Terms and Conditions detailed in the Schedule-II attached therewith.

2. In this connection, **it has been decided to extend the timeline for the submission of application in the Performa as per Annexure "A" attached with the said EoI.** Accordingly, the **application in the prescribed Performa along with relevant documents/papers, etc, should reach positively by 5 PM on 19th February 2024 at the following address -**

Deputy Secretary [Estt/GA]
National Medical Commission
Pocket- 14, Sector- 8, Dwarka,
New Delhi- 110077.

Applications received in the Office of NMC after 5 PM on 19th February 2024 shall not be entertained.

3. **Those who have applied earlier against the said EoI dated 23rd May 2023 need not apply afresh.**

Sd/-
National Medical Commission

Memo No. D-16022/01/2023/NMC/Admn

DATE: 23rd May 2023

**EXPRESSION OF INTEREST (EOI) INVITING APPLICATIONS FOR
EMPANELMENT OF ADVOCATE(S) AS STANDING COUNSELS**

General Info regarding NMC

1. The National Medical Commission (NMC) has been constituted by an Act of Parliament known as National Medical Commission Act, 2019 which came into force on 25.09.2020 by Gazette Notification dated 24.09.2020. The Commission consists of four Autonomous Boards, namely Under-Graduate Medical Education Board (UGMEB), Post-Graduate Medical Education Board (PGMEB), Medical Assessment and Rating Board (MARB) and Ethics and Medical Registration Board (EMRB). The Commission grants recognition of medical qualifications, gives accreditation to medical institutions, grants registration to medical practitioners, and monitors medical practice, and assesses the medical infrastructure in India.

Proposal to engage Standing Counsels

2. The National Medical Commission invites application for engagement of Standing Counsels to represent it in the Hon'ble Supreme Court, High Courts and their Benches all over the country and at other Legal fora, rendering legal advice, drafting of petitions / counter affidavits and vetting of legal documents, etc. For further details, kindly refer Schedule-III underneath.

Detailed info regarding submission of Application etc.

3. The EOI document containing detailed eligibility criteria and the format for application can be perused/downloaded from the website of NMC at www.nmc.org.in (What's New).

Manner of submitting Application

4. The interested Advocate (Candidate) must apply on the format prescribed by the NMC only (**Annexure "A" & "B"**). No other format will be entertained.

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5. The last date for submission of applications is 23rd June 2023. Applications received in NMC after due date shall not be entertained.

Selection Procedure

6. The procedure for selecting Standing Counsels shall be, as far as practicable, as follows:
 - a) Applications received shall be scrutinized by a Screening Committee.
 - b) Once approved by the Competent Authority, the shortlisted candidates shall be interviewed by physical/virtual mode, at the discretion of the Competent Authority.
 - c) NMC reserves the right to increase or decrease the vacancies without assigning any reason.

Note: *It may be noted that even shortlisting or selection by itself shall not confer any right whatsoever in this regard in favour of the Applicant.*

Sd./-
Secretary
National Medical Commission

SCHEDULE - I

NUMBER OF REQUIRED POSITIONS OF STANDING COUNSELS

S.N.	Supreme Court/High Court/Bench	No. of positions
1.	Supreme Court of India, New Delhi	4
2.	High Court of Andhra Pradesh, Amaravati	3
3.	High Court of Karnataka	
	Bengaluru Bench	2
	Dharwad Bench	2
	Kalburgi Bench	2
4.	High Court of Kerala	2
5.	High Court of Madras	
	Principal Bench at Chennai	5
	Madurai Bench	4
6.	High Court of Telangana at Hyderabad	2
7.	High Court of Delhi at New Delhi	5
8.	High Court of Allahabad	
	Allahabad Bench	2
	Lucknow Bench	2
9.	High Court of Punjab & Haryana at Chandigarh	2
10.	High Court of Uttarakhand at Nainital	1
11.	High Court of Himachal Pradesh at Shimla	1
12.	High Court of Jammu & Kashmir & Ladakh at Srinagar	
	Srinagar	1
	Jammu	1
13.	High Court of Rajasthan	
	Jodhpur Bench	2
	Jaipur Bench	2
14.	High Court of Bombay	
	Mumbai Bench	2
	Aurangabad Bench	2
	Nagpur Bench	2
	Goa Bench at Panaji	2
15.	High Court of Gujarat at Ahmedabad	2
16.	High Court of Madhya Pradesh	
	Jabalpur Bench	1
	Indore Bench	1
	Gwalior bench	1

17.	High Court of Guwahati: High Court of Assam, Nagaland, Mizoram and Arunachal Pradesh.	
	Guwahati Bench	1
	Itanagar Bench (State of Arunachal Pradesh)	1
	Kohima Bench (State of Nagaland)	1
	Aizwal Bench (State of Mizoram)	1
18.	High Court of Jharkhand at Ranchi	1
19.	High Court of Calcutta at Kolkata	
	Kolkata	2
	Circuit Bench at Port Blair	1
	Circuit Bench at Jalpaiguri	1
20.	High Court of Orissa at Bhubaneswar	1
21.	High Court of Patna	2
22.	High Court of Chhattisgarh at Bilaspur	2
23.	High Court of Sikkim at Gangtok	1
24.	High Court of Tripura at Agartala	2
25.	High Court of Manipur at Imphal	1
26.	High Court of Meghalaya at Shillong	2

SCHEDULE-II

TERMS AND CONDITIONS OF THE EMPANELMENT

1. Eligibility for Empanelment

- i) The Advocate should be registered with the concerned State Bar Council;
- ii) He/She must have passed the All India Bar Examination(AIBE), if Applicable;
- iii) He/She should not be less than 35 years and should not be exceed more than 70 years of age as on 01.05.2023;
- iv) The Advocate must have 100 appearances before Supreme Court / High Court in last 3 years.
- v) The Advocate should possess minimum experience of 10 years in handling cases pertaining to Constitutional / Civil / Criminal / Educational Institutions matters and etc. at High Court. An Advocate on Record (AoR), Supreme Court of India having minimum experience of 10 (Ten) years required for the empanelment for Supreme Court of India. The preference will be given to those Advocates who have experience in handling Medical Institution / Medical Negligence matters;
- vi) The priority/preference may be given to the Advocate, who has experience of handling court cases of Government Organizations / Institutions / Govt. Departments / PSUs.
- vii) The Competent Authority may relax the eligibility conditions in deserving cases.

2. Undertaking by the Selected Candidate

When selected, the candidate shall have to submit an undertaking that he shall not accept brief against the NMC whether in same court or any other Court whatsoever. The Specimen of the Declaration-cum-Undertaking is given at **ANNEXURE-B**.

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3. Tenure of Empanelment/Engagement

The term of engagement/empanelment will be for a period of three (3) years or until further orders, whichever is earlier. The term of engagement may be extended further on the basis of performance of the Counsel at the discretion of the Competent Authority.

4. Fees and other conditions

- i) No retainer fee will be paid to any of the empanelled Advocate.
- ii) The fee payable to the Advocates shall be governed by the Guidelines for engagement and determination of Professional fee of the Counsels of the NMC bearing no. L-11011/01/2023/NMC/Legal/014627 dated 23.03.2023 issued by the NMC (available at www.nmc.org.in) (What's New).

5. Termination

- a) The Competent Authority reserves the right and discretion to remove any Standing Counsel without assigning any reason.
- b) In case, the Counsel want to discontinue or resign from the engagement, he/she shall give an advance notice of two months to the Competent Authority.

6. Other terms and conditions

- i) The Advocate will be engaged on case-to-case basis and the allocation of work will be decided by NMC. The Advocate will take necessary steps to protect the interest of the NMC in matters entrusted to him from time to time.
- ii) Empanelment does not confer any right or claim that the Advocate shall alone be entrusted with the work of NMC.

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- iii) NMC reserves the right to engage any other Advocate or Government Law Officer in case of need.
- iv) The Advocate shall keep NMC informed regarding the developments in the matters entrusted to her/ him.
- v) In case of any misconduct, the Competent Authority may take appropriate action against the Advocate which includes filing complaint with the concerned Bar Council and recovery of financial loss caused to the Commission due to misconduct/omission of the Advocate.
- vi) In case of any doubt relating to the above terms and conditions and in respect of any item not covered by the above terms and conditions, the decision of NMC shall be final and binding.

7. Confidentiality

The engaged Advocate shall maintain absolute secrecy and confidentiality about the cases of the NMC and any other sensitive information acquired by him/her during the course of defending the NMC in various forums or otherwise.

8. Submission details

Only one application that too for a particular Court/Bench where the Applicant is ordinarily practicing will be accepted from an Advocate against the EOI.

SCHEDULE – III

SCOPE OF SERVICES

The empanelled Advocate shall be responsible for providing the following services to NMC:

- A. represent/ appear on behalf of NMC before the Court for which he/she has been empanelled.
- B. briefing / conferencing with the Senior Advocate engaged in a particular case before the Court / Tribunals and other judicial bodies, and if required, render all assistance to such Senior Advocate, if required.
- C. drafting of brief notes for Senior Law Officers like the Ld. AG, SG, Addl. SGs, DSGs etc.
- D. examination and drafting of legal documents to be filed in various courts of law, including Petitions (such as SLP / Writ Petition / Transfer Petition / Criminal Complaints etc.), Replies/Counter Affidavit, etc., Applications (such as Additional Affidavit/ Miscellaneous Applications, etc.), Appeals (revision/review) on behalf of NMC, as well as prompt removal/curing of defects in Appeals/Petitions filed; as may be pointed out by the registry.
- E. drafting of detailed proceeding Notes for cases.
- F. coordinating with other Ministries/Departments whenever required.
- G. doing legal research for litigation, including research on case citations and precedent cases.
- H. drafting, vetting, settling correspondences, replies to requests from other Ministries/ Departments/ Authorities etc.
- I. render legal advice or written opinions to NMC on civil, criminal, service and such other matters arising in the course of administration of NMC as are referred to him/her.

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- J. apply for the copy of orders/judgments from the Court, of the matters attended by him/her and share the copy of judicial pronouncements at the earliest, from the date of such order (excluding the time taken by the concerned Court in preparation of the copy).
- K. keep NMC informed and updated on all important developments in the designated/entrusted cases, dates of hearing etc..
- L. furnish monthly & yearly statement about the cases represented by him/her before various Courts/Tribunals or any other authority and their outcomes/ developments.
- M. co-ordination with officers of the NMC.
- N. perform such other duties of legal nature which may be assigned to him/her by NMC.

Application for Empanelment as an Advocate/Standing Counsel**Place for Empanelment - (SC/HCs/HC Benches_____)**

1.	Name of the Advocate: Father's Name: Gender: Date of Birth (Age as on 01.05.2023): Residential Address: Office Address: Contact Nos.: Email ID.:					
2.	Years of experience as an Advocate: (Enrolment details-Enclose self-attested copy of Bar Council license)					
3.	Place of practice (Courts/Forums/Tribunals):					
4.	Educational Qualifications [From Matriculation to LLB/LLM] (Enclose self-attested copies of certificates):					
	Sl. No	Qualification	University/Institution	Year of Passing	Marks Obtained/ Total Marks	Percentage
	1	10th				
	2	LL.B				
	3	LL.M				
	4	Others				
	5					
5.	Areas of specializations: (Enclose three(03) Writ Petitions, Counter Affidavits and Rejoinders filed in different cases)					
6.	Names, address & experience details: i) Sr. Associate(s) ii) Associate(s)					

7.	Details of cases won in the applied area of specialization: (Enclose copy of judgments of SC/HC)	
8.	Number of appearances before: i. Supreme Court: ii. High Court:	
9.	Details of empanelment, if any, in State Govt./Union Govt./University/Govt. Institutions/PSUs (Enclose self-attested copy of proof) :	
10.	List of Publications in Law Journal, Reportable Judgment and Books (if any) :	
11.	Annual Income/Turnover for past three financial years:	1. 2019-20: 2. 2020-21: 3. 2021-22:
12.	Misc. (Any other relevant information) (Max. 500 words):	

Signature of Applicant
With seal

Name of Advocate: _____

Date: _____

Place: _____

Declaration-cum-Undertaking

I, _____, S/o _____
R/o _____, hereby, declare that I have verified the details indicated here-in-above and also confirm that all the information submitted is true to the best of my knowledge & belief. In case of any mis-representation /violation/non adherence of any terms and conditions mentioned in the policy, NMC may reject my application at any stage of empanelment without providing any reason.

Further, any information shared by NMC during empanelment process will be confidential information and I will not share, upload or quote, inform to any person, firm or organization under any circumstances what-so-ever. I also undertake that in case any legal action is initiated by concerned Advocate, I will not make NMC as party of legal proceedings and will not make NMC liable/ responsible to any act or omission liable to pay any amount, claim, compensation or damages.

Furthermore, I hereby also undertake that I will not accept brief against the NMC whether in same court or any other Court whatsoever

Signature of Applicant
With seal

Name of Advocate: _____

Date: _____

Place: _____



सत्यमेव जयते
Government of India
राष्ट्रीय आयुर्विज्ञान आयोग
National Medical Commission
MEDIA/PUBLICATION DIVISION



PRESS RELEASE

Date: 19th February, 2024

Subject: National Medical Commission Issues Directive on Post-graduate Medical Student Housing

In a recent public notice dated 8th February 2024, the National Medical Commission (NMC) has addressed concerns regarding hostel accommodation for post-graduate medical students. The notice highlights Regulation 5.6 of the Post Graduate Medical Education Regulation (PGMER), 2023, which mandates colleges to provide suitable residential accommodation to post-graduate students. However, it emphasizes that it is not obligatory for the students to reside in these hostels.

The notice underscores that previous regulations, such as the PGMER, 2000, did not mandate the compulsory stay of post-graduate medical students in college-provided hostels.

Despite the clear directive, the NMC has received numerous complaints from post-graduate students alleging coercion by medical colleges/institutions to stay in designated hostels, accompanied by hefty charges. Such actions are deemed violations of Regulation 5.6 of the PGMER, 2023.

In response to these grievances, the NMC directs all medical colleges and institutes to adhere strictly to the stipulations outlined in the aforementioned Regulation. Failure to comply may result in punitive actions, including monetary penalties, reduction of seats, or suspension of admissions, as outlined in Regulations 9.1 and 9.2 of the PGMER, 2023.

About the National Medical Commission (NMC):

The National Medical Commission is the apex regulatory body for medical education and practices in India. Committed to maintaining high standards in medical education and ensuring the provision of quality healthcare services, the NMC oversees the assessment, accreditation, and regulation of medical colleges and professionals across the country.

For more information about NMC, please visit [<https://www.nmc.org.in/>]

Purnima
19/02-24
(Purnima Tudu)
Deputy Secretary (Publn.)

पॉकेट-14, सेक्टर-8, द्वारका, फेज़-1, नई दिल्ली-110077 | Pocket-14, Sector-8, Dwarka, Phase-1, New Delhi-110077

E-mail : media.division@nmc.org.in | Website : www.nmc.org.in



दूरभाष/Phone :25367033/35/36/37/41
25366650,1800111150
वेबसाइट/ Website : www.nmc.org.in

पॉकेट -14, सेक्टर-8, द्वारका,
फेस-1, नई दिल्ली-110077
Pocket- 14, Sector- ,Dwarka,
Phase - 1, New Delhi-110077



संयुक्त कुटुम्बकम्
ONE EARTH • ONE FAMILY • ONE FUTURE

राष्ट्रीय आयुर्विज्ञान आयोग
NATIONAL MEDICAL COMMISSION
(Establishment Section)

F. No. A-12033/04/2021/NMC/Admin(Estt.)(Pt.I)(eID-8248226)/010059-062 Date: 28th February, 2024

CIRCULAR

Subject: Engagement of retired Government Officers / Employees as Consultant on contract basis in National Medical Commission - inviting applications thereof- reg.

National Medical Commission, invites applications from eligible and desirous candidates retired from Government Service, having considerable experience of functioning of Government/ Ministries/Departments, for engagement as Consultant on contractual full time basis.

2. Details of required Consultants to be engaged are as under:

Sr. No (1)	Position (2)	Number of Positions (4)	Eligibility Condition (5)
I.	Consultant (IT)	02	Government officers retired at the Pay Level 11 of 7th CPC, and above, preferably from a Ministry of Electronics and Information Technology (MeitY) organisation, having experience of handling IT and e-Governance Projects.
II.	Senior Consultant	10*	Retired Government Officer from Level 11 & 12 of the 7 th CPC having experience in the following matters:- a) Proficient in Noting and drafting and are well acquainted with Govt. Rules and Regulations. b) Administrative Matters c) RTI Matters d) Parliament Questions e) CPGRAM f) Court cases / Court Matters etc. g) Adequate Computer Knowledge
III.	Consultant	10*	Retired Government Officer from Level 8,9 & 10 of the 7 th CPC having experience in the following matters:- a) Proficient in Noting and drafting and are well acquainted

28/02/2024

नम्रता कुमारी / Namrata Kumari
अवर सचिव / Under Secretary
राष्ट्रीय आयुर्विज्ञान आयोग / National Medical Commission
पॉकेट-14, सेक्टर-8, द्वारका, फेस-1, नई दिल्ली-110077
Pocket-14, Sector-8, Dwarka, Phase-1, New Delhi-110077

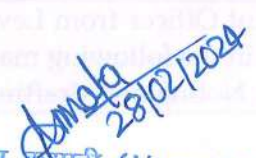
			with Govt. Rules and Regulations.
			b) Administrative Matters
			c) RTI Matters
			d) Parliament Questions
			e) CPGRAM
			f) Court cases / Court Matters etc.
			g) Adequate Computer Knowledge

* NMC retains the right to increase/ decrease the vacancy as per the requirement without any notice.

3. General Condition for all the posts:

- i) **Period of engagement:** initially for a period of one year which is extendable for further period(s) subject to satisfactory performance.
- ii) **Job location:** National Medical Commission, Pocket-14, Sector-8, Dwarka, phase-I, New Delhi-110077.
- iii) **Age:** Age should be less than 64 years as on closing date of this circular.
- iv) **Remuneration:** Last pay drawn minus pension plus transport allowance in accordance with the instructions of Government of India issued from time to time. You will be entitled to Transport Allowance that you were getting at the time of retirement/ superannuation on the Last Pay Drawn without DA. Retired Govt. Officers engaged as Consultants may be allowed TA/DA on official tour, if any, as per their entitlement at the time of retirement.
- v) **Leave:** Paid Leave may be allowed at the rate of 1.5 days for each completed month of service. Accumulation of leave beyond a calendar year may not be allowed.
- vi) **Mode of Selection:** Application received in response to this advertisement will be shortlisted on the basis of experience and qualifications of applicants. Consultants will be selected on Interview basis from shortlisted candidates.
- vii) **Working hours:**
 - Normal Office timings are from 9:30AM to 6:00PM but the post/nature of duties requires monitoring/ follow up beyond office hours.
 - May be required to Work from Home beyond office hours.
 - May also be required to attend office on holidays depending on exigencies of work.

viii) Department of Expenditure's OM F. No. 3-25/2020-EIII dated 09.12.2020 will be followed.


 नम्रता कुमारी / Namrata Kumari
 अवर सचिव / Under Secretary
 राष्ट्रीय आयुर्विज्ञान आयोग / National Medical Commission
 पॉकेट-14, सेक्टर-8, द्वारका, फेज-1, नई दिल्ली-110077
 Pocket-14, Sector-8, Dwarka, Phase-1, New Delhi-110077

- ix) **How to apply:** The applications in the prescribed format (completed in all respects) along with copy of PPO and Last Pay Certificate may be sent to the following address:-

Deputy Secretary (Estt.),
National Medical Commission,
Pocket-14, Sector-8, Dwarka Phase-I,
New Delhi-110077.

- x) **Last date for receipt of application: 15.03.2024 till 05:00 PM.**

4. Eligible retired Officers, in good health may submit their applications in the enclosed format before the closing date. **Applications received with incomplete information or received beyond the closing date will not be considered.**

5. The retired Govt. Officer after selection shall not claim for status of post which they held before/at the time of retirement. The channel of submission shall be decided by Competent Authority/Controlling Officer of individual in NMC.

(Handwritten signature: Namrata Kumari)
(Namrata Kumari)
Under Secretary (Estt.)
राष्ट्रीय आयुर्विज्ञान आयोग / National Medical Commission
पॉकेट-14, सेक्टर-8, द्वारका, फेस-1, नई दिल्ली-110077
Pocket-14, Sector-8, Dwarka, Phase-1, New Delhi-110077

Copy to:

1. Under Secretary, CS.I Division, DoPT, Lok Nayak Bhawan, New Delhi with a request to upload this Circular on website of DoP&T for wide publicity.
2. Under Secretary, Medical Education-I, MoH&FW with a request to publish this Circular on website of MoH&FW.
3. Director (IT Section), NMC with a request to upload this circular on NMC website.
4. Guard file (Estt. Section).

Application for the post of Consultant on contract basis in National Medical Commission

(Last date for receipt of application: 15.03.2024)

Applied for consultant as per S.No mentioned in Circular dated _____	
--	--

Recent Passport size photograph
--

1.	Full Name (in Block Letters)	
2.	Date of Birth	
3.	Email Id	
4.	Mobile No.	
5.	Residential Address	
6.	Educational Qualification (Attach self attested copies of certificate)	
7.	Date of superannuation/retirement	
8.	PPO Number (enclose a copy)	
9.	Post held at the time of retirement	

10.	Last Pay Drawn (Pay Level & Pay)				
11.	Transport allowance (basic) at the time of retirement				
12.	Organisation superannuated from				
13.	Organisation currently working (if any)				
14.	Working Knowledge of MS Office, e-office and Internet browsing (yes/No)				
15.	Brief particulars of experience of last 10 years *	Post held	from	to	Experience/nature of work

*Please attach separate sheet if required.

Undertaking:

I hereby declare that the particulars furnished above are true and correct to the best of my knowledge and belief. I further declare that I was clear from vigilance angle at the time of my retirement. I have read this circular and accept all the terms and conditions for engagement of consultants.

Place:

Date:

(Signature of the applicant)

Mobile:

Email ID:



राष्ट्रीय आयुर्विज्ञान आयोग
National Medical Commission
MEDIA/PUBLICATION DIVISION

PRESS RELEASE

Date: 1st March, 2024

Subject: Invitation to Press Briefing on Legal Cases Disposed/Dismissed concerning Under Graduate Medical Education Board (UGMEB).

Dear Journalists,

I hope this message finds you well. On behalf of the Under Graduate Medical Education Board (UGMEB), we are pleased to extend an invitation to you to attend a press briefing regarding legal cases concerning the UG Board.

Date: 07 March, 2024

Time: 11:00 A.M.

Venue: Conference Hall, 1st Floor, NMC, Dwarka, New Delhi

During this briefing, we will provide detailed insights into the legal matters recently addressed by UGMEB, highlighting our commitment to transparency and accountability in overseeing undergraduate medical education. We believe that keeping stakeholders informed is essential in upholding the integrity and quality of medical education nationwide.

Your participation is highly valued, and we look forward to welcoming you to the press briefing. Whoever wants to join the press briefing may send their details on publication.division@nmc.org.in by 5th March 2024, SPM

About the National Medical Commission (NMC):

The National Medical Commission is the apex regulatory body for medical education and practices in India. Committed to maintaining high standards in medical education and ensuring the provision of quality healthcare services, the NMC oversees the assessment, accreditation, and regulation of medical colleges and professionals across the country.

For more information about NMC, please visit [<https://www.nmc.org.in/>]

Yogender Malik

Best regards,
Dr. Yogender Malik
(Member EMRB and Head Media Division)
National Medical Commission

पॉकेट-14, सेक्टर-8, द्वारका, फेज़-1, नई दिल्ली-110077 | Pocket-14, Sector-8, Dwarka, Phase-1, New Delhi-110077

E-mail : media.division@nmc.org.in | Website : www.nmc.org.in



No. U-14021/01/2024-UGMEB
Government of India
National Medical Commission
(Under Graduate Medical Education Board)



Pocket- 14, Sector- 8,
 Dwarka, Phase-1, New Delhi-77
 Dated: the 20th March, 2024

PUBLIC NOTICE

Subject: Alert against fake letter issued to Medical College/Institution.

This has come to the notice of the Undergraduate Medical Education Board of NMC that a fake letter dated 03.02.2024 issued under the signature of the undersigned is circulating in social media. Copy of the same is annexed herewith.

2. It is brought to the notice of all stakeholders that there is no such letter dated 03.02.2023 issued by UGMEB of NMC. All the stakeholders including Medical Colleges are hereby advised to not to fall in trap of any such fake letter(s), if the same is not received through dedicated email of UGMEB, NMC as well as by post from NMC.

3. Please note that all important letters, Circulars and Public Notice are posted on the National Medical Commission website i.e. www.nmc.org.in. It is advised to check the website of NMC to verify the genuineness of notices, circulars and letters. In case of any doubt same be please be clarified from UGMEB of NMC.

4. All concerned are alerted to reply upon genuine letters, circulars, and notices available on NMC website only. National Medical Commission shall initiate action under the relevant law against such fake messages in social media.

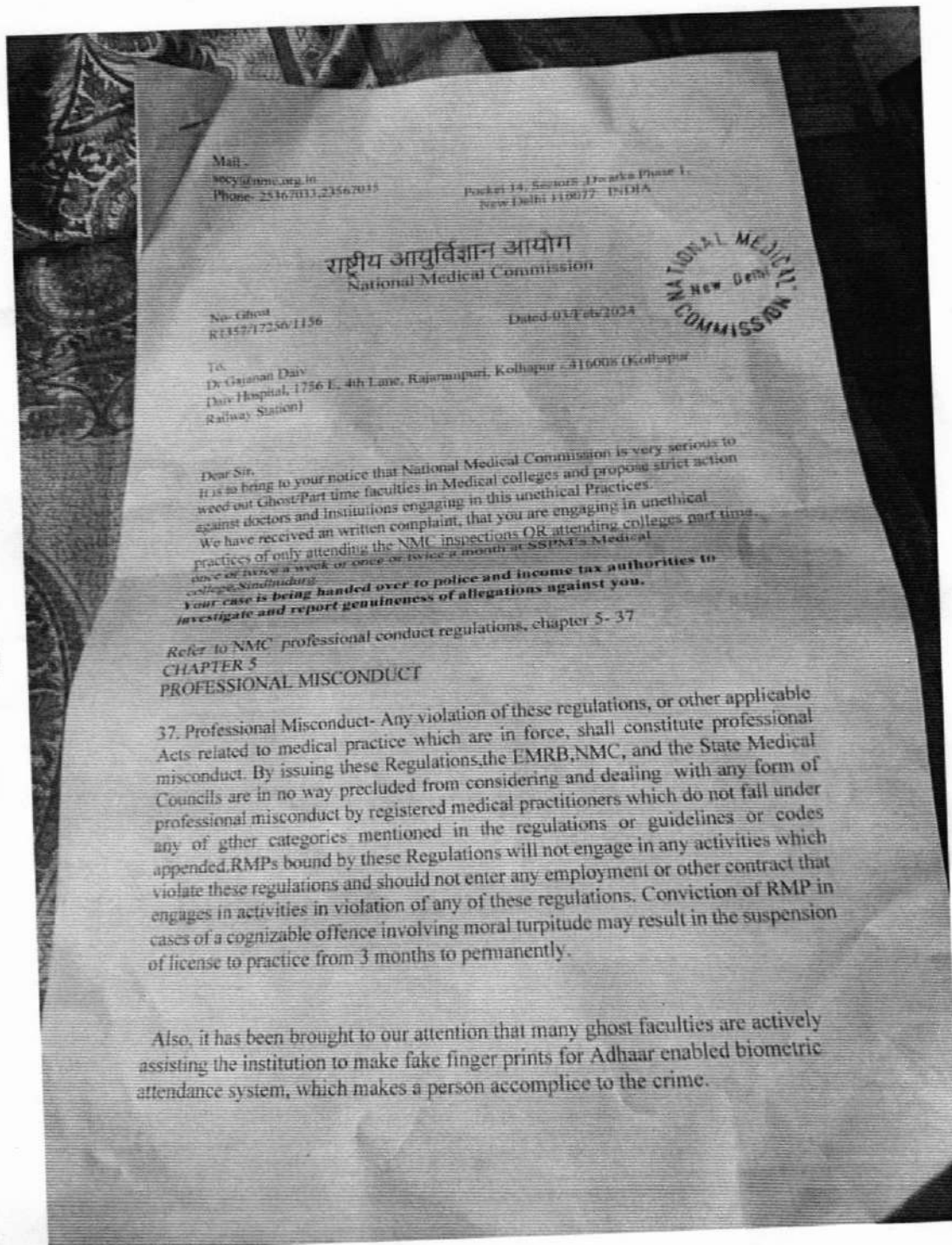
(Shambhu Sharan Kumar)
Director-UGMEB

Signed by
 Shambhu Sharan Kumar
 Date: 20-03-2024 18:24:19



Aruna Vanikar President UGMEB N...

today at 3:35 pm





Aruna Vanikar President UGMEB N...

today at 3:35 pm



THE AADHAAR (TARGETED DELIVERY OF FINANCIAL AND OTHER
SUBSIDIES, BENEFITS AND SERVICES) ACT, 2016

4. Properties of Aadhaar number.
34. Penalty for impersonation.—Whoever impersonates or attempts to impersonate another person, whether dead or alive, real or imaginary, by providing any false demographic information or biometric information, shall be punishable with imprisonment for a term which may extend to three years or with a fine which may extend to ten thousand rupees or with both.

42. General penalty.—Whoever commits an offence under this Act or any rules or regulations made thereunder for which no specific penalty is provided elsewhere than this section, shall be punishable with imprisonment for a term which may extend to 4 [four year] or with a fine which may extend to twenty-five thousand rupees or, in the case of a company, with a fine which may extend to one lakh rupees, or with both.

This is last time warning to you to dissociated from medical colleges, if you are ghost, irregular/part time faculty and with active cooperation in creating fake fingerprints for AEBAS. Continuing being fake/ghost/Part time faculty will invite penalty as per NMC professional conduct rules causing suspension of registration and Jail term (Upto 4 years) under UIDAI act, as an accomplice to impersonation.

Your name has been forwarded to concerned authorities to take action, if you appear for any NMC inspections at ANY MEDICAL COLLEGES IN FUTURE for further action as outlined above.

Please ignore this communication if you are not a faculty or not attached to any medical college.

Shashi

Shambhu Sharan Kumar
Director -UGMEB,National Medical Commission.
National Medical Co



दूरभाष/Phone : 25367033, 25367035,
25367036
फैक्स/Fax : 0091-11-25367024
E-mail: member-
marb@nmcindia.gov.in

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

**National Medical Commission
Medical Assessment & Rating Board (MARB)**

**No. 21336-LEGALMARB (Comp. 8194485)
09-04-2024**

Date:

To

**The Dean/Principal,
Radha Devi Jageshwari Memorial Medical College &
Hospital,
Dr. Kalam Nagar, Manriya-Chhajan, Turki
Muzaffarpur, Bihar (PIN-844127)
Email: jminstitute01@gmail.com**

**Subject: Withdrawal of National Medical Commission Letter
dated 18-04-
2022 and 05-07-2023 in compliance of judgement
pronounced by Hon'ble High Court of Patna (Bihar) in
LPA No 845
of 2023 in CWJC No 7058 of 2022 and other connected
matters-Reg.**

Dear Sir/Madam,

I am directed to refer to judgement pronounced by Hon'ble High Court of Patna (Bihar) dated 21.02.2024 in the case of **National Medical Commission vs Radha Devi Jageshwari Memorial Medical College & Hospital**, LPA No 845 of 2023 in CWJC No 7058 of 2022 with connected matters and Judgement dated 03.08.2023 in CWJC No 10903 of 2023 with connected matters.

2. In compliance of the above mentioned Judgements dated 21.02.2024 and 03.08.2023, the **Medical Assessment & Rating Board (MARB) Order No NMC/UG/2020/000093 dated 18-04-2022** in respect of Radha Devi Jageshwari Memorial Medical College & Hospital regarding "Withdrawal of Letter of Permission, Cancellation of Admissions in 150 Undergraduate MBBS Course for the Academic Year 2021-22 with effect from 19-04-2021-22 and the Medical Assessment & Rating Board (MARB) Order No NMC/UGR/2023-24/Offline dated 05-07-2023 regarding "With-holding of permission for 3rd Batch

(2nd Renewal) in respect of 150 MBBS seats for the Academic Year 2023-24", are hereby withdrawn.

Kindly acknowledge the receipt of this letter.

Signed by Jitlal
Ramprasad Meena
Date: 11-04-2024 09:55:12
Member/President
Medical Assessment & Rating Board (MARB)
National Medical Commission

Copy to:

1. Additional Chief Secretary, Health & Family Welfare Department,
Govt. of Bihar, Vikas Bhawan, Patna -800015 Email:health-
bih@nic.in
2. The Secretary, Department of Medical Education Govt. of Bihar
Vikas Bhawan, Patna-80015. Email: health-bih@nic.in
3. The Registrar, Aryabhatta Knowledge University, Mithapur Farm
Area
Mithapur Patna Bihar-800001 Email:registrar@akubihar.ac.in
4. The Secretary, Ministry of Health & Family Welfare Department,
Nirman
Bhawan, New Delhi-110011
5. The Assistant Director General (ME), Directorate General of Health
Services, 352-A, 1, New Delhi-110011
6. The Secretary, National Medical Commission, Pocket-14, Sector-8,
Dwarka, Phase-1, New Delhi-110077
7. The President, Under Graduate Medical Education Board, National
Medical Commission
8. The President, Post Graduate Medical Education Board, National
Medical Commission
9. IT Division, National Medical Commission
10. Guard File.



राष्ट्रीय आयुर्विज्ञान आयोग
NATIONAL MEDICAL COMMISSION
(Establishment Section)

F. No. A-12034/03/2021/NMC/Admin / 015208 - 212

Date: 10th April, 2024

To,

1. All Ministries/Departments of Government of India
2. All State Governments/Union Territory Governments
3. The Office of Controller General of Accounts

Sub:Filling up of various posts in the National Medical Commission (NMC) and its four Autonomous Boards on Deputation basis/ Short Term Contract basis – reg

Madam/Sir,

The National Medical Commission, a Statutory body set up by an Act of Parliament, the National Medical Commission Act, 2019, proposes to fill up the posts in its headquarters and its four Autonomous Boards at New Delhi on deputation basis. The details of the posts, qualifications and experience prescribed and other terms and conditions are as specified in the Annexures. The terms and conditions of appointment on deputation shall be governed as per the guidelines/orders/instructions issued by the Department of Personnel and Training, Govt. of India.

2. It is requested to give wide publicity within your Ministry/Department and Organisations under your Ministry/Department and forward the applications in the prescribed proforma enclosed alongwith attested copies of ACRs/APARs for the last five years, vigilance clearance and cadre clearance of eligible candidates whose services could be placed at the disposal of the National Medical Commission and its four Autonomous Boards in the event of their selection. The applications should be sent through proper channel in an envelope super-scribing the post applied for to the **Deputy Secretary (Estt.), National Medical Commission, Pocket-14, Sector-08,**

Contd...2/-

[Handwritten signature]
10/04/2024

अध्यक्ष/Under Secretary
राष्ट्रीय आयुर्विज्ञान आयोग/National Medical Commission
पॉकेट-14, सेक्टर-8, द्वारका, फेस-1, नई दिल्ली-110077
Pocket-14, Sector-8, Dwarka, Phase-1, New Delhi-110077

Dwarka Phase I, New Delhi-110077 so as to reach the Commission on or **before 10.05.2024**. In case of any change in the notice the same will be displayed on NMC's Website and as such the interested officers are requested to see the NMC Website www.nmc.org.in regularly.

Namrata
10/04/24

(Namrata Kumari)

Under Secretary(Estt.), NMC

For Officer/In-charge
Public Engineering Section / National Medical Commission
Floor-16, Block-8, G-Block, E-Block
Pocket-14, Sector-8, Dwarka, Phase-I, New Delhi-110077

O/C

Encl: as above

Copy to:

1. The Joint Secretary (ME), MoHFW, New Delhi with the request to upload this circular on the website of MoHFW.
2. The Joint Secretary (Admn.), DoPT, with the request to upload this circular on the website of DoPT.
3. The Joint Secretary (Admn.), Legislative Department/Department of Legal Affairs, with the request to upload this circular on their website.
4. The Joint Secretary (Admn.), Ministry of Electronics and Information Technology with the request to upload this circular on their website.
5. The Office of Controller General of Accounts, with the request to upload this circular on their website.

DETAILS OF THE POST

1.	Name of the Post	Deputy Secretary (Accounts and Finance)
2.	Number of Post	01
3.	Scale of Pay of the Post	Level 12 (Rs. 78,800 - 2,09,200) of Pay Matrix
4.	Mode of Recruitment	By Deputation
5.	Qualification, Experience and Age Limit prescribed for the post	Officers of the Central Government or State Governments or Union territories or Armed Forces Medical Services or autonomous or statutory organization, PSUs or Universities or Recognized Research Institutions: (i) Holding analogous post on regular basis in the parent cadre or departments; or (ii) From amongst Principal Accounts Officer or equivalent in Level - 11 (Rs. 67,700-2,08,700) of Pay Matrix with three years of regular service having experience of Finance, Accounts, Budget matters. Note 1: The period of deputation including the period of deputation in another ex-cadre post held immediately preceding this appointment in the same or some other organisation/Department of the Central Government shall ordinarily not exceed three years. Note 2: The maximum age limit for appointment on deputation shall be Not Exceeding 56 years as on the closing date of receipt of applications.
6.	Brief Description of Duties	1. Ensure efficient and transparent management of NMC finances in line with recognized accounting/auditing standards and procedures. 2. Helps in maintenance of accounts and financial records and performing financial procedures (receipts,

Amish
10/04/2024

उप सचिव / Under Secretary
 नेशनल इंस्टीट्यूट ऑफ मेडिकल साइंस / National Institute of Medical Sciences
 ब्लॉक-14, सेक्टर-3, गुवाहाटी, असम-781 005
 Contact-14, Sector-3, Guwahati, Pincode-781 005

		payments, petty cash, payroll). 3. Responsible for strategic financial planning, budgeting, MIS, taxation and day to day management of accounting and finance function. 4. Give advice on administrative and financial matters. 5. Manage performance of ledger accounting system, leading improvement and system enhancement work. 6. Effectively organize and manage internal and external audits. Produce statutory accounts and other legal returns for NMC.
7.	Period of Deputation	Initially for 3 Years

doneh
10/04/2024

Chief Executive / Financial Officer
NMC / Under Secretary
NMC / Under Secretary / National Director
NMC / Under Secretary / National Director
NMC / Under Secretary / National Director

2

DETAILS OF THE POST

1.	Name of the Post	Deputy Secretary (Legal)
2.	Number of Post	01
3.	Scale of Pay of the Post	Level 12 (Rs. 78,800 – 2,09,200) of Pay Matrix
4.	Mode of Recruitment	By Deputation
5.	Qualification, Experience and Age Limit prescribed for the post	Officers of the Central Government or State Governments or Union territories or Armed Forces Medical Services or autonomous or statutory organization, PSUs or Universities or Recognized Research Institutions: (i) Holding analogous post; or (ii) With three years of service rendered after appointment to the post on a regular basis in Level 11 (Rs. 67,700-2,08,700) of Pay Matrix and having experience of handling legal and legislative matters. Note 1: The period of deputation including the period of deputation in another ex-cadre post held immediately preceding this appointment in the same or some other organisation/Department of the Central Government shall ordinarily not exceed three years. Note 2: The maximum age limit for appointment on deputation shall be Not Exceeding 56 years as on the closing date of receipt of applications.
6.	Brief Description of Duties	1. Provide legal support and advice on relevant legal issues to the commission. 2. Ensure compliance with the internal controls, statutory regulations and other formalities. 3. Keeping up with current changes on all relevant areas of laws and

10/04/2024

अथ सचिव/Under Secretary
राष्ट्रीय आणविकीय शक्ति/Regional Director
प्लॉट-14, सेक्टर-9, इन्दौर, पिन-4, म.प्र.
Plot-14, Sector-9, Indore, Pin-4, M.P.

		contributing to the enhancement of the knowledge base of the NMC's legal functions. 4. Any other matter/work assigned by competent authority.
7.	Period of Deputation	Initially for 3 Years

Amok
10/10/2024
Joint Secretary / Under Secretary
Ministry of Health and Family Welfare / National Medical Commission
Room-14, Sector-3, Noida, Distt. UP-201301, Noida
Block-14, Sector-5, Gurgaon, Phase-1, Haryana-122002

4

DETAILS OF THE POST

1.	Name of the Post	Under Secretary (Legal)
2.	Number of Post	01
3.	Scale of Pay of the Post	Level 11 (Rs. 67,700 - 2,08,700) of Pay Matrix
4.	Mode of Recruitment	By Deputation
5.	Qualification, Experience and Age Limit prescribed for the post	Officers of the Central Government or State Governments or Union territories or Armed Forces Medical Services or autonomous or statutory organization, PSUs or Universities or Recognized Research Institutions: (i) Holding analogous post on a regular basis in the present cadre or department; or (ii) From amongst Section Officers (Legal) or equivalent in Level 8 (Rs. 47,600 - 1,51,100) of Pay Matrix with five years of regular service having at least three years' experience of handling legal/legislative matter. Note 1: The period of deputation including the period of deputation in another ex-cadre post held immediately preceding this appointment in the same or some other organisation/Department of the Central Government shall ordinarily not exceed three years. Note 2: The maximum age limit for appointment on deputation shall be Not Exceeding 56 years as on the closing date of receipt of applications.
6.	Brief Description of Duties	1. Provide legal support and advice on relevant legal issues to the commission. 2. Ensure compliance with the internal controls, statutory regulations and

[illegible]

		other formalities. 3. Keeping up with current changes on all relevant areas of laws and contributing to the enhancement of the knowledge base of the NMC's legal functions. 4. Any other matter/work assigned by competent authority.
7.	Period of Deputation	Initially for 3 Years


 10/04/2024
 Director General / National Council
 and Under Secretary
 National Council
 Sector-14, Gurgaon-122001, Haryana
 Sector-14, Gurgaon-122001, Haryana

DETAILS OF THE POST

1.	Name of the Post	Manager (IT)
2.	Number of Post	03
3.	Mode of Recruitment	By Deputation or failing which on Contract Basis from amongst persons possessing the educational and other qualification and experience as prescribed
4.	Scale of Pay in case of Deputation	Level 11 (Rs. 67,700 - 2,08,700) of Pay Matrix
4.1	Remuneration On Contract Basis	Minimum of the Pay Scale + Existing DA rate at the time of engagement+ TA (Remuneration shall remain fixed during the full contractual period)
5.	Qualification, Experience and Age Limit prescribed for the post	Officers of the Central Government or State Governments or Union territories or autonomous or statutory organisations or PSUs or Universities or Recognized Research Institutions: (i) Holding analogous post on regular basis in the parent cadre or departments; or (ii) With three years of regular service in the grade rendered after appointment to the post on a regular basis in level 8 (Rs. 47,600 - 1,51,100) of Pay Matrix or equivalent; and (iii) Possessing Master of Business Administration/Post Graduate Diploma in Management and Bachelor of Engineering/ Bachelor of Technology or Master of Computer Application. (iv) Eight years of experience of handling IT and e-Governance projects; (v) Knowledge of government domain is desirable. Note 1: The period of deputation including

Handwritten signature
 10/04/2024
 Under Secretary
 National Institute of Technology
 Kharagpur-721 302, India
 E-mail: nsu@nitk.ac.in
 Phone: 0361-2662444, 2662445, 2662446, 2662447, 2662448, 2662449, 2662450, 2662451, 2662452, 2662453, 2662454, 2662455, 2662456, 2662457, 2662458, 2662459, 2662460, 2662461, 2662462, 2662463, 2662464, 2662465, 2662466, 2662467, 2662468, 2662469, 2662470, 2662471, 2662472, 2662473, 2662474, 2662475, 2662476, 2662477, 2662478, 2662479, 2662480, 2662481, 2662482, 2662483, 2662484, 2662485, 2662486, 2662487, 2662488, 2662489, 2662490, 2662491, 2662492, 2662493, 2662494, 2662495, 2662496, 2662497, 2662498, 2662499, 2662500, 2662501, 2662502, 2662503, 2662504, 2662505, 2662506, 2662507, 2662508, 2662509, 2662510, 2662511, 2662512, 2662513, 2662514, 2662515, 2662516, 2662517, 2662518, 2662519, 2662520, 2662521, 2662522, 2662523, 2662524, 2662525, 2662526, 2662527, 2662528, 2662529, 2662530, 2662531, 2662532, 2662533, 2662534, 2662535, 2662536, 2662537, 2662538, 2662539, 2662540, 2662541, 2662542, 2662543, 2662544, 2662545, 2662546, 2662547, 2662548, 2662549, 2662550, 2662551, 2662552, 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		the period of deputation in another ex-cadre post held immediately preceding this appointment in the same or some other organisation/Department of the Central Government shall ordinarily not exceed three years. Note 2: The maximum age limit for appointment on deputation/ absorption shall be Not Exceeding 56 years as on the closing date of receipt of applications.
6.	Brief Description of Duties	1. Ownership of complete software development life cycle and designing the structure of new technology systems, overseeing the implementation of programs, and liaising with the relevant teams. 2. Study the status of IT Infrastructure of commission and assist in coming up with a robust IT infrastructure for better security, disaster recovery and business continuity. 3. Ensure that individual project level initiatives are interoperable, standardized, scalable and secure across various areas of software, hardware and infrastructure. 4. Partner with the vendors and help them in adhering to technical standards/ architecture/ product and strategic control, specifications for the e - governance projects. 5. Any other matter/work assigned by competent authority.
7.	Period of Deputation	Initially for 3 Years


 10/04/2024
 Joint Secretary (IT) / Under Secretary
 National Institute of Electronics
 Plot No. 1, Sector-10, Gurgaon, Haryana
 (Phone: 012-261-1111, Fax: 012-261-1112)

DETAILS OF THE POST

1.	Name of the Post	Computer Programmer
2.	Number of Post	01
3.	Mode of Recruitment	By Deputation or failing which on Contract Basis from amongst persons possessing the educational and other qualification and experience as prescribed
4.	Scale of Pay in case of Deputation	Level 10 (Rs. 56,100 - 1,77,500) of Pay Matrix
4.1.	Remuneration On Contract Basis	Minimum of the Pay Scale + Existing DA rate at the time of engagement+ TA (Remuneration shall remain fixed during the full contractual period) :
5.	Qualification, Experience and Age Limit prescribed for the post	Officers of the Central Government or State Governments or Union territories or autonomous or statutory organization or PSUs or Universities or Recognized Research Institutions: (i)Holding analogous post on regular basis in the parent cadre or departments; or (ii)With five years of service rendered after appointment to the post on a regular basis in level 8 (Rs. 47,600 - 1,51,100) of Pay Matrix or equivalent; and (iii)Possessing Bachelor of Engineering/ Bachelor of Technology in Computer Science /Information Technology/Electronics and Communication or Master of Computer Application. (iv) Having five years of experience in advisory services for IT Technologies/ software background with experience of handling of IIT and e-Governance Projects. Officers with relevant experience in


 Under Secretary
 National Medical Commission
 10th-12, Block-3, Phase-1, Plot-1, Road-1, Sector-14, Dwarka, Phase-1, New Delhi-110044

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		National Informatics Centre/National Informatics Centre Inc. will be preferred. (v) Knowledge of government domain is desirable. Note 1: The period of deputation including the period of deputation in another ex-cadre post held immediately preceding this appointment in the same or some other organisation/Department of the Central Government shall ordinarily not exceed three years. Note 2: The maximum age limit for appointment on deputation/ absorption shall be Not Exceeding 56 years as on the closing date of receipt of applications.
6.	Brief Description of Duties	1. Define, develop, test, analyze, and maintain new software applications in support of the achievement of business requirements. 2. Create and install updates for existing programs and install updates for existing software programs in the commission. 3. Write code in a different language so that programs and applications can be compatible with different perating systems. 4. Identify malicious software and fix software that could be vulnerable to potential hacks. 5. Prevents security breaches and data leaks. 6. Any other matter/work related to IT systems and software assigned by competent authority.
7.	Period of Deputation	Initially for 3 Years


 10/04/2024
 Joint Secretary / Planning Division
 and Officer / Under Secretary
 National Informatics Centre
 10, Connaught Place, New Delhi-110028
 India.

DETAILS OF THE POST

1.	Name of the Post	Accounts Officer
2.	Number of Post	02
3.	Scale of Pay of the Post	level 9 (Rs. 53,100 - 1,67,800) of Pay Matrix
4.	Mode of Recruitment	By Deputation
5.	Qualification, Experience and Age Limit prescribed for the post	Officers of the Central Government or State Governments or Union territories or autonomous or statutory organisation or PSUs or Universities or Recognized Research Institutions: (i) Holding analogous post on regular basis in the parent cadre or departments; or (ii) From amongst Assistant Account Officers or equivalent in level 8 (Rs. 47,600 - 1,51,100) of Pay Matrix with three years of regular service. Note 1: The period of deputation including the period of deputation in another ex-cadre post held immediately preceding this appointment in the same or some other organisation/ Department of the Central Government shall ordinarily not exceed three years. Note 2: The maximum age limit for appointment on deputation/ absorption shall be not exceeding 56 years as on the closing date of receipt of applications.
6.	Brief Description of Duties	1. Supervision of work of accounts section at NMC. 2. Authorizing payments such as salary payable, pension, contingent bills etc. 3. Managing the finance receipts and bank guarantees of NMC. 4. Authorizing and arranging the payments to assessors and TA/DA claim of officials and non-official

Amulya
 16/04/2024
 Under Secretary
 National Model Committee
 1st Floor, Block-6, Room, 6th-1, 1st Floor, 100
 Model-16, Sector-6, Dwarka, Phase-1, New Delhi-110017

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		members. 5. Submission of various reports and returns in connection with GST, TDS etc. to respective authorities. 6. Advising the commission on financial and accounting matters. 7. Preparation of annual accounts of NMC and its trusts. 8. Help with finance audit and attend to audit queries. 9. Any other matter/work assigned by competent authority.
7.	Period of Deputation	Initially for 3 Years


 10/04/2024
 Director General / National Alcohol Control
 Director General / National Alcohol Control
 Director General / National Alcohol Control
 Director General / National Alcohol Control
 Director General / National Alcohol Control

DETAILS OF THE POST

1.	Name of the Post	Accountant
2.	Number of Post	02
3.	Scale of Pay of the Post	Level 5 (Rs. 29,200 - 92,300) of Pay Matrix
4.	Mode of Recruitment	By Deputation
5.	Qualification, Experience and Age Limit prescribed for the post	Officials of the Central Government/State Governments/Union territories or autonomous or statutory organisation or PSUs or Universities or Recognized Research Institutions: (i) Holding analogous post on regular basis in the parent cadre or departments. Note 1: The period of deputation including the period of deputation in another ex-cadre post held immediately preceding this appointment in the same or some other organisation/ Department of the Central Government shall ordinarily not exceed three years. Note 2: The maximum age limit for appointment on deputation/ absorption shall be not exceeding 56 years as on the closing date of receipt of applications.
6.	Brief Description of Duties	1. Assist in work of accounts sections including but not limited to payments, receipts and maintenance of accounts. 2. Arranging payments such as salary payable, pension, contingent bills etc. 3. Maintain a proper record of accounting and receipts of NMC received from colleges, students and other applicants. 4. Arranging the payment of assessors and TA/DA claim of officials and non-official members.

Dwarka
10/04/2024
 Under Secretary
 राष्ट्रीय आयुर्विज्ञान समिति / National Medical Commission
 पॉकेट-14, सेक्टर-8, द्वारका, फेज-1, नई दिल्ली-110017
 Pocket-14, Sector-8, Dwarka, Phase-1, New Delhi-110017

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		5. Preparation of bills and issue of cheque for payment. 6. Accounting and submission of returns of TDS, GST, NPS etc. 7. Any other matter/work assigned by competent authority.
7.	Period of Deputation	Initially for 3 Years


10/04/2024
Joint Director (General) / Joint Director (General)
Joint Director (General) / Joint Director (General)
Joint Director (General) / Joint Director (General)
Joint Director (General) / Joint Director (General)

DETAILS OF THE POST

1.	Name of the Post	Hindi Officer
2.	Number of Post	01
3.	Scale of Pay of the Post	Level 8 (Rs. 47,600 - 1,51,100) of Pay Matrix
4.	Mode of Recruitment	By Deputation
5.	Qualification, Experience and Age Limit prescribed for the post	Officers of the Central Government or State Governments or Union territories or autonomous or statutory organisation or PSUs or Universities or Recognized Research Institutions: (i) Holding analogous post on regular basis in the parent cadre or departments; or (ii) From amongst Senior Hindi Translator or equivalent in level 7 (Rs. 44,900 - 1,42,400) of Pay Matrix with five years of regular service. Note 1: The period of deputation including the period of deputation in another ex-cadre post held immediately preceding this appointment in the same or some other organisation/ Department of the Central Government shall ordinarily not exceed three years. Note 2: The maximum age limit for appointment on deputation/ absorption shall be not exceeding 56 years as on the closing date of receipt of applications.
6.	Brief Description of Duties	- Applying terminology (terminological work) in Hindi and translation work from English to Hindi or vice-a-versa, preferably of technical or scientific literature. - To acquaint officers and staff of NMC with the Official Language Act, Rules and other important orders relating

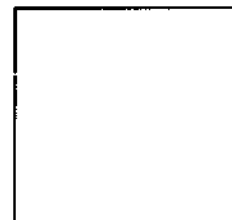

 10/04/2024
 Under Secretary
 National Medical Commission
 Plot-14, Sector-3, Market, Gurgaon, Haryana
 Plot-14, Sector-3, Market, Gurgaon, Haryana

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		to the implementation of Official Language and to assist and help them in the implementation of the same. 3. To ensure proper compliance of the provisions of the Official Language Act and the orders pertaining to 'Hindi Teaching Scheme and Official Language Policy' in NMC. 4. To conduct inspection in the various sections on the progressive use of Official Language. 5. Prepare action plans, in accordance with the annual programme for the implementation of Official Language 6. and to achieve the targets in implementation of Official Language. 7. To prepare drafts, notes, write-up etc. for map, atlases & other publication in Hindi. 8. Any other matter/work assigned by competent authority.
7.	Period of Deputation	Initially for 3 Years


 10/04/2024
 Joint Secretary / Under Secretary
 Higher Education / National Medical Council
 10/04/24, Block-8, Floor, G-1, V-1, Phase-1
 Model-1, Sector-5, Block 2, Phase-1, New Delhi-110016

Proforma for application for post of



1.	Name in Full (IN BLOCK LETTERS)				
2.	Post Applied For				
3.	Date of Birth (DD/MM/YYYY)				
4.	Initial date of appointment in Govt. service				
5.	Date of superannuation (DD/MM/YYYY)				
6.	Service to which you belong				
7.	Status of your present employer (Pl. specify whether central Govt./State Govt./ Autonomous / University/others)				
8.	Office address with Telephone No.				
9.	Residential Address with Telephone No.				
10.	Email Id:				
11.	Educational and other Qualifications possessed by the Officer				
12.	Experience as possessed by the Officer				
13.	Please state clearly whether in the light of entries made by you above, you meet the requisite Qualifications and Work Experience of the post.				
14.	Details of employment in chronological order (If needed, enclose a separate sheet duly authenticated by your signature in the format given below):				
	Name of Office/ Institution	Post held on regular Basis	From	To	Level in the Pay Matrix of the post held on regular Basis
15.	Nature of present employment i.e. Permanent / Ad-hoc/Temporary)				
	Present post held, along with Pay Level and present Basic Pay/Pay Scale/Pay Band and Grade Pay of the post held:				
16.	In case the present employment is held on deputation, please state:				
	a) The date of initial appointment.				
	b) Period of appointment				
	c) Name of the parent office/ organization.				

	d) Name & Pay of the post held in substantive capacity in the parent organization:	
	NOTE: In case of Officers already on deputation, the applications of such officers should be forwarded by the parent cadre/Department along with Cadre Clearance, Vigilance Clearance and Integrity certificate. NOTE: Information under Column 16(c) & 16(d) above must be given in all cases where a person is holding a post on deputation outside the cadre/organisation but still maintaining a lien in his parent cadre/organisation.	
	Additional details about present employment: Please state whether working under a) Central Government b) State Government c) Autonomous Organisation d) Government Undertaking e) Universities f) others	
17.	Additional information, if any, relevant to the post you applied for in support of your suitability for the post. (This among other things may provide information with regard to: (i) additional academic qualification (ii) professional training and (ii) work experience over and above prescribed in the Vacancy Circular/Advertisement) (Note: Enclose a separate sheet duly signed, if the space is insufficient)	

I have carefully gone through the vacancy circular / advertisement and I am well aware that the curriculum Vitae duly supported by documents submitted by me will also be assessed by the Selection Committee at the time of selection for the post. It is also certified that the information furnished above is correct and true to the best of my knowledge. In the event of my selection I shall abide by the terms and conditions of services attached to the post.

Place: -

Signature:

Date: -

Name:

(Certificate to be furnished by the Employer/Head of office/Forwarding authority)

Certified that the information/details provided in the above application by the applicant are true and correct as per the facts available on records. He/she possesses educational qualifications and experience mentioned in vacancy circular. If selected, he/she will be relieved immediately.

2. It is also certified: -

- i. That there is no vigilance/disciplinary case or criminal case pending or contemplated against Shri/ Smt./Ms. _____
- ii. That his / her integrity is certified.
- iii. That his / her CR / APAR dossier in original is enclosed / photocopies of the ACRs/ APAR for the last five years duly attested by an officer of the rank of Under Secretary to the Govt. of India or above, are enclosed.
- iv. That no major / minor penalty has been imposed on him / her during that last ten years or A list of major / minor penalties imposed on his / her during the last ten years is enclosed (as the case may be)
- v. That the cadre controlling authority has no objection to the consideration of the applicant for the post mentioned in this advertisement.

Signature _____
Name and Designation _____
Tel. No. _____
Office Seal

Place:

Date:

List of enclosures:

- 1.
- 2.
- 3.
- 4.
- 5.

19



No. U-15024/9/2023-UGMEB
Government of India
National Medical Commission
(Under Graduate Medical Education Board)



Pocket- 14, Sector- 8,
Dwarka, Phase-1, New Delhi-77

Date: 10th April 2024

PUBLIC NOTICE

In continuation of the Under Graduate Medical Education Board Public Notices of even number dated 22nd March, 2024, 18th March, 2024 and 27th March, 2024 regarding submission of Annual Declaration details/data of respective Institutions on NMC portal as required in the NMC Act, 2019 and various regulations issued by NMC from time to time.

2. Despite extension of last date, some Colleges did not upload the details on the Portal. This has been viewed seriously by the Competent Authority. **Permission for admission in MBBS course for the year 2024-25 shall not be granted to the Colleges/Institutes if they fail to submit Annual Declaration Form within prescribed time.**

3. Since the permission for admission in MBBS Course for this Academic Year i.e. 2024-25 shall only be granted on the basis of Annual Declaration Form, all Colleges/Institutions are hereby directed to submit the details along with requisite fee including GST on NMC Portal **latest by 18th April, 2024.**

4. Technical information/queries may be sought from websupport@nmc.org.in

5. This issues with the approval of the Competent Authority.

(Shambhu Sharan Kumar)

Director-UGMEB

No. M-19011/10/2024-MARB/NMC (Comp.No.8271617)
National Medical Commission
Medical Assessment & Rating Board (MARB)

New Delhi, Dated: 10-04-2024

PUBLIC NOTICE

Subject: Misleading and Baseless News in Print/Electronic Media regarding Establishment of New Medical Colleges and Grant of UG/PG Seats in various Medical Courses for the Academic Year 2024-25 – Regarding.

It has been observed recently that there are some fake news in Print/Electronic Media regarding Establishment of New Medical Colleges and grant of UG/PG Seats in various Medical Courses. It has further been observed that either "Heading" of such news is misleading or the "Contents" therein are baseless.

2. National Medical Commission (NMC) believes in transparency and has been promoting it in letter and spirit. Accordingly, the NMC has been issuing "Public Notice" in the matter from time to time on the Website of NMC, which is the only authentic information for any stakeholder/general public.

3. **The Medical Assessment & Rating Board (MARB), NMC has not approved/sanctioned any New Medical College or increase of UG/PG Seats in various medical courses for the academic year 2024-25 so far. The applications received for this academic year are still under process. Any decision in the matter, whenever is taken by NMC, will be uploaded on the website of NMC immediately.**

4. In view of the above facts, all the stakeholders/general public are requested neither give attention to nor take any cognisance of any misleading or baseless news being published in Print/Electronic Media.

5. This issues with the approval of the Competent Authority.

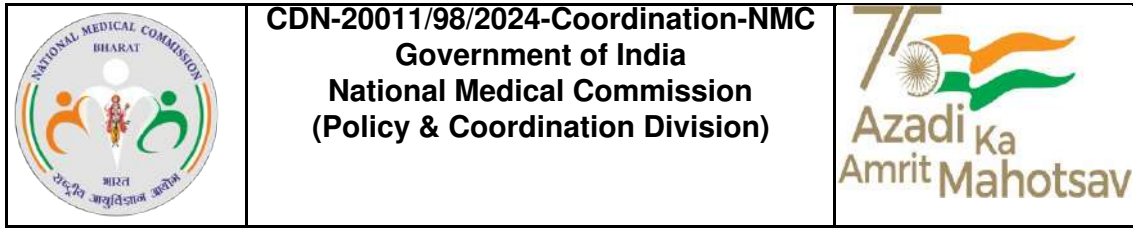
(Arun Kumar Singh)
Deputy Secretary (MARB)

To

All Stakeholders & General Public

Copy to:

Deputy Secretary (IT) for uploading this Public Notice on the website of NMC today itself.



Pocket- 14, Sector-8,
Dwarka, Phase-1, New Delhi-77
16-04-2024

PUBLIC NOTICE

Sub: Directions for submitting details of Stipend paid to UG Interns, Post-Graduate residents and Senior Residents or PGs in Super Specialty by Medical College / Medical Institutions

Hon'ble Supreme Court of India in the WP (Civil) No. 730/2022 & other cases vide their orders dt. 16.09.2023 and 01.04.2024 has directed NMC to submit the details of stipends paid to the Medical interns and residents and accordingly, all the Health Institutions / Medical colleges are hereby directed to submit to NMC the details of stipend paid to their UG Interns, Post-Graduate Residents and Senior Residents or PGs in Super Specialty for the financial year 2023-24 as per **Annexure 1** on E-mail ID:- stipend23-24@nmc.org.in by **23.04.2024** positively.

2. Further for financial year 2024-25 onwards these details should be uploaded on the website of the Medical College / Medical Institutions concerned and required to be updated on monthly basis (by 5th of every month thereafter) as per the **Annexure 2** and at the end of each financial year the complete statement be submitted to NMC on E-mail ID:- stipend24-25@nmc.org.in

3. This issues with the approval of Chairman, NMC.

Signed by B Srinivas

Date: 16-04-2024 15:49:32

Dr .(Prof) B.Srinivas
Secretary

To:

All the Medical Institutions/Colleges concerned.

Copy for information to:

1. PPS to Chairman, NMC.
2. PPS to Secretary, NMC
3. PPS of Presidents of UGMEB/PGMEB/MARB/EMRB
4. Guard File.

Name of the Medical college/Institution and address:

The Medical college/institution hereby declares the stipend paid to different categories of trainees for the financial year 2023-24.

Numbers in each cell of the months refers to the numbers of trainees

Sl #	Category	State Govt Stipend*	College's stipend*	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
1	Interns (MBBS)														
Post-Graduate Residents:															
2	Ist year (MD/MS)														
3	IIInd year (MD/MS)														
4	IIIrd year (MD/MS)														
Senior Residents or PGs in Super Specialty:															
5	Ist year (DM/MCh)														
6	IIInd year (DM/MCh)														
7	IIIrd year (DM/MCh)														

*Cell values indicate the stipend (in INR) paid each month for each trainee

Date:

Signature

Name of Dean/Principal

Name of the Medical college/Institution and address:

The Medical college/institution hereby declares the stipend paid to different categories of trainees for the financial year 2024-25.

Numbers in each cell of the months refers to the numbers of trainees

Sl #	Category	State Govt Stipend*	College's stipend*	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
1	Interns (MBBS)														
Post-Graduate Residents:															
2	Ist year (MD/MS)														
3	IIInd year (MD/MS)														
4	IIIrd year (MD/MS)														
Senior Residents or PGs in Super Specialty:															
5	Ist year (DM/MCh)														
6	IIInd year (DM/MCh)														
7	IIIrd year (DM/MCh)														

*Cell values indicate the stipend (in INR) paid each month for each trainee

Date:

Signature

Name of Dean/Principal

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

पॉकेट-14, सेक्टर-8, द्वारका, फेस -1 ,
नई दिल्ली -110 077
Pocket-14, Sector-8, Dwarka,
Phase-1, New Delhi- 110 077

No U-15027/7/2024-UGMEB

Dated: 26.04.2024

Public Notice

Subject: Online survey on mental health and well being of medical students

Anti Ragging cell in NMC has constituted a National Task Force on Mental Health and Well being of Medical Students. Task Force has decided to conduct an online survey of medical students as well as the faculty in medical colleges.

2. A google form for this purpose has been prepared which may be accessed from the following link:

https://docs.google.com/forms/d/e/1FAIpQLSfEmhp3oEfRGUa6vQI7nw3ieSITguU1w4Qykylo-x8OBh_yMw/viewform

3. All the medical students and faculties of the medical college are requested to kindly submit their responses by 3rd May 2024. Identity of the participants will be kept confidential and will not be shared with anyone. It will be used by the Task Force only for the purpose of analysis and recommendations in its report.



(Aujender Singh)
Deputy Secretary, PGMEB
& Member Secretary National Task Force



**CDN-20011/98/2024-
Coordination.NMC
Government of India
National Medical Commission
Policy & Coordination Division**



Pocket- 14, Sector- 8,
Dwarka, Phase-1, New Delhi-77
30-04-2024

PUBLIC NOTICE

Subject: Directions for submitting details of stipend paid to UG interns, PG residents and Senior Residents or PGs in Super Specialty by Medical Colleges/Medical Institutions.

Ref: NMC Public Notice no.CDN-20011/98/2024-Coordination-NMC Dated 16.04.2024 on the above subject.

Hon'ble Supreme Court of India in the WP(C) No.730/2022 & other cases, vide their orders dt. 16-09-2023 and 01-04-2024, has directed NMC to submit the details of stipends paid to the Medical Interns and residents. Accordingly, all the Health Institutions/Medical Colleges were directed, vide Public Notice dated 16-04-2024, to submit to NMC, the details of stipend paid to their UG interns, PG residents and senior residents or PGs in Super Specialty for the financial year 2023-24 as per Annexure-1 on E-mail ID: stipend23-24@nmc.org.in

2. Further, directed to upload the details for financial year 2024-25 onwards on the website of the Medical College/ Medical Institutions concerned and also required to be updated on monthly basis (by 5th of every month) as per the Annexure-2 and at the end of the financial year, the complete statement be submitted to NMC on E-mail ID: stipend24-25@nmc.org.in

3. It is observed that many colleges have not yet forwarded the requisite data/ information in the prescribed format to the designated E-mail ID for the data relating to FY-2023-24 viz. "stipend23-24@nmc.org.in". In view of the directions of the Supreme Court for submitting the data within 4 weeks, all defaulting Medical Colleges are hereby requested to immediately submit requisite information/data for FY-2023-24 by 02.05.2024 without any further delay and failure on the part of the colleges in submitting the data will be viewed seriously and strict action against the colleges will be taken.

4. Accordingly, all defaulting colleges are requested to forward/ submit their stipend payment details for FY-2023-24 to only the prescribed E-mail ID viz. "stipend23-24@nmc.org.in" by **02.05.2024** invariably.

5. This issues with the approval of Secretary, NMC.

Signed by
Srinidhi Kari

Date: 30-04-2024 13:13:31
K SRINIDHI

UNDER SECRETARY

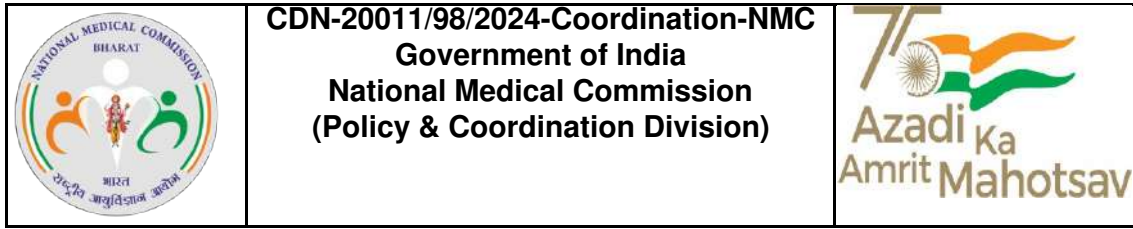
ksrinidhi.kari@gov.in

To:

All defaulting Medical Institutions/Colleges concerned.

Copy for information to:

1. PPS to Chairman, NMC.
2. PPS to Secretary, NMC.
3. PPS to Presidents of UGMEB/ PGMEB/ MARB/ EMRB.
4. Guard File.



Pocket- 14, Sector-8,
Dwarka, Phase-1, New Delhi-77
16-04-2024

PUBLIC NOTICE

Sub: Directions for submitting details of Stipend paid to UG Interns, Post-Graduate residents and Senior Residents or PGs in Super Specialty by Medical College / Medical Institutions

Hon'ble Supreme Court of India in the WP (Civil) No. 730/2022 & other cases vide their orders dt. 16.09.2023 and 01.04.2024 has directed NMC to submit the details of stipends paid to the Medical interns and residents and accordingly, all the Health Institutions / Medical colleges are hereby directed to submit to NMC the details of stipend paid to their UG Interns, Post-Graduate Residents and Senior Residents or PGs in Super Specialty for the financial year 2023-24 as per **Annexure 1** on E-mail ID:- stipend23-24@nmc.org.in by **23.04.2024** positively.

2. Further for financial year 2024-25 onwards these details should be uploaded on the website of the Medical College / Medical Institutions concerned and required to be updated on monthly basis (by 5th of every month thereafter) as per the **Annexure 2** and at the end of each financial year the complete statement be submitted to NMC on E-mail ID:- stipend24-25@nmc.org.in

3. This issues with the approval of Chairman, NMC.

Signed by B Srinivas

Date: 16-04-2024 15:49:32

Dr .(Prof) B.Srinivas
Secretary

To:

All the Medical Institutions/Colleges concerned.

Copy for information to:

1. PPS to Chairman, NMC.
2. PPS to Secretary, NMC
3. PPS of Presidents of UGMEB/PGMEB/MARB/EMRB
4. Guard File.

Name of the Medical college/Institution and address:

The Medical college/institution hereby declares the stipend paid to different categories of trainees for the financial year 2023-24.

Numbers in each cell of the months refers to the numbers of trainees

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6	IIInd year (DM/MCh)														
7	IIIrd year (DM/MCh)														

*Cell values indicate the stipend (in INR) paid each month for each trainee

Date:

Signature

Name of Dean/Principal

Name of the Medical college/Institution and address:

The Medical college/institution hereby declares the stipend paid to different categories of trainees for the financial year 2024-25.

Numbers in each cell of the months refers to the numbers of trainees

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5	Ist year (DM/MCh)														
6	IIInd year (DM/MCh)														
7	IIIrd year (DM/MCh)														

*Cell values indicate the stipend (in INR) paid each month for each trainee

Date:

Signature

Name of Dean/Principal

File No. T -200181 44/2020-NCD FTS:- 8080894
Directorate General of Health Services (National NCD Division)
Ministry of Health & Family Welfare

Nirman Bhawan, New Delhi
Dated: 15th May 2024

To,

1. The Director, All AIIMS
2. State Nodal Officer, All States/UTs
3. Secretary, National Medical Commission
4. Secretary, Pharmacy Council of India
5. Secretary, Indian Nursing Council
6. Secretary, Indian Medical Association
7. Secretary, Dental Council of India

Subject: Celebration/ Observance of World Hypertension Day, 2024.

Dear Sir/Ma'am,

This is in reference to the World Hypertension Day, which is observed every year on 17th May.

In this regard, please refer to the attached letter for the list of suggested activities related to this event. We would like to encourage you to conduct month long celebration/observance of World Hypertension Day 2024 starting from 17th May 2024.

Three best-performing from each categories viz States/UTs, AIIMS, Medical Colleges, Nursing and Pharmacy Colleges, Branches of Indian Medical Association will be felicitated by the National NP-NCD cell and appreciation certificates will be provided to all.

A brief report in PDF along with pictures of all activities may be e-mailed to MoHFW at npncd.india@gmail.com by 25th June 2024.

Yours Sincerely,



Dr. Shikha Vardhan
ADG, Dte GHS, MoHFW
011- 23063875

Copy to:-

1. PS to EA (KKT), MoHFW
2. PS to Addl. DDG & Director (EMR), DteGHS, MoHFW
3. PS to DS (SN), DteGHS, MoHFW
4. PS to DADG (SS), DteGHS, MoHFW
5. PS to SMO (AS), DteGHS, MoHFW

डा० शिखा वर्धन/Dr. Shikha Vardhan
सहायक महानिदेशक/Assistant Director General
स्वास्थ्य सेवा महानिदेशालय/Dte. G.H.S.
स्वास्थ्य एवं परिवार कल्याण मंत्रालय
Ministry of Health & Family Welfare
भारत सरकार/Govt. of India
निरमाण भवन, नई दिल्ली
Nirman Bhawan, New Delhi

List of suggested activities for World Hypertension Day 2024:

1. Display of IEC material for prevention and management of hypertension in prominent places of health facility/health institution
2. Monitor the Blood Pressure of patients and staff at health facility/health institution.
3. Orientation of medical officer and paramedical staff (CHO and ANM at AAM) for taking efforts for prevention and management of hypertension in the community
4. A public event like a walkathon/marathon, rahagiri, cycle rally, rally, screening, public lectures, health workers' training etc. to mark the event.
5. Pledge Ceremony for healthcare professionals for promoting awareness against hypertension.
6. Pledge Ceremony for the public and patients for monitoring their BP regularly.
7. Selfie Booth with Monitoring Blood Pressure
8. Quiz, slogan writing, reel, meme, chart, painting, short film-making competitions.
9. Social Media coverage (Instagram, Facebook, Twitter, LinkedIn, Institutional Website)
10. Radio/TV campaign/newspaper article/talk shows/street dramas/flash mob to spread awareness to monitor blood pressure regularly.
11. Interactions with the community leaders to create awareness. Leveraging Jan Arogya Samiti and community structures for increasing awareness and community mobilisation.
12. BP monitoring and awareness camps at prominent public places e.g. bus stands, railway stations etc. and identified workplaces to make the public aware.
13. Special camps for BP monitoring and awareness generation in vulnerable populations. E.g. old age homes, underprivileged populations in urban slums, rural remote areas and tribal areas.
14. Continuing Medical Education Programme and training of medical officers, nurses and para medical professionals.
15. Felicitating best practicing districts by the State based on screening and management for hypertension.
16. Identifying and involvement of treatment champions (those who come for regular follow up continuously and have kept BP under control) at facility level/district/state level.

The above activities are only suggestive and not exhaustive. Any other relevant activities, as maybe deemed fit, may also be carried out.



F.No20011/128/2024/Coordination-NMC
Government of India
National Medical Commission
Policy & Coordination Division



Pocket- 14, Sector- 8,
Dwarka, Phase-1, New Delhi-77
17-05-2024

Public Notice

Subject : Celebration/Observance of World Hypertension Day-2024

All medical Colleges are hereby informed that World Hypertension Day-2024 will be Celebrated/Observed on 17th May 2024. All Medical Colleges are requested to observe World Hypertension Day on 17.5.2024 with necessary awareness activities etc.

2. The list of suggested activities for month long celebrations/observance of World Hypertension Day-2024 starting from 17th May 2024 received from MoHFW is attached. This is for information that “Three best-performing from each categories viz States/UTs, AIIMS, Medical Colleges, Nursing and Pharmacy Colleges, Branches of Indian Medical Association will be felicitated by the National NP-NCD cell and appreciation certificates will be provided to all. A brief report in PDF along with pictures of all activities may be e-mailed to MoHFW at npncd.india@gmail.com by 25th June 2024.

3. This issues with the approval of Secretary, NMC.

Signed by

Srinidhi Kari

Date: 17-05-2024 08:25:18

K SRINIDHI

UNDER SECRETARY

ksrinidhi.kari@gov.in

Dean/Principal of All Medical Colleges



CDN.20011/128/2024/Coordination-NMC
Government of India
National Medical Commission
Policy & Coordination Division



Pocket- 14, Sector- 8,
Dwarka, Phase-1, New Delhi-77
Dt. 17.05.2024

Public Notice

It has come to our attention that an individual with the mobile number **+917050392639** is impersonating as Dr. B.N. Gangadhar, Chairman of the National Medical Commission (NMC).

2. It is to be informed that this mobile number does not belong to Dr. B.N. Gangadhar, Chairman, NMC.

3. The public is advised not to engage in any conversation with the person using the mobile number **+917050392639**, claiming to be Dr. B.N. Gangadhar. Any individual taking cognizance or acting on such conversations does so at their own risk.

4. This notice is issued to safeguard the public from any misinformation and to prevent any unauthorized activities carried out by the impersonator.

By and with the order of Chairman, NMC.

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

पॉकेट-14, सेक्टर-8, द्वारका, फेस -1 ,
नई दिल्ली -110 077
Pocket-14, Sector-8, Dwarka,
Phase-1, New Delhi- 110 077

राष्ट्रीय आयुर्विज्ञान आयोग

National Medical Commission

Post Graduate Medical Education Board (PGMEB)

NoU-15027/7/2024-UGMEB

Dated: 21.05.2024

Public Notice

Subject: Meeting with the stakeholders in hybrid mode on mental health and well-being of medical Students

Anti-Ragging cell in NMC has constituted a National Task Force on Mental Health and Well-being of Medical Students. Task Force has decided to hold a meeting to hear stakeholders namely Students Association, Students studying in Medical colleges in India or parents of the students.

2. The meeting details will be disseminated through a public notice on the NMC website, with tentative scheduling starting from May 27, 2024 onwards. All the stakeholders are requested to submit their interest by 25th May 2024 through Google Form given below for participating in the meeting which may be held in physical/virtual/hybrid mode:

<https://forms.gle/PxTXkxF1pZniGogc8>



(Aujender Singh)
Deputy Secretary, PGMEB



A-12023/02/2023/NMC/Estt.(8237178)

National Medical Commission

राष्ट्रीय आयुर्विज्ञान आयोग

(Establishment Section)

Pocket- 14, Sector-8,
Dwarka, Phase - 1, New Delhi-110077

Dated: 03.06.2024

CIRCULAR

Subject: Engagement of retired Government Officers / Employees as Consultant (Engineering & Maintenance) on contract basis in National Medical Commission - inviting applications thereof- reg.

National Medical Commission, invites applications from eligible and desirous candidates retired from Government Service, having considerable experience of functioning of Government/ Ministries/Departments, for engagement as Consultant on contractual full time basis.

2. Details of required Consultants to be engaged are as under:

Sr. No (1)	Position (2)	Number of Positions (3)	Qualification and Eligibility Condition (4)
I.	Consultant (Engineering & Maintenance)	01	A) QUALIFICATION:- B.Tech or B.E or Equivalent in Civil / Electrical/ Mechanical B) ELIGIBILITY CONDITIONS:- i) Retired Government Officer at the Level of 11 or above having experience in the Engineering and Maintenance of building. ii) Experience in Civil, Electrical and Mechanical aspects of building maintenance such as fire services; lift services; power backup; Heating, Ventilation and Air Conditioning (HVAC).

3. General Condition for all the posts:

- i) **Period of engagement:** initially for a period of one year which is extendable for further period(s) subject to satisfactory performance.

[Handwritten Signature]
03/06/2024

अजय कुमार गौड़ / Ajay Kumar Gaur
उप सचिव / Deputy Secretary
राष्ट्रीय आयुर्विज्ञान आयोग / National Medical Commission
पॉकेट-14, सेक्टर-8, द्वारका, नई दिल्ली-110077

- ii) **Job Description & Location:** Shall be responsible for safeguarding the office premises/building from any hazard and day-to-day maintenance (Civil/Electrical and Mechanical aspects of the building maintenance), Regular inspections of the building's infrastructure to identify and address potential issues such as leaks, drainage problems, and structural weaknesses, to implement preventive measures and to improve the building's resilience against adverse weather conditions, upgradation/ renovation/beautification, etc.
- iii) **Location:** National Medical Commission, Pocket-14, Sector-8, Dwarka Phase-I, New Delhi-110077
- iv) **Age:** Age should be less than 64 years as on closing date of this circular.
- v) **Remuneration:** Last pay drawn minus pension plus transport allowance in accordance with the instructions of Government of India issued from time to time. Selected Candidate will be entitled to Transport Allowance that he/she was getting at the time of retirement/ superannuation on the Last Pay Drawn without DA. Retired Govt. Officers engaged as Consultants may be allowed TA/DA on official tour, if any, as per their entitlement at the time of retirement.
- vi) **Leave:** Paid Leave may be allowed at the rate of 1.5 days for each completed month of service. Accumulation of leave beyond a calendar year may not be allowed.
- vii) **Mode of Selection:** Application received in response to this advertisement will be shortlisted on the basis of experience and qualifications of applicants. Consultants will be selected on Interview basis from shortlisted candidates.
- viii) **Working hours:**
- Normal Office timings are from 9:30AM to 6:00PM but the post/nature of duties requires monitoring/follow up beyond office hours.
 - May be required to Work from Home beyond office hours.
 - May also be required to attend office on holidays depending on exigencies of work.
- ix) **Department of Expenditure's OM F. No. 3-25/2020-EIII dated 09.12.2020 will be followed.**
- x) **How to apply:** The applications in the prescribed format (completed in all respects) along with copy of PPO and Last Pay Certificate may be sent to the following address:-

Deputy Secretary (Estt.),
National Medical Commission,
Pocket-14, Sector-8, Dwarka phase-I,
New Delhi-110077.

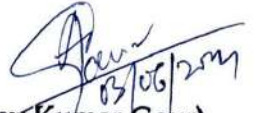

03/12/20

अजय कुमार गौड़ / Ajay Kumar Gaur
उप सचिव / Deputy Secretary
राष्ट्रीय आयुर्विज्ञान आयोग / National Medical Commission
पॉकेट-14, सेक्टर-8, द्वारका, नई दिल्ली-110077

xi) Last date for receipt of application: 21.06.2024.

4. Eligible retired Officers, in good health may submit their applications in the enclosed format before the closing date. Applications received with incomplete information or received beyond the closing date will not be considered.

5. NMC retains the right to increase/ decrease the vacancy as per the requirement without any notice.


(Ajay Kumar Gaur)
Deputy Secretary (Estt.)

All Ministries/ Departments of the Government of India (as per list).

अजय कुमार गौड़ / Ajay Kumar Gaur
उप सचिव / Deputy Secretary
राष्ट्रीय आयुर्विज्ञान आयोग / National Medical Commission
पॉकेट-14, सेक्टर-8, द्वारका, नई दिल्ली-110077
Pocket-14, Sector-8, Dwarka, New Delhi-110077

Copy to:

1. Under Secretary, CS.I Division, DoPT, Lok Nayak Bhawan, New Delhi with a request to upload this Circular on website of DoP&T for wide publicity.
2. Under Secretary, Medical Education-I, MoH&FW with a request to publish this Circular on website of MoH&FW.
3. US(IT Section), NMC with a request to upload this circular on NMC website.
4. Guard file.

Application for the post of Consultant on contract basis in National Medical Commission

(Last date for receipt of application: 21.06.2024)

Applied for consultant as per mentioned in Circular dated 03.06.2024	
--	--

Recent Passport size photograph
--

1.	Full Name (in Block Letters)	
2.	Date of Birth	
3.	Email Id	
4.	Mobile No.	
5.	Residential Address	
6.	Educational Qualification (Attach self attested copies of certificate)	
7.	Date of superannuation/retirement	
8.	PPO Number (enclose a copy)	
9.	Post held at the time of retirement	
10.	Last Pay Drawn (Pay Level & Pay)	
11.	Transport allowance (basic) at the time of retirement	
12.	Organisation superannuated from	
13.	Organisation currently working (if any)	
14.	Working Knowledge of MS Office, e-office and Internet browsing (yes/No)	

15.	Brief particulars of experience of last 10 years *	Post held	from	to	Experience/nature of work

*Please attach separate sheet if required.

Undertaking:

I hereby declare that the particulars furnished above are true and correct to the best of my knowledge and belief. I further declare that I was clear from vigilance angle at the time of my retirement. I have read this circular and accept all the terms and conditions for engagement of consultants.

Place:

Date:

(Signature of the applicant)

Mobile:

Email ID:



A-12023/02/2023/NMC/Estt.(8237178) 1020660

National Medical Commission

राष्ट्रीय आयुर्विज्ञान आयोग
(Establishment Section)Pocket- 14, Sector-8,
Dwarka, Phase - 1, New Delhi-110077

Dated: 03.06.2024

CIRCULAR

Subject: Engagement of retired Government Officers / Employees as Consultant (Engineering & Maintenance) on contract basis in National Medical Commission - inviting applications thereof- reg.

National Medical Commission, invites applications from eligible and desirous candidates retired from Government Service, having considerable experience of functioning of Government/ Ministries/Departments, for engagement as Consultant on contractual full time basis.

2. Details of required Consultants to be engaged are as under:

Sr. No (1)	Position (2)	Number of Positions (3)	Qualification and Eligibility Condition (4)
I.	Consultant (Engineering & Maintenance)	01	A) QUALIFICATION:- B.Tech or B.E or Equivalent in Civil / Electrical/ Mechanical B) ELIGIBILITY CONDITIONS:- i) Retired Government Officer at the Level of 11 or above having experience in the Engineering and Maintenance of building. ii) Experience in Civil, Electrical and Mechanical aspects of building maintenance such as fire services; lift services; power backup; Heating, Ventilation and Air Conditioning (HVAC).

3. General Condition for all the posts:

- i) **Period of engagement:** initially for a period of one year which is extendable for further period(s) subject to satisfactory performance.

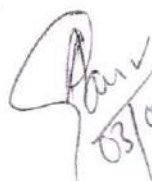
Handwritten signature and initials in blue ink.

Handwritten signature and date 03/06/2024 in blue ink.

अजय कुमार गौड़ / Ajay Kumar Gaur
उप सचिव / Deputy Secretary
राष्ट्रीय आयुर्विज्ञान आयोग / National Medical Commission
पैकेट-14, सेक्टर-8, द्वारका, नई दिल्ली-110077
Page 1 of 5

- ii) **Job Description & Location:** Shall be responsible for safeguarding the office premises/building from any hazard and day-to-day maintenance (Civil/Electrical and Mechanical aspects of the building maintenance), Regular inspections of the building's infrastructure to identify and address potential issues such as leaks, drainage problems, and structural weaknesses, to implement preventive measures and to improve the building's resilience against adverse weather conditions, upgradation/ renovation/beautification, etc.
- iii) **Location:** National Medical Commission, Pocket-14, Sector-8, Dwarka Phase-I, New Delhi-110077
- iv) **Age:** Age should be less than 64 years as on closing date of this circular.
- v) **Remuneration:** Last pay drawn minus pension plus transport allowance in accordance with the instructions of Government of India issued from time to time. Selected Candidate will be entitled to Transport Allowance that he/she was getting at the time of retirement/ superannuation on the Last Pay Drawn without DA. Retired Govt. Officers engaged as Consultants may be allowed TA/DA on official tour, if any, as per their entitlement at the time of retirement.
- vi) **Leave:** Paid Leave may be allowed at the rate of 1.5 days for each completed month of service. Accumulation of leave beyond a calendar year may not be allowed.
- vii) **Mode of Selection:** Application received in response to this advertisement will be shortlisted on the basis of experience and qualifications of applicants. Consultants will be selected on Interview basis from shortlisted candidates.
- viii) **Working hours:**
- Normal Office timings are from 9:30AM to 6:00PM but the post/nature of duties requires monitoring/follow up beyond office hours.
 - May be required to Work from Home beyond office hours.
 - May also be required to attend office on holidays depending on exigencies of work.
- ix) **Department of Expenditure's OM F. No. 3-25/2020-EIII dated 09.12.2020 will be followed.**
- x) **How to apply:** The applications in the prescribed format (completed in all respects) along with copy of PPO and Last Pay Certificate may be sent to the following address:-

Deputy Secretary (Estt.),
National Medical Commission,
Pocket-14, Sector-8, Dwarka phase-I,
New Delhi-110077.

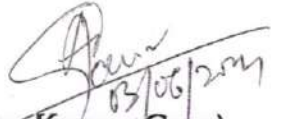

03/04/20

अध्यक्ष कुमार गौड़ / Ajay Kumar Gaur
उप सचिव / Deputy Secretary
राष्ट्रीय आयुर्वेद आयोग / National Medical Commission
पॉकेट-14, सेक्टर-8, द्वारका, नई दिल्ली-110077

xi) Last date for receipt of application: 21.06.2024.

4. Eligible retired Officers, in good health may submit their applications in the enclosed format before the closing date. Applications received with incomplete information or received beyond the closing date will not be considered.

5. NMC retains the right to increase/ decrease the vacancy as per the requirement without any notice.


(Ajay Kumar Gaur)
Deputy Secretary (Estt.)

All Ministries/Departments of the Government of India (as per list).

अजय कुमार गौड़ / Ajay Kumar Gaur
उप सचिव / Deputy Secretary
राष्ट्रीय आर्युर्विज्ञान आयोग / National Medical Commission
पॉकेट-14, सेक्टर-8, द्वारका, नई दिल्ली-110077
Pocket-14, Sector-8, Dwarka, New Delhi-110077

Copy to:

1. Under Secretary, CS.I Division, DoPT, Lok Nayak Bhawan, New Delhi with a request to upload this Circular on website of DoP&T for wide publicity.
2. Under Secretary, Medical Education-I, MoH&FW with a request to publish this Circular on website of MoH&FW.
3. US(IT Section), NMC with a request to upload this circular on NMC website.
4. Guard file.

Application for the post of Consultant on contract basis in National Medical Commission

(Last date for receipt of application: 21.06.2024)

Applied for consultant as per mentioned in Circular dated 03.06.2024	
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Recent Passport size photograph

1.	Full Name (in Block Letters)	
2.	Date of Birth	
3.	Email Id	
4.	Mobile No.	
5.	Residential Address	
6.	Educational Qualification (Attach self attested copies of certificate)	
7.	Date of superannuation/retirement	
8.	PPO Number (enclose a copy)	
9.	Post held at the time of retirement	
10.	Last Pay Drawn (Pay Level & Pay)	
11.	Transport allowance (basic) at the time of retirement	
12.	Organisation superannuated from	
13.	Organisation currently working (if any)	
14.	Working Knowledge of MS Office, e-office and Internet browsing (yes/No)	

15.	Brief particulars of experience of last 10 years *	Post held	from	to	Experience/nature of work

*Please attach separate sheet if required.

Undertaking:

I hereby declare that the particulars furnished above are true and correct to the best of my knowledge and belief. I further declare that I was clear from vigilance angle at the time of my retirement. I have read this circular and accept all the terms and conditions for engagement of consultants.

Place:

Date:

(Signature of the applicant)

Mobile:

Email ID:

**No. N-16021/20/2024-IT-NMC
(8280849)
Government of India
National Medical Commission
(IT Section)**

Sector-8, Dwarka
New Delhi-110075
Dated the 04th June, 2024

Public Notice

Ref.: Circular No. N-16021/25/2023-IT-NMC (8250884) dated 23-11-2023.

The National Medical Commission (NMC) in its 14th meeting held on 01-05-2024, has decided that all medical colleges must ensure ABHA ID as pre-requisite for registration of patients visiting for the OPD/IPD/emergency services in hospitals attached to them. All patients, OP/IP, must have registration done with the ABHA ID in addition to hospital's registration number.

2. The Commission has endorsed a strong need to have authentication of patients and other clinical material in the hospital for decision on the prospects of a college (increased seats in UG or PG, new college, annual renewal of permission/recognition to admit students). The creation of ABHA ID is very simple process and can be facilitated conveniently with the possession of Aadhaar Card that has already been extended to people on a large scale.

3. However, no patient should be denied treatment without the ABHA ID. For decisions in the assessment for the academic year of 2025-26 and thereafter, the patients and related clinical material authenticated with ABHA ID will only be counted.

Signed by B Srinivas
Date: 04-06-2024 16:44:34
(Dr. B Srinivas)
Secretary

**To
All medical colleges/ institutions**

I/3631245/2023

**No. N-16021/25/2023-IT-NMC
(8250884)
Government of India
National Medical Commission
(IT Section)**

Sector-8, Dwarka
New Delhi-110075
November, 2023

Dated the

CIRCULAR

The National Medical Commission, in its 11th meeting held on 18-10-2023, took a decision that patients seen in the medical college hospitals should be encouraged to register through a unique ABHA ID. This process through the HMIS data provides reliable data on the clinical material available in each college for the purpose of UG/PG training.

The digital documentation of clinical material goes a long way in making assessment valid and also aid in the rating procedures.

Therefore, all colleges should provide an appropriate infrastructure in their hospitals to facilitate ABHA ID generation to the patients seeking help in that hospital. It may be noted that the conditions that govern ABHA ID registration prevail over this notice.

Signed by
Pankaj Naresh Agrawal
Date: 23-11-2023 16:46:55
Director

To
All medical colleges/ institutions



N-16015(20)/2/2024-IT-NMC
National Medical Commission
(IT-Division)



दूरभाष / Phone :
 25367033/35/36/37/41
 ई-मेल/ E-mail :
 it.nmc@nmc.org.in
 वेबसाइट/ Website :
 www.nmc.org.in
 Pocket- 14, Sector- 8,Dwarka,
 Phase – 1, New Delhi-110077

Public Notice

Subject:- AEBAS attendance marking - Advance Declaration of Holidays to the Medical Colleges in the Module - reg.

Ref.: F.No. N-16021/24/2023-IT-NMC (8250552) dated 18-01-2024

In continuation to the above referred advisory issued regarding implementation of Adhaar Enabled Biometric Attendance System (AEBAS) in all government and private medical colleges, the following directions are issued hereby for information and compliance.

2. It is observed that Medical Institutions are including the details of Gazetted / Local holidays / leaves of the faculties retrospectively making the AEBAS data inconsistent at various periods of time.

3. Guidelines w.r.t. implementation of AEBAS attendance for marking of attendance of faculty have been issued vide NMC order F.No. D-130024/07/2022/NMC/DMMP Dated 28th July, 2022 (Copy enclosed). Further, vide serial No. 8 of the guidelines issued on 18th October, 2022 (Copy enclosed), it was mandated that *"Faculty, Demonstrators, Tutors, and Senior Residents on leave or official duty must input such details into AEBAS using the 'add leave' and 'add tour' module respectively."* Therefore, all Medical Colleges are requested to ensure that the data w.r.t. Gazetted Holidays, Local Administrative Holidays etc. be included in the AEBAS Module of the College in advance prior to the beginning of the calendar year/semester concerned. Further, the Medical College are also requested to include the details of the leave/tour/vacation etc.

in advance before commencement of the same and no retrospective incorporation / updation of details of holidays/leave/tour/vacations etc is allowed / permissible.

3. Accordingly, All Medical Colleges are requested to strictly follow the above instructions and any violation of the same will be viewed seriously and strict action would be taken against the Medical College concerned.

Dr. B Srinivas

Secretary

To

Dean/Principal of All Medical Colleges/ Institutions



राष्ट्रीय आयुर्विज्ञान आयोग
National Medical Commission

**National Action Plan
on Antimicrobial Resistance
(NAP-AMR)
Module for Prescribers**

2024

Publication Division, National Medical Commission
Pocket-14, Sector-8, Dwarka Phase-1, New Delhi-110077, INDIA

National Action Plan on Antimicrobial Resistance (NAP-AMR)

Module for Prescribers



राष्ट्रीय आयुर्विज्ञान आयोग

National Medical Commission

-Editor-

Dr. Vijaya Lakshmi Nag

Officer in-charge, National Action Plan (NAP-AMR) NMC,
Member (Whole-Time),
Ethics and Medical Registration Board,
National Medical Commission.

Professor and HOD, Department of Microbiology
Ex – Dean Research,
All India Institute of Medical Sciences, Jodhpur.

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Hyderabad, Telangana
Email ID - drmanishamane@gmail.com

★★★★★

अपूर्व चन्द्रा, भा.प्र.से.

सचिव

APURVA CHANDRA, IAS
Secretary



सत्यमेव जयते



आज़ादी का
अमृत महोत्सव

भारत सरकार

स्वास्थ्य एवं परिवार कल्याण विभाग
स्वास्थ्य एवं परिवार कल्याण मंत्रालय

Government of India

Department of Health and Family Welfare
Ministry of Health and Family Welfare



MESSAGE

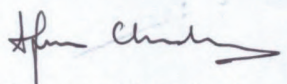
Antimicrobial resistance is recognised as a serious current and future threat in the practice of modern medicine. Misuse and overuse of antimicrobials are the main drivers in the emergence of drug resistant pathogens. AMR impacts all sectors and hence is a "One health" issue. Ministry of Health and Family Welfare developed the National action Plan on AMR in alignment with the Global Action Plan with a "One Health" approach and launched it in April 2017.

One of the Strategic objectives of the NAP AMR is strengthening education and awareness and National Medical Commission is an important stakeholder to implement the activities enlisted under this objective. One such activity is to review and revise the curricula for professionals and allied services by developing an AMR module to bring together segmented knowledge imparted under different subjects.

The containment of AMR demands judicious use of antimicrobials through effective utilisation of laboratory services and continuous improvement in infection prevention and control practices to prevent transmission of AMR pathogens. I hope this AMR module developed by NMC which covers these competencies will impart practical education to medical students thereby promoting prescribing behaviours towards judicious use of antimicrobials in day to day management of patients by these young doctors and thereby sustain the gains of modern medicine over the past years in management of disease. NMC would need to ensure availability of adequate infrastructure, manpower and other resources in medical colleges for practical implementation of these modules.

I convey my best wishes to NMC for release of these modules and for implementing these modules effectively.

Place : New Delhi
Date : 10th April 2024


(Apurva Chandra)



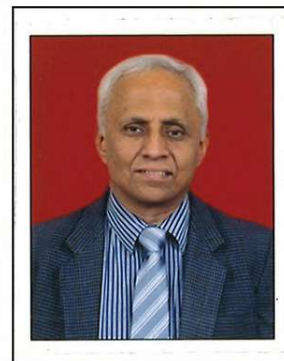
डॉ. बी. न. गंगाधर
Dr. B. N. Gangadhar
अध्यक्ष/ President
चिकित्सा मूल्यांकन और मापन बोर्ड
Medical Assessment & Rating Board
& Officiating Chairman, NMC



राष्ट्रीय आयुर्विज्ञान आयोग
स्वास्थ्य एवं परिवार कल्याण मंत्रालय
भारत सरकार
National Medical Commission
Ministry of Health & Family Welfare
Government of India

MESSAGE

Antimicrobials have served as one of the most important arsenal in modern medicine in the last century and have improved treatment outcomes across both medical and surgical practice. However, their utility is threatened due to increasing resistance of micro-organisms to antimicrobials to such an extent that bacteria resistant to almost all antibiotics are being witnessed.



To combat this increasing trend of antimicrobial resistance, the Government of India released its National Action Plan on Antimicrobial Resistance (NAP-AMR) in 2017 with a "One Health" approach, involving consultation with various stakeholders Ministries/Departments at the national level, in alignment with the Global Action Plan on Antimicrobial Resistance (GAP-AMR) by the World Health Organization (WHO). In addition to the five objectives of the GAP-AMR, India's NAP-AMR has set a target of achieving six main objectives to fulfil its commitment towards the sustainable development goals 2030.

The National Medical Commission has taken up the humungous task of achieving objective under Strategic priority no. 1 and 4 by developing curriculum for prescribers as well as non-prescribers; to improve the awareness and understanding of AMR through training and education and regarding prescription of antibiotics. The prescriber module of NAP-AMR likely focuses on educating and empowering healthcare providers mainly prescribers on appropriate antibiotic use. This may include recommendations on: When to prescribe antibiotics; choosing the right antibiotic for the specific infection; Using the correct dosage and duration of antibiotic treatment.

I am positive that the Medical Colleges and Institutions will actively participate and support National Medical Commission to achieve the objectives in this National Action Plan with enthusiasm and collectively contribute towards making this programme a success.

I assure all support and resources to the stakeholders involved and convey my best wishes.


(Dr. B.N. Gangadhar)



डॉ. अरुणा वी. वाणीकर
Dr. Aruna V. Vanikar
अध्यक्ष/President
स्नातक चिकित्सा शिक्षा बोर्ड
Undergraduate Medical Education Board



राष्ट्रीय आयुर्विज्ञान आयोग
भारत सरकार
National Medical Commission
Government of India

Message

Modern medicine or Allopathy has contributed immensely in improving the health quotient and quality of life. Alexander Fleming's discovery of Penicillin in 1928, was a miracle that came in to save millions of lives from bacterial infections globally. Over the years the research in antimicrobials grew by leaps and bounds. Along with the fast pace of development, human beings also lost the patience of waiting to see response of antibiotics and anti-microbials. Slowly the abuse and overuse of molecular combinations and swift shift from oral to intravenous and central lines occurred by the beginning of 21st century. Thus, along with the threat of global warming that has affected the civilization and human race as also the planet, field of allopathy in the present times. It has affected the recovery from simple respiratory diseases to immunocompromised states universally, with more dire consequences in developing countries than developed countries. As per the WHO data, bacterial AMR was directly responsible for 1.27 million global deaths in 2019. Further, the World Bank estimates that AMR may result in US\$ 1 trillion additional healthcare costs by 2050. India will also be hit hard if aggressive, pro-active steps are not taken to control this human-created threat to the very existence of life.



It is therefore very praise worthy effort by Dr. Vijayalakshmi Nag, member of Ethics and Registration Board (EMRB) of National Medical Commission, who is also the Chair of this committee, and her team to take up this project of 'Antimicrobial Resistance- awareness and steps to control it in India'. This compendium prepared by the team has been done by painstaking efforts of various scientists. It has emerged as an excellent hand-book. It begins with general background of the subject and moves on to describe clinical approaches for prescribing antimicrobials, stewardship, interpretation of antimicrobial sensitivities, watchdogs of the same, various drugs, and further navigates to policy



डॉ. अरुणा वी. वाणीकर
Dr. Aruna V. Vanikar
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Undergraduate Medical Education Board



राष्ट्रीय आयुर्विज्ञान आयोग
भारत सरकार
National Medical Commission
Government of India

making, dos and don'ts, including biomedical waste management and finally covers important aspects of corona pandemic era to close with biomedical waste management and beautiful illustrations obtained from prestigious medical institutions.

I would like to recommend it as a project for all undergraduate students to be taken up preferably during the phase of 'electives' as mandatory training in the end of first block, in the end of Final MBBS part 1. I congratulate the entire team for this work and wish that it achieves the desired result of educating young medical students and in controlling the abuse and overuse of anti-microbials.

Dr. Aruna V. Vanikar,
President, Undergraduate Medical Education Board.



MESSAGE

Invention of anti-microbials paved way for treatment of severe infections, particularly in immuno-compromised patients. Studies have shown the utility of anti-microbial agents in preventing infections in surgeries where there is bacterial contamination. However, indiscriminate and excessive use of these agents have developed resistance mechanism in these organisms making them anti-microbial resistant organism.

Also unnecessary use of anti-microbials comes is the way of development of natural immunity apart from avoidable side effects of these drugs and financial burden on patients. So the time has come for judicious use of anti-microbial agents. Government of India has taken timely step to prepare guidelines for the judicious use of anti-microbials and steps to be taken to prevent anti-microbials resistance.

I thank the government for trusting National Medical Commission for preparing these guidelines in the form of modules and toolkits for the training of all prescribers in an attempt to combat the increasing anti-microbial resistance. Dr Vijaya Lakshmi Nag, Member, Ethics and Medical Registration Board and Professor and HoD (Microbiology), AIIMS, Jodhpur and her team has done an excellent job in preparing this module and its accompanying toolkit keeping in mind the needs of the country in early sensitization of the medical students that represent the cohort of future prescribers. I look forward to the plan being implemented efficiently in all medical colleges and institutions of the country and at all levels wherever antibiotics are used which can be achieved by continued communication, collaboration and public engagement.

Vijay V. Oza

(Dr Vijay Oza)



डॉ. जे. एल. मीना
Dr. J. L. Meena
सदस्य/ Member
चिकित्सा मूल्यांकन और रेटिंग बोर्ड
Medical Assessment & Rating Board



राष्ट्रीय आयुर्विज्ञान आयोग
स्वास्थ्य एवं परिवार कल्याण मंत्रालय
भारत सरकार
National Medical Commission
Ministry of Health & Family Welfare
Government of India

MESSAGE

Antimicrobial resistance (AMR) is one of the most serious global public health threats in this century caused due to misuse/overuse of antimicrobials. According to WHO, It is estimated that bacterial AMR was directly responsible for 1.27 million global deaths in 2019 and contributed to 4.95 million deaths. The World Bank estimates that AMR could result in US\$ 1 trillion additional healthcare costs by 2050, and US\$ 1 trillion to US\$ 3.4 trillion gross domestic product (GDP) losses per year by 2030.



Inappropriate use of antimicrobials leads to development of drug resistance, hence making common infections difficult to treat leading to higher mortality, complications, and prolonged hospital stays. This makes it crucially important that our healthcare professionals should be well versed with the Antimicrobial stewardship program (AMSP) to ensure prudent antimicrobial prescribing focused on "4Ds", practice appropriate infection control techniques like OSHA etc. and learn effectual segregation & disposal of Biomedical Waste (BMW) as per rules.

Together we can make a difference in this fight while ensuring future generations have access to effective treatments for infections. I hope that this module would serve as a guiding light to maintain the effectiveness of antibiotics and preserve our ability to combat infectious diseases.


(Dr J. L. Meena)
22/5/2024

डॉ. विजय लक्ष्मी नाग

Dr. Vijaya Lakshmi Nag

सदस्य/Member

आचार और चिकित्सा पंजीकरण बोर्ड

Ethics and Medical Registration Board

राष्ट्रीय आयुर्विज्ञान आयोग

भारत सरकार

National Medical Commission

Government of India

From Editor's Desk

I am deeply grateful to Prof. S.C. Sharma, the founder Chairman, of the National Medical Commission (NMC) and Ex-Head of the Department of Otorhinolaryngology-Head and Neck Surgery at All India Institute of Medical Sciences, New Delhi for assigning this task, which brought me closure to my field of microbiology and providing necessary support and guidance for accomplishing this task.



Antimicrobial resistance (AMR) has been identified by the World Health Organization (WHO) as one of the top 10 global public health threats against humanity. Misuse and overuse of antimicrobials are the main drivers in developing drug-resistant pathogens. AMR being a “One Health” issue, its containment requires the active participation of various stakeholders, ministries and departments.

The Ministry of Health and Family Welfare developed the National Action Plan on AMR (NAP-AMR) in alignment with the Global Action Plan on AMR (GAP-AMR) with a “One Health” approach at the National level. The NAP-AMR sets out six strategic priorities. Under each strategic priority, specific objectives of key focus areas with elaborate interventions, activities and key outputs, responsible agencies, and expected timelines have been stated. The NMC has been assigned objectives under strategic priorities 1 and 4 of the NAP-AMR.

The National Medical Commission governs medical colleges and medical professionals. It is also responsible for maintaining the quality of medical education in India. For NAP-AMR a letter was circulated to the Directors, Principals and Deans of 606 institutions across the country to collect baseline data on ongoing AMR activities in their institutions. They were to nominate a nodal officer in each institute to facilitate the implementation of the ‘national action plan on antimicrobial resistance’ objectives assigned to NMC. Three hundred fifty (350) medical colleges responded through the prescribed Google form and provided the details of activities going on.

We also invited experts online among nominated nodal officers preferably from all zones of the country to discuss the objectives assigned to NMC under NAP-AMR. We conducted various online & physical meetings to discuss the objectives and ways to achieve the goal.

It's my pleasure to introduce the prescribers' module, produced with the help of subject experts, from the field of Microbiology, Medicine, Pharmacology and Community Medicine from various medical colleges and Institutions of the country. The Prescribers' module is primarily for the residents and faculties working in Government and private medical colleges and institutions across the country. The module can also be used by any medical practitioner.

डॉ. विजय लक्ष्मी नाग

Dr. Vijaya Lakshmi Nag

सदस्य/Member

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राष्ट्रीय आयुर्विज्ञान आयोग

भारत सरकार

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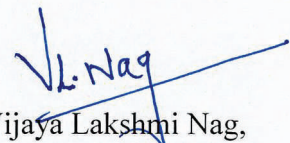
Two more modules in the series are currently in the pipeline. One of these is the 'AMR module for undergraduate medical students and interns to create an awareness of AMR. The other one is for the allied health professionals comprising of nurses, technicians & pharmacists belonging to a significant group responsible for handling anti-microbial, preparing anti-microbial reports and audits for antimicrobial use in the medical colleges and institutions.

These modules are being developed as per the NAP-AMR strategic priorities assigned to NMC and the guidelines provided under NAP-AMR. Modules and Toolkits will help medical professionals acquire the requisite knowledge and skills along with a positive shift in attitude towards responsible antimicrobial use. I am confident that this module will serve as an excellent guide for the prescribers in the fight against AMR by updating their knowledge on key aspects of antimicrobial resistance such as clinical approach for prescribing antimicrobials, microbiological diagnostic stewardship, interpretation of antimicrobial sensitivity results, antimicrobial stewardship, antimicrobial policy, infection control, biowaste management and bundle care approach for device-associated infections.

These modules are written in very simple and understandable language suitable to any cadre of health professional for their understanding or teaching purposes. The PPTs are given chapter-wise to help the nodal officers modify the imparting training and teaching in their respective workplaces according to the need. We aim to train all cadre of health professionals systematically and structured. After the release of this module, the training of nodal officers of the medical colleges will be started with the help of the experts to give them an insight into the purpose, content, utility and use of the module and help further propagate the idea to the health care professionals in the medical institutions.

With this, I acknowledge the sincere efforts of all the contributors and supporters to make this document see the light of the day.

With Regards and best wishes,



Dr. Vijaya Lakshmi Nag,
Officer-In-Charge, NAP-AMR
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राष्ट्रीय आयुर्विज्ञान आयोग
National Medical Commission

**National Action Plan
on Antimicrobial Resistance
(NAP-AMR)
Module for Prescribers**

- 2024 -

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List of Abbreviations

3GCEB	: Third Generation Cephalosporin Resistant Enterobacterales
AMR	: Antimicrobial Resistance
AMSP	: Antimicrobial Stewardship Program
AST	: Antimicrobial Susceptibility Test
AUC	: Area Under the Curve
BMQ	: Breakpoint to MIC Quotient
CDC	: Centre for Disease Control & Prevention
CLSI	: Clinical and Laboratory Standards Institute
CRAB	: Carbapenem Resistant <i>Acinetobacter baumannii</i>
DDD	: Defined Daily Doses
DOT	: Days of Therapy
ESBL	: Extended Spectrum Beta Lactamase
EUCAST	: European Committee on Antimicrobial Susceptibility Testing
GAP-AMR	: Global Action Plan on Antimicrobial Resistance
HBV	: Hepatitis B Virus
HCV	: Hepatitis C Virus
HIV	: Human Immunodeficiency Virus
HLGR	: High Level Gentamicin Resistance
I	: Intermediate
ICMR	: Indian Council of Medical Research
ICU	: Intensive Care Unit
IV	: Intravenous
MIC	: Minimum Inhibitory Concentration
MoHFW	: Ministry of Health & Family Welfare
MDRO	: Multi Drug Resistant Organism
MDR TB	: Multidrug Resistant Tuberculosis
MRSA	: Methicillin Resistant <i>Staphylococcus aureus</i>
NACO	: National AIDS Control Organization
NAP AMR	: National Action Plan on Antimicrobial Resistance
NCDC	: National Centre for Disease Control
OSHA	: Occupational Safety and Health Act
PEP	: Post Exposure Prophylaxis
PCR	: Polymerase Chain Reaction
PK	: Pharmacokinetics
PD	: Pharmacodynamics
R	: Resistant
SARS	: Severe Acute Respiratory Syndrome
SDD	: Susceptibility Dose Dependent
S	: Susceptible
VRE	: Vancomycin Resistant Enterococci
WHO	: World Health Organization

Overview of AMR

Antimicrobial Resistance (AMR) occurs when microorganisms change over time and become resistant to drugs, making common infections harder, increasing the risk of disease spread, severe illness and death. This is a significant threat as it undermines the effectiveness of antibiotics and antimicrobials, which are crucial for surgeries, chemotherapy and managing chronic infections. The emergence of multi-drug resistant organisms (MDROs) further complicates the issue, as these "superbugs" are resistant to many different antimicrobials, making infections very difficult to treat.

AMR is a complex problem that requires a united multisectoral approach that considers factors like antibiotic overuse in humans and animals, hygiene practices, and development of new drugs. It is an ongoing threat to modern medicine throughout the world with a negative effect on patient treatment outcome. Pathogens are developing mechanisms of resistance, making it difficult to treat common infectious diseases like pneumonia, tuberculosis and foodborne diseases.

Antibiotic prescribing is determined by various factors, including the socio-cultural and socio-economic factors of each country and the beliefs of patients and professionals regarding antibiotic use. The shortage of appropriate diagnostic tools, the insufficient regulatory policies of country can further cause an increase in over-the-counter antibiotics. Medical professionals have to be prepared appropriately in order to face the challenges of antimicrobial use in everyday clinical practice.

Background and Objectives

In 2015, understanding the gravity of the problem of antimicrobial resistance (AMR), the World Health Assembly (WHA) has adopted the Global Action Plan on AMR (GAP-AMR) in collaboration with the World Health Organization (WHO), Food & Agricultural Organization (FAO) & World Organization for Animal Health (WOAH).

The World Health Organization (WHO) has outlined five core objectives for NAP-AMR that countries should strive towards:

1. Improve awareness and understanding: This involves educating the public, healthcare professionals, and policymakers about AMR through effective communication, education, and training programs.

2. Strengthen knowledge and evidence base: This objective focuses on improving surveillance of AMR trends, conducting research on resistant pathogens, and identifying best practices for infection prevention and control.
3. Reduce the incidence of infection: Strategies here target preventing infections in the first place, including promoting hygiene and sanitation practices, and ensuring access to clean water.
4. Optimize use of antimicrobial medicines: This objective aims to ensure antimicrobials are used appropriately in both human and animal health. This involves developing national guidelines for antibiotic use, promoting antimicrobial stewardship programs, and tackling the misuse of antibiotics in agriculture.
5. Develop economic case for investment: This objective highlights the need for sustainable investment in research and development of new diagnostics, vaccines, and antibiotics to combat AMR. It also emphasizes the economic burden of AMR and the return on investment for proactive measures.

Later in May 2017, the WHO resolution urged member states to align National Action Plans on AMR (NAP-AMR) with GAP-AMR. In India the Core Working Group as notified by MoHFW had developed “National Action Plan on AMR” involving consultation with various stakeholders Ministries/ Departments at the national level. The strategic objectives of NAP-AMR are aligned with the GAP-AMR based on national needs & priorities.

The NAP-AMR sets out six strategic priorities (**Fig 1**) and under each strategic priority, specific objectives of key focus areas with elaborate interventions, activities and key outputs along with responsible agencies and expected timelines, have been stated.



Fig 1: Six strategic priorities in national action plan for antimicrobial resistance in India

Objectives under National Medical Commission:

NMC is responsible in following specific objectives under priority 1 and 4 for human health

- **Strategic priority 1- Improve awareness and understanding of AMR through effective education and training**

The intervention activities mentioned for achieving the objectives are- Improve knowledge and capacity of key stakeholders regarding AMR and related topics- by strengthening and consolidating AMR and related topics as core components of professional education and training

Target audience:

Medical students, Doctors (Residents, Faculty, Medical officers etc.) and allied health professionals (Nurses, Pharmacist, Technicians and other allied health professionals) and the administrators,

This is to be achieved by-

- Reviewing and revising curricula of undergraduate medical professionals-**Undergraduate module.**
 - Reviewing and developing training modules for in-service medical professionals – **Prescribers’ module.**
 - Reviewing and developing training modules for allied health professionals- **Non prescribers’ module.**
- **Strategic priority 4- Optimise the use of antimicrobial agents in human health**

**The intervention activities mentioned for achieving the objective are-
Improve knowledge and skills of prescribers, dispensers & medical trainees**

This is to be achieved by-

- Developing structured (and mandatory) training programmes on optimal antimicrobial use
- Collaborate with regulatory bodies to mandate periodic training to optimise antibiotic use through pre-service and in-service trainings

The aim of the Prescribers module is to facilitate institutions and professionals in developing an understanding of AMR and its importance in clinical practice and medical education. This training module will assist in imparting required knowledge and skill of the prescribers and will assist in rational prescription of antimicrobials and implementation of antimicrobial stewardship in teaching hospitals.

Two other modules are in process of development-

- The training module and toolkit for undergraduate students
- The training module and toolkit for Non-prescribers i.e. for allied health professionals

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Clinical Approach for Prescribing Antimicrobials

2

Learning Objectives

At the end of the session, a prescriber should be able to:

- identify common presentations of infective syndromes
- know the importance of taking thorough history, clinical examination and selection of appropriate investigations for diagnosis of infective disease.

2.1 Introduction

The use of antimicrobials has grown manifold in the recent years. Easy access of antimicrobials and the haste to start them in any suspected infective aetiology is primarily responsible of their misuse, and in turn lead to increased anti-microbial resistance (AMR). Infective disorders can be bacterial, viral, fungal or parasitic. Identification of the clinical problem and making a differential diagnosis at the bed side will help in deciding of whether to start or not to start any antimicrobial.

The history should assess the risk of infection based on the symptoms and signs and the common patterns of presentation of different diseases such as upper respiratory tract infections (URTI), lower respiratory tract infection (LRTI), urinary tract infection (UTI), meningitis, diarrhoea, skin and soft tissue infections etc.

2.2. One way of clinical assessment is to follow a “Syndromic Approach”. (**Fig 2**) A patient suspected of infective disorder may be classified into following syndromes:

- **Acute febrile illness with Rash:**

An acute febrile illness with a rash can have various causes, ranging from infectious to non-infectious etiologies. Some common conditions that present with fever and rash include:

1. **Viral Infections:**

- **Dengue Fever:** A mosquito-borne viral infection characterized by sudden onset of high-grade fever, headache, backache, joint pain, muscle pain and rash.
- **Chickenpox (Varicella):** Fever, malaise and a rash that starts as red spots and progresses to vesicles.
- **Measles:** Characterized by a high fever, cough, running nose, red eyes (conjunctivitis) and a rash that starts as erythematous macule behind the ear, on the neck and hairline and spreads to the trunk and the extremities by the 2nd day.
- **Rubella (German measles):** Presents with a low-grade fever, enlarged lymph nodes and a rash that starts on the face and spreads to the trunk and extremities.

2. **Bacterial Infections:**

- **Scarlet Fever:** Caused by streptococcal bacteria, it presents with fever, sore throat, and a characteristic sandpaper-like rash.

- Rocky Mountain Spotted Fever: Caused by rickettsial infection and transmitted by ticks, it presents with fever, headache, and a rash that starts on the wrists, ankles, and spreads centrally.
 - Meningococemia: Infection with *Neisseria meningitidis* can cause fever, headache, and a petechial rash.
3. Other Infections:
- Lyme Disease: Caused by *Borrelia burgdorferi* transmitted by ticks, it presents with fever, headache, and a characteristic bull's eye rash (erythema migrans).
 - Rickettsial Diseases: Various infections such as Typhus and Q fever can present with fever and rash.
4. Non-Infectious Causes:
- Drug Reactions: Some medications can cause febrile illnesses with rashes, such as Stevens-Johnson syndrome or Drug Reaction with Eosinophilia and Systemic Symptoms (DRESS).
 - Autoimmune Diseases: Conditions like lupus erythematosus or Kawasaki disease may present with fever and rash.
 - Toxic Shock Syndrome: Associated with certain bacterial infections or tampon use, it presents with fever, rash, and other systemic symptoms.
- **Acute febrile illness with Jaundice:**
 1. **Viral Hepatitis:** Viral infections, particularly Hepatitis A, B, C and E viruses, can cause acute febrile illness with jaundice. Symptoms may include fever, fatigue, abdominal pain, nausea, vomiting, dark urine, and yellowing of the skin and eyes (jaundice).
 2. **Malaria:** Severe cases of malaria, caused by *Plasmodium* parasites and transmitted by mosquitoes. If the case turns into a complicated malaria, the patient may present with jaundice because of the haemolysis.
 3. **Leptospirosis:** This bacterial infection, typically acquired through exposure to contaminated water or soil, can cause fever, muscle aches, headache, and jaundice.
 4. **Typhoid Fever:** Caused by *Salmonella* Typhi bacteria, typhoid fever can present with high fever, abdominal pain, splenomegaly, headache, and jaundice in severe cases.
 5. **Acute Biliary Tract Infections:** Cholangitis and cholecystitis can lead to fever, abdominal pain, and jaundice. Every patient of jaundice does not require antimicrobials. Their blood sample should be sent to laboratory for identifying type of hepatotropic virus and symptomatic management should be initiated. Conditions like leptospirosis and acute biliary tract infections are emergencies which require empirical antibiotics as per guidelines.
 - **Acute febrile illness with Neurological involvement:**

Some possible causes of acute febrile illness with neurological involvement are:

1. **Meningitis:** Inflammation of the protective membranes covering the brain and spinal cord (meninges) can be caused by bacterial, viral, parasitic or fungal infections. Symptoms include fever, severe headache, neck stiffness, altered mental status, and photophobia.
2. **Encephalitis:** Inflammation of the brain, often caused by rickettsial infections like scrub typhus and viral infections such as Herpes Simplex virus, Japanese Encephalitis virus, West Nile virus. Symptoms may include fever, headache, confusion, seizures, and focal neurological deficits.
3. **Cerebral Malaria:** A severe form of malaria caused by *Plasmodium* parasites, which can lead to neurological symptoms such as altered consciousness, seizures, and coma, in addition to fever and other systemic manifestations.
4. **Acute Flaccid Paralysis:** Certain viral infections, such as poliovirus or enteroviruses, can cause acute flaccid paralysis, characterized by sudden weakness or loss of muscle tone. Fever may or may not be present, depending on the specific virus.
5. **Guillain-Barré Syndrome (GBS):** An autoimmune disorder where the immune system attacks the peripheral nerves, leading to muscle weakness and sometimes paralysis. GBS can be triggered by viral or bacterial infections, and fever may accompany the neurological symptoms.

Bacterial meningitis is a life threatening condition. CSF examination should be done if there are no contraindications, and the sample should be sent to laboratory for analysis. Empirical antibiotics are initiated and later modified as per available results from laboratory. Cerebral malaria requires rapid identification of malarial parasite in the blood and initiation of antimalarials.

- **Acute febrile illness with Respiratory syndrome:**

Most of the respiratory illnesses do not require antimicrobials. Viral infections are self-limited and treated symptomatically. However, if patient of respiratory symptoms presents with expectoration and signs of septicaemia, pneumonia should be suspected. Sputum sample should be sent to laboratory and empirical antibiotic may be initiated.

Some of the causes of acute febrile illness with respiratory involvement are:

1. **Influenza (Flu):** A viral infection caused by influenza viruses, which can lead to fever, cough, sore throat, nasal congestion, body aches, and fatigue. In severe cases, pneumonia may develop.
2. **Pneumonia:** Inflammation of the alveoli in one or both lungs, typically caused by bacterial, viral, or fungal infections. Symptoms include fever, cough, shortness of breath, chest pain, and sputum production.
3. **Acute Respiratory Infections (ARIs):** Various viral infections, such as respiratory syncytial virus (RSV), adenovirus, or parainfluenza virus, can cause ARIs with fever, cough, and difficulty in breathing.
4. **COVID-19:** The disease caused by the novel coronavirus (SARS-CoV-2) can present with fever, cough, shortness of breath, fatigue, muscle aches, and loss of taste or smell.

In severe cases, it can lead to pneumonia and acute respiratory distress syndrome (ARDS).

5. **Tuberculosis (TB):** An infectious disease caused by *Mycobacterium tuberculosis* bacteria, which primarily affects the lungs. Symptoms may include fever, cough (haemoptysis sometimes), chest pain, weight loss, and fatigue.
- **Acute febrile illness with abdominal involvement:** Gastroenteritis, acute appendicitis, cholecystitis, diverticulitis, acute viral hepatitis and liver abscess are the conditions involved.
- **Acute febrile illness with Renal involvement:**
 1. **Urinary tract infections:** Patient present with symptoms like increased frequency of micturition, burning micturition and fever. Morning mid-stream sample as discussed later in the module should be collected and sent to laboratory for microscopic and culture examination. Antimicrobials may be initiated empirically in situations like pregnancy, diabetes etc and can then be modified as per available reports.
Pyelonephritis: This is a bacterial infection of the kidneys, often causing fever, flank pain, and urinary symptoms. Antibiotics have to be started in suspected cases after sending complete urine examination and urine culture. If there is a suspicion of pyelonephritis blood cultures also need to be sent.
 2. **Scrub typhus** can rarely present as fever, pneumonia, hepatitis and acute renal failure.
 3. **Glomerulonephritis:** This refers to inflammation of the glomeruli, can be caused by infections, autoimmune diseases, or other systemic conditions.
 4. **Haemolytic Uremic Syndrome (HUS):** This is a rare but serious condition characterized by the destruction of red blood cells, acute kidney injury, and low platelet count. It is often caused by certain strains of bacteria, such as *E. coli*, and can occur following gastrointestinal infections or urinary tract infections.
 5. **Systemic Lupus Erythematosus (SLE):** This is an autoimmune disease that can affect multiple organs, including the kidneys and can lead to acute kidney failure, nephrotic syndrome and chronic renal failure (CRF).
- **Acute febrile illness with cardiovascular involvement:**
Myocarditis, infective endocarditis, pericarditis, Kawasaki disease, viral haemorrhagic fevers such as dengue fever, yellow fever, Ebola fever present with cardiovascular involvement including vascular leakage, haemorrhage and shock.

2.3 Accurate history and thorough clinical examination

- The clinician should always take a detailed history of presenting infection, history of any surgical, medical disorders, co-morbidities like diabetes as these may predispose an individual to infections. History of previous hospital admission, recurrent infections in the past, surgical intervention or any organ transplant should be taken. Previous use of antibiotics in such situations may predispose for AMR in current illness.

- A detailed physical examination is an important part of the evaluation of a patient with fever to arrive at a diagnosis. Finding an eschar on general physical examination pinpoints the diagnosis of scrub typhus. Finding a murmur on examination of cardiovascular system examination can point towards an infective endocarditis
- Urinary tract infections (UTI) and skin infections like foot ulcers develop in diabetic patients. The collection of mid-stream urine samples in suspected UTI cases should be done. Prescribers may refer to the proper collection technique of urine samples in male and females as described later in this module.
- Recording cardinal symptoms of major systems like fever, cough, sputum, breathlessness, haemoptysis, chest pain may suggest an infective respiratory illness like pneumonia. The decision to treat with antibiotics should be made by the presence of severity and laboratory report of sputum and culture examination.
- Jaundice and abdominal pain may be present in medical conditions like viral hepatitis, alcoholic hepatitis, leptospirosis, malaria, dengue etc. or in surgical conditions like choledocholithiasis or cholangitis. Prescribers should take a detailed history of any recent travel, drug abuse, blood transfusion, recent surgeries etc. to narrow down the differential diagnosis.
- History of unconsciousness, headache, and altered behaviour should raise the suspicion of meningitis or meningoencephalitis and if accompanied by signs of meningeal irritation, CSF should be done. As CSF is a precious sample, prescribers should be aware of collection technique and transportation of this sample to the laboratory.
- Sometimes a patient of valvular heart disease may present with fever raising the suspicion of infective endocarditis. Blood culture is the diagnostic test of choice for identifying the causative organism in such cases. Therefore, proper technique of blood culture sampling and proper communication with the microbiology laboratory is the key to successful diagnosis and management in such cases.
- The communication between the clinicians and laboratory is vital. The positive culture reports must be conveyed rapidly to prescribers so that the therapeutic interventions can be made in desired time frame. The decision of starting antibiotics should be governed by the antibiograms.
- This will not only be a cost-effective approach of treating infections but also reduce AMR.

2.4 Prescription of antimicrobials should be based on the following steps:

Step 1: Making a clinical diagnosis based on accurate history taking and thorough clinical examination helps in selecting the right test for the right patient. A clinical diagnosis also helps in predicting most likely organism causing a clinical syndrome. The sample must be collected before the start of antimicrobials.

Step 2: The empiric antibiotic therapy must be limited to seriously ill patients. This choice should be based upon institutional/local antibiograms.

Step 3: Choose the appropriate antibiotic based on clinical evaluation and most likely pathogen keeping antibiogram in mind.

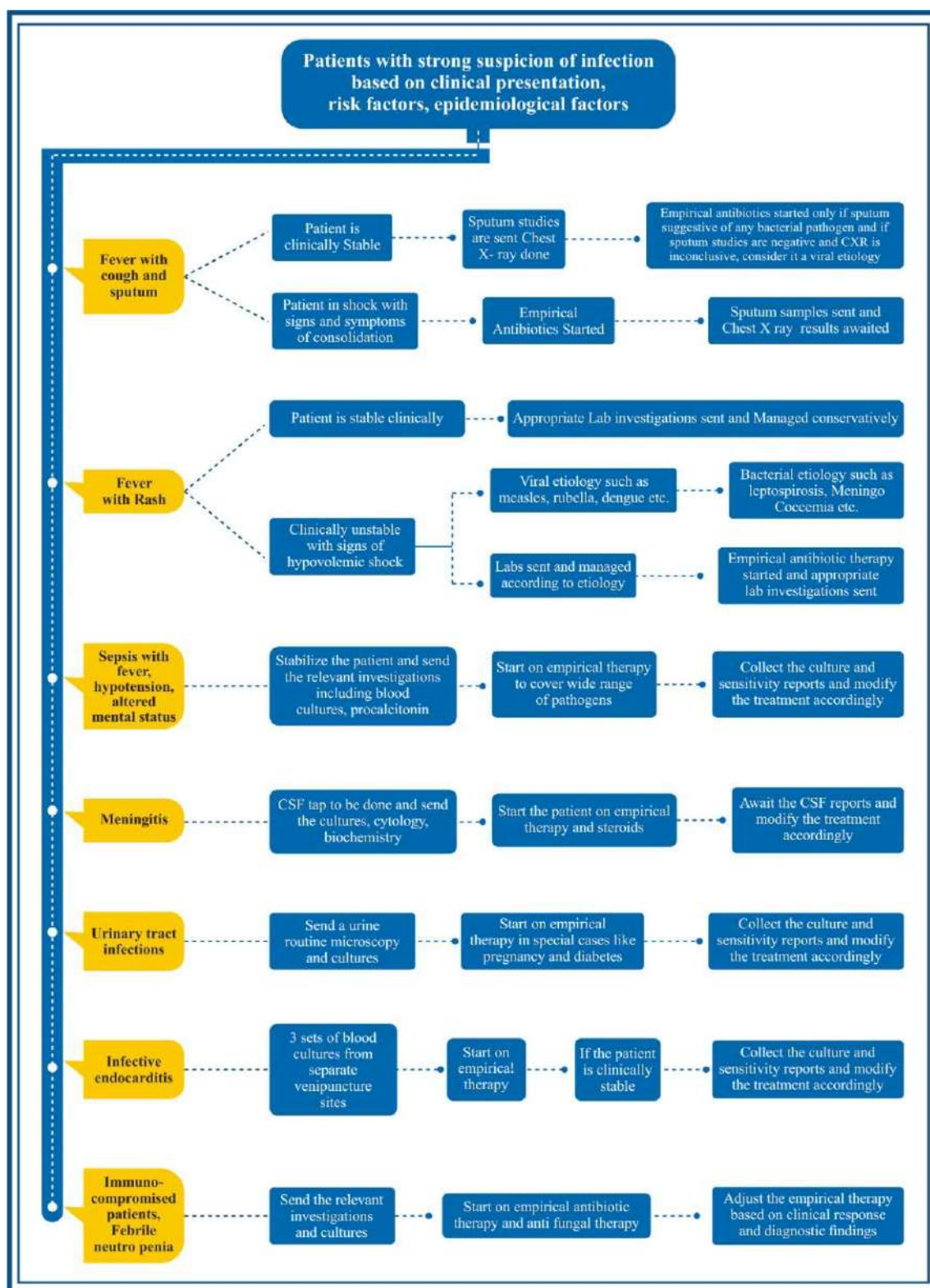


Fig 2: Syndromic approach to Acute Febrile Illness

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Microbiological Diagnostic Stewardship

3

Learning Objectives

On completion of this chapter, the prescriber should be able to:

- define diagnostic stewardship
- understand the difference between infection and colonization
- describe the sample collection techniques, precautions, transport and rejection criteria of common samples.

3.1 Introduction

Diagnostic stewardship refers to **“co-ordinated guidance and interventions to improve appropriate use of microbiological diagnostics to guide therapeutic decisions. It should promote appropriate, timely diagnostic testing, including specimen collection, and pathogen identification and accurate, timely reporting of results to guide patient treatment.”**

3.2 Correct sample for correct report

- The microbiology laboratories must be effectively utilized by the clinicians to assist them to prescribe appropriate antimicrobials.
- The 4 T of diagnostic stewardship:
 1. choosing the right **Test** from
 2. the right **Type** of sample, collected at
 3. the right **Time**, in order to
 4. guide **Treatment** decisions.
- Appropriate selection of samples, their proper collection and transport helps to improve the diagnostic performance of a microbiology laboratory.
- The turn-around time for laboratory investigations must be known to all clinicians.
- The ability to distinguish between viral and bacterial infection is also useful, since patients with viral infections may be able to be managed without antimicrobials.
- Many pathogenic microorganisms may be found as part of the normal commensal flora. Isolation of these organisms may not necessarily indicate infection. Likewise, many body sites have a normal commensal flora and samples sent to the laboratory in the absence of signs or symptoms of infection may be difficult to interpret. Therefore, the clinician must understand the limitations of testing and result interpretation and be able to put these into clinical context rather than simply take a result at face value.

- A common mistake is to send a sample for a wide range of diagnostic tests when the likelihood that the patient has the conditions concerned is low. This often means that a positive test result is more likely to be a false-positive result than a genuine result. So, the patient may be given an incorrect diagnosis and be treated for something that they do not have. Equally important, they are not treated for whatever it is that they do have.
- A blood culture can easily be contaminated with skin organisms at the time that the sample is being taken. Patients with contaminated blood cultures are often commenced on unnecessary antimicrobial therapy while the issue is being investigated. They may also have other investigations to investigate an infection that they haven't got.

3.3 General precautions while collecting samples

- The sample for bacterial culture must be collected prior to antimicrobial therapy whenever possible.
- Appropriate specimen from suspected site of infection must be collected in correct container according to case definition.
- The sample must be collected by trained staff after precise instructions to the patient.
- It must be transported within 1-2 hours after collection, in the correct package.
- Blood and CSF should never be refrigerated, can be kept at room temperature (37°C) at the collection site and transported at room temperature.
- All samples must be accompanied by a request form with complete clinical, demographic and epidemiological information.

3.4 Colonization and infection

- Most organisms which colonize are harmless commensals and should not be treated.
- An organism isolated from a sample taken from a normally sterile site like the CSF, blood, pleural fluid etc. is likely to be a true invader and the causative pathogen.
- An organism isolated from a non-sterile specimen like sputum or a wound swab may be a colonizer.
- If the organism is persistently isolated despite 'effective' systemically administered therapy, careful clinical decision must be taken keeping in mind the organism may be a multidrug resistant pathogen or simply a colonizer.

3.5 Sample collection techniques

1. Blood

- Preferably collect paired blood sample for culture from two different sites (e.g. right and left antecubital fossa) to differentiate between probable pathogens and possible contaminants and to increase the rate of isolation. The dilution ratio should be 1 ml of blood to 10 ml of culture media.
- Wear gloves, thoroughly disinfect the venepuncture site.

- Cleanse an area about 50 mm in diameter with 70% ethanol and allow to air-dry.
- Apply 2% tincture of iodine or chlorhexidine/ alcohol-based disinfectant in a circular action, swab the area beginning at the point where the needle will enter the vein.
- Allow the disinfectant to dry on the skin for at least 1 minute.
- Wipe the top of the bottle cap using an ethanol swab and allow to dry before injecting the sample aseptically into the bottle.
- Inoculated blood culture bottles should be transported to the laboratory immediately or held at room temperature until they reach the laboratory.

2. CSF

- Sequentially collect CSF into a minimum of three sterile calibrated tubes.

Lumbar puncture

- Disinfect the puncture site with antiseptic solution and alcohol in a manner identical to phlebotomy skin preparation for blood culture to prevent specimen contamination and introduction of infection.
- Insert a needle with stylet at the L3-L4, L4-L5, or L5-S1 interspace. When the subarachnoid space is reached, remove the stylet; spinal fluid will appear in the needle hub.
- Measure the hydrostatic pressure with a manometer.
- Sequentially collect the CSF into three calibrated sterile tubes labelled.
- Physicians should be instructed to sequentially collect 0.5-2.0 ml of CSF into three sterile calibrated tubes (in each tube) if only routine chemistry (total protein and glucose), bacteriology (culture & sensitivity), and haematology (cell count) are required.

3. Sterile body fluids

- Normally sterile body fluids such as pleural, pericardial, peritoneal, synovial, etc. should be collected with needle and syringe using sterile technique.
- The aspirated fluid (1-5ml) should be transferred into aerobic and anaerobic blood culture bottles preferably, retaining some (0.5 ml) in syringe for Gram stain and direct plating.
- If culture bottles are not available at site the aspirated fluid should be transferred to a sterile screw-capped tube or a paediatric isolator tube.
- The sample should not be submitted in syringe with needle attached. The syringe should be cap secured to prevent leakage.
- Swab specimens are inferior and should NEVER be used if fluid specimens can be obtained.

4. Urine

- Preferably, early morning first midstream urine (2-5ml) to be collected in sterile, wide mouth, leak proof container.

- In catheterized patients, clamp the catheter, clean the catheter wall vigorously with 70% ethanol and aspirate 5 to 10 ml of urine via a sterile needle and syringe above the clamp. Never collect urine sample from the urine collection bag or by disconnecting the catheter from the tube of the urine collection bag.
- In non-catheterized patients, the following instructions should be given:
 - ✓ Female: Wash the hands, cleanse the area around the urethral opening with soap and water, and collect the midstream urine in a sterile container with the labia held apart.
 - ✓ Male: Wash the hands, retract the foreskin, cleanse the glans with soap and water, collect midstream urine in the sterile container.
- Urine samples must be sent to the laboratory as soon as possible (preferably immediately). In case of delay of more than 1 hour, the sample must be refrigerated.

5. Sputum

- Use a clean/sterile, wide mouth leak-proof container, and collect the sample preferably during early morning after rinsing mouth with water but before brushing, fluid or food intake.
- Patient is instructed to cough deeply after taking a deep breath.
- Specimen must be sputum, and not saliva.
- Samples must be sent to the laboratory as soon as possible preferably within (2 hours of collection). In case of delay, the sample should be refrigerated (except in case if *Streptococcus pneumoniae* and/or *Haemophilus influenzae* infection is suspected).
- In case of external soiling of the sample container with sample, a phenol-containing disinfectant should be used to wipe the outside of the container.

6. Endotracheal aspirate (ETA)

- Endotracheal aspiration is done with a sterile technique using a 22-inch, 12F suction catheter.
- The catheter is introduced through the endotracheal tube for at least 30 cm. Gentle aspiration is then performed without instilling saline solution.
- The first aspirate is discarded, the second aspirate is collected after tracheal instillation of 5 ml saline in a mucus collection tube.
- If very little secretion is produced by the patient, chest vibration or percussion for 10 min is used to increase the retrieved volume (> 1 mL).
- Send the specimen to the laboratory as soon as possible.

7. Bronchoalveolar lavage (BAL)

In this procedure 100-300 ml volume of saline is infused to a lung segment through the bronchoscope to obtain cells and protein of the pulmonary interstitium and alveolar spaces and a portion of it to be sent to the laboratory as soon as possible.

8. Throat/nasopharyngeal swabs

- The procedure is explained to the patient, including that they may gag briefly.
- After wearing appropriate PPE the patient should be positioned such that the light source illuminates the posterior oropharynx.
- The patient is asked to open the mouth and relax the tongue by saying "aaaah" and the tongue is pressed down using a tongue depressor.
- Both tonsils and the posterior pharynx are swabbed.
- The swab is then placed in the culture medium, or a suitable transport medium, or sterile test tube.
- For collection of nasopharyngeal swabs, the patient must be seated comfortably with the back of their head against the headrest. The swab is inserted in the nose horizontally, along an imaginary line between the nostril and the ear.
- The swab should be placed in viral transport medium (VTM) if viral diagnostics is required.

9. Stool

- Freshly voided sample should be collected in a clean/sterile wide mouth leak-proof container.
- If the above is not possible, then the patient can be advised to transfer stool from a clean bedpan / nappy pad which is not mixed with urine, disinfectant etc. including mucus or blood part.
- If the patient (infant/small children) is passing loose stool then sterile plastic catheter (disposable) no. 26 is to be used. Transport to the laboratory within 2 hrs of collection.
- Collect at least 5 ml of sample in case of liquid stool, approximately 1 g (walnut-sized) sample in case of semi-formed or formed stool.
- In case of delay, contact to microbiologist for preferable transport media.

10. Pus/ tissue biopsy aspirate

- **In case of open wounds**, debride to clear overlying debris with scalpel and swabs or sponges, and thoroughly rinse with sterile saline prior to collection of samples.
- Collect biopsy or curette sample from base or advancing margin of the lesion. The specimen must never be sent in formalin for culture.
- **In case of closed wounds**, disinfect the area as for collection of blood sample before aspiration.
- Pus from an abscess is best collected at the time the abscess is incised and drained, or after it has ruptured naturally.
- Collect the sample (at least 1 ml) by using a syringe and needle and put in a sterile container or blood collection tube without anticoagulant (e.g., vacutainer or similar type).

- A portion of the samples should also be placed in a sterile tube containing anaerobic medium like Robertson's cooked meat media (RCM) if an anaerobic culture is required.
- Collect swabs only when tissue or aspirate cannot be obtained as swab is not an appropriate/ preferred sample for culture.
- Send the specimen to the laboratory as soon as possible.

11. Genital swabs

- For vaginal swabs the excess mucus is cleaned with cleaning swab and discarded.
- The swab is inserted into the cervical canal and rotated for 15-30 seconds.
- The swab should be immediately broken off and placed into the transport tube.
- For endocervical swabs, the sample should be collected with help of speculum.

Table 1 summarizes the sample collection techniques described above.

3.6 Sample rejection criteria

- Samples collected in incorrect containers or in broken, poorly sealed and leaking containers.
- Unlabelled specimens or mismatch between sample requisition form and container.
- Unacceptable delay between specimen collection and arrival at laboratory.
- Sample stored incorrectly before or during transport.
- Inadequate quantity of specimen.
- 24 hours urine collection.
- Foley's catheter tips and endotracheal tube tips.
- Urine from the bag of a catheterized patient.

3.7 Follow up cultures

- Whether treatment has been successful or not is best judged by clinical criteria, but it is useful to know whether the infecting organism has been eliminated.
- Repeated cultures are, therefore, sometimes indicated.

3.8 Rapid tests

- These tests rapidly confirm the presence of a bacterial pathogen or help to rule out a bacterial infection and hence used for selection of appropriate therapy.
- PCR identification of respiratory viruses in children with lower respiratory tract infection help to exclude viral infection.
- Inflammatory markers such as Procalcitonin, C-Reactive Protein etc. guide prescribers to institute rational therapy especially in sepsis cases. They can be useful to differentiate between a bacterial and a viral infection and therefore is a potential guide to initiate antimicrobial therapy.

Table 1: Summary of sample collection and transport

Sample	Collection	Transport	Remarks
Blood	1ml blood per 10ml media for conventional culture; and as per instruction in case of automated culture	Immediately or at room temperature	
CSF	0.5-2 ml in sterile container	Immediately or at room temperature	Never refrigerate
Sterile body fluids (Pleural, Pericardial, peritoneal etc.)	1-5 ml sterile container	Immediately or refrigerate if delay up to 2 hours	Do not transport in capped syringe
Urine	2-5ml	Immediately or refrigerate if delay of more than 1 hour	Give proper instructions for collection and transport to patient
Sputum	Sample coughed up into container	Immediately or at room temperature	
Throat/oropharyngeal swabs	two swabs (culture and microscopy)	Immediately before drying, in VTM for viral diagnostics	Wear appropriate PPE
Stool	1g (formed stool) to 5ml (liquid stool)	Immediately or at room temperature	Sample to be sent to the laboratory within 15minutes for trophozoites
Pus/ Tissue biopsy/ aspirates	Sterile wide mouth container	Immediately or refrigerate if delay up to 4 hours	Do not add formalin or saline
Genital swabs	Dacron or rayon swabs	Immediately	Add to VTM if viral diagnostics is required.

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Interpretation of Antimicrobial Sensitivity Results

Learning Objectives

On completion of this chapter, the prescriber should be able to:

- understand the importance of quality assured antimicrobial susceptibility testing (AST)
- interpret the antimicrobial susceptibility testing report
- interpret the surrogate and cascade reporting.

4.1 Introduction

- The microbiology laboratory must be accessible for 24 hours.
- The communication between the clinicians and laboratory is vital.
- The reports must be conveyed promptly to the prescribers so that the therapeutic interventions can be made in desired time frame.
- The results of AST are used to:
 - ✓ choose the most appropriate empirical antimicrobial agent.
 - ✓ establish antimicrobial prescription policies at institutional/state/national level.
 - ✓ predict upcoming resistance.
 - ✓ assess the efficacy of newly developed antimicrobial agents.

4.2 Antimicrobial Susceptibility Testing

- Antimicrobial susceptibility testing is done by manual and automated methods.
- Automated methods are available commercially that provide extrapolated Minimum Inhibitory Concentration (MIC) results within 12-18 hours.
- Worldwide there are two popular guidelines to ensure quality testing in AST: Clinical and Laboratory Standards Institute (CLSI, formerly NCCLS) and European Committee on Antimicrobial Susceptibility Testing (EUCAST).
- The choice of antimicrobials for AST must be made as per guidelines and in consultation with clinicians keeping the hospital formulary in mind.

4.3 Interpretation of AST result

- Interpretive criteria of susceptibility are based on standard dosing in a patient with normal renal function tests and in absence of co-morbidities. The results of AST are reported as:
 - i. **Susceptible:** The bacteria are inhibited by the usually achievable concentrations of antimicrobial agent when the dosage recommended to treat the site of infection is used.
 - ii. **Intermediate:** The bacteria for which the response rates to usually attainable blood and tissue levels of antimicrobial agent are lower compared to susceptible isolates. It

is a buffer zone between the susceptible and resistant categories. It also indicates that the clinical response will be achieved in cases where antimicrobials are concentrated at the site of infection such as urine.

- iii. **Resistant:** The bacteria which are not inhibited by the usually achievable concentrations of the agent with normal dosage regimens and that the clinical efficacy of the agent against the isolate may not be sufficient.
- iv. **Susceptible-dose dependent (SDD):** The susceptibility of the bacteria depends on the dosage regimen that is used in the patient.
- v. **Non-susceptible (NS):** Only a susceptible breakpoint is designated because of the absence or rare occurrence of resistant strains. Also, it does not necessarily mean that the isolate has a resistance mechanism.
- **Indicator/Surrogate drugs:** An indicator drug is used to detect the presence of the mechanism that gives resistance not only to the indicator, but also to related agents (Table 2).

Table 2: Indicator/surrogate/equivalent antimicrobials used in AST reports

Bacteria	Antimicrobial tested	Inference (if indicator found resistant)
<i>Staphylococcus</i> spp.	Cefoxitin surrogate predicting MRSA	Cefoxitin resistant is MRSA: Resistant to all beta-lactam agents except ceftobiprole and ceftaroline
	Ciprofloxacin or ofloxacin	Acquisition of at least one target mutation that leads to resistance to all fluoroquinolones. This may lead to development of resistance during therapy with other quinolones
	Erythromycin	Can be used to predict the activity of azithromycin or clarithromycin also
<i>Enterococcus</i> spp.	Ampicillin	Can be used to predict the activity of amoxicillin, amoxicillin-clavulanate, ampicillin-sulbactam, and piperacillin-tazobactam among non- β -lactamase producing enterococci.
<i>Enterococcus</i> spp.	Gentamicin (high level)	Determines loss of synergism of aminoglycosides with beta-lactam agents and glycopeptides irrespective of MIC value
Enterobacterales	Ciprofloxacin	Resistant to all fluoroquinolones
	Ceftriaxone or cefotaxime	3 rd generation cephalosporin
Enterobacterales, <i>P.aeruginosa</i> , <i>Acinetobacter baumannii</i> complex	Colistin or polymyxin b	Any one agent can be used
<i>Klebsiella</i> spp./ <i>E. coli</i>	Ceftazidime	Resistant to all cephalosporin except cephamycins (cefoxitin, cefotetan)

Gram-negative isolates from uncomplicated UTIs	Cefazolin	Predicts results for all oral cephalosporins such as cefaclor, cefdinir, cefpodoxime, cefprozil, cefuroxime, cephalexin, and loracarbef
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- **Equivalent Agents:** Results from one antimicrobial can be used to predict results for the other antimicrobials. For example, sensitivity to erythromycin can be used to predict sensitivity to clarithromycin or azithromycin.

4.4 Selective Testing: AST for particular drug- microbe combinations are not performed due to the following reasons (**Table 3**):

Table 3: Reasons for selective testing and reporting

Reasons	Examples
Bacteria suspected of being contaminants or normal flora.	If one of the two blood cultures reveals the growth of <i>Staphylococcus epidermidis</i> , AST is not reported in ordinary circumstances as the isolate is usually a suspected contaminant/ commensal flora.
Susceptibility or resistance can be predicted based on the organism identification alone (i.e., no resistance yet identified or intrinsic resistance*).	Ceftriaxone AST is not performed for <i>Pseudomonas aeruginosa</i> because <i>P. aeruginosa</i> is intrinsically resistant to ceftriaxone. Group A streptococci is not tested against penicillin as resistance has not been reported.
A particular drug-microbe combination may not have interpretative breakpoints	CLSI or FDA breakpoints for tigecycline in case of <i>Acinetobacter baumannii</i> are not available
A particular drug-microbe combination may be inappropriate for a given site of infection.	Daptomycin AST results are not reported on isolates from a respiratory source as it is inhibited by surfactant.
A drug may be inappropriate for a particular patient population.	AST results for certain drug classes such as fluoroquinolones or tetracyclines may not be reported for children.

4.5 Cascade reporting (CR): In this, AST results of secondary (e.g., broader-spectrum, costlier) agents may only be reported if an organism is resistant to primary agents within a particular drug class. This helps to guide clinicians toward using narrower-spectrum agents. Restricted antimicrobials/second-line antimicrobials should be reported only in cases of resistance to first-line/unrestricted antimicrobials.

Example: Carbapenem AST results are not reported for *Escherichia coli* if the isolate is susceptible to ceftriaxone.

4.6 Interpretation of MIC results

- MIC is the lowest concentration of antimicrobial agent that prevents the in- vitro growth of bacteria.
- The absolute value of the MICs reported on susceptibility testing must not be evaluated vertically between the different drugs tested. For example, if there is an antimicrobial A with a MIC of 0.5 mg/L and the breakpoint 2 mg/L, and an antimicrobial B with a MIC of 2 mg/L but breakpoint of 16 mg/L, the drug with a MIC more favourable is the antimicrobial B. The ratio of clinical breakpoint MIC to MIC of organism is named breakpoint to MIC quotient (BMQ). Higher the BMQ, better the clinical response.

4.7 Organism specific AST results

- **Enterococci**

- ✓ Cephalosporins, clindamycin, and trimethoprim-sulfamethoxazole may appear active in- vitro but are not effective clinically and should not be reported as susceptible or prescribed even when reported as susceptible.
- ✓ Combination therapy with ampicillin, penicillin, or vancomycin (for susceptible strains) plus an aminoglycoside is usually indicated for serious enterococcal infections. This synergy is lost in presence of penicillin resistance or high-level resistance to gentamicin (HLGR).

- **Staphylococci**

- ✓ Penicillin-susceptible staphylococci are also susceptible to other β -lactam agents with established clinical efficacy for staphylococcal infections.
- ✓ Methicillin (oxacillin)-resistant staphylococci are resistant to all currently available β -lactam antimicrobial agents, with the exception of ceftaroline.
- ✓ Inducible clindamycin resistance if present then antimicrobial therapy with clindamycin may fail clinically.

- ***Salmonella* and *Shigella* species**

- ✓ Aminoglycosides, first- and second-generation cephalosporins and cephamycins may appear active in- vitro but are not effective clinically and should not be reported as susceptible or prescribed even when reported as susceptible.
- ✓ For extraintestinal isolates of *Salmonella* spp., a third-generation cephalosporin should additionally be tested and reported, and if requested, chloramphenicol and azithromycin may be tested and reported.
- ✓ Susceptibility testing is indicated for typhoidal *Salmonella* (*S. enterica* ser. Typhi and *Salmonella enterica* ser. Paratyphi (A–C) isolated from extraintestinal and intestinal sources.
- ✓ Routine susceptibility testing is not indicated for non-typhoidal *Salmonella* spp. isolated from intestinal sources. However, susceptibility testing is indicated for all *Shigella* isolates.

- ✓ Only ampicillin, a fluoroquinolone, and trimethoprim-sulfamethoxazole should be reported routinely in case of stool isolates of *Salmonella* and *Shigella* spp.
- For CSF isolates, the following must not be prescribed/ reported:
 - ✓ Only orally administered antimicrobials
 - ✓ First- and second-generation cephalosporins and cephamycins
 - ✓ Doripenem, ertapenem, and imipenem
 - ✓ Clindamycin
 - ✓ Macrolides
 - ✓ Tetracyclines
 - ✓ Fluoroquinolones

4.8 Sample specific AST results

AST results are provided only if clinical assessment suggests infection in the following situations:

- **Urine:** The urine of patients with indwelling catheters frequently becomes colonised. Unless the patient becomes systemically unwell, treatment is not indicated.
- **Sputum:** Antimicrobial therapy may be indicated if clinical or radiological evidence of lower respiratory tract infection is present. Otherwise, this probably represents upper airway colonisation, for which antimicrobial therapy is not required.
- **Pus Swab:** Antimicrobial therapy may be indicated in case of cellulitis or deep-seated infection only.

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Antimicrobial Resistance: Principle and Implications

5

Learning Objectives

On completion of this chapter, the prescriber should be able to:

- define and explain the differences between antimicrobials and antibiotics
- outline the drivers for resistance
- outline the global epidemiology of key antimicrobial resistant pathogens and antimicrobial consumption
- explain the clinical and economic impact of drug resistant infections and health care acquired infections.

5.1 Introduction

- ‘Antimicrobials’ is a broad term that is used for all agents that act against different types of microorganisms namely bacteria (antibacterial), viruses (antiviral), fungi (antifungal) and parasites (antiparasitic).
- Antibiotic refer to compounds that are produced by microorganisms and act against bacteria.
- Antimicrobials are unique, and pose special challenges due to following:
 - ✓ Limited shelf life: The efficacy of antimicrobials wanes over time.
 - ✓ Multispecialty usage: They are used for prophylaxis and treatment of various conditions in a variety of situations.
 - ✓ Inappropriate use: May harm other people who are even not exposed to the antimicrobial.
 - ✓ Limited drug development: Past three decades have not seen significant development and licensing of antimicrobials.
 - ✓ Change in natural bacterial flora: Overuse of antimicrobials tend to select bacteria with resistance to proliferate in environment and body.

5.2 Overview of Antimicrobial resistance

- Antimicrobial resistance (AMR) occurs when microorganisms such as bacteria, viruses, fungi, and parasites develop changes and fail to respond to antimicrobials.
- This makes standard treatments ineffective, prolonging infections that can increase the risk of spread to others. The resistant microbes are able to grow/multiply in the presence of drug that would normally kill them or limit their growth.
- AMR is a now recognized as a grave public health problem. As per estimations, AMR will be responsible for the death of 10 million people by 2050 and will cost as much as US\$ 100 trillion.

- Multiple agencies including WHO agree that spread of AMR is an urgent issue that requires a global, coordinated action plan to address. A report in Lancet estimates that the magnitude of bacterial AMR is almost equivalent to major diseases such as HIV and malaria, and potentially much larger.

5.3 Mechanism of action of antimicrobials

Antimicrobials act on bacteria in multiple ways. They can kill the cell (bactericidal) or retard its multiplication (bacteriostatic) (Table 4). They can act by

- Inhibition of cell wall or cell membrane synthesis in microbes.
- Disruption of essential processes such as protein synthesis of microbes.
- Disruption of nucleic acid synthesis in microbes.

Table 4: Bacteriostatic and bactericidal antimicrobials

Bactericidal	Bacteriostatic
Beta lactams, glycopeptides, cyclic lipopeptides, aminoglycosides, fluoroquinolones	Macrolides, clindamycin, tigecyclines, tetracyclines, linezolid

5.4 Mechanism of antimicrobial resistance

Bacteria may develop resistance to an antimicrobial by several mechanisms and resist getting killed or inhibited by the antimicrobial. Some bacteria inherently do not respond to certain drugs (intrinsic resistance) while others may stop responding to a drug to which it is originally sensitive (acquired resistance). Some of the common intrinsic resistance in common bacteria is given in Table 5:

Table 5: Intrinsic resistance in some commonly isolated bacteria

Bacteria	Drug
Gram positive bacteria	Aztreonam
All Gram negative bacteria	Glycopeptides, Lipopeptides
<i>Klebsiella</i> species	Ampicillin, Amoxicillin-clavulanate, Ticarcillin, Cefazolin
<i>Citrobacter</i> species	Ampicillin, 1 st & 2 nd generation Cephalosporins, Cephamycins
<i>Proteus</i> species	Colistin, Cefazolin, Tetracycline, Nitrofurantoin
<i>Pseudomonas aeruginosa</i>	Ampicillin, Amoxicillin, Amoxicillin-clavulanate, Trimethoprim-sulphamethoxazole, Sulfonamides,

	1 st and 2 nd generation Cephalosporins, Cefotaxime, Ceftriaxone, Ertapenem, Chloramphenicol, Tetracycline
<i>Acinetobacter species</i>	Ampicillin, Amoxicillin-clavulanate, Aztreonam, Chloramphenicol, Fosfomycin, Ertapenem,
<i>Enterococcus</i>	Aminoglycosides, Cephalosporins, Clindamycin, many β -lactams, Aztreonam, Polymyxin B/colistin, and Nalidixic acid

Acquired resistance: Bacteria may stop responding to a drug to which it is originally sensitive) by in any of the following actions:

- Production of enzymes that destroy the antibacterial drug (e.g., beta-lactamases in penicillin and cephalosporins)
- Expression of efflux systems that prevent the drug from reaching its intracellular target (e.g., efflux pump mechanism [fluoroquinolone resistance])
- Reduction of permeability of drug through mutation of porin proteins (as seen with aminoglycosides)
- Modification of the drug's target site (e.g., penicillin-binding protein)
- Production of an alternative metabolic pathway that evades the action of the drug (e.g., folate metabolism)

5.5 Drivers of Antimicrobial Resistance

In the latter half of the 21st century, bacteria have developed resistance against every class of antimicrobial drug. The development of AMR is multifactorial. The risk factors most commonly found to be associated with development of antimicrobial resistance are:

1. Excessive and irrational prescriptions of antimicrobials in community and hospitals
2. Increase in invasive procedures, transplants surgeries and immunosuppressive therapy.
3. Increase use of prosthetic devices amenable to super-infection and resistant bacteria.
4. Lack of effective preventive infection control measures such as hand hygiene, isolation procedures of patients with multi drug resistant organisms.
5. Lack of effective antimicrobial stewardship programs restricting antimicrobial usage in community and hospitals.
6. Use of antimicrobial in agriculture sector, animal husbandries and fisheries.
7. Improper disposal of antimicrobials and antimicrobial residues which leads to finding their way in community and entering food chain through food, animals and water.

5.6 Key Antimicrobial Resistant Pathogens:

The World Health Organization (WHO) has identified a list of priority pathogens that pose a critical threat to human health due to their resistance to antimicrobials. These pathogens as per the recent 2024 list include:

- **Carbapenem resistant Enterobacterales (CRE)** These include *Klebsiella* spp. and *Escherichia coli* that are resistant to carbapenems and are placed atop in the critical list of priority pathogens.
- **Third generation cephalosporin-resistant Enterobacterales (3GCREB)** - Gram-negative bacteria resistant to third-generation cephalosporins, a broad class of antibiotics used to treat many different types of infections.
- **Carbapenem resistant *Acinetobacter baumannii* (CRAB)** The emergence of CRAB poses a formidable challenge due to limited treatment options particularly in ICU settings.
- **Methicillin-resistant *Staphylococcus aureus* (MRSA)** – *S. aureus* resistant to many common antibiotics, making it difficult to treat skin infections, pneumonia, and bloodstream infections.
- **Vancomycin-resistant *Enterococcus* (VRE)** - one of the last-resort antibiotics used to treat serious infections.
- **Fluoroquinolone-resistant bacteria** - This includes strains of *E. coli*, *Salmonella* and *Campylobacter* that are resistant to fluoroquinolones, commonly used to treat urinary tract infections, diarrhea, and respiratory infections

5.7 Global Epidemiology of AMR:

AMR is a global problem, but its impact varies from country to country. Low- and middle-income countries are often disproportionately affected due to factors like limited access to clean water and sanitation, overcrowding, and poor infection control practices in healthcare settings. The breakdown of the global epidemiology of AMR is as follows:

- **High burden:** Low- and middle-income countries in Southeast Asia, Africa, and Latin America.
- **Emerging burden:** Eastern Europe and Central Asia.
- **Established burden:** High-income countries in Europe and North America.

5.8 Antimicrobial Consumption: The overuse and misuse of antimicrobials are major drivers of AMR. This includes:

- Using antibiotics for viral infections, which are ineffective.
- Taking antibiotics for an incomplete course of treatment.
- Using antibiotics for non-medical purposes, such as promoting growth in livestock.

5.9 Impact of AMR: The consequences of AMR include:

- Increased morbidity and mortality from infections.
- Longer hospital stays and higher healthcare costs.
- Limited treatment options for common infections.
- The emergence of untreatable "superbugs."

For Combating AMR a multi-pronged approach has been included in NAP-AMR that includes-

- **Surveillance:** Monitoring AMR trends to identify emerging threats.
- **Stewardship:** Promoting the responsible use of antimicrobials in humans and animals.
- **Infection prevention and control:** Implementing measures to prevent infections in healthcare settings.
- **Research and development:** Developing new antibiotics, diagnostics, and vaccines.

5.10 Clinical Impact: both drug resistant infections (DRIs) and hospital acquired infections (HAIs) pose significant challenges for patient care. The clinical impact are-

- **Drug resistant infections**
 - **Increased mortality:** DRIs are associated with higher death rates, because effective treatment options become limited, and alternative drugs may have lower efficacy or more severe side effects.
 - **Treatment delays:** due to delay in diagnosis worsen the course of the infection.
 - **Limited treatment options:** for DRIs, effective antibiotics may be scarce or unavailable or having serious side effects.
 - **Increased length of hospital stay**
- **Hospital acquired infections**
 - **Increased mortality** compared to community-acquired infections due to compromised immune status of the patient making them more susceptible to severe complications.
 - **Antibiotic resistance:** the frequent use of antibiotics in hospitals selects for resistant strains, making it harder to treat future infections.
 - **Increased complications** like pneumonia, sepsis, and organ failure.
 - **Psychological impact in form of** anxiety, stress, and depression in patients, impacting their overall well-being.

5.11 Economic impact: combined effect of DRIs and HAIs are-

- **Increased costs:** due to longer hospital stays, the use of more costly antibiotics, and the need for additional treatments for complications.
- **Reduced productivity:** due to longer recovery times, leading to lost workdays and decreased productivity.
- **Strain on healthcare systems:** due to increased demand for resources to treat DRIs and HAIs limited resources available for other patients.
- **Global economic impact:** The World Bank estimates that AMR alone could push an additional 10 million people into poverty by 2030.

5.12 To mitigate impact of AMR

To reduce the clinical and economic burden of DRIs and HAIs, several strategies are crucial:

- **Antimicrobial stewardship**
- **Infection prevention and control**
- **Surveillance**
- **Research and development** of new antibiotics, diagnostics, and vaccines to combat DRIs and HAIs.

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Antimicrobial Policy

6

Learning Objectives

On completion of this chapter, the prescriber should be able to:

- describe the attributes and features of antimicrobial policy
- understand the key elements of developing hospital antimicrobial policy
- assist in developing antimicrobial policy.

6.1 Introduction

- Hospital antimicrobial policy helps to minimize the morbidity and mortality due to antimicrobial-resistant infection; and helps to preserve the effectiveness of antimicrobial agents in the treatment and prevention of communicable diseases.
- The policy must define prophylaxis, empirical and definitive therapy and must incorporate specific recommendations for the treatment of different high-risk/special groups such as immunocompromised hosts; hospital-associated infections and community-associated infections.
- The hospital antimicrobial policy should be based upon the following factors:
 - ✓ prevalent local antibiogram
 - ✓ spectrum of antimicrobial activity
 - ✓ pharmacokinetics/ pharmacodynamics of antimicrobials
 - ✓ adverse effects and potential to select resistance of antimicrobials
 - ✓ cost of the therapy
 - ✓ special needs of individual patient groups like immunosuppressed, pregnant women, etc.

6.2 Development of antimicrobial policy

Key elements of developing hospital antimicrobial policy are given in **Fig 3**.

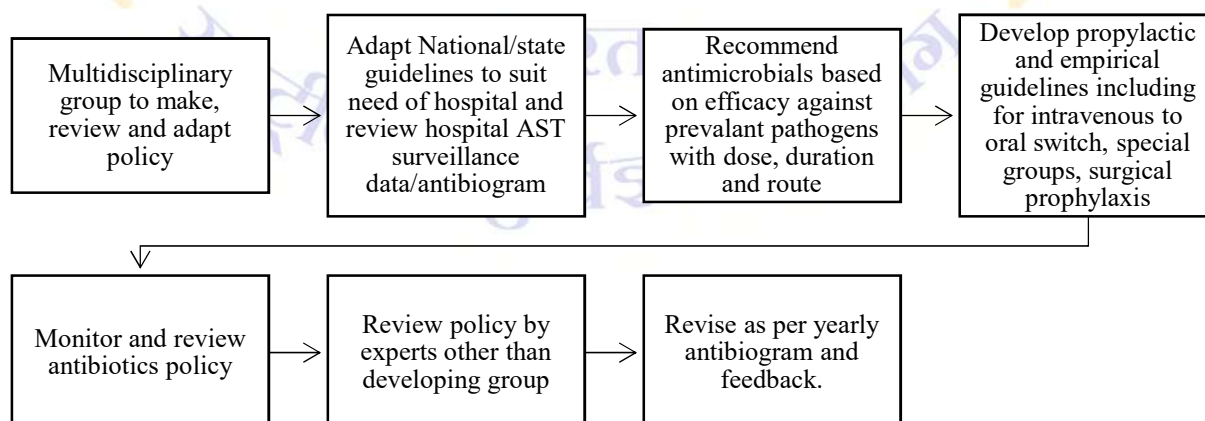


Fig 3: Key elements of developing hospital antimicrobial policy

★★★★★

Antimicrobial Stewardship in Humans

Learning Objectives

On completion of this chapter, the prescriber should be able to:

- define antimicrobial stewardship
- outline the goals, strategies and interventions of antimicrobial stewardship
- describe the core and supplemental interventions
- outline the pharmacokinetics and pharmacodynamics approach to antimicrobial prescription
- describe and interpret antibiogram
- understand the utility of antibiogram in formulating empirical therapy.

7.1 Introduction

- **Antimicrobial stewardship** has been defined as *“coordinated interventions designed to improve and measure the appropriate use of antimicrobial agents by promoting the selection of the optimal antimicrobial drug regimen including dosing, duration of therapy, and route of administration”*.

7.2 Goals of Antimicrobial stewardship

The goals can be briefly described as:

- Ensure the best clinical outcome, for treatment or prevention of infection
- Minimize unintended consequences of antimicrobial use such as adverse drug reactions, emergence of clones of antimicrobial resistance
- Minimize healthcare costs without compromising quality of care
- Accurate diagnostics and diagnostic pathways

Antimicrobial stewardship program (AMSP) have a direct responsibility to ensure prudent antimicrobial prescribing. It focuses on “4Ds” of prescribing antimicrobials (**Fig 4**).

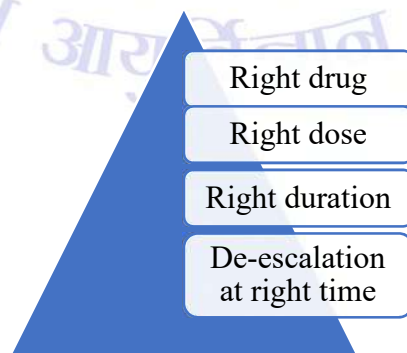


Fig 4: 4Ds of prescribing antimicrobials

7.3 AMSP interventions

Interventions can be introduced in phased manner or in whole hospital depending upon the facilities and motivation. Broadly the interventions that can be introduced are given below (Table 6).

Table 6: Core and supplemental interventions in antimicrobial stewardship

Core interventions	Supplemental interventions
Prospective audit	Dose optimization and combination therapies
Antimicrobial timeouts	Streamlining or de-escalation of therapy
Antimicrobial consumption analysis	Parenteral to oral conversion
Formulary restriction	Laboratory surveillance and feedback
Guidelines and clinical pathways	Information, education and communication

Core Interventions

Prospective audit

Regular bedside review of the patients to be done to analyse the prescriptions related to antimicrobial prescribing. After reviewing, feedback should be provided to the prescriber advising change if required on the optimal antimicrobial therapy.

Antimicrobial “Time outs”

Antimicrobials are often started empirically in hospitalized patients while diagnostic information is being obtained. All prescribers should review antimicrobials prescription after 48 hours to assess all 4Ds of antimicrobial stewardship.

Antimicrobial consumption analysis

Quantitative analysis of antimicrobial consumption: It should be collected from pharmacy purchase stores which will give proxy data of overall consumption of antimicrobials by the population (antimicrobial consumption surveillance).

- Qualitative analysis of appropriateness of prescription: Information regarding which patients are being given what antibiotics, their indications, dose and duration is collected using point prevalence surveys. It gives antimicrobial use surveillance.

Formulary Restriction

- Antimicrobials included on the hospital formulary should be divided into three groups:
 1. Unrestricted: may be prescribed by any clinician
 2. Consultant only: may only be prescribed by a consultant
 3. Restricted: may only be prescribed following prior discussion with, and approval by, the antimicrobial stewardship team

- This list should be reviewed periodically preferably every year on the basis of antimicrobial usage data and rates of antimicrobial resistance.

Guidelines and clinical pathways

- Every hospital must develop antimicrobial prescription guidelines based on principles of rational antimicrobial prescription.
- In absence of local guidelines, National Antimicrobial prescription guidelines may be adopted.

Supplemental Interventions

Dose optimization and combination therapies

- Antimicrobial must be given at the optimal dose, frequency and duration, based on individual patient characteristics such as age, weight, renal function, likely causative organism, site of infection, and pharmacokinetic and pharmacodynamic characteristics of the antimicrobial agent(s).
- A few combinations are considered synergistic, such as:
 - ✓ Aminoglycoside and beta-lactam antimicrobial.
 - ✓ Beta-lactam antimicrobial and beta-lactamase inhibitor.
 - ✓ Beta-lactam antimicrobial and glycopeptide (vancomycin/teicoplanin)
 - ✓ Sulphamethoxazole and Trimethoprim

Antimicrobial drug therapy cannot be considered in isolation, it may be ineffective in cases where pus is not drained, septic shock is not treated and hypoxia/ anaemia are not corrected.

Streamlining or de-escalation of therapy

All empiric antimicrobial therapy should be reviewed on a daily basis by the clinician responsible for the patient's care. Special attention must be paid to factors such as:

- Antimicrobial combinations with overlapping spectrum of activity. For example: Drugs like meropenem, clindamycin and piperacillin tazobactam provide cover against anaerobic bacteria and hence additional anaerobic antimicrobial such as metronidazole should not be given.
- Prolonged use of broad spectrum antimicrobials
- Unauthorised use of restricted agents
- Antimicrobial use not in accordance with hospital antimicrobial policy.
- Clear criteria for prescribing intravenous antimicrobials.

Parenteral to oral conversion

- Always review intravenous prescription after 48 hours (at least) and switch to oral if possible.

- Early switch from intravenous (IV) agents to the equivalent oral preparation offers several benefits:
 - ✓ Decreased total cost of therapy,
 - ✓ Decreased potential for line associated infections,
 - ✓ Potential for decreased length of stay and patient preference,
 - ✓ Increased patient comfort and mobility,
 - ✓ Savings in nursing time spent preparing and administering intravenous doses.

Laboratory surveillance and feedback

The Microbiology laboratory must share antimicrobial susceptibility data as an antibiogram with the prescribers. Also, feedback on follow up cultures must be promptly provided to allow timely review of antimicrobial prescriptions.

Utility of antibiograms

- Empiric antimicrobial therapy is started to provide initial control of a presumed infection of unknown cause. Hence, local cumulative antibiograms are required to select appropriate empiric antimicrobials for patients with common infections.
- It also provides a broad overview of local antimicrobial resistance over time (e.g. the proportion of *S. aureus* isolates that are methicillin-resistant).
- Can provide an overview of the emergence of antimicrobial resistance in particular settings over time.
- It can assist in managing infections due to multidrug-resistant organisms.

Information, Education and Communication (IEC)

- **Prescriber IEC:** Educational aids to guide prescribers at the point of prescribing such as clinical algorithms for the diagnosis of infection, or methods to standardise documentation of treatment decisions must be displayed at important locations in hospitals by the hospital administration in consultation with the AMSP committee.
- **Patient IEC:** Patients, their families and general public should be educated through awareness program, regarding appropriate use of antimicrobials such as:
 - ✓ When antimicrobials are not needed, like in cases of upper respiratory tract infections which are mostly of viral etiology and do not require antimicrobials.
 - ✓ Inappropriate use may cause antimicrobial associated diarrhoea, allergic reaction, colonization with drug resistant bacteria, and autoimmune diseases, likely through disturbing the microbiome etc.
 - ✓ They should be made aware of the importance of adherence to antimicrobial treatment.

7.4 Pharmacokinetic (PK) and pharmacodynamic (PD) approach to optimize antimicrobial prescription: right antimicrobial selection for an infection PK and PD both

to be considered (PK -how the drug behaves in the body and PD (how it interacts with the target pathogen)-

- **Matching the antibiotic to the site of infection:** like tissue penetration ensures the antibiotic reaches the target location in sufficient concentrations.
- **Dosage Optimization:** the appropriate dose and dosing frequency to maintain effective antibiotic levels throughout the treatment course.
- **Patient-Specific Adjustments:** Factors like age, weight, kidney function, and liver function can affect PK parameters. PK/PD allows for adjustments to ensure optimal drug exposure for each patient.

7.5 Interpretation of antibiogram results: should be interpreted in conjunction with other factors like-

- the patient's clinical condition,
- local resistance patterns, and
- potential for adverse effects.

7.6 Principles of rational prescription

The general principles guiding antimicrobial prescription must be followed for all patients. Some of these principles are given below:

- Do NOT use antimicrobials
 - ✓ To treat colonization or contamination unless there is clear indication such as immunosuppression or post splenectomy.
 - ✓ As general prophylaxis or “Feel good” factor.
 - ✓ To treat infections which have high suspicion of viral causes such as influenza
- Use antimicrobials only
 - ✓ In cases of high degree of suspicion of infection.
 - ✓ After a treatable infection has been recognized
 - ✓ For prevention of infection where evidence has demonstrated that the potential benefits outweigh the risks.
- Empirical therapy must be based on local/national prescribing guidelines.
- Use targeted therapy instead of broad-spectrum antimicrobials unless there is a clear clinical reason (for example, mixed infections or life-threatening sepsis).
- Review broad spectrum antimicrobials as early as possible and promptly switch to narrow spectrum agents when sensitivity results become available.
- Choose antimicrobials as determined by the sensitivity of identified causative organism.
- The indication for which the patient is being prescribed the antimicrobials should be documented in the drug chart and case notes by the prescriber.
- Always have a stop/review date on antimicrobial order form/ patient chart. No antimicrobial should be written for indefinite time.

- Pre-surgical prophylaxis guidelines must be followed.

7.7 Strategic approach for development and intervention of AMSP

The strategic approach must be as per the availability of resources in the local settings:

- **Committee preparation:** An AMS committee is required to provide leadership and overall coordination of the AMS programme. Committee must include Administrative leader, Clinicians from each clinical department, Clinical pharmacist, Microbiologist, Nursing officer etc. as per standard guidelines.
- **Prescribers' education:** The policy-makers and health care administrators to provide opportunities for physicians to address information gaps through clinical education and continuing professional development.
- **Development of Institution-specific guidelines and interventions:** Institution-specific guidelines or algorithms can be adapted from national or international evidence-based guidelines to reflect local epidemiology, access to diagnostic testing and drug availability.



Infection Control

8

Learning Objectives

On completion of this chapter, the prescriber should be able to:

- define and describe the elements of standard precautions
- define and describe transmission-based precautions.
- define biomedical waste management
- describe various segregation methods and their disposal as per BMW rules.
- define device associated infections
- define and describe preventive care bundles for device associated infections

Introduction

Microbes are a part of everyday life and are found in our environment (air, soil, water), and in/ on our bodies. Many microbes live in and on our bodies without causing harm but a small portion of them are known to cause infection. Many microbes live without causing harm but a small portion of them is known to cause infection. For any infection to occur, a sequence of events occur that transmit an infectious microorganism to a susceptible host. Three things are necessary for an infection to occur:

- **Source:** Places where infectious agents live (e.g., sinks, surfaces, human skin, water, food)
- **Susceptible Person** with a way for microbes to enter the body
- **Transmission:** how the microbes are moved to the susceptible person

Interactions are more common in hospital environment and provide microorganisms an opportunity to cause infection in susceptible host. Healthcare-associated infections (HAIs/ HCAIs) are influenced by the interaction between host, pathogen and environmental factors. This chain of transmission is favoured by health care workers.

In order to prevent HAIs, this chain of transmission needs to be broken by appropriate infection control Practices

Infection control prevents or stops the spread of infections in healthcare settings. There are two tiers of recommended precautions to prevent the spread of infections in healthcare settings: Standard precautions and transmission-based precautions.

8.1 Standard Precautions

Standard precautions (previously known as universal precautions) are the minimum infection prevention practices that apply to all patient care, regardless of the suspected or confirmed infection status of the patient, in any setting where healthcare is delivered. Standard precautions consider every person (patient or staff) as potentially infectious and susceptible to infection. It aims to prevent transmission of infections from:

- Patient to healthcare worker
- Healthcare worker to patient
- Patient to patient (cross-transmission)
- Hospital environment to patient
- Hospital waste to community (spread)

The basis of standard precautions is that it presumes all specimens are potentially infectious. Standard precautions apply to blood, semen, vaginal secretions, synovial fluid, cerebrospinal fluid, pleural fluid, peritoneal fluid, pericardial fluid and amniotic fluid. They do not apply to feces, nasal secretions, sputum, sweat, tears, urine, vomitus and saliva. Given below in **Table 7** are the elements of standard precautions:

Table 7: Elements of standard precautions

i. Hand hygiene	vi. Patient care equipment/ devices management
ii. Personal protection equipment/ PPE (gown, mask, face protection, gloves, goggles etc.)	vii. Environmental control
iii. Safe injection practices	viii. Respiratory hygiene/cough etiquettes
iv. Sharp management	ix. Proper disposal of biomedical waste
v. Spill management	

(Source: www.cdc.gov/HAI/settings/outpatient/outpatient-care-gl-standard-precautions.html, Version 2.3 - September 2016)

i) Hand hygiene

- Hand hygiene is the single most important strategy in preventing HAIs. Clean hands prevent infections and this applies in any setting, at home, at school or at work.
- In healthcare settings, handwashing is the simple and most effective way to prevent potentially fatal infections spreading from patient to patient and from patient to healthcare worker and vice versa. However, this is often overlooked by most healthcare personnel.
- Hence, it is essential to emphasise its importance and educate the personnel about the correct technique of handwashing.
- Key points where hand hygiene should be performed are known as the five moments of hand hygiene as given below:

- ✓ Before touching a patient, even if gloves are to be worn,
- ✓ Before coming out of the patient's care area after touching the patient or the patient's immediate environment,
- ✓ After contact with blood, body fluids or excretions or wound dressings,
- ✓ Prior to performing any aseptic task (e.g., placing an intravenous line or preparing an injection),
- ✓ If hands are likely to move from a contaminated body site to a clean body site during patient care; and after removal of gloves

The 5 moments of hand hygiene are given in **Fig 5**

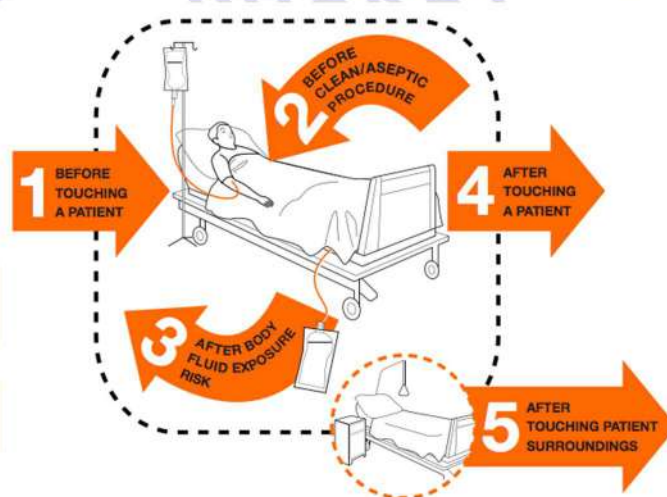


Fig 5: The WHO 5 moments of hand hygiene

(Source: <https://openwho.org/courses/IPC-HH-en>)

- **Good hand hygiene practices**, which include the use of alcohol-based hand rubs and washing with soap and water, are critical to reducing the risk of spreading infections in ambulatory care settings.
- The process takes around 40–60 seconds in its entirety. Steps of hand washing are given in **Fig 6**.
- Hands must be fully dried, as moisture can breed microorganisms. A cloth towel should not be used as the organisms can remain and be transmitted. If possible, paper towel should be used to turn off the tap and dry hands. Unwashed hands of a nurse or any healthcare worker are loaded with bacteria.

How to Handwash?

WASH HANDS WHEN VISIBLY SOILED! OTHERWISE, USE HANDRUB

 Duration of the entire procedure: 40-60 seconds



(Source: <https://www.who.int/teams/integrated-health-services/infection-prevention-control/hand-hygiene/training-tools>)

Fig 6 : Steps of handwashing

If soap and water are not available, then alcohol-based hand sanitiser (hand rub) can be used to clean hands. They significantly reduce the number of organisms on skin and are fast-acting. However, if hands are visibly dirty, then washing with soap and water is the only method that should be used. Using a hand rub generally reduces the time to around 15–20 seconds (**Fig 7**). However, for surgical scrub (prior to performing surgery), the process takes five minutes. When using an alcohol-based hand sanitiser: Apply product to the palm of one hand, rub hands together and then rub the product over all surfaces of hands and fingers until hands are dry.

How to Handrub?

RUB HANDS FOR HAND HYGIENE! WASH HANDS WHEN VISIBLY SOILED

 Duration of the entire procedure: 20-30 seconds



(Source: Guideline on Hand Hygiene in Health Care in the Context of Filovirus Disease Outbreak Response, WHO, 2014)

Fig 7 : Steps of hand rub

ii) Personal protective equipment (PPE)

As per OSHA (Occupational Safety and Health Act) PPE is defined as “*Specialized clothing or equipment worn by an employee for protection against infectious materials*”. It refers to wearable equipment intended to improve healthcare workers safety from exposure to or contact with infectious agents. It includes gloves, lab coats, gowns, goggles, and masks.

The purpose of PPE is to prevent blood and body fluids from reaching the worker’s skin or mucous membranes. A full PPE is required while providing care to patients who have highly infectious diseases like COVID-19, Ebola and Nipah virus infections, which require isolation and barrier nursing in containment areas of the hospital.

The group of items used in PPE can be used separately or in combination, acting as a barrier to prevent contact between health workers and a patient/object/environment.

Recommendations on use of PPE is based on the expert opinions regarding disease transmissions, known portals of entry, perception of risk and severity of transmission. All PPE should be made of standard impervious material.

Components of PPE

- **Gowns and aprons:** Gown is meant to cover the body from the neck to the knees and the arms down to the wrists with an opening and closing mechanism, usually at the back. These protect health care worker's clothes/scrubs from getting contaminated while performing procedures that might create spatters of blood or body fluids.

The gowns can be disposable or non-disposable. Apron is made of waterproof material and is worn over gown as barrier. The same gown should not be worn for the care of more than one patient.

- **Safety eyewear such as glasses, wraparounds, goggles:** The purpose of safety eyewear is to prevent aerosols, spatters and droplets from coming in contact with conjunctival mucus membrane. Personal glasses are not a substitute for goggles. The safety eyewear should fit snugly over and around eyes. To wear, the goggles must be positioned over eyes and secured to the head using the ear pieces or headband.
- **Face protectors and face shields:** These should cover forehead, extend below chin and wrap around side of face. To wear face shield, position it over face and secure on brow with headband. It should be then adjusted to fit comfortably covers the entire face and wearer does not require additional eye protection or a mask to guard against droplet-transmissible agents. Mouth, nose and eye protection should be in place during procedures likely to generate splashes or sprays of blood or other body fluids.
- **Masks:** Just like conjunctiva, mucous membranes of the nose and mouth are portals of entry for infectious agents. So, it is essential to protect them. The barriers can be in the form of mask or respirators. Masks are made up of impervious material and can be pleated or preformed. Efficiency of masks reduces with moisture and should be changed frequently. Masks can be surgical or N-95 NIOSH or CDC certified.
- **Boots, jumpsuits, overall and hoods:** These do not provide any added protection but only prevent soiling of clothes or street shoes.
- **Gloves:** These are intended to prevent contact of hands with contaminated sources such as the skin of patients colonized or infected with multidrug resistant microorganisms. A surgical mask should be worn when placing a catheter or injecting material into the spinal canal or subdural space. There are two methods of wearing sterile gloves:
 - **Closed gloving:** In this method the hands are covered by the gown sleeves. The hands remain inside the cuff and the gloves are worn one hand after another.
 - **Open gloving:** The gloves are worn by touching the inner surface of the gloves for one hand followed by outer sterile surface for the other hand.

The gloves should be placed on top of the cuff of the gown while using long-sleeve gowns. With reference to gloves, the following precautions are recommended:

- Gloves should be worn when there is a possibility of contact with blood, body fluids, mucous membranes, non-intact skin or contaminated equipment.
- Gloves should always be changed between patients or if they develop breaks or tears.
- Gloves should not be washed for the purpose of reuse.

- Under no circumstance should glove use replace hand hygiene.
- Hand hygiene should be performed immediately after removing the gloves.

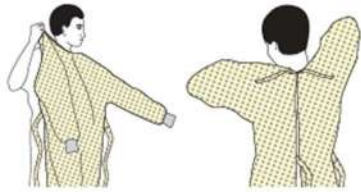
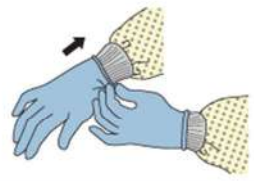
Donning of PPE

Before donning PPE make sure that hair is tied and all jewellery is removed. The worker must ensure that the PPE is of correct size before breaking open the seal.

The PPE must be worn in the following order as shown in **Fig 8**.

SEQUENCE FOR PUTTING ON PERSONAL PROTECTIVE EQUIPMENT (PPE)

The type of PPE used will vary based on the level of precautions required, such as standard and contact, droplet or airborne infection isolation precautions. The procedure for putting on and removing PPE should be tailored to the specific type of PPE.

- 1. GOWN**
 - Fully cover torso from neck to knees, arms to end of wrists, and wrap around the back
 - Fasten in back of neck and waist
- 2. MASK OR RESPIRATOR**
 - Secure ties or elastic bands at middle of head and neck
 - Fit flexible band to nose bridge
 - Fit snug to face and below chin
 - Fit-check respirator
- 3. GOGGLES OR FACE SHIELD**
 - Place over face and eyes and adjust to fit
- 4. GLOVES**
 - Extend to cover wrist of isolation gown

USE SAFE WORK PRACTICES TO PROTECT YOURSELF AND LIMIT THE SPREAD OF CONTAMINATION

- Keep hands away from face
- Limit surfaces touched
- Change gloves when torn or heavily contaminated
- Perform hand hygiene



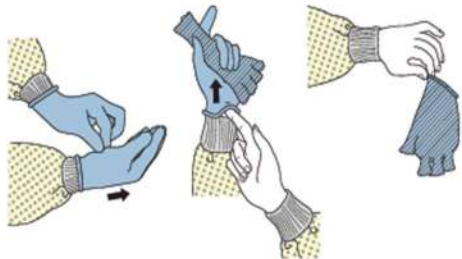
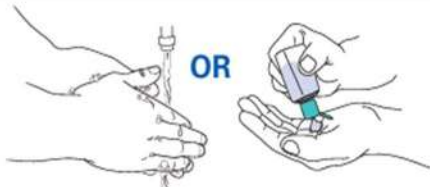
Fig 8: Donning of PPE (source: <https://www.cdc.gov/hai/pdfs/ppe-sequences>)

Doffing of PPE

PPE should be removed in an order that minimizes the potential for cross contamination. PPE should be doffed in the following order as shown in **Fig 9**.

HOW TO SAFELY REMOVE PERSONAL PROTECTIVE EQUIPMENT (PPE)
EXAMPLE 1

There are a variety of ways to safely remove PPE without contaminating your clothing, skin, or mucous membranes with potentially infectious materials. Here is one example. **Remove all PPE before exiting the patient room** except a respirator, if worn. Remove the respirator **after** leaving the patient room and closing the door. Remove PPE in the following sequence:

- 1. GLOVES**
 - Outside of gloves are contaminated!
 - If your hands get contaminated during glove removal, immediately wash your hands or use an alcohol-based hand sanitizer
 - Using a gloved hand, grasp the palm area of the other gloved hand and peel off first glove
 - Hold removed glove in gloved hand
 - Slide fingers of ungloved hand under remaining glove at wrist and peel off second glove over first glove
 - Discard gloves in a waste container
- 2. GOGGLES OR FACE SHIELD**
 - Outside of goggles or face shield are contaminated!
 - If your hands get contaminated during goggle or face shield removal, immediately wash your hands or use an alcohol-based hand sanitizer
 - Remove goggles or face shield from the back by lifting head band or ear pieces
 - If the item is reusable, place in designated receptacle for reprocessing. Otherwise, discard in a waste container
- 3. GOWN**
 - Gown front and sleeves are contaminated!
 - If your hands get contaminated during gown removal, immediately wash your hands or use an alcohol-based hand sanitizer
 - Unfasten gown ties, taking care that sleeves don't contact your body when reaching for ties
 - Pull gown away from neck and shoulders, touching inside of gown only
 - Turn gown inside out
 - Fold or roll into a bundle and discard in a waste container
- 4. MASK OR RESPIRATOR**
 - Front of mask/respirator is contaminated — **DO NOT TOUCH!**
 - If your hands get contaminated during mask/respirator removal, immediately wash your hands or use an alcohol-based hand sanitizer
 - Grasp bottom ties or elastics of the mask/respirator, then the ones at the top, and remove without touching the front
 - Discard in a waste container
- 5. WASH HANDS OR USE AN ALCOHOL-BASED HAND SANITIZER IMMEDIATELY AFTER REMOVING ALL PPE**


PERFORM HAND HYGIENE BETWEEN STEPS IF HANDS BECOME CONTAMINATED AND IMMEDIATELY AFTER REMOVING ALL PPE



Fig 9: Doffing of PPE (source: <https://www.cdc.gov/hai/pdfs/ppe-sequences>)

iii) Safe injection practices

Safe injection practices prevent transmission of infectious diseases between patients and between patients and healthcare workers (HCW) during the preparation and administration of parenteral medicines. The following are recommended:

- Aseptic techniques should be used when preparing and administering medicines.
- Access diaphragms of medicine vials should be cleaned with 70% alcohol before inserting a device into the vial.
- Medicine should never be administered from the same syringe to multiple patients.
- A used syringe should not be used to draw medicine from a vial or solution.
- Fluid infusion or administration sets (e.g., intravenous tubing) should not be used for more than one patient.

Multi-dose vials should be dedicated to a single patient whenever possible.

iv) Sharp management

- Sharps like needle and syringes have to be rendered unusable and disinfected immediately on use at source before disposal.
- Containers should be available at point of use or generation point.
- Sharps or needles should not be purposely bent or broken by hand. The needle is put inside disposal container with the sharp end first. Never push or force in with the hand. Have a clear view of the container opening and the inside of the container during disposal.
- Used needles should not be re-capped on any account. One hand scoop technique can be done if needed.
- If needle and syringe need to be transported from one area to another, then a rigid walled container must be used.
- The sharps container must be removed when half filled. The lids must be securely closed.

Sharp Injury management: In the event of a needlestick injury/ splash of blood or body fluid into the eye, the area should be washed with running tap water or with an eye wash and, the following protocol needs to be followed immediately to prevent transmission of HBV, HCV and HIV.

- The event needs to be reported to the infection control nurse and medical officer incharge/infection control officer. The source patient's status should be verified. (If the status is not known, and with consent of the patient, the person may be tested for HIV, hepatitis B and hepatitis C).
- If the patient is known to be HIV-positive or if the status is unknown, post-exposure prophylaxis (PEP) is initiated (according to NACO, CDC and WHO guidelines).
- Hepatitis B—if the healthcare worker is vaccinated, no treatment is required, but if not vaccinated, HBIG and HB vaccine are initiated as per guidelines.
- Hepatitis C—no treatment is currently recommended.

v) Spill Management

- Body fluid spills can be spills that are visibly contaminated with blood and those which are not. Both types of spills require same treatment.
- Exposure to blood and other body fluids poses a risk of infection to health care persons and patients. Spillages of blood must be dealt with immediately.
- Any splashes of blood or body fluids on the skin must be washed off immediately with soap and water.

Procedure for Spill Management

- Spillage of less than 30 ml is treated as small and more than 30 ml as large spill.
- Infection control nurse must be informed in case of large spill after immediate action has been taken by the concerned department.
- Staff must be trained in proper procedure to manage spills.
- Spill management protocols must also be displayed at prominent locations (sample given in **Fig 10**) in the hospital especially at point of use as a ready reference for the staff for management of spills.

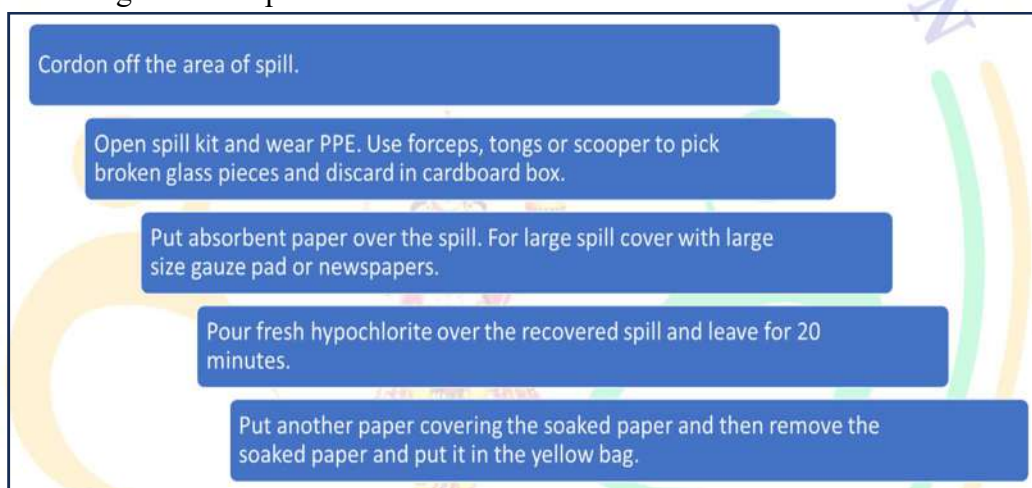


Fig 10: Steps in spill management

Spill kit: A spill kit must be readily available with all departments especially where risk of spill is more, like laboratory, sample collection room, wards etc. Spill kit must have the following contents (**Table 8**):

Table 8: Contents of a spill kit

• Gloves-2 pairs • Apron • Mask • Shoe covers • Absorbent material like newspaper or blotting paper	• Waste disposal bag • Cleaning equipment – bucket, mop, cloth, soap etc. • Freshly prepared 1% sodium hypochlorite solution • Forceps, tongs or scooper
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vi) Patient Care Equipment/ Devices management

- Medical equipment may be reusable or meant for single use. Reusable medical equipment (e.g., endoscopes) come with instructions for their cleaning and disinfection or sterilisation, as appropriate. Single-use devices are labelled by the manufacturer for one-time use and come with reprocessing instructions.
- Reusable medical equipment (e.g., blood glucose meters and other point-of-care devices, surgical instruments, endoscopes) is cleaned and reprocessed appropriately before being used on another patient.
- Soiled patient care equipment: Wear gloves if visibly contaminated and practice routine hand hygiene. Follow procedures for routine care, cleaning and disinfection of environment surface, especially frequently touched surfaces in patient care areas.

vii) Environmental Cleaning

- Cleaning refers to the removal of visible soil and organic contamination from a device or environmental surface with appropriate chemical agents. This process removes large number of microorganisms from surfaces and must always be performed before disinfection.
- Handling soiled or contaminated linen: Gloves should be used at all times. The linen must be inspected for any needles, or syringes etc. while stripping. Linen should not to be placed on floor but in a yellow doubled plastic bag sealed by a knot.
- **Terminal disinfection** is the method of thorough cleaning of the patient bed, surroundings, and the patient utilities after the discharge of the patient. Do not admit another patient in the same room for at least 12 hours.

viii) Respiratory Hygiene/Cough Etiquette

- This refers to the standard precautions to be taken by any individual with signs of illness including cough, congestion, rhinorrhoea or increased production of respiratory secretions. Such individuals need to be promptly identified to prevent transmission of respiratory infections.

The elements of Respiratory Hygiene/Cough Etiquette include:

- Education of staff, patients, and visitors in a Health Care Facility (HCF).
- Posted signs (in languages understood by the population served), with instructions to patients and accompanying family members/ friends beginning at the point of initial encounter in a HCF (e.g., triage, reception and waiting areas in emergency departments, outpatient clinics and physician offices).
- Source control measures (covering the mouth/nose with a tissue while coughing with prompt disposal of used tissues or using surgical masks on the coughing person as appropriate).
- Hand hygiene after contact with respiratory secretions.

- Spatial separation (ideally >3 feet), of persons with respiratory infections in common waiting areas when possible.
- Health Care Practitioner (HCPs) are advised to observe Droplet Precautions and perform hand hygiene when caring for such patients.
- HCPs who have a respiratory infection are advised to avoid direct patient contact, especially with high- risk patients. At least a mask should be worn while providing patient care.
- Provide tissues and no-touch receptacles (e.g., foot-pedal operated lid or open, plastic-lined waste basket) for disposal of tissues.



8.2 Transmission based Precautions

Introduction

CDC recommends two tiers of precautions to prevent transmission of infectious agents. The standard precautions as mentioned earlier apply to all irrespective of their disease status while transmission- based precautions are to be followed in case the patient is known case or is suspected to be infected or colonized with infectious agents.

- As these patients carry a high risk of transmitting the pathogen to the healthcare worker and adjacent patients, further measures are needed in addition to standard precautions to prevent transmission of infection. Usually, these patients must be isolated and the appropriate transmission-based precautions must be used. Following transmission-based precautions are followed in addition to standard precautions (**Table 9**):
- Airborne precautions
- Droplet precautions
- Contact precautions
- **Airborne precautions:** These are to be followed for droplet nuclei $<5\mu\text{m}$, e.g., tuberculosis, chicken pox, measles and influenza. This requires:
 - Isolation of patients in individual room with adequate ventilation: This includes, where possible, negative pressure; door closed; at least twelve air exchanges per hour; exhaust to outside placed away from intake ducts
 - Staff wearing high-efficiency masks in room
- **Droplet precautions:** These are to be followed for droplet nuclei $>5\mu\text{m}$, e.g., meningococcal meningitis, diphtheria, respiratory syncytial virus. The following procedures are required:
 - Individual room for the patient, if available
 - Surgical mask for healthcare workers
 - Restricted circulation for the patient; patient wears a surgical mask if leaving the room
 - Teach the patient to follow respiratory hygiene/cough etiquette.
- **Contact precautions:** Direct contact occurs when performing patient- care activities that require touching the patient's skin. Indirect contact occurs when touching potentially contaminated environmental surfaces or equipment in the patients' environment
 - Individual room for the patient if available; grouping patients if possible
 - Staff wear gloves on entering the room; a gown for patient contact or contact with contaminated surfaces or material
 - Wash hands before and after contact with the patient, and on leaving the room

- Restrict patient movement outside the room
- Appropriate environmental and equipment cleaning, disinfection, and sterilisation

Contact Precautions are to be followed for patients infected with organisms capable of transmission through either direct or indirect contact, e.g., patients with enteric infections and diarrhoea which cannot be controlled or skin lesions which cannot be contained, and multidrug-resistant organisms [MDRO].

Table 9: Elements of specific precautions

Specific precautions	Source Control: patient to wear mask	Isolation of patient	Restriction of movement of patients	Appropriate PPE to be used	Disposable or dedicated patient equipment	Prioritize cleaning or disinfection of patient rooms
Contact Precautions	No	No	Limit movement outside room. Follow contact precautions if transfer is needed covering colonized areas of the patient's body.	Gloves and gown	Yes	Daily and no room and material should be allowed to be used by another patient prior to cleaning.
Droplet Precautions	MUST wear mask.	In single room possibly.	Yes	Gloves, apron and mask	Yes	-do-
Airborne Precautions	Fit-tested NIOSH-approved N95 or higher level respirator for healthcare personnel.	In airborne infection isolation room with negative pressure. If not possible then mask patient and place in a private room with the door closed	Yes	Full PPE with fit-tested NIOSH approved N95 or higher level respirator for healthcare personnel.	Yes	-do-

Isolation of Patients

- All patients admitted with contagious infections must be isolated. Patients infected with MRSA and multi drug-resistant organisms, which are resistant to three or more classes of antibiotics, need to be isolated and treated by barrier nursing.
- The nursing care is individualised so that the infection does not spread to other patients via the nurse.
- All personal protective equipment is dedicated to single use.
- For the isolated patients, transmission-based precautions must be followed in addition to the standard precautions.

Table 10 shows patients who should be isolated into separate rooms or wards are those with:

Table 10: Patients with clinical presentations/ diseases that require isolation

• Undiagnosed rashes and fevers • Chickenpox • Measles • Severe acute respiratory syndrome (SARS)	• Influenza • Patients known to be colonised with MRSA, VRE, and other multi-drug resistant organisms • Multidrug-resistant tuberculosis (MDR-TB)
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Protective isolation or reverse barrier nursing) is practised when the patient requires protection. **Reverse barrier nursing** works by protecting vulnerable patients, such as those with impaired immune systems (immune- compromised), against infection by medical staff.

Multidrug Resistant Organisms

- The increased occurrence of antimicrobial-resistant microorganisms (methicillin-resistant *S. aureus* [MRSA], extended spectrum beta-lactamase [ESBL] or vancomycin-resistant enterococci [VRE]) is a major medical concern.
- The spread of multi resistant strains of *S. aureus* and VRE is usually by transient carriage on the hands of healthcare workers.
- The following precautions are required for the prevention of spread of MDRO:
 - ✓ Minimise ward transfers of staff and patients
 - ✓ Ensure early detection of cases, especially if admitted from another hospital; screening of high-risk patients may be considered
 - ✓ Isolate infected or colonised patients in a single room, isolation unit or cohorting in a larger ward
 - ✓ Re-enforce handwashing with antiseptic by staff after contact with infected or colonised patients
 - ✓ Use of personnel protective equipment (PPE)
 - ✓ Proper waste segregation and disposal system

Consider treating MRSA nasal carriers with mupirocin.

★★★★★

8.3. Proper Disposal of Biomedical Waste

Introduction

Biomedical or hospital waste refers to any waste generated while providing health care, performing research and undertaking investigations or related procedures on human beings or animals in hospitals, clinics, laboratories or similar establishments (Management and Handling Rules: Government of India, 2016). The objectives of biomedical waste management are to prevent harm resulting from waste, minimise its volume, retrieve reusable materials and ensure safe and economical disposal.

Reduction in volume of waste can be achieved by proper planning and using reusable items wherever safely possible.

Segregation refers to the separation of waste at the point of generation into the various types with respect to their category and mode. Segregated waste must be put into different coloured containers, as prescribed in the rules, for appropriate treatment. These guidelines were modified in 2018. The colour coding is shown in **Table 11**.

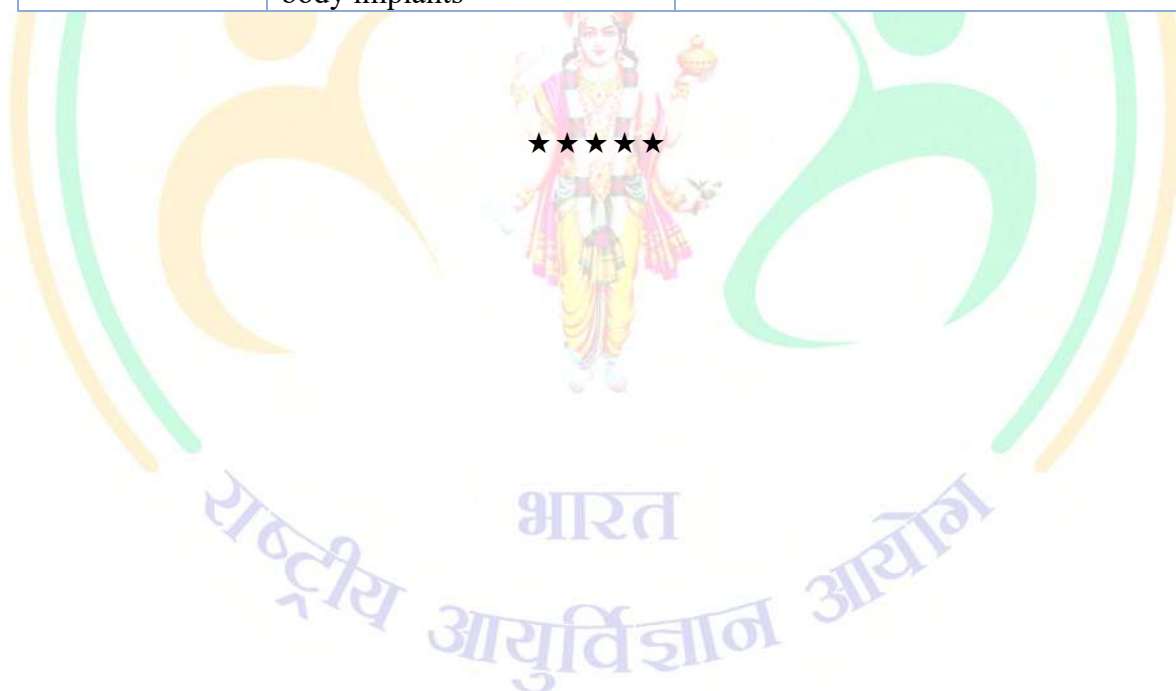
Storage refers to the measures taken to ensure that biomedical waste is kept safely at the point of generation before being sent to the biomedical waste treatment facility.

Treatment of waste means all the procedures and processes intended to reduce the bulk of the waste and make it non-infectious and harmless.

Table 11: Colour-coded bags for biomedical waste segregation

Colour of the bag	Type of waste	Waste treatment
Yellow	a) Human anatomical waste b) Animal anatomical waste c) Soiled waste	Incineration or plasma pyrolysis or deep burial
	d) Expired or discarded medicines	Returned to the manufacturer or supplier for incineration at temperature >1,200°C
	e) Chemical waste	Incineration, plasma pyrolysis, deep burial or encapsulation
	f) Chemical liquid waste	Pre-treatment and then disposal
	g) Discarded linen, mattresses, beddings contaminated with blood or body fluids	Non-chlorinated chemical disinfection followed by incineration or plasma pyrolysis
	h) Microbiology, biotechnology and other clinical laboratory waste	Pre-treat to sterilise with non-chlorinated chemicals on-site as per NACO or WHO guidelines and thereafter send for incineration
Red	Contaminated waste (recyclable) like plastic bag, bottles, pipes or containers	Autoclaving or microwaving/hydroclaving followed by shredding or mutilation

Colour of the bag	Type of waste	Waste treatment
		Treated waste to be sent to registered or autoclaved recyclers or for energy recovery of plastics to diesel or fuel oil or for road-making
White, translucent	Waste sharps including metals: Needles, syringes with fixed needles, needles from needle tip cutter or burner, scalpels, blades	Autoclaving or dry-heat sterilisation; followed by shredding or mutilation or encapsulation in metal container or cement concrete sent for final disposal to iron foundries (having consent to operate from the state pollution control committees) or sanitary landfill or designated concrete waste sharp pit
Blue cardboard box with blue label or blue leak- and puncture-proof container	Glassware: Broken or discarded and contaminated glass including medicine vials and ampoules except those contaminated with cytotoxic wastes; metallic body implants	Disinfection (by soaking the washed glass waste after cleaning with detergent and sodium hypochlorite treatment) or through autoclaving or microwaving or hydroclaving, then sent for recycling



8.4 Preventive Bundles for Device Associated Infections

Introduction

- Device associated infections: These healthcare-associated infections are infections that can be associated with the devices used in medical procedures, such as catheters or ventilators.
- Care bundles: These are a set of interventions that when applied together result in better prevention of device associated infections than individual elements implemented alone.
- Some recommended preventive bundles are as below. The hospitals may modify these bundles according to their availability of resources and other logistics.

I) Central line insertion and care bundle

- Hand hygiene
- Maximal barrier precautions upon insertion/manipulation
- PI/ alcohol/ chlorhexidine skin antisepsis
- Optimal catheter site selection, with avoidance of the femoral vein for central venous access in adult patients
- Daily review of line necessity with prompt removal of unnecessary lines

II) Preventive bundle for urinary catheter insertion/care

- Catheterize only if absolutely necessary
- Reduce the duration of catheterization
- Closed drainage
- Intermittent catheterization
- External collection devices
- Ensure dependent drainage
- Use of systemic antimicrobials: Only if patient is symptomatic and culture suggests UTI
- Compared with latex catheters, silastic catheter has a decreased incidence of urethritis and possibly urethral strictures. However, because of its lower cost and similar long term outcomes, latex is preferably used for long term catheterization.
- Remove catheters as early as possible

III) Recommended preventive bundle for Ventilator Associated Pneumonia (VAP)

- Avoid unnecessary antibiotics
- Avoid unnecessary stress ulcer prophylaxis
- Sucralfate for stress ulcer prophylaxis
- Oral intubation
- Selective digestive decontamination
- Short-course parenteral antibiotics

- Appropriate hand disinfection
- Appropriate staffing
- Avoid tracheal intubation
- Shorten duration of mechanical ventilation
- Semi recumbent positioning
- Avoid gastric overdistention
- Subglottic suctioning
- Avoid ventilator circuit changes/manipulation
- Drain ventilator circuit condensate
- Prevent accidental extubation

★★★★★



**Prescribers' toolkit for combating
AMR**

Prescribers' toolkit for combating AMR

9

Table 12: The competencies, learning objectives and the assessment methods

S. No. and Competency addressed	Learning objectives	Domain	Target audience	Teaching learning methods (TLM)	Assessment method
1. Background and objectives	1.1 Understand the present burden of AMR 1.2 Understand the concept of this national program 1.3 Assist in implementing this program	K	Prescribers	Theory session- 30 min	Written: MCQ, SAQ
2. Clinical approach for prescribing antimicrobials	2.1 Identify common presentations of infective syndromes 2.2 Describe and understand the importance of taking thorough history, clinical examination and selection of appropriate investigations for diagnosis of infective disease soft tissue infections etc).	K	Prescribers	Exploratory and interactive theory session with case studies- 60 min	Written: MCQ -Case based discussion Clinical problem solving
3. Microbiological diagnostic stewardship	3.1 Define diagnostic stewardship 3.2 Understand the difference between infection and colonization 3.3 Describe the sample collection techniques, precautions, transport and rejection criteria of common samples.	K, A, S	Prescribers	Exploratory and interactive theory session with demonstration of collection containers, videos for collection- 60 min	Written: SAQ, MCQ
4. Interpretation of antimicrobial sensitivity results	4.1 Understand the importance of quality assured antimicrobial susceptibility testing (AST) 4.2 Interpret the antimicrobial susceptibility testing report. 4.3 Interpret the surrogate and cascade reporting.	K, S	Prescribers	Exploratory and interactive theory session with samples of AST reports- 60 min	Written: SAQ, MCQ, Case discussion, AST problem solving

5. Antimicrobial resistance: Principle and implications	5.1 Define and explain the differences between antimicrobials and antibiotics 5.2 Outline the drivers for resistance 5.3 Outline the global epidemiology of key antimicrobial resistant pathogens and antimicrobial consumption 5.4 Explain the clinical and economic impact of drug resistant infections and health care acquired infections	K	Prescribers	Exploratory and interactive theory session-40min	Written: SAQ, MCQ
6. Antimicrobial policy	6.1 Describe the attributes and features of antimicrobial policy 6.2 Describe the key elements of developing hospital antimicrobial policy 6.3 Assist in developing antimicrobial policy	K	Prescribers	Exploratory and interactive theory session with examples from in house antibiotic policy- 30 min	Written: SAQ, MCQ
7. Antimicrobial stewardship in humans	7.1 Define antimicrobial stewardship 7.2 Outline the goals, strategies and interventions of antimicrobial stewardship 7.3 Describe the core and supplemental interventions 7.4 Outline the pharmacokinetics and pharmacodynamics approach to antimicrobial prescription 7.5 Describe and interpret antibiogram 7.6 Understand the utility of antibiogram in formulating empirical therapy	K, S	Prescribers	Exploratory and interactive theory session with examples of in house antibiograms and their interpretation-60 min	Written: SAQ, MCQ, Case based problem

8. Infection control	8.1 Define standard precautions 8.1.1 Describe the elements of standard precautions 8.1.2 Describe moments and steps of hand hygiene 8.2 Define and describe transmission-based precautions 8.3 Define and describe various segregation methods of biomedical waste and their disposal as per BMW rules. 8.4 Define device associated infections 8.4.1 Define preventive care bundles for device associated infections 8.4.2 Describe care bundles for different types of device associated infections	K	Prescribers	Exploratory and interactive theory session- 15 + 15 + 15 + 15 min = 60 min	Written: SAQ, MCQ
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Case scenario 1

A 55 year old man presented with fever for 5 days, cough and sputum. He was a known diabetic and was hospitalised last year for similar complaints. On examination: conscious, drowsy, pulse: 110/ minute, BP: 100/60 mm Hg, RR: 26/ minute, Temp: 100 degree F. Chest examination: Crepitations right infrascapular region.

Q1: Describe the presenting complaints?

Q2: Discuss the Co- morbidities?

Q3: Discuss the relevant past history of any illness and treatment history and its importance?

Q4: Discuss the differential diagnosis?

Q5: Demonstrate the examination of this patient.

Q6: Discuss based on your examination, the site of care and type of care for this patient.

Case scenario 2

A 45-yr old patient, diagnosed case of chronic kidney disease (on maintenance hemodialysis) presents with high grade fever for two weeks. He complains of swelling over cheek with blood discharge from nose. The doctor requests for fungal infection screen

- Discuss the differential diagnosis of infection in this case
- Plan the investigations and management in the case for infections in immunocompromised.

Case scenario 3

1. A two-year old girl presents with fever for five days with cough and fast breathing for two days. At examination she is lethargic, has weak thready pulses with tachycardia (suggestive of shock).
 - a. Demonstrate clinical skills to assess for sepsis and shock in this patient
 - b. Identify and prescribe the first-hour bundle of care in sepsis in this child and monitoring care
 - c. Plan rational investigations in this case
2. A 4 year old toddler with runny nose, sore throat since two days. On examination she has inflamed tonsils with white patch over it.
 - a. Discuss the differential diagnosis of infection in this case (keeping both viral & bacterial etiology)
 - b. Plan the investigations & management in this case.

★★★★★



**Powerpoint Presentations on
NAP-AMR
Module for Prescribers**

(The presentations are based on modules, prescribers can modify
according to their need)

Background and Objectives

NMC Module on AMR for prescribers

1. Background and Objectives

Learning Objectives

On completion of this chapter, the prescriber should be able to:

- understand the gravity of problem of AMR
- understand the concept of this program
- assist in implementing this program

1. Background and Objectives

Background

- Antimicrobials are essential for treating infectious diseases, and also in facilitating life saving procedures like organ transplants, surgeries, treatment of autoimmune diseases and cancer etc.
- Antimicrobials are also used in animals, such as pets, livestock, wildlife, and aquatic animals to combat infectious diseases.
- Of the 2152 studies published by Indian institutions on AMR, a significant majority focused on humans (48.3 %), while a small fraction in animal-related aspects (3.3 %) and the environment (4.2 %)

1. Background and Objectives

Background cont..

- The chances of developing AMR is high due to excessive use of antimicrobials. Various studies have reported an increase in antibiotic consumption among humans in India.
- In 2019 alone, worldwide 1.27 million deaths were directly caused by AMR, exceeding the toll of HIV and Malaria combined.
- 2019 data revealed that humans consumed a total of 5071 million Daily Defined Doses (DDD), with "Watch category" drugs accounting for 54.9 % of DDDs, and "Access category" drugs accounting for 27.0 %.

1. Background and Objectives

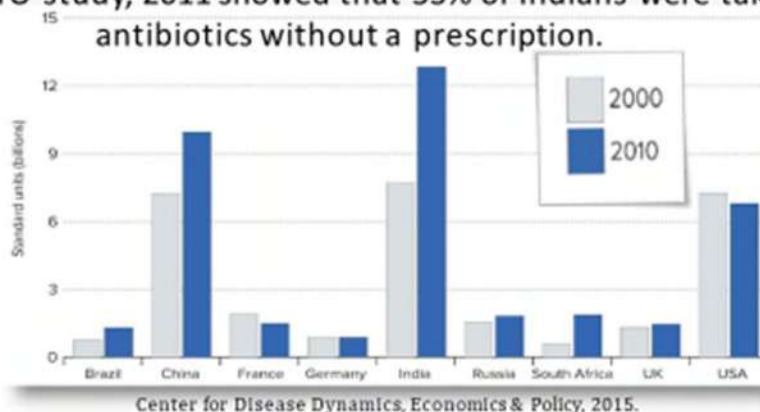
Background Cont..

- Challenging factors that contribute to the AMR burden in India include-
 - a high prevalence of infectious diseases,
 - incompatible IPC practices,
 - easy access to antibiotics without prescriptions,
 - lack of awareness,
 - limited laboratory resources for disease-based diagnosis etc.
- In 2010, India was the largest user of antimicrobials among the BRICS (Brazil, Russia, India, and China) countries.

1. Background and Objectives

TOTAL ANTIBIOTIC CONSUMPTION IN 2000 AND 2010

WHO study, 2011 showed that 53% of Indians were taking antibiotics without a prescription.



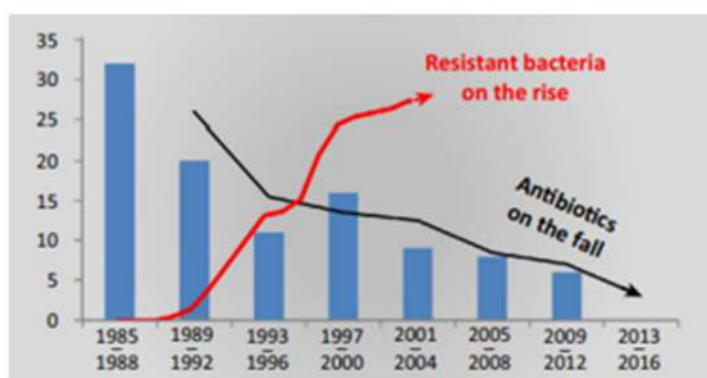
1. Background and Objectives

Fallout of such antibiotic consumption

- Due to such high consumption of antibiotics, rising antimicrobial resistance is being witnessed across the globe.
- Under pressure to survive the antibiotics, bacteria develop resistance through one or more mechanisms described ahead.
- The issue of AMR is further complicated by the lack or slow development of newer classes of antibiotics.

1. Background and Objectives

Rise of Antimicrobial Resistance



Adapted from: Schallerie TF, Hack IM. Overcoming the current deadlock in antibiotic research. Trends Microbiol. 2014 Apr;22(4):165-7. doi: 10.1016/j.tmic.2013.12.007. PMID: 24686433.

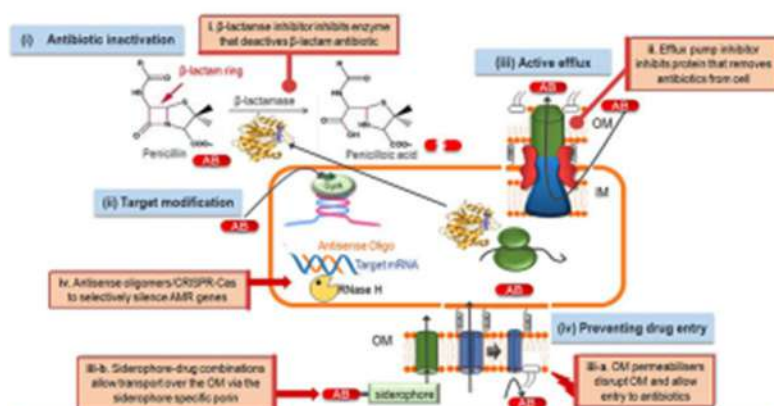
1. Background and Objectives

Innovation Gap



Adapted from: Huchings M, Travers A, Winkler R. Antibiotics: past, present and future. Curr Opin Microbiol. 2019 Oct;51:72-80. doi: 10.1016/j.coi.2019.10.008. Epub 2019 Nov 25. PMID: 31755402.

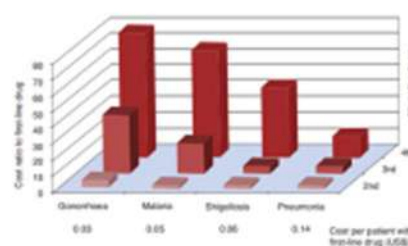
1. Background and Objectives



1. Background and Objectives

The Evolving threat of AMR

- Moving towards Post Antibiotic era
- Simple infections like Sore throat, ear infection, urinary tract infection, Tuberculosis and Malaria are becoming incurable.
- Longer treatment /Hospital stay-Financial burden
- Higher chances of treatment failure and death
- As per GRAM project Drug resistant infections were the leading cause of deaths world wide in 2019.



Adapted from: The evolving threat of antimicrobial resistance: Options for action, WHO, 2012

1. Background and Objectives

GAP-AMR

- In Year 2015, understanding the gravity of the problem of AMR, the World Health Assembly (WHA) has adopted the GAP on AMR including antibiotic resistance in collaboration with WHO, Food & Agricultural Organization (FAO) & World Organization for Animal Health (OIE)
- In February 2016, an International Conference "Combating AMR A Public Health Challenge & Priority" was organised by Government of India & WHO
- In May 2017, the WHO Resolution urges Member States to align NAP on AMR with GAP-AMR

1. Background and Objectives

AMR Global Action Plan (GAP)



- Adopted by World Health Assembly in May 2015
- Technical blueprint on **what to do**
 - Consolidates global scientific consensus & draws upon countries, FAO, OIE, civil society & others
- Reflects **stepwise approach** recognizing countries have different starting points, priorities



The goal of the plan is to ensure continuity of successful treatment and prevention of infectious diseases with effective and safe medicines that are quality assured, used in responsible way and accessible to all who need them-

1. Background and Objectives

NAP-AMR

- The Core Working Group notified by MoHFW drafted "National Action Plan on AMR" (NAP-AMR)
- The Strategic Objective of NAP-AMR are aligned with the GAP based on National needs & priorities
- In addition to the 5 priorities of GAP- AMR
- India has a **India specific sixth priority** including International, National and Sub-national Collaboration on AMR.

1. Background and Objectives

National Action Plan on AMR (NAP-AMR)

- Developed by Ministry of Health and Family Welfare which needs to be launched across the country so as to bring about an alignment with the Global Action Plan on AMR with a "One Health" approach.
- The NAP-AMR Strategic intervention activity (1.2.1.1; 1.2.1.4 & 4.6.1.1) under NMC, can be accessed at <http://www.ncdc.gov.in/writeReadData/linkimages/AMR/File545.pdf>
- NAP-AMR released in April 2017;
Cover all five objectives as listed in GAP-AMR and adds an additional objective related to strengthening India's Leadership on AMR



1. Background and Objectives

Alignment of NAP-AMR and GAP-AMR

National action Plan on AMR (NAP-AMR): 6 strategic priorities



The 5 objectives outlined in the GAP-AMR, along with India specific one additional objective

1. Background and Objectives

Strategy 1. Improve awareness and understanding of AMR through effective communication, education and training

Objective 1.2 Improve knowledge and capacity of key stakeholders regarding AMR and related topics.

Strategic intervention and activity

1.2.1 Strengthen and consolidate AMR and related topics as core components of professional education and training.

- 1.2.1.1. Review and revise curricula of professionals in human health
- 1.2.1.4. Review and develop curriculum and resources for in-service training of different professionals and allied services
- Develop a module on AMR to bring together the segmented knowledge being imparted under different subjects (Microbiology, Pharmacology, Medicine, PSM, etc.)

Key outputs

- Professional curricula revised
- Training module developed on AMR (of in-service and pre-service trainings)

1. Background and Objectives

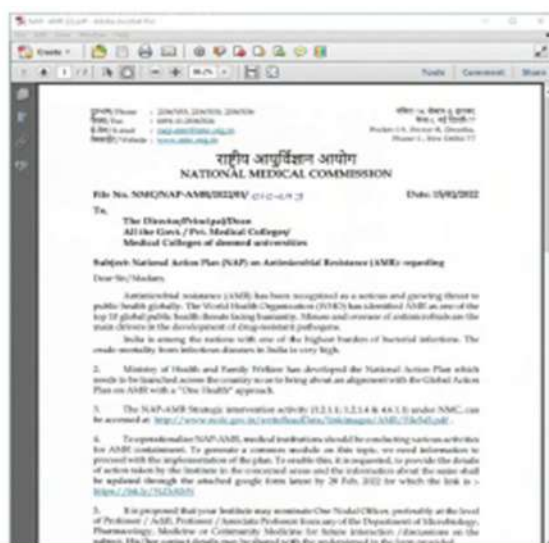
Strategy 4. Optimize the use of antimicrobial agents in health, animals and food.

Objective 4.6 Improve knowledge and skills of prescribers, dispensers and medical trainees.

Strategic intervention and activity-

- 4.6.1. Develop structured (and mandatory) training programmes on optimal antimicrobial use
- 4.6.1.1. Collaborate with regulatory bodies to mandate periodic training to optimise antibiotic use through pre-service and in-service trainings.

1. Background and Objectives

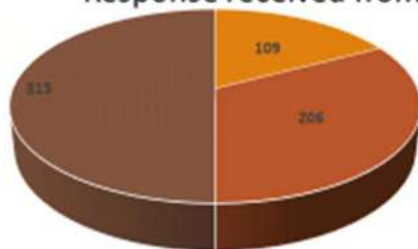


Circulated to all Medical colleges & INIs on 15.02.2022 to-

- Collect base line ongoing AMR activities in Medical Colleges & INIs
- Nomination of the Nodal officer from Microbiology/ Pharmacology/ Medicine/ Community Medicine of each Medical Colleges & INIs

1. Background and Objectives

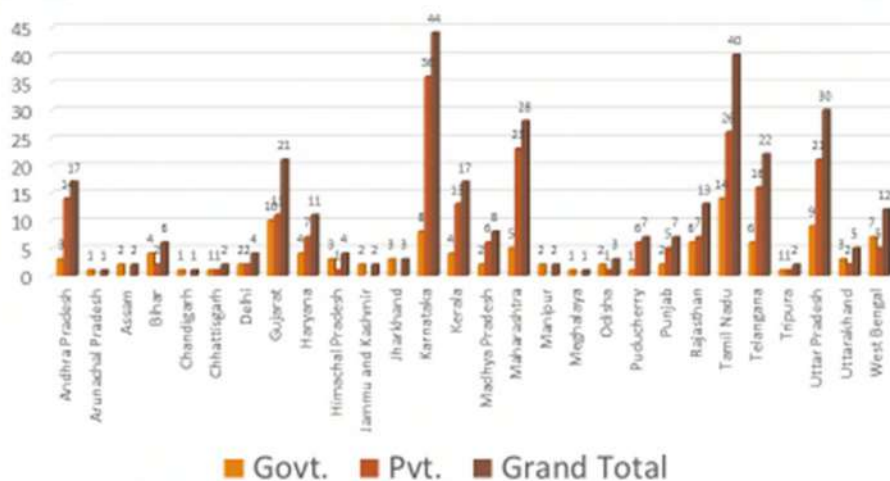
Response received from Govt. & Pvt Medical Colleges



■ Govt. ■ Pvt. ■ Grand Total

- Circular sent to 606 Medical Colleges
- More than 350 responses received
 - 127 Government Medical Colleges
 - 223 Private Medical Colleges

1. Background and Objectives

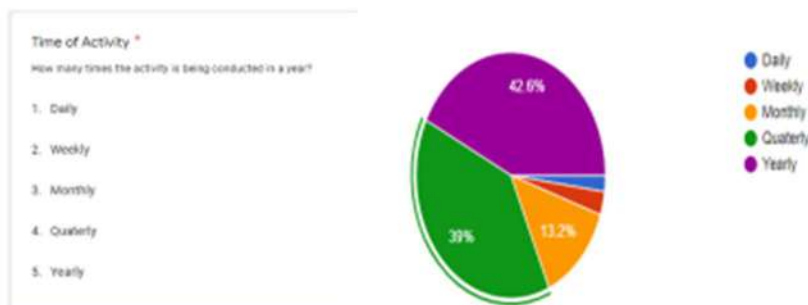


■ Govt. ■ Pvt. ■ Grand Total

Response received from different States

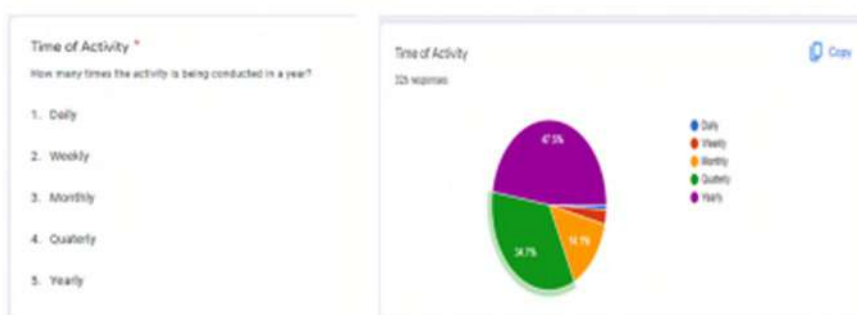
1. Background and Objectives

Objective 1. To Improve awareness and understanding of AMR among Undergraduate, Postgraduate students, and Teaching professionals



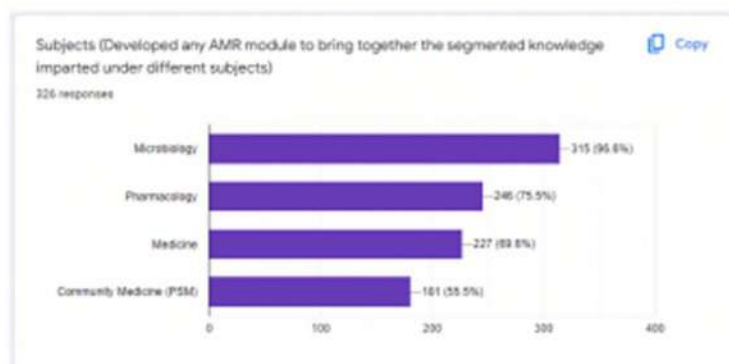
1. Background and Objectives

2. To Improve awareness and understanding of AMR among Allied Health professionals



1. Background and Objectives

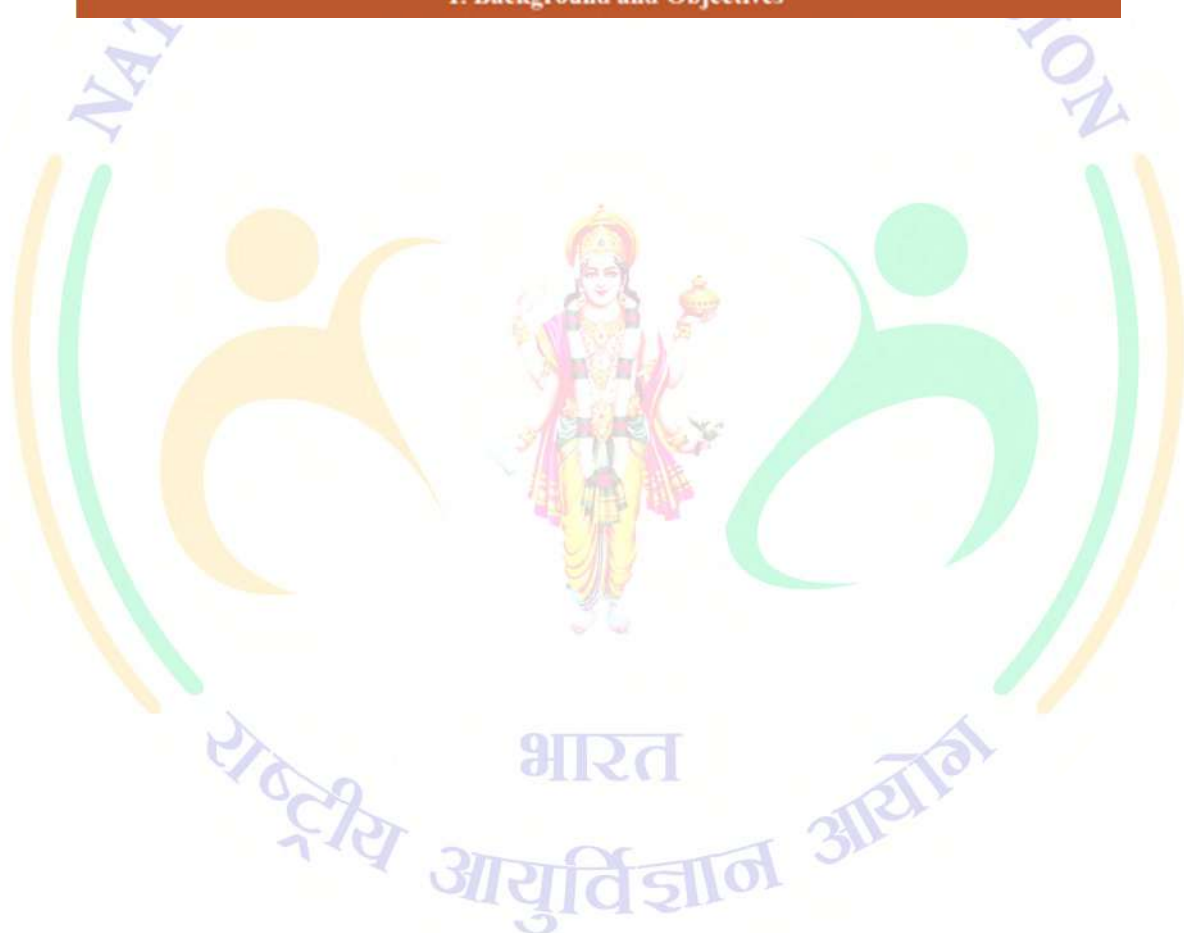
3. Developed any AMR module to bring together the segmented knowledge imparted under different subjects



1. Background and Objectives

THANK YOU

1. Background and Objectives



Clinical Approach to prescribing antimicrobials

NMC NAP-AMR Module for Prescribers

2. Clinical Approach to prescribing antimicrobials

Learning Objectives

At the end of the session, a prescriber should be able to:

- Identify common presentations of infective syndrome
- Know the importance of taking thorough history, clinical examinations and selection of appropriate investigations for diagnosis of infective disease.

2. Clinical Approach to prescribing antimicrobials

Introduction

The Miracle Maker Sir Alexander Fleming

- Discovered Penicillin in 1928 and Predicted Antimicrobial Resistance.
- The greatest possibility of evil in self-medication is the use of too small doses so that instead of clearing up infection, the microbes are educated to resist penicillin and a host of penicillin-fast organisms is bred out which can be passed to other individuals and from them too other until they reach someone who gets a septicemia or a pneumonia which penicillin cannot save.

Sir Alexander Fleming



2. Clinical Approach to prescribing antimicrobials

Introduction cont...

Decision to Start Antimicrobials is like using "Your most powerful weapon"

- ✓ Identification of the clinical problem
- ✓ Symptoms and signs and the common patterns of presentation of different diseases. (**Syndromic approach**) (URI, LRTI, UTI, Meningitis, Diarrhoea, Skin and Soft tissue infections etc.
- ✓ Making a differential diagnosis at the bed side
- ✓ Use rapid diagnostic tests
- ✓ Wrong diagnosis/wrong antimicrobial will increase AMR



2. Clinical Approach to prescribing antimicrobials

Introduction cont....

Decision to Start Antimicrobials

- ✓ Too small doses can increase AMR
- ✓ Once Antimicrobial started, its immediate withdrawal will increase AMR
- ✓ Clinicians should be aware of side effects and drug interactions
- ✓ Use of broad spectrum antibiotics like fluoroquinolones can cause collateral damage and can impact future treatment options
- ✓ Unnecessary use of fluoroquinolones may be the reason for increased number of pre-XDR TB in India.

2. Clinical Approach to prescribing antimicrobials

Localization of fever

LOCALIZATION	NO LOCALIZATION
• Acute rheumatic fever • Hepatitis • Meningitis • H1N1 • Pneumonia • Urinary tract infection • Infective endocarditis • Tuberculosis	• Infective endocarditis • Tuberculosis • Enteric fever • Brucellosis • Malaria • Dengue • Scrub typhus • Leptospirosis

2. Clinical Approach to prescribing antimicrobials

It is important to identify *Organ involved and Organism responsible* to treat with appropriate antibiotic for right duration

ORGAN OR SITE OF INFECTION

- **Upper Respiratory Tract Infections:**
 - Strep throat: full 10 day oral therapy
 - Rhino viral: none
 - H1N1: Antiviral
- **Meningitis:** 14 day therapy
- **Infective Endocarditis:** 6-8 weeks therapy
- **Community Acquired Pneumonia:** 2 weeks therapy

ORGANISMS CAUSING PNEUMONIA

- M. tuberculosis: 6 months
- Nocardia: 12 months
- Melioidosis: 6 months

2. Clinical Approach to prescribing antimicrobials

Empirical use of Antimicrobials may be needed in the presence of Red Flag Signs

- Sepsis/ Septicaemic shock
- Organ dysfunction
- Altered mental state
- Pregnancy
- Immunocompromised
 - Neutropenic
 - On steroids
 - Diabetes
 - Connective tissue disease
 - CRF and CLD

2. Clinical Approach to prescribing antimicrobials

History and host factors

- Past hospital admissions
- Comorbidities -DM
- COPD, Tuberculosis, compliance to ATT
- Bronchial asthma
- Drug abuse
- Recent travel
- Blood transfusions
- Recurrent infections
- Surgical interventions
- Immunocompromised state
- Pregnancy
- Extremes of age
- Cancer
- Occupation
- Exposure to pets
- Look at old records

2. Clinical Approach to prescribing antimicrobials

Physical examination and signs of organ dysfunction

An important part of the evaluation of a patient with fever is to arrive at a diagnosis:

- An eschar on general physical examination pinpoints the diagnosis of scrub typhus
- Maculopapular rash can be part of dengue fever
- A murmur on CVS examination can point towards an infective endocarditis
 - Tachycardia
 - Tachypnea
 - Raised JVP
 - Percent Saturation
 - Hypotension
 - Altered sensorium
 - Anuria

Discourage antibiotic prescription over telephone as we can miss vital information

2. Clinical Approach to prescribing antimicrobials

Assessment

- Organ system involvement
- Organism
- Host factors (DM, steroids, immunosuppression, splenectomy, special situations)
- Clinically patient stable or not
- General physical examination- pallor, cyanosis, clubbing, lymph nodes, rash, jaundice, pedal edema, koilonychia, rash, eschar
- Diagnosis at initial evaluation
- Differential diagnosis

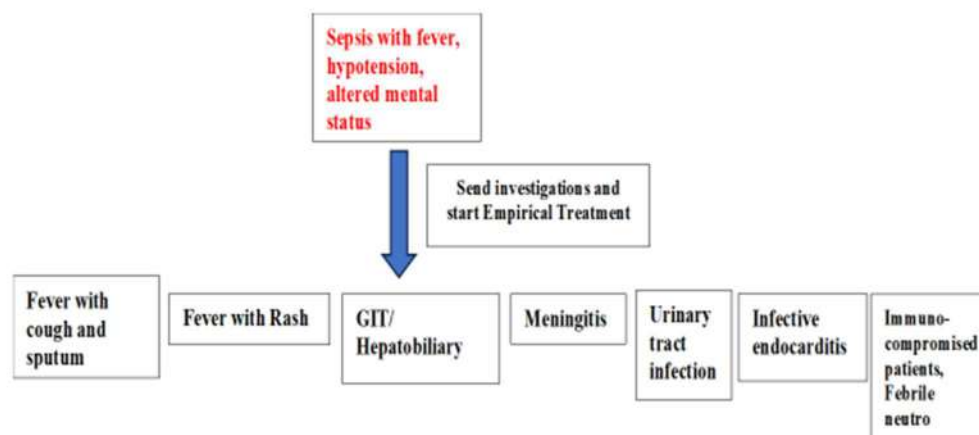
2. Clinical Approach to prescribing antimicrobials

The communication between the clinicians and laboratory is vital.

- ✓ Clinicians should be aware of rapid diagnostic tests and use them appropriately.
- ✓ Blood cultures should be sent before starting IV antibiotics.
- ✓ The positive diagnostic tests and culture reports must be conveyed by phone to clinicians so that the therapeutic interventions can be made in desired time frame.
- ✓ The decision of starting antibiotics empirically should be governed by the local epidemiology and hospital antibiograms.

2. Clinical Approach to prescribing antimicrobials

Syndromic Approach to Acute Febrile Illness



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i) Fever with rash



Rash of dengue: islands of white in a sea of red

Infectious Causes:

- Dengue Fever: Common viral infection characterized by sudden onset high grade fever, headache, backache, joint pain, muscle pain and rash. We need to establish diagnosis early and avoid antibiotics.
- Chikungunya fever: fever, severe arthralgias and myalgias and rash
- Chickenpox (Varicella): Fever, malaise and a rash that starts as red spots and progresses to vesicles. This is mostly a clinical diagnosis, early antivirals can reduce morbidity.
- Measles and Rubella are not common as they are prevented effectively by vaccines in childhood.

2. Clinical Approach to prescribing antimicrobials

Fever with Rash

Infectious Causes cont....

- **Rickettsial Diseases:**
Various infections such as Scrub Typhus and Q fever can present with fever and rash.
- **Bacterial Infections:**
 - Meningococemia: Infection with *N. meningitidis* can cause fever, headache, and a petechial rash.
 - Lyme Disease: Caused by *B. burgdorferi* transmitted by ticks, it presents with fever, headache, and a characteristic bull's eye rash (erythema migrans).
 - Toxic Shock Syndrome: Associated with certain bacterial infections or tampon use, it presents with fever, rash, and other systemic symptoms.

Non-Infectious Causes:

- Drug Reactions: Stevens-Johnson syndrome or Drug Reaction with Eosinophilia and Systemic Symptoms (DRESS).
- Autoimmune Diseases: Conditions like lupus erythematosus or Kawasaki disease

2. Clinical Approach to prescribing antimicrobials

Case 1

A 35yr, male TV cable operator from a village in Telangana

History

- Fever
-2wks, high grade, associated with chills and rigors, intermittent.
- H/o cough with no expectoration.
- No h/o chest pain, or shortness of breath.
- No h/o rash, vomiting or pain abdomen, dysuria.
- No h/o seizures, loss of consciousness.
- Not a diabetic or hypertensive.

Examination

- Well built and well nourished
- Faint maculopapular rash was noted on trunk
- No pallor, cyanosis, clubbing, lymphadenopathy
- Vitals stable, febrile, mild confusion
- Systemic examination normal

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Management

- Haemogram showed mild thrombocytopenia
- Urine examination was normal
- Serum creatinine 1.2mg/dl
- RBS 109mg/dl
- Chest radiograph Normal
- ECG Normal
- MP and PF were negative
- Dengue NS1 Ag and Ab negative

DD

Dengue fever

Leptospirosis

Pneumonia with sepsis

- Started on IV antibiotics Inj Ceftriaxone 1 gram IV BD
- Paracetamol
- Rabeprazole

However

- Delirious, sick looking, hypotension,
- Respiratory system
-Tachypnea
-Revealed bilateral crepitations more on right side.
- SpO₂ on room air-89%
- No focal neurologic deficits noted.
- Developed hematuria and malena.

2. Clinical Approach to prescribing antimicrobials

Laboratory Investigations

- RBS 122mg/dl
- Serum Creatinine 1.5 mg/dl
- SGOT 363 IU/dl
- SGPT 278 IU/dl
- ALP 345 IU/dl
- Total bilirubin - 2.2
—Conjugated bilirubin 1.2
- S protein 5.5 g/dl, S Alb 2.9
- TT 9 sec
- Fibrinogen 241 mg/dl
- D dimer 10.79
- PT 14 sec
- APTT 31
- Platelets 20,000
- Pf HRP2 -negative
- NS1 antigen was negative
- Dengue serology was done thrice-negative
- Blood culture –sterile
- Urine culture sterile
- Serology for Brucella abortus and melitensis- negative
- Leptospira serology - negative
- ASO titre <200
- Urine culture -no growth
- Second set of blood culture negative
- IgM RF 55(normal <40)
- ANA- negative

2. Clinical Approach to prescribing antimicrobials

Final Diagnosis

- Hepatitis
- Thrombocytopenia-bleeding manifestations
- Delirium
- Pneumonia
- Renal failure

Final clue

- Weil felix
 - OX K- 1:320
 - OX 2- 1:80
 - Ig M scrub

Final Diagnosis: Scrub typhus

Doxycycline 100mg twice daily for 7 to 15days

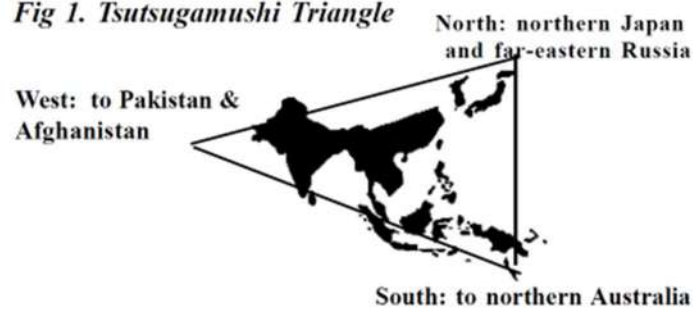
Eschar in a case of pneumonia



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Geographic Distribution

Fig 1. Tsutsugamushi Triangle



An estimated one billion people are at risk for scrub typhus and one million cases occur annually

2. Clinical Approach to prescribing antimicrobials

Eschar from the bite of a Leptotrombidium mite.

Eschar in Scrub typhus



(b) High-power photomicrograph (original magnification, $\times 400$, hematoxylin-eosin stain) shows dermal vasculitis with perivascular infiltrates that consist mostly of lymphocytes and macrophages.

Eschar from the bite of a *Leptotrombidium* mite.
(a) Photograph shows an epidermal ulcer covered by a black crust surrounded by an erythematous halo.

Jeong Y J et al. Radiographics 2007;27:161-172

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2. Clinical Approach to prescribing antimicrobials

ii) Fever with Jaundice

- ✓ **Viral Hepatitis:** Hepatitis A, B, C and E viruses
- ✓ **Malaria**
- ✓ **Leptospirosis**
- ✓ **Typhoid Fever**
- ✓ **Scrub typhus**
- ✓ **Acute Biliary Tract Infections**
- ✓ **Every patient of jaundice do not require antimicrobials.**
- ✓ **Their blood sample should be sent to laboratory** for identifying hepatotropic virus.
- ✓ **Conditions like leptospirosis and acute biliary tract infections** are emergencies and should be treated with appropriate antibiotics.

2. Clinical Approach to prescribing antimicrobials

Liver Abscess

The most frequent **symptoms** of hepatic abscess include the following:

- Fever (either continuous or spiking), Chills, Right upper quadrant pain
- Anorexia, Malaise, Cough or hiccoughs due to diaphragmatic irritation.
- Referred pain to the right shoulder
- Individuals with solitary lesions usually have a more insidious course with
 - weight loss
 - anemia of chronic disease.
- With such symptoms, malignancy often is the initial consideration.
- Fever of unknown origin (*FUO*) frequently can be an initial diagnosis in indolent cases.

2. Clinical Approach to prescribing antimicrobials

Liver Abscess cont....

Clinical signs:

- Fever and tender hepatomegaly -most common.
- Mid epigastric tenderness, with or without a palpable mass, is suggestive of left hepatic lobe involvement.
- Decreased breath sounds in the right basilar lung zones, with signs of atelectasis and effusion on examination or radiologically, may be present.
- **pleural or hepatic friction rub** due to diaphragmatic irritation and inflammation of Glisson's capsule.
- **Jaundice** may be present in as many as 25% of cases and usually is associated with biliary tract disease or the presence of multiple abscesses

2. Clinical Approach to prescribing antimicrobials

Liver Abscess cont...

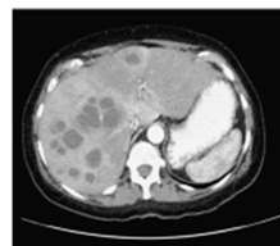
Investigations:

- Random blood sugar, CBC
- LFT
 - Elevation of alkaline phosphatase (most common liver function abnormality)
 - Hypoalbuminemia
- Elevations of transaminase and bilirubin level
- CT and ultrasound – modalities of choice and help distinguish from tumors, hemangiomas and cysts.
- CT or ultrasound-guided aspiration should be sent for *gram stain and culture*.
- Pyogenic abscesses are more common than amebic liver abscess
- Common organisms causing liver abscesses are E.coli, Klebsiella, pseudomonas, proteus, streptococcus, enterococci and staphylococci.
- Send blood cultures as they are positive in roughly 50% of cases
- Isolation of unusual organisms like *Burkholderia Pseudomallei* needs a prolonged treatment.

2. Clinical Approach to prescribing antimicrobials

Liver Abscess cont...

- Hepatic abscesses are usually hypodense on a CT scan and may display a rim of contrast enhancement in less than 20% of cases.
- **Percutaneous needle aspiration** Under CT scan or ultrasound guidance, needle aspiration of cavity material can be performed. Diagnostic + therapeutic.
- **Percutaneous drainage** has become the *standard of care* and should be the first intervention considered for small cysts (Seldinger or trochar technique).
- Pus should be sent for culture and sensitivity and started on antibiotics



CT abdomen showing pyogenic abscess

2. Clinical Approach to prescribing antimicrobials

Malaria

CLINICAL FEATURES

- Fever with chills and Rigors associated with headache occasionally altered sensorium
- Examination: Pallor, icterus, enlarged liver or spleen
- Labs: anemia, leucopenia and thrombocytopenia
 - **Rapid diagnostic tests:** HRP2, LDH and aldolase are produced by parasite from ring to trophozoite stage.
 - **pLDH pan detects all species**
Rapid test for Plasmodium vivax-(pLDH)
Sensitivity-77%, Specificity-98%
 - **Rapid test** for plasmodium falciparum- based on histidine-rich protein 2 (HRP2)- high positive predictive and negative predictive values.
Sensitivity-98%, Specificity-88%

COMPLICATIONS

- **Cerebral malaria, DIC, ATN, ARDS and Severe hemolysis.**
- Jaundice 2.5% in severe malaria with falciparum infection but hepatitis is unusual.
- Micro occlusion of portal venous branches by parasitized red blood cells, intrahepatic cholestasis due to reticuloendothelial blockage hepatic microvillus dysfunction
- Elevated serum bilirubin (conjugated fraction which is dominant in patients with hepatopathy)

2. Clinical Approach to prescribing antimicrobials

Management

Empiric management is some times inevitable but should not be routine

- Chloroquine combined with primaquine is the treatment of choice for chloroquine-sensitive infections.
- Uncomplicated PF Malaria-artemether plus lumefantrine, Artesunate plus amodiaquine, artesunate plus mefloquine, and artesunate plus sulfadoxine-pyrimethamine.
- Artesunate plus tetracycline or doxycycline or clindamycin; any of these combinations to be given for 7 days
- Quinine plus tetracycline or doxycycline or clindamycin; any of these combinations should be given for 7 days.
- **Artemisinin and its derivatives should not be used as monotherapy.**

2. Clinical Approach to prescribing antimicrobials

Enteric Fever

- Systemic infection with the *Salmonella typhi* or *S. paratyphi*.
- Transmission via food or beverages handled by an individual who chronically sheds the bacteria through stool or less commonly, urine.
- Hand-to-mouth transmission after neglecting hand hygiene.
- Oral transmission via sewage-contaminated water or eating shellfish.
- Incubation period 7-14days (3-21 days).
- The most prominent symptom is prolonged fever (101.8°–104.9°F), which can continue for up to 4 weeks if untreated.
- Many a times no specific localization of fever, sometimes associated with gastrointestinal manifestations in the form of loose motions, constipation, anorexia, nausea and abdominal pain.
- Other symptoms include headache, chills, cough, sweating, rarely arthralgia.

2. Clinical Approach to prescribing antimicrobials

Enteric Fever cont.....

PHYSICAL FINDINGS

- Mild pallor, Splenomegaly, Abdominal tenderness
- At approximately the end of the first week of illness, the fever plateaus at 103-104°F (39-40°C).
- The patient develops rose spots, which are salmon-colored, blanching, truncal, maculopapular usually 1-4 cm wide, generally resolve within 2-5 days.
- During the second week of illness, the signs and symptoms progress.
- Relative bradycardia and rarely infective endocarditis
- Gastrointestinal bleeding and intestinal perforation most commonly occur in the third and fourth weeks of illness.
- Neurologic manifestations- meningitis, Guillain-Barré syndrome and neuropsychiatric symptoms.

COMPLICATIONS

- Disseminated intravascular coagulation
- Hematophagocytic syndrome
- Hepatic and splenic abscesses and granulomas
- Endocarditis, pericarditis, myocarditis
- Hepatitis
- Glomerulonephritis
- Pyelonephritis
- Severe pneumonia
- Severe sepsis and death

2. Clinical Approach to prescribing antimicrobials

Diagnosis & Treatment

Culture:

- Blood culture is the preferred method of diagnosis. A single culture is positive in only ≈50% of cases, however multiple blood cultures increase the sensitivity
- Bone marrow culture is more invasive (and therefore less commonly performed), it increases the sensitivity to ≈80% of cases and is relatively unaffected by previous or concurrent antibiotic use.
- Stool culture is not usually positive during the first week of illness and has less diagnostic sensitivity than blood culture.
- Urine culture has a lower diagnostic yield than stool culture.

2. Clinical Approach to prescribing antimicrobials

Diagnosis & Treatment cont...

- **Rapid diagnostic tests:** available for typhoid fever, but their sensitivity and specificity are not optimal.
- The Widal test measures elevated antibody titers; it is unreliable but widely used because of its low cost.
- Serologic tests do not distinguish acute from past infection or vaccination and lack specificity; thus, blood culture remains the preferred method to diagnose acute infections.

Treatment:

- Includes Intravenous ceftriaxone 1 gram IV twice a day for 14 days or switch to oral medicines as per susceptibility reports.
- All strains that have intermediate susceptibility to fluoroquinolones on disk testing (as defined by national guidelines) should be considered fluoroquinolone-resistant.

2. Clinical Approach to prescribing antimicrobials

iii) Fever with Neurologic Manifestations

- ❖ **Meningitis:**
Triad of Fever, severe headache, neck stiffness, altered mental status, photophobia, seizures, abnormal movements, weakness of limbs, behavioural changes, nausea, vomiting -Raised ICT causes altered sensorium
- ❖ Etiology: bacterial- *S.pneumoniae*, *N.meningitidis*, Gr B streptococci, *Listeria spp* and *H. influenzae*.
- ❖ Viral, Rickettsial, fungal infections, Tubercular (TBM can have acute presentation)
- ❖ Medical emergency-Ct brain and MRI
- ❖ Diagnosis by CSF examination
 - ❖ PMN >100 cells/μl
 - ❖ Decreased glucose
 - ❖ Increased protein
 - ❖ Increased opening pressure
 - ❖ Grams stain and CS

2. Clinical Approach to prescribing antimicrobials

Fever with Neurologic Manifestations cont...

- ❖ **Encephalitis:** Inflammation of the brain: Bacterial, Rickettsial infections like **scrub typhus**, Diphtheria, viral infections such as Herpes simplex virus, Japanese Encephalitis virus rarely rabies
- ❖ **Cerebral Malaria:** a severe form of malaria
P. falciparum can be diagnosed early by rapid diagnostic tests, malarial parasite in the blood smear and initiate of antimalarials appropriately

2. Clinical Approach to prescribing antimicrobials

iv) Fever with Respiratory Symptoms

- Common respiratory symptoms include: Fever, throat pain, cough, running nose, sputum, breathlessness, haemoptysis, chest pain.
- Associated symptoms like wheezing, fatigue may be present
- Common aetiologies - influenza, RSV, Rhino, adeno or COVID 19.

Most of the respiratory illnesses do not require antimicrobials.

However respiratory viral infections can cause lower respiratory infections

- Diagnosis by nasal swab for RTPCR
- Treatment : Oseltamivir for Influenza,
- Specific antivirals for COVID 19
- Streptococcal pharyngitis needs antibiotics
- Throat swab for aerobic culture can identify organism



2. Clinical Approach to prescribing antimicrobials

Categorization of Pneumonia by Clinical Setting

Community-acquired pneumonia	Typical (i.e. classic) pneumonia	Nosocomial pneumonia	Hospital-acquired pneumonia
	Atypical pneumonia		Ventilator-associated pneumonia (VAP)
	Aspiration pneumonia		Healthcare-associated pneumonia (HCAP)
Pneumonia in the elderly	Community acquired pneumonia	Cystic fibrosis and anatomic disorders	Bronchopulmonary sequestration, tracheomalacia, or bronchomalacia
	Nursing home residents		

2. Clinical Approach to prescribing antimicrobials

Categorization of pneumonia by causative agents

Typical pneumonia	Atypical pneumonia
Streptococcus pneumonia (M/C)	Legionella spp
Haemophilus influenza	Mycoplasma pneumoniae
Moraxella catarrhalis	Chlamydia pneumoniae
Staphylococcus aureus	Chlamydia psittaci
Aerobic gram negative bacteria (E.coli, Klebsiella...)	Coxiella burnetii
Micro-aerophilic bacteria and anaerobes	Respiratory viruses- influenza-A,B; parainfluenza virus, SARS-CoV2, Rhinovirus, Adenovirus, Respirator syncytial virus, Human metapneumo/boca virus

2. Clinical Approach to prescribing antimicrobials

Clinical & Investigational findings of Typical vs Atypical Pneumonia

Pneumonia	Atypical	Typical
Clinical course	Subacute onset Protracted disease	Abrupt onset
Symptoms	Extrapulmonary and pulmonary (flu-like illness, myalgias, rhinorrhea, odynophagia, diarrhea, prominent headache) Dry cough; scant sputum	Confined to the lung, Pleuritic chest pain Productive cough with colored sputum
Leucocytosis	Absent	Present
Gram stain, blood and sputum cultures	No evidence of a pathogen	<i>S. pneumoniae</i> (or <i>K. pneumoniae</i> , <i>S. aureus</i> ...)
Chest X-ray	Patchy, ill-defined infiltrates, scattered on both lungs	Lobar pneumonia, pleural effusion
Prognosis	Often favorable, even without antibiotics	Significant mortality despite penicillin

2. Clinical Approach to prescribing antimicrobials

Chest x-ray findings



Lobar pneumonia – Strep pneumoniae



Bronchopneumonia – Staph. Aureus



Interstitial pneumonia - PCP



Miliary pneumonia - TB



Nodular infiltrates – Round pneumonia – Septic emboli

2. Clinical Approach to prescribing antimicrobials

Community Acquired Pneumonia -OPD based treatment

STATUS	STANDARD REGIMEN
No co-morbidities or risk factors for antibiotic resistance ^a	Combination therapy with amoxicillin (1 g tid) + either a macrolide ^b or doxycycline (100 mg bid) Or Monotherapy with doxycycline (100 mg bid) Or Monotherapy with a macrolide ^{b,c}
With comorbidities ^d ± risk factors for antibiotic resistance ^a	Combination therapy with Amoxicillin/clavulanate ^e or a cephalosporin ^f + either a macrolide ^b or doxycycline (100 mg bid) Or Monotherapy with a respiratory fluoroquinolone ^g

^aAntibiotic treatment within the past 3 months or contact with the health care system. ^bAzithromycin (500 mg on day 1, then 250 mg/d for 4 days), clarithromycin (500 mg bid), or clarithromycin ER (1000 mg/d). ^cIf local prevalence of pneumococcal resistance is <25%. ^dIncluding chronic heart, lung, liver, or kidney disease; diabetes mellitus; alcoholism; malignancy; or asplenia. ^e500/125 mg tid or 875/125 mg bid. ^fCefpodoxime (200 mg bid) or cefuroxime (500 mg bid). ^gLevofloxacin (750 mg/d), moxifloxacin (400 mg/d), or Gemifloxacin (320 mg/d).

2. Clinical Approach to prescribing antimicrobials

Community Acquired Pneumonia –Inpatient treatment

DISEASE SEVERITY, RISK STATUS	REGIMEN
Non-severe	
No risk factors	A β-lactam ^a + a macrolide ^b or A respiratory fluoroquinolone ^c
Prior respiratory isolation	Add coverage for MRSA ^d or Pseudomonas aeruginosa ^e
Recent hospitalization, antibiotic treatment, ± LV ^f	Add coverage for MRSA ^d or P. aeruginosa ^e only if cultures are positive
Severe	
No risk factors	A β-lactam ^a + a macrolide ^b or A β-lactam ^a + respiratory fluoroquinolone ^c
Prior respiratory isolation	Add coverage for MRSA ^d or P. aeruginosa ^e
Recent hospitalization, antibiotic treatment ± LV ^f	Add coverage for MRSA ^d or P. aeruginosa ^e

^aAmpicillin-sulbactam (1.5-3 g q6h). ^bAzithromycin (500 mg/d) or clarithromycin (500 mg bid). ^cLevofloxacin (750 mg/d), moxifloxacin (400 mg/d), or Gemifloxacin (320 mg/d). ^dVancomycin (15 mg/kg q12h, with adjustment based on serum levels) or linezolid (600 mg q12h). ^ePiperacillin-tazobactam (4.5 g q6h), cefepime (2 g q8h), ceftazidime (2 g q8h), imipenem (500 mg q6h), meropenem (1 g q8h), or aztreonam (2 g q8h). ^fObtain cultures. MRSA rapid nasal PCR can also be used if available. Abbreviations: LV, local validation (local prevalence, resistance, risk factors); MRSA, Methicillin-resistant Staphylococcus aureus.

2. Clinical Approach to prescribing antimicrobials

v) Fever with GI symptoms: Acute Gastroenteritis

- History of recent travel.
- Recent consumption of potentially unsafe food.
- Recent antibiotic exposure (risk of C. difficile).
- Immunosuppression.
- Organisms (bacterial, parasitic or viral)
- Investigations: Stool culture, Stool microscopy (for parasites), Vibrio cholerae antigen (e.g. in outbreaks), Test for C. difficile (if recent antibiotic exposure)
- Treatment: Rehydration and electrolyte replacement is the main treatment for acute infectious diarrhea.
- Antibiotics are needed only if host is immunocompromised or there is blood in stool due to shigella or amoebic dysentery.

2. Clinical Approach to prescribing antimicrobials

vi) Fever with Urinary Symptoms

- Uncomplicated UTI:
- **Cystitis:** Frequency of micturition, urgency, dysuria, haematuria and suprapubic discomfort.
 - Morning mid-stream urine sample should be collected and sent for microscopic and culture examination.
 - Antimicrobials may be initiated empirically in situations like pregnancy, diabetes and other immunocompromised conditions to be modified as per available reports.
 - Nitrofurantoin and Fosfomycin, TMP-SMX and quinolones.
- **Pyelonephritis:** Fever, flank pain, urinary symptoms, sometimes altered sensorium. Antibiotics have to be started in suspected cases after sending complete urine examination, urine culture and blood cultures.

2. Clinical Approach to prescribing antimicrobials

Fever with Urinary Symptoms cont....

- Organisms: E coli, Klebsiella, Proteus, Staphylococci and Enterococcus.
- Pyelonephritis can cause **Acute kidney injury (AKI) and sepsis.**
- Treatment: IV antibiotics-IV ceftriaxone, Piperacillin and tazobactam, Carbapenem.

AKI can be **caused by other Infectious agents:** Leptospirosis, Scrub typhus, Complicated malaria and gram negative bacterial infections.

- Autoimmune diseases like SLE affect kidney causing chronic kidney disease need to be differentiated.
- Clinicians should be aware of increasing number of ESBL producing organisms
- Avoid using quinolones like Levofloxacin and Moxifloxacin in our country.

2. Clinical Approach to prescribing antimicrobials

Acute febrile illness with CVS involvement

- Myocarditis,
- infective endocarditis,
- pericarditis,
- Kawasaki disease,
- viral haemorrhagic fevers- such as dengue fever, yellow fever, Ebola fever present with cardiovascular involvement including vascular leakage, haemorrhage and shock.

2. Clinical Approach to prescribing antimicrobials

Steps of antimicrobial prescription

- **Step 1:** Making a clinical diagnosis based on accurate history and clinical examination helps in selecting the right test for the right patient.
- A clinical diagnosis also helps in predicting most likely organism causing a clinical syndrome. The sample must be collected before the start of antimicrobials.
- **Step 2:** The empiric antibiotic therapy must be limited to seriously ill patients. This choice should be based upon institutional/local antibiograms.
- **Step 3:** Choose the appropriate antibiotic based on clinical evaluation and most likely pathogen keeping antibiogram in mind.

2. Clinical Approach to prescribing antimicrobials

THANK YOU

2. Clinical Approach to prescribing antimicrobials

भारत
राष्ट्रीय आयुर्विज्ञान आयोग

Microbiological Diagnostic Stewardship

NMC Module on AMR for Prescribers

3. Microbiological Diagnostic Stewardship

Learning Objectives

On completion of this chapter, the prescriber should be able to:

- define diagnostic stewardship
- understand the difference between infection and colonizers
- describe the sample collection techniques, precautions, transport and rejection criteria of common samples.

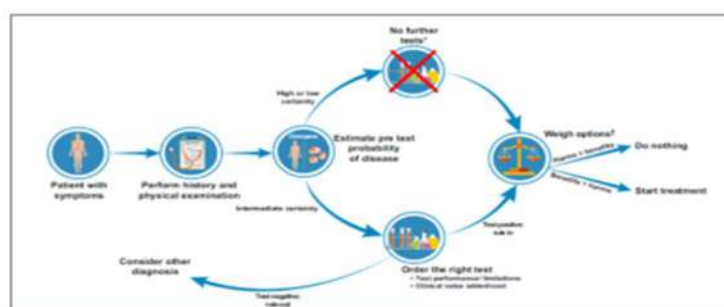
3. Microbiological Diagnostic Stewardship

What is Diagnostic Stewardship?

“Co-ordinated guidance and interventions to improve appropriate use of microbiological diagnostics to guide therapeutic decisions. It should promote appropriate, timely diagnostic testing, including specimen collection, and pathogen identification and accurate, timely reporting of results to guide patient treatment.”

Diagnostic stewardship means ordering the right tests for the right patient at the right time to ensure optimal clinical care.

3. Microbiological Diagnostic Stewardship



The 4 Ts of diagnostic stewardship

- Choosing the right **Test** for
- right **Type** of sample,
- collected at the right **Time**, in order
- to guide **Treatment** decisions.

<https://doi.org/10.1016/j.jmoldx.2020.06.012>

3. Microbiological Diagnostic Stewardship

Specimen collection: key issues

- Consider differential diagnoses.
- Decide on test(s) to be conducted.
- Decide on clinical samples to be collected to conduct these tests
 - consultation between Microbiologist & the Clinicians - a must.

3. Microbiological Diagnostic Stewardship

Correct sample for Correct report

- Appropriate selection of samples
- Proper collection
- Transport
- Turn-around time for laboratory investigations.
- Distinguish between viral and bacterial infection

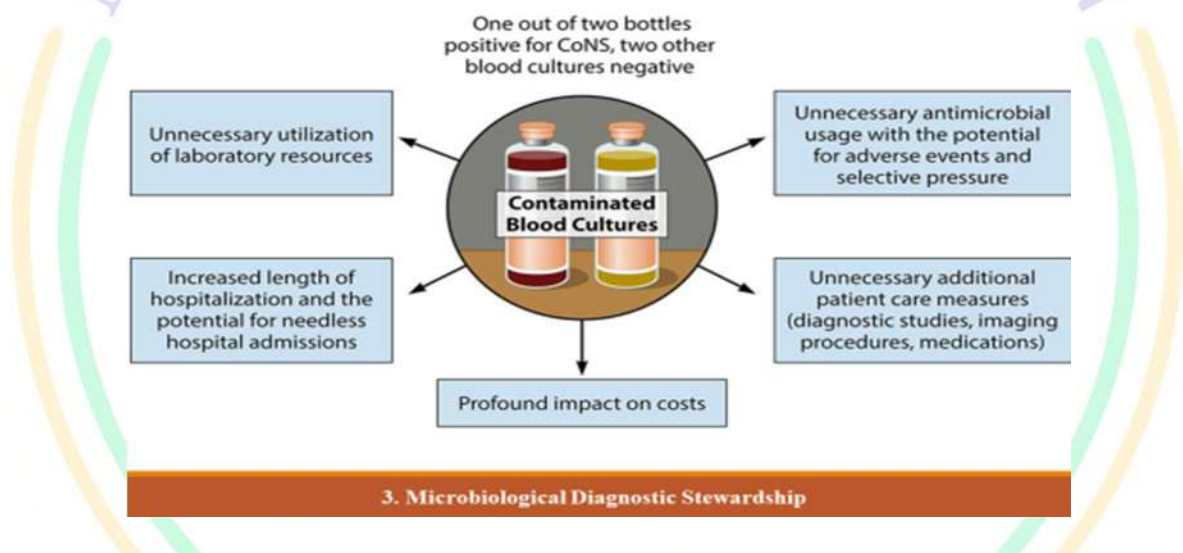
3. Microbiological Diagnostic Stewardship

General precautions while collecting samples

- **Bacterial culture** must be collected prior to antimicrobial therapy.
- Always choose **correct container** as per case definition.
- Collection should be done by **trained staff** after precise instructions to the patient.
- Transported **within 2 hours** after collection, in the correct package.
- Blood and CSF should never be refrigerated.
- All samples must be **accompanied by completely filled request form**.

3. Microbiological Diagnostic Stewardship

Aseptic Precautions



Infection v. colonization

- Most organisms which colonize are **harmless commensals and should not be treated**.
- An organism isolated from a sample taken from a normally sterile site like the CSF, blood, pleural fluid etc. is likely to be a **true invader and the causative pathogen**.
- An organism isolated from a non-sterile specimen like sputum or a wound swab **may be a colonizer**.
- If the organism is persistently isolated despite 'effective' systemically administered therapy, careful clinical decision must be taken keeping in mind the organism may be a multidrug resistant pathogen or simply a colonizer.

3. Microbiological Diagnostic Stewardship

Infection v. colonization

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3. Microbiological Diagnostic Stewardship

SAMPLE COLLECTION TECHNIQUES

3. Microbiological Diagnostic Stewardship

1. Blood

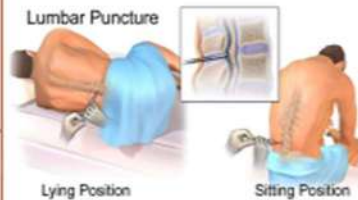
- Preferably collect paired blood samples for culture from two different sites (e.g. right and left ante cubital fossa).
- Dilution ratio: 1 ml of blood to 10 ml of culture media.
 - Wear gloves, thoroughly disinfect the venepuncture site.
 - Cleanse an area about 50 mm in diameter with 70% ethanol and allow it to air-dry.
 - Apply 2% tincture of iodine or chlorhexidine/ alcohol based disinfectant in a circular action, swab the area beginning at the point where the needle will enter the vein.
 - Allow the disinfectant to dry on the skin for at least 1 minute.
 - Wipe the top of the bottle cap using an ethanol swab and allow it to dry before injecting the sample aseptically into the bottle.
 - Inoculated blood culture bottles should be transported to the laboratory immediately or held at room temperature until they reach the laboratory.

3. Microbiological Diagnostic Stewardship

2. Cerebrospinal Fluid

Lumbar puncture

- Disinfect the puncture site with antiseptic solution and alcohol
- Insert a needle with stylet at the L3-L4, L4-L5, or L5-S1 interspace.
- When the subarachnoid space is reached, remove the stylet; spinal fluid will appear in the needle hub.
- Measure the hydrostatic pressure with a manometer.

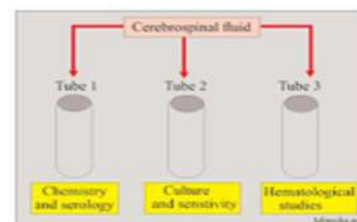


<https://smartmedicalbuyer.com/blogs/smb-blog/equipment-used-in-a-lumbar-puncture>

3. Microbiological Diagnostic Stewardship

Collection and transport-CSF

- Sequentially collect into three calibrated sterile tubes- routine chemistry (total protein and glucose) (tube no. 1), bacteriology (C&S) (tube no. 2), and haematology (cell count) (tube no. 3)
- Transport
- Never Refrigerate
- If delay; store at room temperature/incubator



<https://labpedia.net/cerebrospinal-fluid-analysis-part-2-cerebrospinal-fluid-csf-normal-abnormal-interpretations/>

3. Microbiological Diagnostic Stewardship

3. Sterile body fluids

- Normally sterile body fluids such as pleural, pericardial, peritoneal, synovial, etc. should be collected with needle and syringe using sterile technique.
- The aspirated material (1-5ml) should be transferred to a sterile screw-capped tube or a paediatric Isolator tube.
- Samples should not be submitted in syringe with a needle attached.
- Swab specimens are inferior and should NEVER be used if fluid specimens can be obtained.

3. Microbiological Diagnostic Stewardship

4. Urine: Midstream sample

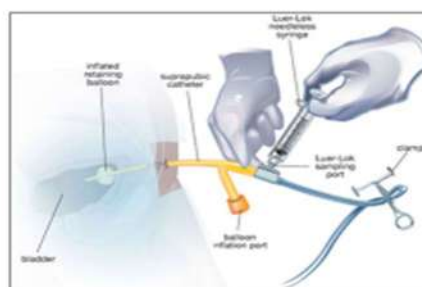
- Preferably, early morning first midstream urine (2-5ml) in sterile, wide mouth, leak proof container.
- Instructions to patients:
 - **Female:** Wash the hands, cleanse the area around the urethral opening with soap and water,, and collect the midstream urine in a sterile container with the labia held apart.
 - **Male:** Wash the hands, retract the foreskin, cleanse the glans with soap and water, collect midstream urine in the sterile container.
- Transport to the laboratory within 2 hours of collection. Refrigerate if delayed.



3. Microbiological Diagnostic Stewardship

Urine: Catheterized Patient

- Clamp the catheter, clean the catheter wall vigorously with 70% ethanol and aspirate 5 to 10 ml of urine via a sterile needle and syringe above the clamp.
- Never collect urine sample from the urine collection bag or by disconnecting the catheter from the tube of the urine collection bag.



<https://terablog.org/health/services/when-a-suprapubic-catheter-is-necessary/>

3. Microbiological Diagnostic Stewardship

Urine: Suprapubic aspiration

- The skin above the bladder is disinfected and a sterile needle and syringe is plunged into the bladder.
- Urine is aspirated and placed in a sterile container.
- It is collected primarily from infants and comatose patients.



<https://basicmedicalkey.com/suprapubic-catheter-insertion-and-or-change/>

3. Microbiological Diagnostic Stewardship

5. Sputum

- Use a clean, wide-mouthed leak-proof container,
- Collect preferably during early morning after rinsing mouth with water but before brushing, fluid or food intake.
- Instruct patient to cough deeply after taking a deep breath.
- External soiling of container with sample: Clean with phenol-containing disinfectant to wipe the outside of the container.

Specimen must be sputum, not Saliva.

Transport

- Send within 2 hours of collection.
- Refrigerate if delay (except in case if *S. pneumoniae* and/or *H. influenzae* infection suspected).



ET tip, suction tip-
not recommended

3. Microbiological Diagnostic Stewardship

Case 1

A 10 year old boy with H/o of sore throat, fever, malaise since 1 day visits a pediatrician accompanied by his parents. O/E cervical lymph nodes are enlarged and tonsils inflamed.



https://en.wikipedia.org/wiki/Strapycoccal_pharyngitis

3. Microbiological Diagnostic Stewardship

6. Endotracheal aspirate (ETA)

- Endotracheal aspiration is done with a sterile technique using a 22-inch, 12F suction catheter.
- The catheter is introduced through the endotracheal tube for at least 30 cm. Gentle aspiration is then performed without instilling saline solution.
- The first aspirate is discarded, the second aspirate is collected after tracheal instillation of 5 ml saline in a mucus collection tube.
- If very little secretion is produced by the patient, chest vibration or percussion for 10 min is used to increase the retrieved volume (> 1mL).
- Send the specimen to the laboratory as soon as possible.

3. Microbiological Diagnostic Stewardship

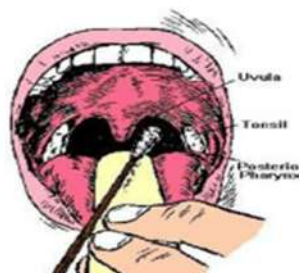
7. Bronchoalveolar lavage (BAL)

- In this procedure 100-300 ml volume of saline is infused to a lung segment through the bronchoscope
- to obtain cells and protein of the pulmonary interstitium and alveolar spaces and a portion of it to be sent to the laboratory as soon as possible.

3. Microbiological Diagnostic Stewardship

8. Throat swab (posterior pharyngeal swab)

- Hold tongue away with tongue depressor
- Locate areas of inflammation and exudate in posterior pharynx, tonsillar region of throat behind uvula.
- Avoid swabbing soft palate; do not touch tongue.
- Rub area back and forth with cotton or Daron swab. **Replace it in the tube.**

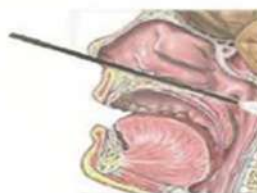


<https://dsp.mohfw.gov.in/WriteReadData/892s/29900297861565252769.pdf>

3. Microbiological Diagnostic Stewardship

Nasopharyngeal swab

- Tilt head backwards.
- Insert flexible fine-shafted polyester swab into nostril and back to nasopharynx.
- Leave in place **for** a few seconds.
- Withdraw slowly in a rotating motion and place in the transport medium.



<https://dsp.mohfw.gov.in/WriteReadData/892s/29900297861565252769.pdf>

3. Microbiological Diagnostic Stewardship

Nasopharyngeal aspirate

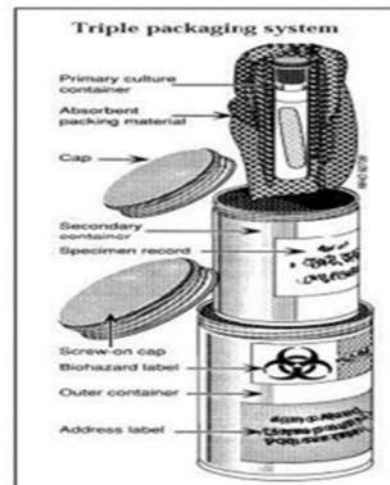
- Tilt head slightly backward
- Instill 1-1.5 ml of VTM /sterile normal saline into one nostril
- Use aspiration trap
- Insert silicon catheter in nostril and aspirate the secretion gently by suction in each nostril.
- Transfer in the transport medium.



3. Microbiological Diagnostic Stewardship

Triple packaging system for transport

<https://idsp.mohfw.gov.in/WriteReadData/1892s/290297861565252769.pdf.pdf> (mohfw.gov.in)



3. Microbiological Diagnostic Stewardship

9. Stool

- Use a clean, wide-mouthed leak-proof container, to collect the stool sample.
- NEVER collect from the bedpan/toilet bowl.
- Collect at least 5 ml of sample in case of liquid stool, approximately 1 g (walnut-sized) sample in case of semi-formed or formed stool.
- Transport immediately for microscopy.

3. Microbiological Diagnostic Stewardship

10. Pus/tissue biopsy



<https://www.vicniss.org.au/media/1926/1500-rod-james-skin-and-soft-tissue-swabs-2.pdf>

3. Microbiological Diagnostic Stewardship

Pus/tissue biopsy aspirate

Open wounds

- Debride to clear overlying debris with scalpel and swabs or sponges, and thoroughly rinse with sterile saline prior to collection of sample.
- Collect biopsy or curette sample from base or advancing margin of the lesion. The specimen must never be sent in formalin for culture.

Closed wounds

- Disinfect the area as for collection of blood sample collection before aspiration.
- Pus from an abscess is best collected at the time the abscess is incised and drained, or after it has ruptured naturally. At least 1ml of pus should be collected.

Swab is not an appropriate/ preferred sample for culture.

3. Microbiological Diagnostic Stewardship

11. Genital swabs

- Excess mucus is cleaned with cleaning swab and discarded.
- Swab is inserted into the cervical canal and rotated for 15-30 seconds.
- Swab should be Immediately broken off swab into the transport tube.

3. Microbiological Diagnostic Stewardship

Sample rejection criteria

- Samples collected in incorrect containers or in broken, poorly sealed and leaking containers.
- Unlabelled specimens or mismatch between sample requisition form and container.
- Unacceptable delay between specimen collection and arrival at laboratory
- Sample stored incorrectly before or during transport.
- Inadequate quantity of specimen.
- 24 hours urine collection.
- Foley's catheter tips and endotracheal tube tips.
- Urine from the bag of a catheterized patient.

3. Microbiological Diagnostic Stewardship

Follow up cultures

- Whether treatment has been successful or not is best judged by clinical criteria, but it is useful to know whether the infecting organism has been eliminated.
- Repeated cultures are, therefore, sometimes indicated.

3. Microbiological Diagnostic Stewardship

Rapid tests

PCR for respiratory viruses in children with LRTI

- help to monitor response to therapy,
 - Guide the duration of antimicrobial therapy.
- Inflammatory markers such as **Procalcitonin, C- Reactive Protein** etc.
- Guide prescribers to institute rational therapy especially in sepsis cases.
 - Useful to differentiate between a bacterial and a viral infection and therefore is a potential guide to initiate antimicrobial therapy.
 - Confirm the presence of a bacterial pathogen or help to rule out a bacterial infection rapidly.

Used for selection of appropriate therapy.

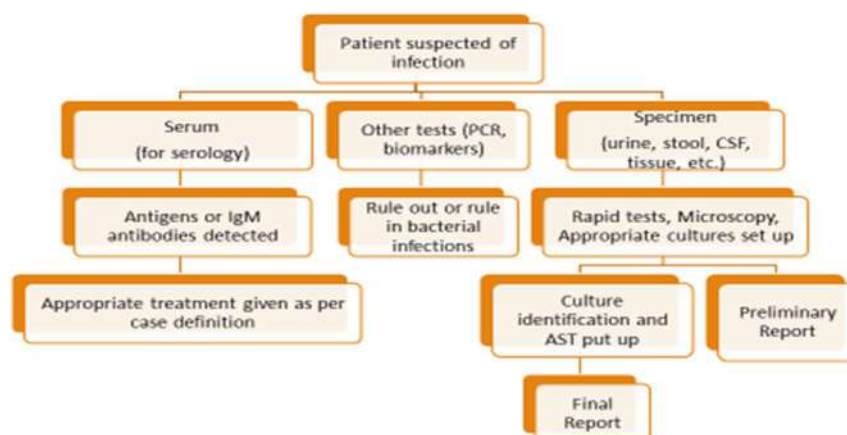
3. Microbiological Diagnostic Stewardship

Summary of sample collection and transport

Sample	Collection	Transport	Remarks
Blood	1ml blood per 10ml media	Immediately or at room temperature	
CSF	1-3 ml in sterile container	Immediately or at room temperature	Never refrigerate
Sterile body fluids (Pleural, Pericardial, peritoneal etc)	1-5 ml sterile container	Immediately or refrigerate if delay up to 4 hours	Do not transport in capped syringe
Urine	2-5ml	Immediately or refrigerate if delay up to 2 hours	Give proper instructions for collection and transport to patient
Sputum	Mucoid sample coughed up into container	Immediately or at room temperature	
Throat/ oropharyngeal swabs	Two swabs (culture and microscopy)	Immediately before drying, in VTM for viral diagnostics	Wear Appropriate PPE
Stool	1g (formed stool) to 5ml (liquid stool)	Immediately or at room temperature	Sample to be sent to the laboratory within 15 minutes for trophozoites
Pus/ Tissue biopsy/ aspirates	Sterile wide mouth container	Immediately or refrigerate if delay up to 4 hours	Do not add formalin or saline
Genital swabs	Dacron or rayon swabs	Immediately	Add to VTM if viral diagnostics is required.

3. Microbiological Diagnostic Stewardship

Choosing the right test



3. Microbiological Diagnostic Stewardship

THANK YOU

3. Microbiological Diagnostic Stewardship

4

Interpretation of Antimicrobial Susceptibility Results

NMC Module on AMR for Prescribers

4. Interpretation of Antimicrobial Susceptibility Results

Learning Objectives

On completion of this chapter, the prescriber should be able to:

- understand the importance of quality assured antimicrobial susceptibility testing (AST).
- interpret the antimicrobial susceptibility testing report.
- interpret the surrogate and cascade reporting.

4. Interpretation of Antimicrobial Susceptibility Results

Round the Clock -Microbiology Laboratory

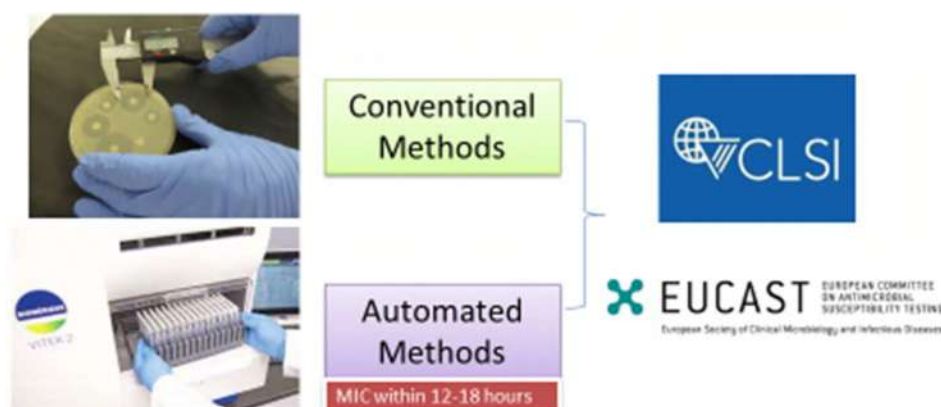
Prompt and rapid issue of reports so that the therapeutic interventions can be made in the desired time frame.

➤ The results of AST are used to:

- Choose the most appropriate antimicrobial agent
- Establish antimicrobial prescription policies
- Predict upcoming resistance
- Assess the efficacy of newly developed antimicrobial agent

4. Interpretation of Antimicrobial Susceptibility Results

Antimicrobial Susceptibility Testing



4. Interpretation of Antimicrobial Susceptibility Results

Case Scenario-1

(Objective: Interpretation of AST)

A 60 year Male, hypertensive, diabetic, presents to the OPD with H/O high grade fever with chills since 3 days, dysuria, abdominal pain associated with nausea, vomiting & pedal edema with decreased urine outputs since 1 day.

- WBC- 18,900/mm³
- Creatinine – 1.8 mg/dl,
- Abg – Metabolic acidosis.
- CUE - plenty of pus cells/HPF with bacteria++

4. Interpretation of Antimicrobial Susceptibility Results

DEPARTMENT OF MICROBIOLOGY
CULTURE & ANTIMICROBIAL SUSCEPTIBILITY REPORT

Name: XX	Age/Sex: XX
IP Number: XX	OP/IP: XX
Sample: Midstream Urine	Sample received on: 01.01.2024
Lab ID: X	Reporting date: 03.01.2024

Microscopy: Urine wet mount shows plenty of inflammatory cells (10³ HPF)

Organism isolated: *Klebsiella pneumoniae* isolated in culture (> 10⁵ CFU/ml) Significant bacteriuria

Susceptibility pattern:

Antibiotic	Susceptibility pattern	Antibiotic	Susceptibility pattern
Cefotaxime	R	Gentamicin	S
Ceftriaxone	R	Amikacin	S
Cefuroxime	R	Ciprofloxacin	R
Cefepime	SDD	Colistin	R
Aztreonam	R	Nitrofurantoin	R
Amoxycillin/Clavulanic acid	S	Norfloxacin	R

S: Susceptible, I: Intermediate, R: Resistant, SDD: Susceptible Dose Dependent

Comments:
Intrinsic Resistance: *Klebsiella pneumoniae* is intrinsically resistant to Ampicillin, Amoxycillin and Ticarcillin.

Additional notes:

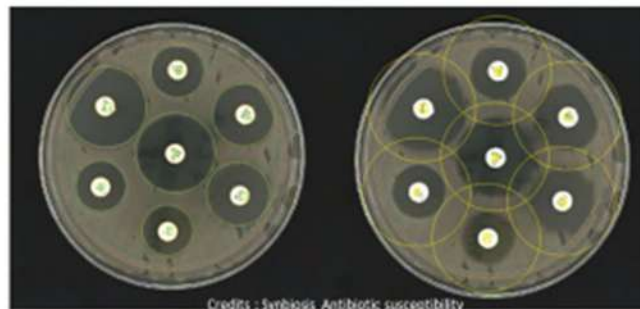
- If Carbapenem Resistant Enterobacteriaceae (CRE) is isolated, monotherapy with colistin is not advisable
- Kindly provide the provisional diagnosis, complete clinical history and antibiotic history in the requisition form.
- Cascade reporting is being followed. Second line drugs are being reported only if all the first line drugs are resistant

XXXXX
Signature of the Microbiologist

AST by
conventional
DD method

4. Interpretation of Antimicrobial Susceptibility Results

Interpretation of AST Result



4. Interpretation of Antimicrobial Susceptibility Results

S. I. R ??

- Interpretive criteria of susceptibility are based on standard dosing in a patient with normal renal function tests and in the absence of co-morbidities. The results of AST are reported as:

Susceptible

Bacteria are inhibited by the usually achievable concentrations

Intermediate

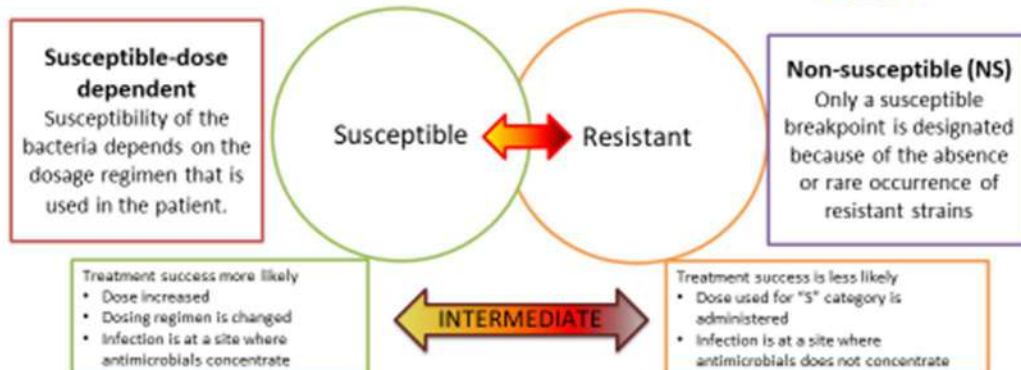
Buffer zone between the susceptible and resistant categories.

Resistant

Bacteria which are not inhibited by the usually achievable concentrations

4. Interpretation of Antimicrobial Susceptibility Results

One size does not fit all!



4. Interpretation of Antimicrobial Susceptibility Results

Case Scenario 2

(Objective: Interpretation of Indicator antimicrobials)

A 46 year old gentleman presented to the hospital with complaints of right paraspinal back pain since 2 months with increasing intensity. MRI of the lumbar and thoracic spine revealed a large multiloculated abscess with osteomyelitis. A pig tail catheter drain was inserted and pus was sent for culture and sensitivity.

Gram stain showed moderate inflammatory cells and plenty of Gram positive cocci in clusters.

Culture showed growth of *Staphylococcus aureus*.

4. Interpretation of Antimicrobial Susceptibility Results

DEPARTMENT OF MICROBIOLOGY
CULTURE & ANTIBIOTIC SUSCEPTIBILITY REPORT

Name: XX	Age/Sex: XX
IP Number: XX	OP/IP: XX
Sample: Catheter Drain	Sample received on: 01.01.2024
Lab ID: X	Reporting date: 03.01.2024

Microscopy: Grams stain shows moderate inflammatory cells and plenty of Gram positive cocci arranged in clusters.

Organism isolated: Culture shows growth of *Staphylococcus aureus*.

Susceptibility pattern:

Antibiotic	Susceptibility pattern	Antibiotic	Susceptibility pattern
Penicillin	R	Tetracycline	R
Cefazolin	R	Ciprofloxacin	S
Clindamycin	S	Gentamicin	S
Erythromycin	R	Vancomycin	S
Cladaxycin	S → R	Linezolid	S

S: Susceptible, I: Intermediate, R: Resistant, SDD: Susceptible Dose Dependent
 **Methicillin Resistant *Staphylococcus aureus* (MRSA)
 ***Inducible Clindamycin Resistant (Positive)

Comments: All beta lactam drugs including BL/BLI combinations will fail against MRSA

Intrinsic Resistance:

- All *Staphylococcus aureus* isolates are intrinsically resistant to Acetaminophen, Colistin, Nalidixic acid, Polymyxin B and Colistin
- MRSA indicates presence of mutation of the target binding site for the beta lactam drugs (Penicillin Binding Protein 2a)

XXXXX
Signature of the Microbiologist

AST by
conventional
DD method

4. Interpretation of Antimicrobial Susceptibility Results

Interpretation of AST Result

Indicator / Surrogate drugs:

- Indicates resistance not only to the indicator, but also to related agents (Table in next slide).

Equivalent Agents:

- One antimicrobial can be used to predict results for the other antimicrobials.
- For Example susceptibility to erythromycin can be used to predict susceptibility to clarithromycin or azithromycin.

4. Interpretation of Antimicrobial Susceptibility Results

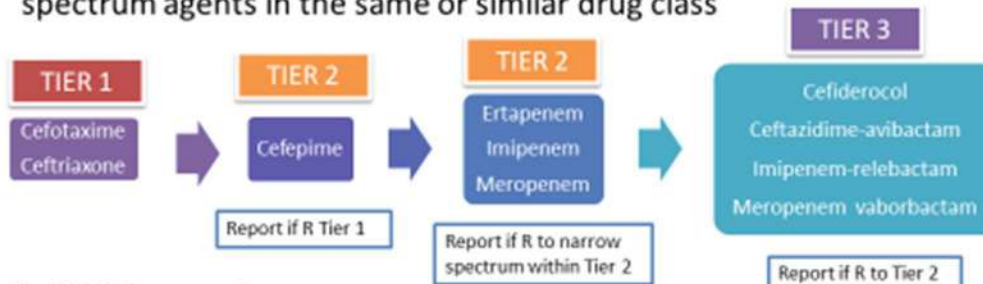
Indicator/surrogate/equivalent antimicrobials used in AST reports

Organism	Susceptibility Result	Inference / Action / Conclusion
Staphylococcus	Cefoxitin R (35 °C)	Report as Oxacillin R (Not Fox R), target Based Resistance, R to All Beta lactams (except Ceftaroline)
	Erythro R (15-26 mm) Clinda D+ve	Inducible Clindamycin Resistance +ve. Avoid Clindamycin. Report as R
Pneumococcus	Oxa zone ≥20mm i.e. S	Isolates of pneumococci with oxacillin zone sizes ≥20 mm are susceptible (MIC ≤0.06 µg/mL) to penicillin
Enterococcus	Penicillin Susceptibility	Enterococci susceptible to penicillin are predictably susceptible to ampicillin, amoxicillin, ampicillin-sulbactam, amoxicillin-clavulanate, and piperacillin-tazobactam for non-β-lactamase producing Enterococci
	Ampicillin Susceptibility	Same as above but Enterococci susceptible to ampicillin cannot be assumed to be susceptible to penicillin.

4. Interpretation of Antimicrobial Susceptibility Results

Cascade Reporting

Results for broader spectrum or secondary agents are only reported if the isolate tests resistant to primary or narrower spectrum agents in the same or similar drug class



Eg. *Klebsiella pneumoniae*

4. Interpretation of Antimicrobial Susceptibility Results

Cascade Reporting

Microbiology Chart Report

bioMérieux Customer: VK2C22149
Patient Name: XXXX
Location: XXXX
Lab ID: XXXX

Printed April 2, 2024 3:40:16 PM EST

Selected Organism: *Escherichia coli*

Source/Specimen: _____

Comments: _____

Identification Information		Analysis Time:	4.85 hours	Status:	Final
Selected Organism	100% Probability	<i>Escherichia coli</i>			
ID Analysis Message	Bionumber:	2405610440524610			

Susceptibility Information		Analysis Time:	7.53 hours	Status:	Final
Antimicrobial	MIC	Interpretation	Antimicrobial	MIC	Interpretation
Amoxicillin/Clavulanic Acid	≤ 32	R	Meropenem	≤ 0.25	S
Piperacillin/Tazobactam	≤ 4	R	Aztreonam	2	S
Cefuroxime	≤ 64	R	Ceftazidime	≤ 16	S
Cefuroxime Axetil	≤ 64	R	Ciprofloxacin	≤ 4	S
Ceftriaxone	≤ 64	R	Cefepime	≤ 0.5	S
Cefepime/Sulbactam	16	R	Polymyxin B	≤ 16	S
Cefepime	≤ 8	S	Colistin	≤ 0.5	S
Ertapenem	≤ 0.12	S	Imipenem	≤ 20	S
Imipenem	≤ 0.25	S			

AES Findings

Confidence: Consistent

Report only 1st tier antibiotics
Follow Cascade reporting

4. Interpretation of Antimicrobial Susceptibility Results

Case Scenario 3

(Objective: Role of MIC & BMQ ratio)

A 45 year old lady from Mizoram, post TKR of left knee 15 days back presented with pain, inflammation and pus discharge at the site of operation

- Patient denied any associated features of fever or chills
- Blood cultures were sent which were sterile after 48 hours of incubation
- Pus cultures showed growth of *Escherichia coli* with the following susceptibility pattern:
- What would be the preferred antimicrobial agent?

AST Pattern	Antibiotic
Susceptible	Piperacillin tazobactam, Cefoperazone sulbactam, Meropenem, Imipenem, Amikacin, Gentamicin, Tigecycline
Resistant	Ceftazidime, Cefuroxime, Ceftriaxone, Cefepime, Ciprofloxacin.

4. Interpretation of Antimicrobial Susceptibility Results

The minimal inhibitory concentration (MIC) may help to choose the most appropriate treatment.

It defines the in vitro levels of susceptibility or the resistance of specific bacterial strains to a targeted antibiotic.

Reliable assessment of MIC has a significant impact on the choice of a therapeutic strategy, which affects efficiency of an infection therapy.



Review

When and How to Use MIC in Clinical Practice?

Magréault, Sophie & Joubert, Françoise & Carbonnelle, Etienne & Zahar, Jean-Ralph. (2022). When and How to Use MIC in Clinical Practice?. *Antibiotics*. 11. 3748. 10.3390/antibiotics11123748.

4. Interpretation of Antimicrobial Susceptibility Results

Microbiology Chart Report

Printed April 2, 2024 3:40:18 PM IST

Ward/Room: XXXX
Patient Name: XXXX
Location: XXX
Lab ID: XXX

Selected Organism: *Escherichia coli*

Source: Pus

Comments:

Identification Information	Analytic Status	4.85 hours	Status	Final
Selected Organism	93% Probability	<i>Escherichia coli</i>		
ID Analysis Message	240511040524019			

Susceptibility Information		Analytic Status	7.55 hours	Status	Final
Antimicrobial	MIC	Interpretation	Antimicrobial	MIC	Interpretation
Cefazolin	<= 32	R	Amikacin	<= 0.25	S
Piperacillin/Tazobactam	<= 4	S	Meropenem	<= 0.25	S
Cefepime	<= 64	R	Acetaminophen	2	S
Cefepime/Amikacin	<= 64	R	Gentamicin	<= 1	S
Cefepime	<= 64	R	Ciprofloxacin	<= 4	R
Cefepime/Sulbactam	<= 64	R	Levofloxacin	<= 8	R
Cefepime	<= 32	R	Tigecycline	<= 0.5	S
Aminoglycosides	<= 64	R	Trimethoprim/Sulfamethoxazole	<= 320	R

AES Findings

Confidence: Consistent

Which antibiotic can be preferred??

Meropenem
MIC <0.25

OR

Tigecycline
MIC <0.5

OR

Any other
Antimicrobial???

4. Interpretation of Antimicrobial Susceptibility Results

Should I Choose the Antibiotic With the Lowest MIC?

Michael J. Postelnick, BScPharm
DISCLOSURES | August 14, 2009

Lower the MIC value; the better is the Antibiotic??

4. Interpretation of Antimicrobial Susceptibility Results

MIC Therapeutic Index(BMQ ratio)

BMQ Ratio: Susceptible BP/MIC

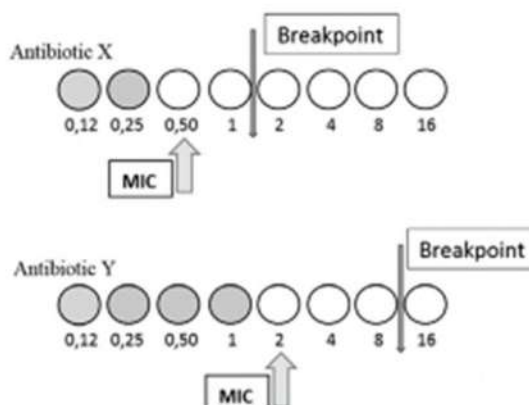
BMQ ratio for Antibiotic X

$$1/0.5 = 2$$

BMQ ratio for Antibiotic Y

$$8/2 = 4$$

The higher the BMQ the higher the therapeutic efficacy



4. Interpretation of Antimicrobial Susceptibility Results

MIC Therapeutic Index cont...

The Break point to MIC quotient of an antimicrobial refers to the ratio of susceptible breakpoint divided by MIC of the test isolate. The higher the BMQ the better the therapeutic efficacy.

MIC value should be assessed in relation to the distance from the breakpoint value of susceptibility.

There is an antibiotic X with a MIC of 0.5 mg/L and breakpoint 2 mg/L, and an antibiotic Y with a MIC of 2 mg/L but breakpoint of 16 mg/L: the drug with a MIC more favorable is the antibiotic Y (Figure 2).

4. Interpretation of Antimicrobial Susceptibility Results

MIC Guiding Table

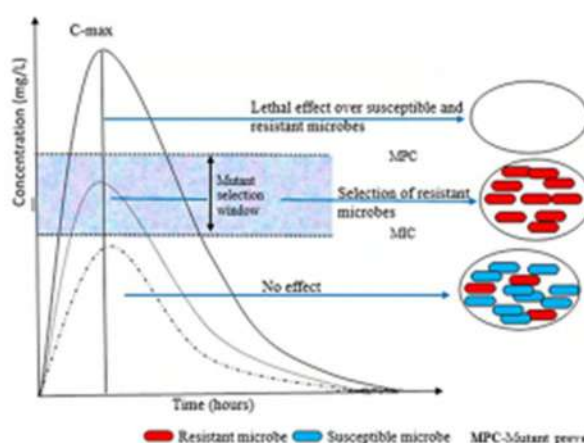
Antibiotic	Detectable MIC Range lower than Susceptible MIC BP					S	I	R	Detectable MIC Range lower than Susceptible MIC BP	
Ceftazidime	0.12	0.25	0.5	1.0	2.0	4.0	8.0	16.0	32.0	64.0
Ciprofloxacin				0.06	0.12	0.25	0.5	1.0	2.0	4.0
Levofloxacin						0.12	0.25-1	2.0	4.0	8.0
Gentamicin			0.5	1.0	2.0	4.0	8.0	16.0		
Cotrimoxazole					20.0	40.0		80.0	160.0	320.0
Cefepime		0.12	0.25	0.5	1.0	2.0	4.0-8.0	16.0	32.0	64.0
Piperacillin/tazobactam					4.0	8.0	16.0	32.0	64.0	128.0
Cefoperazone/sulbactam					8.0	16.0	32.0	64.0		
Amikacin		1.0	2.0	4.0	8.0	16.0	32.0	64.0		
Aztreonam				1.0	2.0	4.0	8.0	16.0	32.0	64.0
Imipenem				0.25	0.5	1.0	2.0	4.0	8.0	16.0
Meropenem				0.25	0.5	1.0	2.0	4.0	8.0	16.0
Tigecycline			0.25	0.5	1.0	2.0	4.0	8.0		

4. Interpretation of Antimicrobial Susceptibility Results

Antimicrobial agent	Line	MIC (µg/ml)	Interpretation	BMQ
Ceftazidime	First line	32	R	NA
Ciprofloxacin	First line	≥4	R	NA
Levofloxacin	First line	≥8	R	NA
Gentamicin	First line	≤0.5	S	8
Trimethoprim/Sulfamethoxazole	First line	≥320	R	NA
Cefepime	2 nd line	≥32	R	NA
Piperacillin/tazobactam	2 nd line	≤4	S	2
Cefoperazone/sulbactam	2 nd line	≤8	S	2
Amikacin	2 nd line	2	S	8
Aztreonam	Restricted	16	R	NA
Imipenem	Restricted	≤0.25	S	4
Meropenem	Restricted	≤0.25	S	4
Tigecycline	Restricted	≤0.5	S	4

High BMQ i.e. Greater Distance b/w Susceptible BP & MIC, Better Bug Kill

Reason Why We Need MIC Values & High BMQ



Mutant Selection Window (MSW) is an antimicrobial concentration range extending from the MIC required to block the growth of wild-type bacteria up to that required to inhibit the growth of the least susceptible, single-step mutant

When $C_{max} \geq 4 \times MIC$, it usually covers the MPC as well.

Thümler, Robinson & Mathew, *et al* (2023). Potential Causes of Spread of Antimicrobial Resistance and Preventive Measures in One Health Perspective: A Review. *Infection and drug resistance*. 16: 7133-7143.

Selective Reporting

Reporting results for specific antimicrobial agents based on defined criteria unrelated to the AST results

The Criteria may be:

- Sample specific
- Organism specific
- Site specific
- Based on mechanism of resistance, clinical setting, patient demographics and availability of breakpoints.

4. Interpretation of Antimicrobial Susceptibility Results

Selective Reporting - Sample specific

AST results are provided only if clinical assessment suggests infection in the following situations:

- **Urine:** The urine of patients with indwelling catheters frequently becomes colonized. Unless clinically indicated, treatment is not required.
- **Sputum:** Antimicrobial therapy may be indicated if clinical or radiological evidence of lower respiratory tract infection is present. Rule out colonization.
- **Pus:** Antimicrobial therapy may be indicated in case of cellulitis or deep-seated infection only.

4. Interpretation of Antimicrobial Susceptibility Results

Selective Reporting - Organism specific

Enterococcus sp

- Cephalosporins, clindamycin, and trimethoprim-sulfamethoxazole may appear active in vitro but are not effective clinically and should not be reported.

Staphylococcus sp

- Methicillin (oxadillin)-resistant staphylococci are resistant to all currently available β -lactam antimicrobial agents, with the exception of ceftaroline.

Salmonella and Shigella species

- Aminoglycosides, first- and second-generation cephalosporins and cephamycins may appear active in vitro but are not effective clinically and should not be reported as susceptible.

4. Interpretation of Antimicrobial Susceptibility Results

Selective Reporting - Site specific

Antibiotic	Selective reporting
Nitrofurantoin	Only in Uncomplicated lower UTI
Tigecycline	Skin, soft tissue and abdominal infections only. Not to be reported in Blood. High volume of distribution
Aminoglycosides	Never given for Abscess and anaerobic infections
Daptomycin	Not effective in lung infections
1 st and 2 nd Generation Cephalosporins, Carbapenems, Clindamycin, Tetracyclines and Flouroquinolones	Should not be reported in CSF samples

4. Interpretation of Antimicrobial Susceptibility Results

Selective Reporting based on

Mechanism of Resistance	Clinical setting	Patient demographics	Breakpoints not available
If inducible clindamycin is positive Clindamycin should be reported resistant regardless of interpretation	- IV drugs suppressed for OPD patients - Renal impairment Aminoglycosides, colistin and vancomycin are suppressed from reporting.	Suppression of antimicrobials known to cause adverse drug reactions in children such as ciprofloxacin, tetracycline and chloramphenicol.	Tigecycline breakpoints for <i>Acinetobacter baumannii</i> are not available..

4. Interpretation of Antimicrobial Susceptibility Results

Antibiotic-Should not be Reported

Site / Patient	Antibiotic
Blood	Tigecycline (High Volume of distribution: Doesn't Stay in Blood)
Abscesses	Aminoglycosides (Never for AnO2 Infections & Salmonella / Shigella)
Lungs	Daptomycin
Urine	Macrolides, Tigecycline, Chloramphenicol, Clindamycin
Children	Fluoroquinolones, Tetracyclines, Chloramphenicol, Cotrimoxazole (infants)
Pregnancy	Tetracyclines, Fluoroquinolones, Aminoglycosides, Metronidazole

4. Interpretation of Antimicrobial Susceptibility Results

Comments as Foot Notes in the AST: Don't overlook!

Resistant to all tested antimicrobials	Consider 90-60 rule-suggests that 90% of susceptible results predict success, while 60% of resistant results still have successful treatment outcomes
Susceptible dose dependant (SDD)	If MIC is 4µg/ml, recommended dose of Cefepime is 1gm thrice daily or 2 gm twice daily & If MIC is 8µg/ml, recommended dose of Cefepime is 2gm thrice daily
Vancomycin Resistant Enterococci(VRE)	Kindly ensure appropriate infection control measures.
Colistin reported as susceptible	*Colistin Warning comments* If planning to start colistin as therapeutic option kindly remember, clinical and Pk/Pd data demonstrate colistin is of limited efficacy Use in combination with one or more active antimicrobials Renal dose adjustments required

4. Interpretation of Antimicrobial Susceptibility Results

Comments on Intrinsic Resistance

A 60-year Male, diabetic (poorly controlled), presented with H/O high grade fever and chills for 3 days associated with dysuria, flank pain, nausea & vomiting

- Initial Lab parameters -WBC- 18,900/mm³;
- Creatinine – 1.8 mg/dl,
- CUE - plenty of pus cells/hpf with bacteria++;
- Urine C/S report –*Providentia* sp >10⁵ CFU/ml
- Considering the following susceptibility pattern the patient was started on combination of Colistin and Meropenem.

Colistin susceptibility not mentioned

AST Pattern	Antibiotic
Susceptible	Tigecycline
Resistant	Meropenem Amikacin, Gentamicin, Norfloxacin

Failure to mention comments on "intrinsic resistance" would result in improper choice of antimicrobial agent.

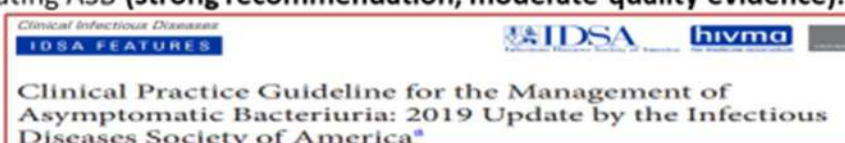
4. Interpretation of Antimicrobial Susceptibility Results

Case Scenario 4

(Objective: Reporting based on patient symptoms)

Asymptomatic bacteriuria (ASB) is a common finding in many populations, including healthy women and persons with underlying urologic abnormalities.

In healthy premenopausal, nonpregnant women or healthy postmenopausal women, IDSA recommends against screening for or treating ASB (**strong recommendation, moderate-quality evidence**).



Lindsay E. Nicolle, Kalpana Gupta, Suzanne F. Bradley et al. Clinical Practice Guideline for the Management of Asymptomatic Bacteriuria: 2019 Update by the Infectious Diseases Society of America. *Clinical Infectious Diseases*. Volume 68, Issue 10, 15 May 2019. Pages e83–e110

4. Interpretation of Antimicrobial Susceptibility Results

Points to Remember...

- ✓ Infants, children, healthy non pregnant females and diabetics should not be screened or treated for asymptomatic bacteriuria.
- ✓ Presence of indwelling catheter is not an indication for antimicrobial therapy.

4. Interpretation of Antimicrobial Susceptibility Results

Case Scenario 5

(Objective: Reporting based on Clinical correlation)

- Biopsy on HPE showed Squamous cell Carcinoma (high grade)
- Sputum microscopy -Many pus cells , no bacteria
- Bacterial culture -
Burkholderia Cepacia (Moderate)

Antibiotic	Sensitivity
Amikacin	Resistant
Ceftazidime	Resistant
Meropenem	Susceptible
Piperacillin Tazobactam	Intermediate
Colistin	Resistant
Cotrimoxazole	Susceptible

Plan of Treatment?

Treat bacterial infection and start ATT simultaneously as clinical features are highly s/o of Tuberculosis ?

4. Interpretation of Antimicrobial Susceptibility Results

Points to Remember...

- ✓ Always remember the syndrome of presentation
- ✓ Put effort to confirm the diagnosis
- ✓ Don't treat colonizers

4. Interpretation of Antimicrobial Susceptibility Results

Case Scenario 6

(Objective: Reporting based on appropriate sample)

A 57 year old diabetic patient following below knee amputation presented with wound infection. Wound swab showed growth of Carbapenem resistant *Acinetobacter baumannii*

Microbiology Chart Report		Printed: April 1, 2024 3:48:18 PM EDT			
Institution: XXXX Patient Name: XXXX Location: XXX Lab ID: XXX					
Selected Organism: <i>Acinetobacter baumannii</i> MH005					
Source: Wound swab					
<table border="1"> <tr> <th>Comments</th> </tr> <tr> <td> </td> </tr> </table>				Comments	
Comments					
Identification Information Selected Organism: <i>Acinetobacter baumannii</i> ID Analysis Message:		Analysis Time: 4.87 hours Status: Final			
Susceptibility Information Analysis Time: 7.83 hours Status: Final					
Antimicrobial	MIC	Interpretation	Antimicrobial	MIC	Interpretation
Piperacillin/Tazobactam	>= 328	R	Aztreonam	>= 64	R
Colistin	>= 64	R	Meropenem	>= 32	R
Carbapenem sulbactam	>= 64	R	Ciprofloxacin	>= 8	R
Colistin	>= 32	R	Levofloxacin	>= 8	R
Aztreonam	>= 64	R	Moxifloxacin	>= 32	R
Carbapenem sulbactam	>= 64	R	Clarithromycin	>= 32	R
Imipenem	>= 32	R	Trimethoprim/Sulfamethoxazole	>= 328	R
Meropenem	>= 32	R			
AES Findings Confirmed: ☒					

4. Interpretation of Antimicrobial Susceptibility Results

Case Scenario 6 cont...

(Objective: Reporting based on appropriate sample)

What is the most appropriate management?

1. Treat with Colistin
2. Treat with combination of Colistin and Carbapenem therapy
3. Go ahead with wound closure followed by antibiotic therapy
4. None of the above

4. Interpretation of Antimicrobial Susceptibility Results

Points to Remember...

- ✓ Appropriate sample collection: Rule out surface contamination and colonization as swabs are considered to be inferior to tissue samples.
- ✓ Look for signs of sepsis
- ✓ Wound inspection (Presence of pus/healthy granulation tissue)

4. Interpretation of Antimicrobial Susceptibility Results

Points to Remember

- Commence therapy with Narrow spectrum agents.
- Be hasty in De-escalation whenever possible.
- Take note of Organism, Site and Patient Profile before prescribing antibiotics.
- Treat only when clinically significant or if a True pathogen is isolated.
- Read comments with caution.
- Appropriate sample collection is the fundament of a good susceptibility report..

4. Interpretation of Antimicrobial Susceptibility Results

THANK YOU

4. Interpretation of Antimicrobial Susceptibility Results

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Antimicrobial Resistance - Principle and Implications

NMC Module on AMR for Prescribers

5. Antimicrobial Resistance - Principle and Implications

Learning Objectives

On completion of this chapter, the prescriber should be able to:

- define and explain the differences between antimicrobials and antibiotics
- outline the drivers for resistance
- Explain the intrinsic and acquired resistance
- outline the global epidemiology of key antimicrobial resistant pathogens and antimicrobial consumption

5. Antimicrobial Resistance - Principle and Implications

Introduction

- 'Antimicrobials' is a broad term that is used for all agents that act against different types of microorganisms namely bacteria (antibacterial), viruses (antiviral), fungi (antifungal) and parasites (antiparasitic).
- Antibiotic refer to compounds that are produced by microorganisms and act against bacteria.



5. Antimicrobial Resistance - Principle and Implications

Antimicrobials pose special challenges

- **Limited shelf life:** The efficacy of antimicrobials wanes over time.
- **Multispecialty usage:** They are used for prophylaxis and treatment of various conditions in a variety of situations.
- **Inappropriate use:** May harm other people who are not even exposed to the antimicrobial.
- **Limited drug development:** Past three decades have not seen significant development and licensing of antimicrobials.
- **Change in natural bacterial flora:** Overuse of antimicrobials tend to select bacteria with resistance to proliferate in the environment and body.

5. Antimicrobial Resistance - Principle and Implications

Overview of Antimicrobial Resistance (AMR)

Antimicrobial Resistance (AMR) occurs when bacteria, viruses, fungi and parasites change over time and no longer respond to medicines making infections harder to treat and increasing the risk of disease spread, severe illness and death.

- It makes standard treatments ineffective, prolonging infections that can increase the risk of spread to others.
- The resistant microbes are able to grow/multiply in the presence of drug that would normally kill them or limit their growth.

5. Antimicrobial Resistance - Principle and Implications

Antimicrobials- Mechanism of Action

- Inhibition or disruption of:
 - Cell wall or cell membrane synthesis of microbes
 - Protein synthesis of microbes
 - Nucleic acid synthesis in microbes
 - Metabolism or enzyme

Bactericidal	Bacteriostatic
Beta lactams	Macrolides
Glycopeptides	Clindamycin
Cyclic lipopeptides	Tigecyclines
Aminoglycosides	Tetracyclines
Fluoroquinolones	Linezolid

5. Antimicrobial Resistance - Principle and Implications

Mechanism of AMR

Some bacteria inherently do not respond to certain drugs (intrinsic resistance) while others may stop responding to a drug to which it is originally sensitive (acquired resistance).

Bacteria	Examples of Intrinsic resistance exhibited against drugs
Gram positive	Aztreonam
All Gram negative	Glycopeptides, Lipopeptides
Klebsiella species	Amoxicillin-clavulanate, Cefazolin
Citrobacter species	1 st & 2 nd generation cephalosporins, Cephamycins
Proteus species	Colistin, Cefazolin, Tetracycline, Nitrofurantoin
Pseudomonas aeruginosa	Amoxi-clav, Co-trimoxazole, I and II gen cephalosporins, Cefotaxime, Ceftriaxone, Ertapenem, Chloramphenicol, Tetracycline
Acinetobacter species	amoxicillin-clavulanate, aztreonam, chloramphenicol, Fosfomycin, ertapenem
Enterococcus	Aminoglycosides, Cephalosporins, clindamycin, many β -lactams

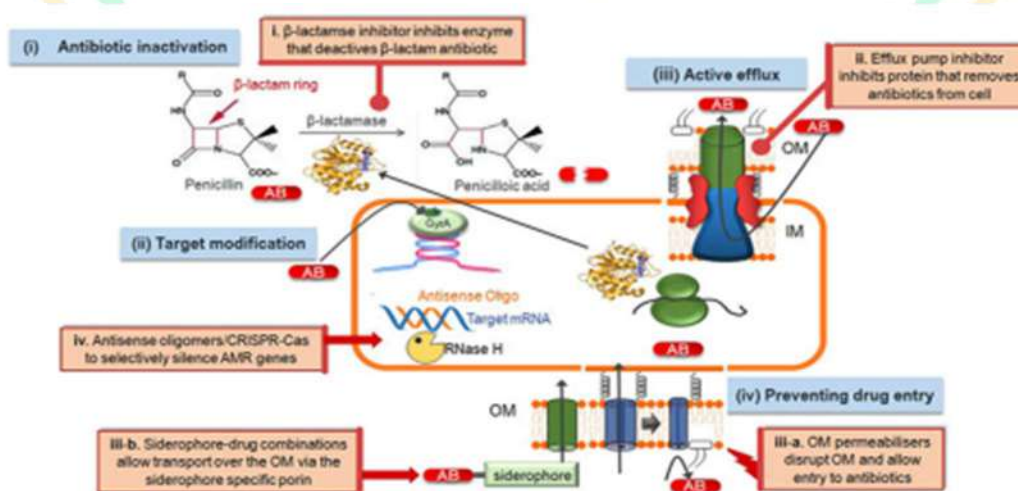
5. Antimicrobial Resistance - Principle and Implications

Mechanism of AMR cont..

Acquired resistance: Bacteria may stop responding to a drug to which it is originally sensitive by any of the following actions:

- Production of enzymes that destroy the antibacterial drug (e.g., beta-lactamases)
- Expression of efflux systems that prevent the drug from reaching its intracellular target (e.g., fluoroquinolone resistance)
- Reduction of permeability of drug through mutation of porin proteins (aminoglycosides)
- Modification of the drug's target site (e.g., penicillin-binding protein)
- Production of an alternative metabolic pathway that evades the action of the drug (e.g., folate metabolism).

5. Antimicrobial Resistance - Principle and Implications



Source: Biosci Rep. 2019;39(4):BSR20180474. doi:10.1042/BSR20180474.

5. Antimicrobial Resistance - Principle and Implications

Drivers of AMR

- The development of AMR is multifactorial.
- The risk factors most commonly found to be associated with development of antimicrobial resistance are:
 - Excessive and irrational prescriptions of antimicrobials in community and hospitals
 - Increase in invasive procedures, transplants surgeries and immunosuppressive therapy.
 - Increase use of prosthetic devices amenable to superinfection and resistant bacteria.

5. Antimicrobial Resistance - Principle and Implications

Drivers of AMR

Risk factors (continued):

- Lack of effective preventive infection control measures such as hand hygiene, isolation procedures of patients with multi drug resistant organisms.
- Lack of effective antimicrobial stewardship programs restricting antimicrobial usage in community and hospitals.
- Use of antimicrobial in agriculture sector, animal husbandries and fisheries.
- Improper disposal of antimicrobials and antimicrobial residues which leads to finding their way in community and entering food chain through food, animals and water.

5. Antimicrobial Resistance - Principle and Implications

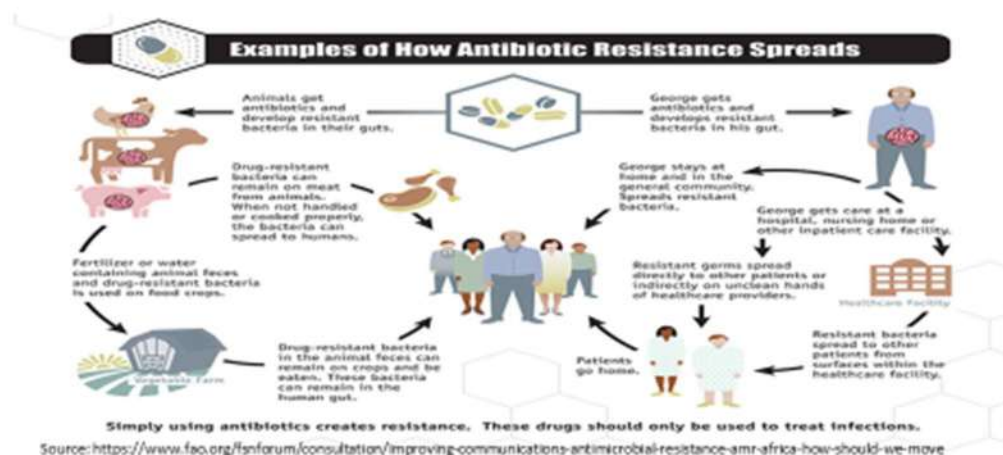
Drivers of AMR



Source: CDC - Drivers of resistance in healthcare settings and community level

5. Antimicrobial Resistance - Principle and Implications

Drivers of AMR



5. Antimicrobial Resistance - Principle and Implications

Drug Resistance in Bacteria

- For common bacterial infections, high rates of resistance against antibiotics have been observed world-wide, indicating that we are running out of effective antibiotics.
- For eg. The rate of resistance to ciprofloxacin, varied from 8.4% to 92.9% for *E. coli*.
- *K. pneumoniae* for ciprofloxacin from 4.1% to 79.4% in countries reporting to the Global AMR and use Surveillance System (GLASS).

5. Antimicrobial Resistance - Principle and Implications

Drug Resistance in Bacteria cont..

- Resistance in *K. pneumoniae* to last resort treatment (carbapenem antibiotics) has spread to all regions of the world.
- *K. pneumoniae* is a major cause of hospital acquired infections such as pneumonia, blood stream infections, infection in newborns and in ICU patients.
- Resistance to fluoroquinolone antibiotics in *E. coli*, used for the treatment of UTI, is widespread.
- Colistin is the only last resort treatment for life-threatening infections caused by carbapenem resistant Enterobacteriaceae (e.g. *E. coli*, *Klebsiella* etc.)

5. Antimicrobial Resistance - Principle and Implications

Drug Resistance in Bacteria cont..

- Bacteria resistant to colistin have also been detected in several countries and regions, causing infections for which there is no effective antibiotic treatment available.
- *Staphylococcus aureus* are part of skin flora and are also common cause of infectious both in the community and in health care facilities.
- People with Methicillin – resistance *S. aureus* (MRSA) infections are more likely to die than people with drug sensitive infections.

5. Antimicrobial Resistance - Principle and Implications

Key antimicrobial resistant pathogens

- WHO priority list 2024 lists drug resistant pathogens that pose a critical threat to human health due to their resistance to antimicrobials.
- **Carbapenem resistant Enterobacterales (CRE)** These include *Klebsiella* spp. and *Escherichia coli* that are resistant to carbapenems and are placed atop in the critical list of priority pathogens.
- **Third generation cephalosporin-resistant Enterobacterales (3GCREB)** - Gram-negative bacteria resistant to third-generation cephalosporins, a broad class of antibiotics used to treat many different types of infections.
- **Carbapenem resistant *Acinetobacter baumannii* (CRAB)** - The emergence of CRAB poses a formidable challenge due to limited treatment options particularly in ICU settings.

5. Antimicrobial Resistance - Principle and Implications

- **Methicillin-resistant *Staphylococcus aureus* (MRSA)** – *S. aureus* resistant to many common antibiotics, making it difficult to treat skin infections, pneumonia, and bloodstream infections.
- **Vancomycin-resistant *Enterococcus* (VRE)** - one of the last-resort antibiotics used to treat serious infections.
- **Fluoroquinolone-resistant bacteria** - This includes strains of *E. coli*, *Salmonella* and *Campylobacter* that are resistant to fluoroquinolones, commonly used to treat urinary tract infections, diarrhea, and respiratory infections.

5. Antimicrobial Resistance - Principle and Implications

Global Epidemiology of AMR

5. Antimicrobial Resistance - Principle and Implications

Antimicrobial Consumption

- The overuse and misuse of antimicrobials are major drivers of AMR. This includes:
 - Using antibiotics for viral infections, which are ineffective.
 - Taking antibiotics for an incomplete course of treatment.
 - Using antibiotics for non-medical purposes, such as promoting growth in livestock.

5. Antimicrobial Resistance - Principle and Implications

Impact of AMR

- Increased morbidity and mortality from infections.
- Longer hospital stays and higher healthcare costs.
- Limited treatment options for common infections.
- The emergence of untreatable "superbugs."

5. Antimicrobial Resistance - Principle and Implications

Clinical Impact

- **Drug resistant infections**
 - Increased mortality
 - Treatment delays
 - Limited treatment options
 - Increased length of hospital stay
- **Hospital acquired infections**
 - Increased mortality
 - Antibiotic resistance
 - Increased complications like pneumonia, sepsis, and organ failure.
 - Psychological impact in form of anxiety, stress, and depression in patients

5. Antimicrobial Resistance - Principle and Implications

Economic impact

- **Increased costs:** due to longer hospital stays, more costly antibiotics, need for additional treatments for complications.
- **Reduced productivity:** due to longer recovery times → lost workdays and decreased productivity.
- **Strain on healthcare systems:** due to increased demand for resources to treat DRIs and HAIs limited resources available for other patients.
- **Global economic impact:** The World Bank estimates that AMR alone could push an additional 10 million people into poverty by 2030.

5. Antimicrobial Resistance - Principle and Implications

THANK YOU

5. Antimicrobial Resistance - Principle and Implications

Antimicrobial Policy

NMC Module on AMR for prescribers

6. Antimicrobial Policy

Learning Objectives

On completion of this session, the prescriber should be able to:

- describe the attributes and features of antimicrobial policy
- understand the key elements of developing hospital antimicrobial policy
- assist in developing antimicrobial policy

6. Antimicrobial Policy

Aim of Antimicrobial Policy

- Reduce morbidity and mortality due to antimicrobial resistance in hospitalized patients.
- Preserve the effectiveness of antimicrobial agents in the treatment and prevention of communicable diseases.
- Provide uniform guidance for use of antimicrobials for treatment and prophylaxis.

6. Antimicrobial Policy

Antimicrobial Policy

- Empirical
- Specific
- Prophylaxis

The policy must incorporate specific recommendations for the treatment of different high-risk/special groups such as immunocompromised hosts; hospital-associated infections and community-associated infections.

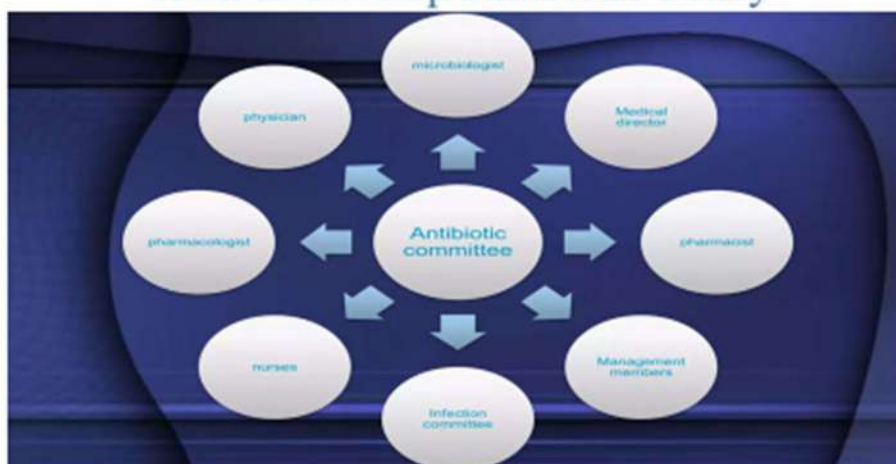
6. Antimicrobial Policy

Objectives of Antibiotic policy/Antimicrobial policy

- Prescribing strategies to optimise the indication
- Selection and dosing
- Route of administration
- Duration and timing of antibiotic therapy to maximise clinical cure or prevention of infection whilst limiting the unintended consequences of antibiotic use, including toxicity and selection of antimicrobials

6. Antimicrobial Policy

Team to Develop Antibiotic Policy



6. Antimicrobial Policy

Development of Antimicrobial Policy



6. Antimicrobial Policy

THANK YOU

6. Antimicrobial Policy

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Antimicrobial Stewardship in Humans

7

NMC Module on AMR for Prescriber

7. Antimicrobial Stewardship in Humans

Learning Objectives

On completion of this chapter, the prescriber should be able to:

- define Antimicrobial stewardship
- outline the goals, strategies and interventions of Antimicrobial stewardship
- describe the core and supplemental interventions
- outline the pharmacokinetics and pharmacodynamics approach to antimicrobial prescription
- describe and interpret antibiogram
- understand the utility of antibiogram in formulating empirical therapy

7. Antimicrobial Stewardship in Humans

Definition

Antimicrobial stewardship has been defined as *“coordinated interventions designed to improve and measure the appropriate use of antimicrobial agents by promoting the selection of the optimal antimicrobial drug regimen including dosing, duration of therapy, and route of administration”*.

7. Antimicrobial Stewardship in Humans

Goals of Antimicrobial Stewardship

- Ensure the best clinical outcome, for treatment or prevention of infection
- Minimize unintended consequences of antimicrobial use such as adverse drug reactions, emergence of clones of antimicrobial resistance
- Minimize healthcare costs without compromising quality of care
- Accurate diagnostics and diagnostic pathways

7. Antimicrobial Stewardship in Humans

“4Ds” of Prescribing Antimicrobials

Antimicrobial stewardship program (AMSP) have a direct responsibility to ensure prudent antimicrobial prescribing.



4Ds of prescribing antimicrobials

7. Antimicrobial Stewardship in Humans

AMSP Interventions

- Interventions can be introduced in a phased manner or in the whole hospital depending upon the facilities and motivation. Broadly the interventions that can be introduced are given below:

Core interventions	Supplemental interventions
Prospective audit	Dose optimization and combination therapies
Antimicrobial timeouts	Streamlining or de-escalation of therapy
Antimicrobial consumption analysis	Parenteral to oral conversion
Formulary restriction	Laboratory surveillance and feedback
Guidelines and clinical pathways	Information, education and communication

7. Antimicrobial Stewardship in Humans

Core Interventions

1. Prospective audit

- Regular bedside review of the patients to be done to analyse the prescriptions related to antimicrobial prescribing.
- After reviewing, feedback should be provided to the prescriber advising change if required on the optimal antimicrobial therapy.

7. Antimicrobial Stewardship in Humans

Core Interventions cont..

2. Antimicrobial “Time outs”

- Antimicrobials are often started empirically in hospitalized patients while diagnostic information is being obtained.
- All prescribers should review antimicrobials prescription after 48 hours to assess all 4Ds of antimicrobial stewardship.

7. Antimicrobial Stewardship in Humans

Core Interventions cont..

3. Antimicrobial consumption analysis

- **Quantitative analysis of antimicrobial consumption:** It should be collected from pharmacy purchase stores which will give proxy data of overall consumption of antimicrobials by the population (antimicrobial consumption surveillance).
- **Qualitative analysis of appropriateness of prescription:** Information regarding which patients are being given what antibiotics, their indications, dose and duration is collected using point prevalence surveys.
- It gives antimicrobial use surveillance.

7. Antimicrobial Stewardship in Humans

Core Interventions cont..

4. Formulary Restriction

- Antimicrobials included on the hospital formulary should be divided into three groups:
 - (i) **Unrestricted:** may be prescribed by any clinician
 - (ii) **Consultant only:** may only be prescribed by a consultant
 - (iii) **Restricted:** may only be prescribed following prior discussion with, and approval by, the antimicrobial stewardship team
- This list should be reviewed periodically preferably every year on the basis of antimicrobial usage data and rates of antimicrobial resistance.

7. Antimicrobial Stewardship in Humans

Core Interventions cont..

5. Guidelines and clinical pathways

- Every hospital must develop antimicrobial prescription guidelines based on principles of rational antimicrobial prescription.
- In absence of local guidelines, National Antimicrobial prescription guidelines may be adopted.

7. Antimicrobial Stewardship in Humans

Supplemental Interventions

1. Dose optimization and combination therapies

Antimicrobial must be given at the optimal:

- Dose
- Frequency and duration
- Based on individual patient characteristics such as age, weight, renal function
- Likely causative organism
- Site of infection, and
- Pharmacokinetic and pharmacodynamic characteristics of the antimicrobial agent(s)

7. Antimicrobial Stewardship in Humans

Supplemental Interventions cont..

1. Dose optimization and combination therapies

A few combinations are considered synergistic, such as:

- Aminoglycoside and beta-lactam antimicrobial.
- Beta-lactam antimicrobial and beta-lactamase inhibitor.
- Beta-lactam antimicrobial and glycopeptide (vancomycin/teicoplanin)
- Sulphamethoxazole and Trimethoprim

Antimicrobial drug therapy cannot be considered in isolation, it may be ineffective in cases where pus is not drained, septic shock is not treated and hypoxia/ anaemia are not corrected

7. Antimicrobial Stewardship in Humans

Supplemental Interventions cont..

2. Streamlining or de-escalation of therapy

- All empiric antimicrobial therapy should be reviewed on a daily basis by the clinician responsible for the patient's care.
- Special attention must be paid to factors such as:
 - Antimicrobial combinations with overlapping spectrum of activity.
 - Prolonged use of broad spectrum antimicrobials
 - Unauthorised use of restricted agents
 - Antimicrobial use not in accordance with hospital antimicrobial policy.
 - Clear criteria for prescribing intravenous antimicrobials.

7. Antimicrobial Stewardship in Humans

Supplemental Interventions cont..

3. Parenteral to oral conversion

- Always review intravenous prescription after 48 hours (at least) and switch to oral if possible.
- Early switch from intravenous (IV) agents to the equivalent oral preparation offers several benefits:
 - Decreased total cost of therapy,
 - Decreased potential for line associated infections,
 - Potential for decreased length of stay and patient preference,
 - Increased patient comfort and mobility,
 - Savings in nursing time spent preparing and administering intravenous doses.

7. Antimicrobial Stewardship in Humans

Supplemental Interventions cont..

4. Laboratory surveillance and feedback

- The Microbiology laboratory must share antimicrobial susceptibility data as an antibiogram with the prescribers.
- Also, feedback on follow up cultures must be promptly provided to allow timely review of antimicrobial prescriptions.

7. Antimicrobial Stewardship in Humans

Supplemental Interventions cont..

5. Utility of antibiograms

- Empiric antimicrobial therapy is started to provide initial control of a presumed infection of unknown cause.
- Hence, local cumulative antibiograms are required to select appropriate empiric antimicrobials for patients with common infections.
- It also provides a broad overview of local antimicrobial resistance over time (e.g. the proportion of *S. aureus* isolates that are methicillin-resistant).
- Can provide an overview of the emergence of antimicrobial resistance in particular settings over time.
- It can assist in managing infections due to multidrug-resistant organisms.

7. Antimicrobial Stewardship in Humans

Supplemental Interventions cont..

6. Information, Education and Communication (IEC)

- **Prescriber IEC:** Educational aids to guide prescribers at the point of prescribing such as:
 - Clinical algorithms for the diagnosis of infection, or
 - Methods to standardise documentation of treatment decisions must be displayed at important locations in hospitals by the hospital administration in consultation with the AMSP committee.

7. Antimicrobial Stewardship in Humans

Supplemental Interventions cont..

- **Patient IEC:** Patients, their families and general public should be educated through awareness program, regarding appropriate use of antimicrobials such as:
- When antimicrobials are not needed, like in cases of upper respiratory tract infections of viral etiology.
- Inappropriate use may cause antimicrobial associated diarrhoea, allergic reaction, colonization with drug resistant bacteria, and autoimmune diseases, likely through disturbing the microbiome etc.
- They should be made aware of the importance of adherence to antimicrobial treatment

7. Antimicrobial Stewardship in Humans

Case Scenario 1

- A 40 year old female with symptoms of dysuria and lower abdominal pain from 2 days.
- Urine exam: WBCs: 20-25
RBCs: 1-2
- Rx
- Inj. Ceftriaxone, 1gr i.v od for 5 days
- Liq. Alkalizer, 10 ml, thrice a day

7. Antimicrobial Stewardship in Humans

Case Scenario 2

- Male, 50 Years, D.M., HTN, presents with symptoms of fever, breathlessness, tachypnea from 2 days.
- CBC: TLC: 20,000
- Chest X ray: shows consolidation rt side
- Rx
- Ceftriaxone 1 gr, twice daily
- Patient shows no improvement and deteriorates and succumbs to his illness.

7. Antimicrobial Stewardship in Humans

Principles of Rational Prescription

The general principles guiding antimicrobial prescription must be followed for all patients. Some of these principles are given below:

- **Do NOT use antimicrobials:**
 - To treat colonization or contamination unless there is clear indication such as immunosuppression or post splenectomy.
 - As a general prophylaxis or “Feel good” factor.
 - To treat infections which have high suspicion of viral causes such as influenza

7. Antimicrobial Stewardship in Humans

Principles of Rational Prescription cont..

- **Use Antimicrobials only:**
 - In cases of high degree of suspicion of infection.
 - After a treatable infection has been recognized
 - Prevention of infection where evidence has demonstrated that the potential benefits outweigh the risks.
- Empirical therapy must be based on local/national prescribing guidelines.

7. Antimicrobial Stewardship in Humans

Principles of Rational Prescription cont..

- Use targeted therapy instead of broad-spectrum antimicrobials unless there is a clear clinical reason (for example, mixed infections or life-threatening sepsis).
- Review broad spectrum antimicrobials as early as possible and promptly switch to narrow spectrum agents when sensitivity results become available.
- Choose antimicrobials as determined by the sensitivity of identified causative organisms.

7. Antimicrobial Stewardship in Humans

Principles of Rational Prescription cont..

- The indication for which the patient is being prescribed the antimicrobials should be documented in the drug chart and case notes by the prescriber.
- Always have a stop/review date on antimicrobial order form/patient chart. No antimicrobial should be written for indefinite time.
- Pre-surgical prophylaxis guidelines must be followed.

7. Antimicrobial Stewardship in Humans

Strategic Approach for Development and Intervention of AMSP

The strategic approach must be as per the availability of resources in the local settings:

Committee preparation: An AMS committee is required to provide leadership and overall coordination of the AMS programme.

- Committee must include Administrative leader, Clinicians from each clinical department, Clinical pharmacist, Microbiologist, Nursing officer etc. as per standard guidelines.

- **Clinicians education:** The policy-makers and health care administrators to provide opportunities for physicians to address information gaps through clinical education and continuing professional development.

7. Antimicrobial Stewardship in Humans

Strategic Approach cont..

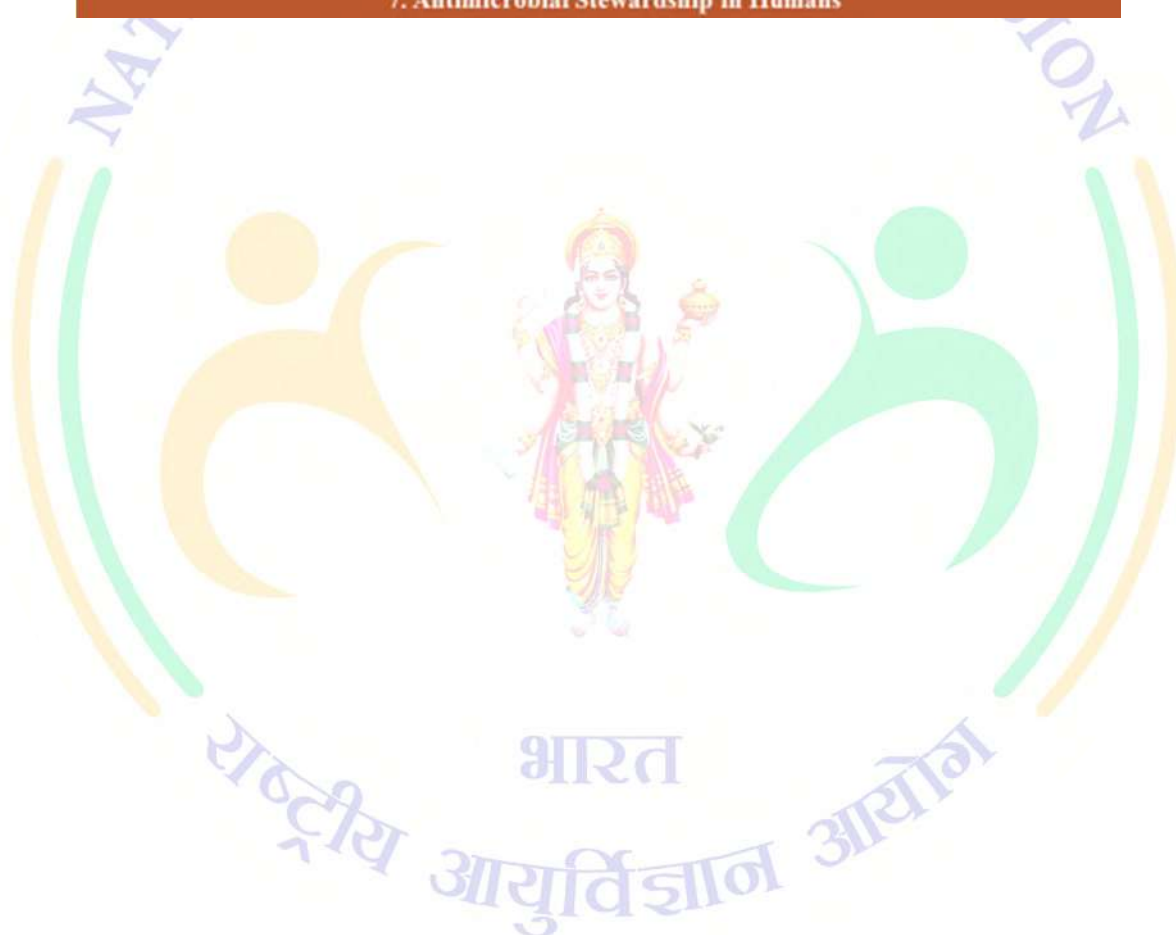
Development of Institution-specific guidelines and interventions:

Institution-specific guidelines or algorithms can be adapted from national or international evidence-based guidelines to reflect local epidemiology, access to diagnostic testing and drug availability.

7. Antimicrobial Stewardship in Humans

THANK YOU

7. Antimicrobial Stewardship in Humans



Infection Prevention & Control (IPC)

NMC Module on AMR for Prescribers

8. Infection Prevention & Control (IPC)

Learning Objectives

On completion of this chapter, the prescriber should be able to:

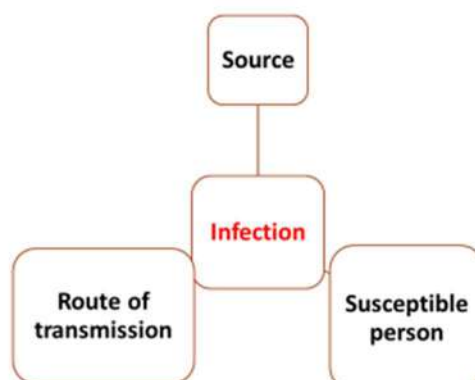
- define standard precautions
- describe the elements of standard precautions
- describe moments and steps of hand hygiene
- define and describe transmission-based precautions.
- define and describe biomedical waste management
- describe various segregation methods of biomedical waste and their disposal as per BMW rules.
- define device associated infections
- define and describe preventive care bundles for device associated infections

8. Infection Prevention & Control (IPC)

Need for IPC Program

- Healthcare Associated Infections (HAI) common adverse events
- Increase morbidity & mortality
- Increase duration of hospital stay
- Increase antibiotic use & increase AMR
- Increase overall treatment costs
- Economic burden
- Bad publicity for hospital

Infection Cycle



8. Infection Prevention & Control (IPC)

Inter-relationship of AMR & IPC

AMR & IPC

AIM OF IPC PROGRAM

- Prevention & stopping transmission of hospital acquired infections (HAI)
- Reduce Antibiotic Use
- Reduce Antimicrobial Resistance



8. Infection Prevention & Control (IPC)

Route of Transmission

Infections are spread by following routes-

- Contact (Direct/ Indirect)
- Airborne (aerosol)
- Respiratory (droplet nuclei)
- Fomite (surface)
- Inoculation or parenteral
- Faeco-oral
- Health care transmission

8. Infection Prevention & Control (IPC)

Modes of Transmission of Disease

- Transmission is the process by which a pathogen spreads from one host to another. Diseases or infections are transmitted in many ways.
- **Direct transmission:** This occurs when the pathogen is transmitted directly from an infected person. Direct transmission are-
 - Person to person
 - Droplet transmission
 - Spread by Skin
 - Spread through body fluids or blood

8. Infection Prevention & Control (IPC)

Modes of Transmission of Disease cont..

- **Indirect transmission:** Contact occurs from a reservoir to contaminated surfaces or objects, or to vectors such as mosquitoes, flies, mites, fleas, ticks, rodents or dogs.

Indirect transmission are-

- Airborne transmission
- Contaminated objects
- Vector borne diseases
- Food and drinking water
- Through animals
- Environmental factors

8. Infection Prevention & Control (IPC)

Strategies for Prevention of Hospital Acquired Infections (HAIs)

- **Standard precautions:** are the minimum standard of IPC practices that should be used by **all** health-care workers, during the care of **all** patients, at **all** times, in **all** settings.

Includes-

- **Transmission based precautions:**
 - are used in addition to standard precautions for patients with known or suspected infection or colonization with transmissible and/or epidemiologically significant pathogens.
 - The type of transmission-based precautions assigned to a patient depends on the transmission route of the microorganism: contact, droplet, or airborne

8. Infection Prevention & Control (IPC)

Strategies for Prevention cont..

Standard Precautions components

- Risk assessment
- Hand hygiene
- Respiratory hygiene and cough etiquette
- Patient placement
- Personal protective equipment
- Aseptic technique
- Safe injections and sharps injury prevention
- Environmental cleaning
- Handling of laundry and linen
- Waste management
- Decontamination and reprocessing of reusable patient care items and equipment.

8. Infection Prevention & Control (IPC)

Hand Hygiene

Hand Hygiene-

- A general term that applies to either -handwashing, antiseptic handwash, antiseptic handrub, or surgical hand antisepsis
- Alcohol-based handrubs reduce bacterial counts on hands more effectively than plain soaps, and in a majority of studies more effectively than antimicrobial soaps.

8. Infection Prevention & Control (IPC)

Hand Hygiene

- It is one of the basic measures of standard precaution
- Hand hygiene is the simplest, most effective measure for preventing nosocomial infections, however it is the most neglected one too.

8. Infection Prevention & Control (IPC)

Hand Hygiene

Hand Rub

- Alcohol based Hand sanitizers
- 20-30 seconds

Hand wash

- Using Soap & Water
- 40-60 seconds
- Hands soiled



(Source: <https://openwho.org/courses/IPC-HH-en>)

8. Infection Prevention & Control (IPC)

Routine Hand Washing Tips

Jewelry

- Rings should either be removed or moved to ensure washing underneath them.
- Rings can make donning gloves more difficult and may cause gloves to tear more readily.

8. Infection Prevention & Control (IPC)

Condition of Nails and of Hands

- Artificial nails should be avoided.
- Nails should be kept short, rounded, and unvarnished, and the routine use of nail brushes should be avoided.
- The hands, including the nails, should be inflammation free

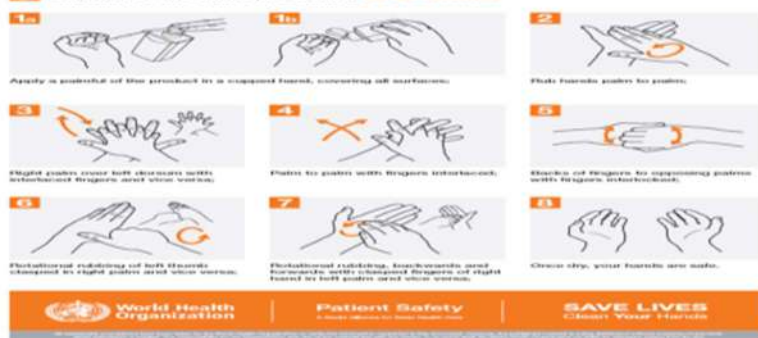
8. Infection Prevention & Control (IPC)

Activity 1:- Demonstration of Steps of Handrub

How to Handrub?

RUB HANDS FOR HAND HYGIENE! WASH HANDS WHEN VISIBLY SOILED

Duration of the entire procedure: 20-30 seconds



(Source: Guideline on Hand Hygiene in Health Care in the Context of Filovirus Disease Outbreak Response, WHO, 2014)

8. Infection Prevention & Control (IPC)

Donning of PPE

(source: <https://www.cdc.gov/hai/pdfs/ppe-sequences>)



Activity 2:- Donning of PPE

8. Infection Prevention & Control (IPC)

Doffing of PPE

source: <https://www.cdc.gov/hai/pdfs/ppe-sequences>



Activity 3:- Doffing of PPE

8. Infection Prevention & Control (IPC)

Inoculation Precautions

- Rational/ Safe Injection Practices
- Safe procedures for handling sharps
- Recapping of needle should be avoided
- Metallic waste disposed into a puncture resistant container.
- Have maximum visibility & properly position the patient during exposure-prone procedures such as phlebotomy.
- Fingers must be protected from injury by using forceps for holding suturing needles.

8. Infection Prevention & Control (IPC)

Spill Management

Cordon off the area of spill.

Open spill kit and wear PPE. Use forceps, tongs or scooper to pick broken glass pieces and discard in cardboard box.

Put absorbent paper over the spill. For large spill cover with large size gauze pad or newspapers.

Pour fresh hypochlorite over the recovered spill and leave for 20 minutes.

Put another paper covering the soaked paper and then remove the soaked paper and put it in the yellow bag.

8. Infection Prevention & Control (IPC)

Activity 4- Demonstration of Spill Management

- You are the medical officer in hospital emergency. A RTA victim is brought to the emergency with an open left femur fracture and was bleeding profusely. After initial investigations & treatment the patient was stabilized and transferred to the Orthopaedics department for further management.
- You observe that about 50-60 ml spilled blood is present in the cubicle where this patient was received.
- What instructions would you like to give regarding management of this blood spill?

8. Infection Prevention & Control (IPC)

Airborne precautions

- These are to be followed for droplet nuclei $<5\mu\text{m}$, e.g., tuberculosis, chicken pox, measles and influenza. This requires:
- Isolation of patients in individual room with adequate ventilation: This includes, where possible, negative pressure; door closed; at least twelve air exchanges per hour; exhaust to outside placed away from intake ducts
- Staff wearing high-efficiency masks in room

8. Infection Prevention & Control (IPC)

Droplet precautions

- These are to be followed for droplet nuclei $>5\ \mu\text{m}$, e.g., meningococcal meningitis, diphtheria, respiratory syncytial virus. The following procedures are required:
- Individual room for the patient, if available
- Surgical mask for healthcare workers
- Restricted circulation for the patient; patient wears a surgical mask if leaving the room
- Teach the patient to follow respiratory hygiene/cough etiquette.

8. Infection Prevention & Control (IPC)

Contact precautions

- Direct contact occurs when performing patient- care activities that require touching the patient's skin. Indirect contact occurs when touching potentially contaminated environmental surfaces or equipment in the patients' environment
Individual room for the patient if available; grouping patients if possible
- Staff wear gloves on entering the room; a gown for patient contact or contact with contaminated surfaces or material
- Wash hands before and after contact with the patient, and on leaving the room
- Restrict patient movement outside the room
- Appropriate environmental and equipment cleaning, disinfection, and sterilisation

8. Infection Prevention & Control (IPC)

Summary

Type	Isolation room or cohorting	Hand Hygiene	Gloves	Gown	Mask	Eye protection	Handling of equipment	Visitors
Standard	Not required	Yes	Possible contact with blood/body fluid	If soiling likely	For aerosol generating procedures	For aerosol generating procedures	Single use or reprocessed	No additional precautions
Contact	Essential	Yes	Essential	Essential	For aerosol generating procedures	For aerosol generating procedures	Preferential single use/ patient dedicated equipment	Same as HCW's
Droplet	Essential	Yes	Possible contact with blood/body fluid	If soiling likely	Surgical mask	For aerosol generating procedures	Single use or reprocessed	Restricted visitor policy. Precautions same as HCW's
Airborne	Negative Pressure	Yes	Possible contact with blood/body fluid	If soiling likely	N 95 mask	For aerosol generating procedures	Single use or reprocessed	Restricted visitor policy. Same as HCW's

8. Infection Prevention & Control (IPC)

Biomedical Waste Management

8. Infection Prevention & Control (IPC)

Definition

Any waste generated while providing health care, performing research and undertaking investigations or related procedures on human beings or animals in hospitals, clinics, laboratories or similar establishments

8. Infection Prevention & Control (IPC)

Non-compliance

The occupier is liable for penalty for contravention of the provisions of the Act and the Rules, orders and directions as specified in **Rule 15. of the E(P)Act,1986,**

“whosoever fails to comply or contravenes any of the provisions of the Act and the Rules, orders and directions be **punishable with imprisonment for a term which may extend to five years or with fine which may extend to one lakhs rupees or both**”

8. Infection Prevention & Control (IPC)

Definition of Occupier

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

8. Infection Prevention & Control (IPC)

Authorisation

- Every occupier or operator handling bio-medical waste, irrespective of the quantity shall make an application in Form II for authorization under BMW Rules and consent under Air Act & Water Act.
- The authorisation shall be one time for non-bedded occupiers.

8. Infection Prevention & Control (IPC)

Generation Rate of Waste

General waste 85%

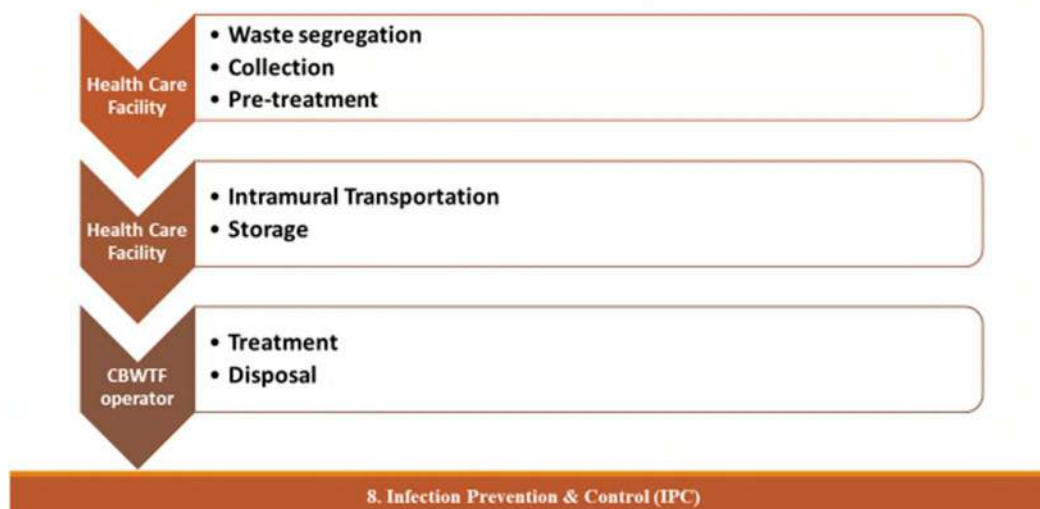
Infectious waste 10%

Chemical waste 5%

Radioactive waste 1%

8. Infection Prevention & Control (IPC)

Steps involved in BMW Management



Segregation at Source

- Segregated at the point of generation

Yellow bag and bin	Red bag and bin	Blue container or box	White puncture proof container

- Four colour coded containers/bags as per BMW guideline
- Non-chlorinated colour coded bags of 55 microns are used

8. Infection Prevention & Control (IPC)

Segregation at Source cont..

- The bags should be labelled with ward and date before placing into the bin
- All patient care areas and laboratories will be provided with appropriate colour coded bags placed in appropriate bins.
- Infection control nursing officer will be responsible to ensure that proper
- Guidelines are followed during the segregation of wastes.

8. Infection Prevention & Control (IPC)

YELLOW BAG (non-chlorinated plastic bag)	RED COLOUR (non-chlorinated plastic bag) Contaminated Waste (Recyclable)	Blue (Cardboard boxes with blue colored marking)	White (Translucent Puncture proof container)
(a) Human Anatomical Waste (b) Animal Anatomical Waste (c) Soiled Waste (d) Expired or Discarded Medicines (e) Chemical Waste (f) Chemical Liquid Waste (g) Discarded linen, mattresses, beddings contaminated with blood or body fluid. (h) Microbiology, Biotechnology and other	Wastes generated from disposable items such as tubing, bottles, intravenous tubes and sets, catheters, urine bags, syringes (without needles and fixed needle syringes) and Vaccutainers with their needles cut) and gloves.	(a) Glassware: Broken or discarded and contaminated glass including medicine vials and ampoules except those contaminated with cytotoxic wastes. (b) Metallic Body Implants	Waste sharps including Metals: Needles, syringes with fixed needles, needles from needle tip cutter or burner, scalpels, blades, or any other contaminated sharp object that may cause puncture and cuts. This includes both used, discarded and contaminated metal
 BIOHAZARD संक्राणकारी	 BIOHAZARD संक्राणकारी	 BIOHAZARD संक्राणकारी	 BIOHAZARD संक्राणकारी

YELLOW BAG (non-chlorinated plastic bag)**(a) Human Anatomical Waste:**

Human tissues, organs, body parts and foetus below the viability period (as per the Medical Termination of Pregnancy Act 1971, amended from time to time).

(b) Animal Anatomical Waste :

Experimental animal carcasses, body parts, organs, tissues, including the waste generated from animals used in experiments or testing in veterinary hospitals or colleges or animal houses.

(c) Soiled Waste:

Items contaminated with blood, body fluids like dressings, plaster casts, cotton swabs and bags containing residual or discarded blood and blood components.

8. Infection Prevention & Control (IPC)**(d) Expired or Discarded Medicines:**

Pharmaceutical waste like antibiotics, cytotoxic drugs including all items contaminated with cytotoxic drugs along with glass or plastic ampoules, vials etc.

(e) Chemical Waste:

Chemicals used in production of biological and used or discarded disinfectants.

(f) Chemical Liquid Waste :

Liquid waste generated due to use of chemicals in production of biological and used or discarded disinfectants, Silver X-ray film developing liquid, discarded Formalin, infected secretions, aspirated body fluids, liquid from laboratories and floor washings, cleaning, house-keeping and disinfecting activities etc.

8. Infection Prevention & Control (IPC)

(g) Discarded linen, mattresses, beddings contaminated with blood or body fluid.

(h) Microbiology, Biotechnology and other clinical laboratory waste:

Blood bags, Laboratory cultures, stocks or specimens of microorganisms, live or attenuated vaccines, human and animal cell cultures used in research, industrial laboratories, production of biological, residual toxins, dishes and devices used for cultures.



8. Infection Prevention & Control (IPC)

RED COLOUR (non-chlorinated plastic bag)

• **Contaminated Waste (Recyclable)**

(a) Wastes generated from disposable items such as tubing, bottles, intravenous tubes and sets, catheters, urine bags, syringes (without needles and fixed needle syringes) and Vacutainers with their needles cut) and gloves.



8. Infection Prevention & Control (IPC)

White (Translucent Puncture proof container)

Waste sharps including Metals:

- Needles, syringes with fixed needles, needles from needle tip cutter or burner, scalpels, blades, or any other contaminated sharp object that may cause puncture and cuts. This includes both used, discarded and contaminated metal sharps



8. Infection Prevention & Control (IPC)

Blue (Cardboard boxes with blue colored marking)**(a) Glassware:**

Broken or discarded and contaminated glass including medicine vials and ampoules except those contaminated with cytotoxic wastes.

(b) Metallic Body Implants

8. Infection Prevention & Control (IPC)

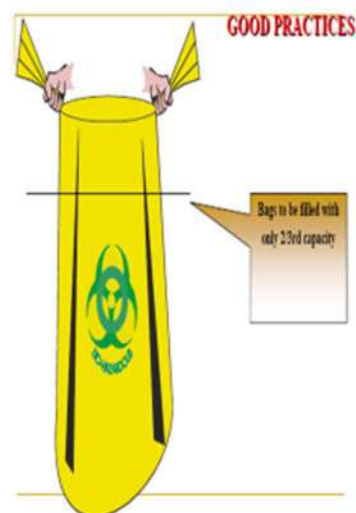
Handling and Transport

- The staff handling and transporting the bio-medical waste should wear appropriate PPE including boots and to prevent occupational hazard.
- All bins containing BMW should have biohazard label on them in accordance with Schedule IV Part A.
- Posters indicating waste segregation will be made available at all areas of patient care.
- Microbiology and all other clinical laboratory waste should be pre-treated by sterilisation before packing and sending to the common bio-medical waste treatment facility.

8. Infection Prevention & Control (IPC)

Handling and Transport cont..

- When waste bag/containers are $\frac{3}{4}$ th full, they should be sealed.
- Foot operated or lidded bins should be used and in good working condition.
- Plastic waste bags should be fully enclosed within the bins.
- Origin of the waste is marked on the waste bag.



8. Infection Prevention & Control (IPC)

Storage

- A dedicated, well ventilated and clean area for storage of BMW within the hospital premises should be there.
- No untreated Bio medical waste will be kept stored beyond a period of **48 hours**.
- Each bag/container is weighed and the weight recorded in record sheet which has to be signed by appropriate personnel.
- At the end of month the record sheet will be submitted to the waste management committee for record keeping.

8. Infection Prevention & Control (IPC)

Transport



- Transport to be carried out on daily basis from central storage to CBMTF.
- Closed type transport vehicle
- Trained driver in basic handling of BMW.

8. Infection Prevention & Control (IPC)

Preventive Bundles for Device Associated Infections

8. Infection Prevention & Control (IPC)

Device Associated Infections

- These healthcare-associated infections are infections that can be associated with the devices used in medical procedures , such as catheters or ventilators .

8. Infection Prevention & Control (IPC)

Care Bundles

- These are a **set of interventions** that when applied together result in better prevention of device associated infections than individual elements implemented alone.
- Some recommended preventive bundles are given below. The hospital may modify these bundles according to their availability of resources and other logistics.

8. Infection Prevention & Control (IPC)

Care Bundles cont..

These include

- Bundles for the prevention of central line-associated bloodstream infections (CLABSI)
- Bundle for the prevention of catheter-associated urinary tract infections (CAUTI)
- Bundle for the prevention of ventilator associated pneumonia (VAP)

8. Infection Prevention & Control (IPC)

Checklist for Prevention of CLABSI

For Clinicians

1. Follow proper insertion practices

- Perform hand hygiene before insertion.
- Adhere to aseptic technique.
- Use maximal sterile barrier precautions (i.e., mask, cap, gown, sterile gloves, and sterile full body drape).
- Choose the best insertion site to minimize infections and noninfectious complications based on individual patient characteristics.

8. Infection Prevention & Control (IPC)

Checklist for Prevention of CLABSI

- Avoid femoral site in obese adult patients.
- Use Subclavian rather than Jugular veins.
- Prepare the insertion site with >0.5% chlorhexidine with alcohol.
- Place a sterile gauze dressing or a sterile, transparent, semipermeable dressing over the insertion site.

8. Infection Prevention & Control (IPC)

Checklist for Prevention of CLABSI cont..

- For patients 18 years of age or older, use a **chlorhexidine impregnated dressing** with an FDA cleared label that specifies a clinical indication for reducing CLABSI for short term non-tunneled catheters unless the facility is demonstrating success at preventing CLABSI with baseline prevention practices.

8. Infection Prevention & Control (IPC)

Checklist for Prevention of CLABSI cont..

2. Handle and maintain central lines appropriately

- ✓ Comply with **hand hygiene** requirements.
- ✓ Bathe ICU patients over 2 months of age with a chlorhexidine preparation on a daily basis.
- ✓ Scrub the access port or hub with friction immediately prior to each use with an appropriate **antiseptic** (chlorhexidine, povidone iodine, an iodophor, or 70% alcohol).

8. Infection Prevention & Control (IPC)

Checklist for Prevention of CLABSI cont..

- ✓ Use only sterile devices to access catheters.
- ✓ Immediately replace dressings that are wet, soiled, or dislodged.
- Perform routine dressing changes using aseptic technique with clean or sterile gloves.
 - Change gauze dressings at least every two days or semipermeable dressings at least every seven days.

8. Infection Prevention & Control (IPC)

Checklist for Prevention of CLABSI cont..

- Change administrations sets for continuous infusions no more frequently than every 4 days, but at least every 7 days.
 - ✓ If blood or blood products or fat emulsions are administered change tubing every 24 hours.
 - ✓ If propofol is administered, change tubing every 6-12 hours or when the vial is changed.
 - ✓ Perform daily audits to assess whether each central line is still needed.

8. Infection Prevention & Control (IPC)

Catheter Associated Urinary Tract Infections (CAUTI)

8. Infection Prevention & Control (IPC)

Definition

Catheter-associated UTI (CAUTI): A UTI where an indwelling urinary catheter (IUC) was in place for more than **two consecutive days** in an inpatient location on the date of event or the day before, with day of device placement being Day 1.

8. Infection Prevention & Control (IPC)

1. Core Prevention Strategies

- Insert catheters only for appropriate indications
- Leave catheters in place only as long as needed
- Ensure that only properly trained persons insert and maintain catheters
- Insert catheters using aseptic technique and sterile equipment (acute care setting)
- Following aseptic insertion, maintain a closed drainage system
- Maintain unobstructed urine flow.
- Hand hygiene and Standard (or appropriate isolation) Precautions.

8. Infection Prevention & Control (IPC)

2. Supplemental Prevention Strategies

- Consideration of alternatives to indwelling urinary catheterization
- Use of portable ultrasound devices for assessing urine volume to reduce unnecessary catheterizations
- Use of antimicrobial/antiseptic-impregnated catheters (after first implementing core recommendations for use, insertion, and maintenance)

8. Infection Prevention & Control (IPC)

Ventilator Associated Pneumonia (VAP)

8. Infection Prevention & Control (IPC)

Definition

Ventilator Associated Pneumonia (VAP):

A pneumonia where the patient is on mechanical ventilation for > 2 consecutive calendar days on the date of event, with day of ventilator placement being Day 1 AND the ventilator was in place on the date of event or the day before.

8. Infection Prevention & Control (IPC)

Maintenance Care Bundle for Mechanical Ventilation

- ❖ Adherence to hand hygiene
- ❖ Elevation of head of the bed to 30-45°
- ❖ Daily oral care with Chlorhexidine 2% solution
- ❖ Need of Peptic ulcer disease prophylaxis to be assessed daily- If needed sucralfate should be given
- ❖ DVT prophylaxis should be provided
- ❖ Daily assessment of readiness to remove mechanical ventilator must be documented.

8. Infection Prevention & Control (IPC)

Suggested Practices

- ❖ Bundles are not '**silver bullet**' solutions for all infection risks and should be implemented in a targeted group of patients, in a common hospital location, so that the elements of the bundle can be delivered as part of a single process of care.
- ❖ Ensure the elements of the care bundle are concise, simple, and prescriptive since numerous, complex bundle elements may hinder the success and effectiveness of frontline adoption and implementation.

8. Infection Prevention & Control (IPC)

Suggested Practices cont..

- ❖ Identify members of the healthcare team to test the implementation of the proposed bundle elements. It is recommended that these team members are early adopters of change.
- ❖ Bundle elements should not be static, but must adapt to changing evidence and best practices as new evidence emerges.
- ❖ Create awareness through the necessary training and education and provide the team with the applicable guidelines, evidence, toolkits and supplies (if any) to execute the implementation of a bundle.
- ❖ Once an appropriate methodology has been established, implement the interventions of each bundle element every time for every eligible patient.

8. Infection Prevention & Control (IPC)

Suggested Practices cont..

- ❖ Track compliance to the care bundle as an **“all or none”** measure and feedback results to frontline teams. Feedback should be delivered frequently (weekly or monthly if possible) to encourage improvement and sustainability.
- ❖ IHI improvement methods to re-design care processes and improve quality of care should be adopted when gaps or system breakdowns.
- ❖ The most effective programs include those with robust leadership, stringent protocols, participation of all members of the available healthcare team.

8. Infection Prevention & Control (IPC)

THANK YOU

8. Infection Prevention & Control (IPC)

भारत
राष्ट्रीय आयुर्विज्ञान आयोग

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**NAP-AMR Cell, National Medical Commission,
Pocket - 14, Sector -8, Dwarka Phase - 1, New Delhi-110077, India.**

Email ID – napamr2022@gmail.com | Website – www.nmc.org.in

About National Medical Commission (NMC):

The National Medical Commission (NMC) is India's premier regulatory body overseeing medical education and practice. Committed to upholding the highest standards in healthcare education, NMC ensures the delivery of quality medical education and training across the nation.

For more information about NMC, please visit
www.nmc.org.in



राष्ट्रीय आयुर्विज्ञान आयोग
National Medical Commission

Publication Division, National Medical Commission
Pocket-14, Sector-8, Dwarka Phase-1, New Delhi-110077, INDIA

E-Compendium link - <https://www.nmc.org.in/e-compendium-of-nmc-2020-2023/>



A-12023/02/2023/NMC/Estt.(8237178) 1026658

National Medical Commission

राष्ट्रीय आयुर्विज्ञान आयोग
(Establishment Section)

Pocket- 14, Sector-8,
Dwarka, Phase - 1, New Delhi-110077

Dated: 04.07.2024

CIRCULAR

Subject: Engagement of retired Government Officers / Employees as Consultant (Engineering & Maintenance) on contract basis in National Medical Commission - inviting applications thereof- reg.

The reference is invited to Commission's, circular of even no. dated 03.06.2024 (copy enclosed), on the subject mentioned above and it is hereby conveyed that the last date to apply from the said post of Consultant (Engineering & Maintenance) is **extended upto 16.07.2024**. All the other terms and condition remains same.

Encl: As Above


(Ajay Kumar Gaur)
Deputy Secretary (Estt.)

All Ministries/Departments of the Government of India (as per list).

Copy to:

1. Under Secretary, CS.I Division, DoPT, Lok Nayak Bhawan, New Delhi with a request to upload this Circular on website of DoP&T for wide publicity.
2. Under Secretary, Medical Education-I, MoH&FW with a request to publish this Circular on website of MoH&FW.
3. Sh. S.K. Meena, Commr.-Cum-Secretary, Delhi Development Authority (DDA), Vikas Sadan, INA, New Delhi-110023.
4. DG, Central Public Works Department (CPWD), A-Wing, Room No.- 101 Nirman Bhawan, New Delhi-110011
5. US(IT Section), NMC with a request to upload this circular on NMC website.
6. Guard file.

Pl. get this uploaded
3
4/7
A80 (IT)



Pocket- 14, Sector-8,
Dwarka, Phase - 1, New Delhi-110077
Dated: 03.06.2024

CIRCULAR

Subject: Engagement of retired Government Officers / Employees as Consultant (Engineering & Maintenance) on contract basis in National Medical Commission - inviting applications thereof-reg.

National Medical Commission, invites applications from eligible and desirous candidates retired from Government Service, having considerable experience of functioning of Government/ Ministries/Departments, for engagement as Consultant on contractual full time basis.

2. Details of required Consultants to be engaged are as under:

Sr. No (1)	Position (2)	Number of Positions (3)	Qualification and Eligibility Condition (4)
I.	Consultant (Engineering & Maintenance)	01	A) QUALIFICATION:- B.Tech or B.E or Equivalent in Civil / Electrical/ Mechanical B) ELIGIBILITY CONDITIONS:- i) Retired Government Officer at the Level of 11 or above having experience in the Engineering and Maintenance of building. ii) Experience in Civil, Electrical and Mechanical aspects of building maintenance such as fire services; lift services; power backup; Heating, Ventilation and Air Conditioning (HVAC).

3. General Condition for all the posts:

- i) **Period of engagement:** initially for a period of one year which is extendable for further period(s) subject to satisfactory performance.

[Handwritten signature]
ASO (IT)

[Handwritten signature]
03/06/2024

अजय कुमार गौड़ / Ajay Kumar Gaur
उप सचिव / Deputy Secretary
राष्ट्रीय आयुर्विज्ञान आयोग / National Medical Commission
पॉकेट-14, द्वारका - 1, नई दिल्ली - 110077
पिन-110077

- ii) **Job Description & Location:** Shall be responsible for safeguarding the office premises/building from any hazard and day-to-day maintenance (Civil/Electrical and Mechanical aspects of the building maintenance), Regular inspections of the building's infrastructure to identify and address potential issues such as leaks, drainage problems, and structural weaknesses, to implement preventive measures and to improve the building's resilience against adverse weather conditions, upgradation/ renovation/beautification, etc.
- iii) **Location:** National Medical Commission, Pocket-14, Sector-8, Dwarka Phase-I, New Delhi-110077
- iv) **Age:** Age should be less than 64 years as on closing date of this circular.
- v) **Remuneration:** Last pay drawn minus pension plus transport allowance in accordance with the instructions of Government of India issued from time to time. Selected Candidate will be entitled to Transport Allowance that he/she was getting at the time of retirement/ superannuation on the Last Pay Drawn without DA. Retired Govt. Officers engaged as Consultants may be allowed TA/DA on official tour, if any, as per their entitlement at the time of retirement.
- vi) **Leave:** Paid Leave may be allowed at the rate of 1.5 days for each completed month of service. Accumulation of leave beyond a calendar year may not be allowed.
- vii) **Mode of Selection:** Application received in response to this advertisement will be shortlisted on the basis of experience and qualifications of applicants. Consultants will be selected on Interview basis from shortlisted candidates.
- viii) **Working hours:**
- Normal Office timings are from 9:30AM to 6:00PM but the post/nature of duties requires monitoring/follow up beyond office hours.
 - May be required to Work from Home beyond office hours.
 - May also be required to attend office on holidays depending on exigencies of work.
- ix) **Department of Expenditure's OM F. No. 3-25/2020-EIII dated 09.12.2020 will be followed.**
- x) **How to apply:** The applications in the prescribed format (completed in all respects) along with copy of PPO and Last Pay Certificate may be sent to the following address:-

Deputy Secretary (Estt.),
National Medical Commission,
Pocket-14, Sector-8, Dwarka phase-I,
New Delhi-110077.


03/06/20

अध्यक्ष, राष्ट्रीय चिकित्सा आयोग
एनएमसी, पॉकेट-14, सेक्टर-8, द्वारका फेज-1, नई दिल्ली-110077
03/06/20

Application for the post of Consultant on contract basis in National Medical Commission

(Last date for receipt of application: 21.06.2024)

Applied for consultant
as per mentioned in
Circular dated 03.06.2024

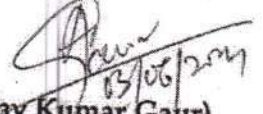
Recent Passport
size photograph

1.	Full Name (in Block Letters)	
2.	Date of Birth	
3.	Email Id	
4.	Mobile No.	
5.	Residential Address	
6.	Educational Qualification (Attach self attested copies of certificate)	
7.	Date of superannuation/retirement	
8.	PPO Number (enclose a copy)	
9.	Post held at the time of retirement	
10.	Last Pay Drawn (Pay Level & Pay)	
11.	Transport allowance (basic) at the time of retirement	
12.	Organisation superannuated from	
13.	Organisation currently working (if any)	
14.	Working Knowledge of MS Office, e-office and Internet browsing (yes/No)	

xi) Last date for receipt of application: 21.06.2024.

4. Eligible retired Officers, in good health may submit their applications in the enclosed format before the closing date. Applications received with incomplete information or received beyond the closing date will not be considered.

5. NMC retains the right to increase/ decrease the vacancy as per the requirement without any notice.


(Ajay Kumar Gaur)
Deputy Secretary (Estt.)

All Ministries/ Departments of the Government of India (as per list).

राज्य कुमार गौड़ / Ajay Kumar Gaur
उप सचिव / Deputy Secretary
राष्ट्रीय आयुर्विज्ञान आयोग / National Medical Commission
पॉकेट-14, सेक्टर-8, द्वारका, नई दिल्ली-110077
Pocket-14, Sector-8, Dwarka, New Delhi-110077

Copy to:

1. Under Secretary, CS.I Division, DoPT, Lok Nayak Bhawan, New Delhi with a request to upload this Circular on website of DoP&T for wide publicity.
2. Under Secretary, Medical Education-I, MoH&FW with a request to publish this Circular on website of MoH&FW.
3. US(IT Section), NMC with a request to upload this circular on NMC website.
4. Guard file.

15.	Brief particulars of experience of last 10 years *	Post held	from	to	Experience/nature of work

*Please attach separate sheet if required.

Undertaking:

I hereby declare that the particulars furnished above are true and correct to the best of my knowledge and belief. I further declare that I was clear from vigilance angle at the time of my retirement. I have read this circular and accept all the terms and conditions for engagement of consultants.

Place:

Date:

(Signature of the applicant)

Mobile:

Email ID:



National Medical Commission

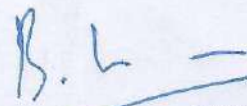
Press Release

This Commission has been acknowledged by the GST authorities for the FY 2023 -24 for stellar performance and on the compliances in GST regime. Attached is the **Certificate of Appreciation issued by the **Chairman, CBIC, Ministry of Finance, Government of India**.**

This is recognition for entire organization i.e. NMC and its Boards.

All the concerned officers/officials of accounts/ finance division of NMC including the consultant CA agency deserve praise for their indefatigable work related to GST regulations and compliances.

In future too, NMC envisages such achievement may continue and grow further. So all the stakeholder medical colleges/institutions and medical fraternity may note that **all the remittances in form of fees etc. may be invariably deposited alongwith applicable rate of GST** (i.e. @18% as applicable now). The GST related details are NMC GST No. 07AAGAN6607H1ZI, Name of Account Holder: National Medical Commission Own Resources Fund, Account No.90682160000025, Name of Bank-Canara Bank (Branch code-19109), IFSC -CNRB0019109, MICR-110015487


Secretary, NMC



Government of India
Ministry of Finance

**CERTIFICATE
OF APPRECIATION**

The Central Board of Indirect Taxes and Customs conveys its appreciation to NATIONAL MEDICAL COMMISSION having GST registration number 07AAGAN6607H1ZI for their prompt filing of returns and payment of Goods and Services Tax during the financial year 2023-24, thereby substantially contributing to building a strong and resilient nation.

Sanjay Kumar Agarwal
Chairman

No. M-19011/11/2023-MARB/NMC (8244596)
National Medical Commission (NMC)
Medical Assessment & Rating Board (MARB)

Pocket- 14, Sector- 8, Dwarka, Phase – 1,
New Delhi-77

Dated: 23rd July 2024

PUBLIC NOTICE

Subject: Impersonation of attendances in AEBAS in medical colleges/institutions – reg.

It has come to attention of National Medical Commission (NMC) that in some medical institutions the faculty members are marking bio-metric attendance on AEBAS using fake finger prints.

2. This is viewed seriously by the National Medical Commission. It is advised that all faculty members must mark their attendance personally in the AEBAS connected to the NMC at their medical college. Any incidence of impersonation shall attract appropriate action.

3. This issues with the approval of the Chairman, NMC.

Prof. (Dr). B Srinivas
Secretary

To,

All Medical Institutions/Colleges / faculty concerned.

No. M-19011/11/2023-MARB/NMC (8244596)
National Medical Commission (NMC)
Medical Assessment & Rating Board (MARB)

Pocket- 14, Sector- 8, Dwarka, Phase – 1,
New Delhi-77

Dated: the 23rd July 2024

PUBLIC NOTICE

**Subject: Updating of Faculty details on the website of medical Colleges/
Institutions. – Regarding.**

All Medical Institutions must update the college website as regard the faculty in each department as follows:

- a. The list of faculty must be available separately under each Department (the medical superintendent, Principal, Dean, if are from any of the Departments may also be indicated here);
 - b. The list must have name of the faculty members, his/her recent Photo, educational qualification, latest designation and Registration number issued by the respective State Medical Council;
 - c. The names reflected in the list must be onboard in the AEBAS system of the college;
 - d. **The faculty list in the website must be uploaded latest by 31st July, 2024.**
Any incorrect, incomplete and/or late submission of information shall attract appropriate action against the medical institutions/medical colleges concerned;
and
 - e. **The list will be updated every month. The deadline for such updating shall be the last day of every month.**
2. This issues with the approval of the Chairman, NMC.

Prof. (Dr.) B Srinivas
Secretary

To

All Medical Institutions/Colleges concerned.



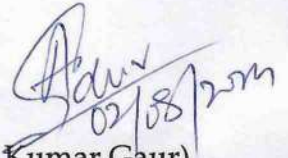
Pocket- 14, Sector-8,
Dwarka, Phase - 1,
New Delhi-110077

Dated the 2nd August 2024

OFFICE ORDER

Consequent upon his repatriation to National Health Authority vide Ministry of Health and Family Welfare's Office Memorandum No. U.12011/02/2024-ME-I dated 01.08.2024, Dr. Jitunal Ramprasad Meena, Whole-Time Member, Medical Assessment & Rating Board (MARB), National Medical Commission is **hereby relieved of his duties in National Medical Commission with effect from the forenoon of 2nd August 2024**. He is advised to report to CEO, National Health Authority.

2. This issues with the approval of Chairman, NMC.


(Ajay Kumar Gaur)
Deputy Secretary (Estt.)

Copy to:

1. Dr. Jitunal Ramprasad Meena, Member, MARB - with the request to submit 'No dues' Certificate as per Performa enclosed for issuing Last Pay Certificate, and to submit Form regarding declaration of Assets and Liabilities (enclosed) as required under NMC Act, 2019
2. PS to Hon'ble HFM
3. PS to Hon'ble MoS(PGJ)
4. PS to Hon'ble MoS (AP)
5. Sr. PPS to Secretary (HFW)
6. PPS to AS(ME)
7. PPS to Chairman NMC
8. PPS to all Presidents/ Members of the Boards, NMC
9. PPS to Secretary, NMC
10. O/o CVO, NMC
11. The CEO, National Health Authority, Jeevan Bharti Building, Connaught Place, New Delhi. Vigilance Clearance will be forwarded separately.
12. All Directors/DS/US, NMC
13. All Sections/Boards, NMC
14. Personal file of the Officer concerned
15. Guard file

o/c



**No. N-16021/33/2024-IT-NMC
(8291616)
Government of India
National Medical Commission
(O/o Secretary)**

Sector-8, Dwarka
New Delhi-110075

Dated the 13th August, 2024

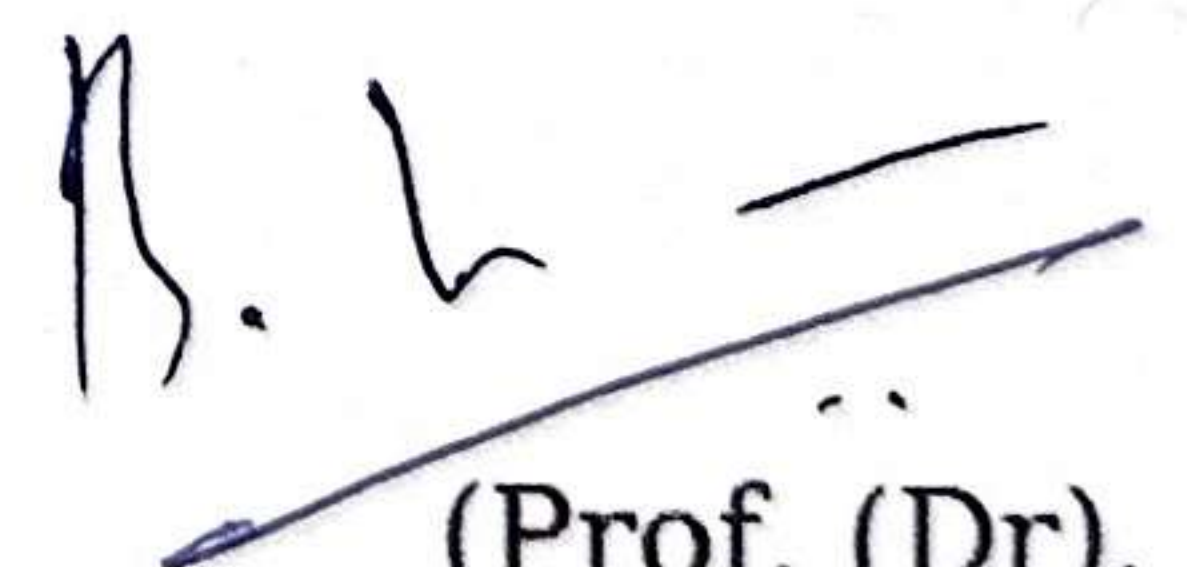
PUBLIC NOTICE

Subject: Advisory for all Medical Colleges and Institutions for ensuring safe work place environment.

Incidents of violence against Doctors in Medical Colleges have been reported in the recent past. All Medical Colleges are requested to develop a policy for safe work environment within the College and Hospital campus for all the staff members including Faculty, medical Students and resident Doctors. The policy should ensure adequate safety measures at OPD, wards, casualty, hostels and other open areas in the campus and residential quarters. Corridors and campus be well lit in the evening for staff to walk safely from one place to other and all sensitive areas be covered by CCTV for monitoring.

2. Adequate security measures including posting of adequate security staff (male and female) should be made available at the OPD, wards, casualty, labor rooms, hostels and residential quarters and other open areas in the Medical College and Hospital campus.

3. Any incident of violence against the medical students should be promptly investigated by the college management and FIR should be lodged with the Police. A detailed action taken report on any incident of violence should invariably be sent to the National Medical Commission (NMC) within 48 hours of the incident.


(Prof. (Dr).
B. Srinivas)
Secretary

Copy to:

- i. ACS/ PS/ Secretaries/ Department/s of Medical Education in all States/ Union Territories
- ii. PPS to Chairman, NMC
- iii. PPS to Presidents/ Members of all Boards of NMC
- iv. DMMP-I System Integrator- for uploading of NMC Website



The National Task Force on Mental Health and Well-being of Medical Students

2024





The Report of the National Task Force on Mental Health and Well-being of Medical Students

National Medical Commission

New Delhi – 110077, INDIA

June 2024

(Re)Visioning....

The core mission of every medical college is education, which is why it is often said that medical education is the foundation of a country's healthcare system. The essential goal is to enlighten young minds and guide them to become compassionate and skilled healthcare professionals. These institutions are not merely centers for healthcare services; they are where medical knowledge, critical thinking, compassionate care, and scientific inquiry are cultivated and nurtured.

Medical teachers play an irreplaceable role in shaping the future of healthcare. They are the pillars of the medical community, dedicating themselves not only to the clinical care of patients but also to the profound responsibility of nurturing the next generation of doctors. They guide medical students by transferring knowledge, imparting skills, and mentoring them in compassionate and ethical care. They embody and instil the values of compassion, empathy, and ethical care, mentoring students to become not just competent doctors, but compassionate healers. The impact of guidance from medical teachers is profound, enduring, and infinite.

In medical colleges, providing healthcare services and conducting research are important, but these activities should augment and serve the primary purpose of training and educating medical students. It should not be the other way around, where medical students are used to fill gaps caused by a lack of resources in the healthcare system. This distinction is crucial. Blurring these lines can weaken academic standards and jeopardize the safety and well-being of patients and the future healthcare system of the country. It's essential to maintain this balance with clarity and conviction.

Acknowledgments

On behalf of the National Task Force on Mental Health and Well-being of Medical Students, we extend our heartfelt gratitude to all those who have contributed to the successful completion of this final report. This comprehensive endeavor has been a testament to the collective spirit and dedication of countless individuals and institutions who have united with a shared vision for enhancing the mental health and well-being of our medical students.

A heartfelt and profound thanks to Dr. B.N Gangadhar, Chairperson of the NMC, whose visionary leadership and unwavering guidance have been the driving force behind the success of this initiative.

We extend special gratitude to Dr. Aruna V. Vanikar, whose crucial role in planning and providing unconditional support has been indispensable to the success of this task. Her dedication and commitment have been a cornerstone of our efforts. We also thank Dr. Vijayendra Kumar, a member of UGMEB, for his invaluable support.

Our sincere gratitude goes to Dr. Vijay Oza, President of the Post Graduate Medical Education Board (PGMEB), for his invaluable insights, support, and contributions. Additionally, we thank Dr. Vijaya Lakshmi Nag, a member of the Ethics and Medical Registration Board (EMRB). We would like to thank Dr. B. Srinivas, Secretary, for his unwavering support and guidance. We also express our deepest appreciation to the entire staff of the National Medical Commission (NMC) for their unwavering support and commitment throughout this project. Our heartfelt thanks go to all the undergraduate, postgraduate medical students and faculty, who participated in the online survey and shared their views. Your voices have been pivotal in shaping this report, and your courage and openness in discussing mental health challenges are truly commendable. We also extend our heartfelt thanks to the Deans, Heads of Departments, Administrators, Wardens, and other members of medical colleges who organized and provided logistical support for in-person meetings.

We would like to express our heartfelt gratitude to the reviewers, Dr. Ananda Pandurangi, Dr. Deepak B. Saxena, Dr N.S Harshavardhana, Dr. M Kishor, Dr. Prashant Kumar, and Dr. Rahul Saini. Their insightful suggestions and comments have significantly enhanced the robustness of these recommendations.

We extend our sincere gratitude to those who played crucial roles behind the scenes, ensuring the smooth execution of this initiative. Your dedication and hard work, often unseen, have not gone unnoticed. To anyone we may have inadvertently omitted, please know that your contributions are deeply appreciated. It stands as a testament to the power of collaboration and the shared commitment to improving the mental health and well-being of our future medical professionals. Together, we have taken a significant step towards fostering a more supportive and resilient environment for our medical students.

Thank you all for your unwavering support and dedication.

The National Task Force on Mental Health and Well-being of Medical Students

Chairman

Dr. Suresh Bada Math,

Professor of Psychiatry, Head of Unit-5,
Head of Telemedicine Centre, Head of Forensic Psychiatry,
Officer-in-charge of NIMHANS Digital Academy,
NIMHANS, Bangalore. Email : sureshbm@gmail.com

Members

Dr. Yogender Malik,

Professor of Forensic Medicine and Toxicology,
Bhagat Phool Singh Govt Medical College for Women, Sonipat.
Member (Full Time) Ethics and Medical Registration Board, National Medical Commission,
New Delhi.

Dr. Nandini Desai,

Dean & Professor, M.P.Shah Government Medical College,
Jamnagar, Gujarat.

Dr. Geeta Guin,

Professor & Head, Department of Obstetrics & Gynecology,
Netaji Subhash Chandra Bose Medical College, Jabalpur.

Dr. Naveen Sankhyan,

Professor of Pediatrics, Advanced Pediatrics Center,
PGIMER, Chandigarh.

Dr. Vijay Kumar,

Professor of Plastic & Reconstructive Surgery, King George's Medical University, Lucknow.

Dr. Bhavuk Garg,

Professor of Orthopaedics, AIIMS, New Delhi.

Dr. K.Senthil,

Professor of Medicine, Govt Medical College, Madurai &
Part time Member, Post Graduate Medical Education Board,
National Medical Commission, New Delhi.

Dr. Pushpendra Malik,

Professor of Surgery,
Bhagat Phool Singh Govt Medical College for Women, Sonipat.

Dr. Reetu Hooda,

Professor of Obstetrics & Gynaecology,
Pt.B.D.Sharma PGIMS, Rohtak.

Dr. Kamlesh J Upadhyay,
Professor & Head, Department of Medicine,
B.J. Medical College, Ahmedabad.

Dr. Sumit Rana,
Professor of Psychiatry, Lady Hardinge Medical College, New Delhi.

Dr. Vijay Silan,
Associate Professor of Community Medicine,
Bhagat Phool Singh Govt. Medical College for Women, Sonipat.

Dr. Sunaina Hooda,
Assistant Professor of Pathology,
Bhagat Phool Singh Govt. Medical College for Women, Sonipat.

Member Secretary

Shri. Aujender Singh,
Deputy Secretary, PGMEB, NMC, New Delhi.

Co-opted Member

Dr. V. Senthil Kumar Reddi,
Professor of Psychiatry, Head of Emergency Psychiatry & Acute Care Service
NIMHANS, Bangalore.

2. Terms and References of the National Task Force

Term: The National Task Force on Mental Health and Well-being of Medical Students will submit its final report by 31st May, 2024. During this period task force will submit its progress report to the Anti-Ragging Cell of NMC once in a month.

References:

Scope of Work: The Task Force shall study existing literature and data on mental health & suicide of medical students, analyze factors contributing to these challenges, and propose evidence-based strategies for improving mental health & prevention of suicides. The committee may visit the Colleges where incidents of suicides have been reported.

Reporting: The Task Force shall submit a comprehensive report outlining key findings and actionable recommendations for promoting the mental health of medical students by 31st May 2024. The task force will submit the monthly progress report to the Anti-Ragging Cell.

Meetings: The Task Force shall convene regular meetings, either virtually or in person, as necessary to fulfil its mandate. Additionally, committees may visit the medical colleges where incidents of suicide have been reported. The committee may co-opt other Members on a need basis to facilitate its study and timely finalization of the report.



डॉ. बी. न. गंगाधर
Dr. B. N. Gangadhar
अध्यक्ष/ President
चिकित्सा मूल्यांकन और मापन बोर्ड
Medical Assessment & Rating Board
& Officiating Chairman, NMC



सत्यमेव जयते



आज़ादी का
अमृत महोत्सव



राष्ट्रीय आयुर्विज्ञान आयोग
स्वास्थ्य एवं परिवार कल्याण मंत्रालय
भारत सरकार

National Medical Commission
Ministry of Health & Family Welfare
Government of India

MESSAGE

It is with a profound sense of responsibility and deep commitment to the well-being of our future healthcare providers that I present the comprehensive report of "The National Task Force on Mental Health and Well-being of Medical Students." This report is not just a document but a beacon of hope for the thousands of medical students who dedicate their lives to the noble pursuit of medicine.

Our medical students face immense stress and challenges that often go unrecognized. The rigorous demands of medical education, coupled with the high expectations and pressures, place an extraordinary burden on their mental health. It is heart-wrenching to acknowledge that many of our brightest minds struggle silently, some even to the point of contemplating suicide. This is a reality we can no longer ignore.

In our quest to provide world-class healthcare, we must remember that the core responsibility of medical colleges is education. Health services, while essential, should remain secondary to our primary mission: nurturing knowledgeable, compassionate, and resilient medical professionals. The need for a paradigm shift from service back to medical education is urgent and imperative.

I am proud to highlight the critical role of yoga in this transformation. Yoga, with its holistic approach to mental and physical well-being, has proven to be a powerful tool in preventing mental illness, reducing stress, and building resilience. Integrating yoga into the daily routine of medical students can create a healthier, more balanced environment, empowering them to face their challenges with greater strength and serenity.

This report stands as a testament to the tireless efforts and unwavering dedication of the National Task Force. I extend my heartfelt congratulations to the chairman and all the members of the task force for their remarkable work in bringing out this comprehensive and insightful report. Your commitment to the mental health and well-being of our medical students is commendable and deeply appreciated.

Let us move forward together, armed with the insights and recommendations of this report, to create an environment where our medical students can thrive academically and personally. Together, we can build a future where the well-being of our healers is prioritized, ensuring that they, in turn, can provide the best care to our society.


(Dr. B.N. Gangadhar)

डॉ. अरुणा वी. वणीकर
Dr. Aruna V. Vanikar

अध्यक्ष/ President

स्नातक चिकित्सा शिक्षा बोर्ड

Under Graduate Medical Education Board

राष्ट्रीय आयुर्विज्ञान आयोग
स्वास्थ्य एवं परिवार कल्याण मंत्रालय
भारत सरकार

National Medical Commission
Ministry of Health & Family Welfare
Government of India

MESSAGE

'Education is not the filling of a pail, but the lighting of a fire. We want that education by which character is formed, strength of mind is increased, the intellect is expanded, and by which one can stand on one's own feet. The only way to do good work is to love what you do.'

Swami Vivekananda

I am happy to present to the readers this report of "The National Task Force on Mental Health and Well-being of Medical Students." This landmark document prepared with a great responsibility is one more attempt of our unwavering commitment to the future leaders of our society - the medical students who will become compassionate caregivers and public health pioneers of tomorrow.

Our mission extends beyond imparting knowledge; it is about nurturing resilient medical professionals equipped to face multifaceted challenges beyond their careers. Medical students are the bedrock of our healthcare system, and it is our duty to ensure they receive not only the finest education but also the support and mentorship necessary to thrive both personally and professionally.

Our aim is to create medical doctors who are humble but not be humiliated, and to make best possible decisions in the worst situations. Mentor-mentee program is the cornerstone of this vision. By fostering meaningful relationships between experienced professionals and students, we can guide them through the rigors of medical education, providing support and wisdom they need to succeed. This report calls for a paradigm shift - from a singular focus on knowledge acquisition to a more holistic approach that emphasizes skill development and compassionate care.

The recommendations of this report aim to significantly reduce mental health issues, drug abuse, and suicides that disturb our profession. This holistic approach will not only benefit our medical students but will also have a ripple effect, enhancing an overall health and well-being of the communities they serve.

I extend my heartfelt congratulations to Dr. Suresh Bada Math, Chairman, and the members of the National Task Force, for their tireless efforts and dedication in bringing forth this comprehensive report. Your work will undoubtedly pave the way for a brighter, healthier future for our medical students and, by extension, for our entire society.

Together, let us commit to creating an environment where our future medical professionals are knowledgeable, compassionate, and equipped to lead. Let us build a healthcare system where mental health is prioritized, ensuring the well-being of those who dedicate their lives to caring for others.

With deep appreciation and hope for a brighter future,


(Dr. Aruna V. Vanikar)

डॉ विजय ओझा

Dr Vijay Oza

अध्यक्ष/President

स्नातकोत्तर आयुर्विज्ञान शिक्षा बोर्ड

Post Graduate Medical Education Board



राष्ट्रीय आयुर्विज्ञान आयोग

भारत सरकार

National Medical Commission

Government of India

MESSAGE

It is with a deep sense of responsibility and urgency that I present the report of "The National Task Force on Mental Health and Well-being of Medical Students." This comprehensive report sheds light on the critical mental health issues faced by our postgraduate students, who are the backbone of our public healthcare ecosystem.

Our postgraduate students operate in a challenging and often toxic environment, filling critical gaps in the public healthcare ecosystem. They endure immense stress and workload, often without the necessary support and resources. This report highlights the urgent need to invest in the mental health and well-being of these young doctors who are integral to our nation's health. We must initiate a dimensional change in our medical education system, one that prepares these budding doctors to become a resilient healthcare force. By addressing the mental health challenges they face, we can ensure they not only provide exceptional care within our nation but also extend their compassionate services globally.

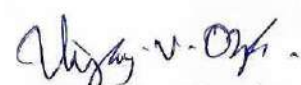
The young Indian medical force, through their dedication and compassionate care, has the potential to bond countries in the true spirit of '*vasudhaiva kutumbakam*' - the world is one family.

This report calls for a strategic investment in public health and a renewed focus on creating a supportive educational framework. By implementing these recommendations, we can transform our medical education system and ensure our postgraduate students are equipped with the resilience and skills necessary to thrive in their careers.

I extend my heartfelt congratulations to the chairman and members of the National Task Force for their unwavering dedication and hard work in bringing this comprehensive report to fruition.

Together, let us commit to building a resilient, compassionate medical community that prioritizes mental health and well-being. Let us empower our young doctors to be the healers and leaders our world needs.

With sincere gratitude and hope for a transformative future,



(Dr Vijay Oza)

डॉ. (प्रो.) बी. श्रीनिवास (एमडी)
सचिव

Dr. (Prof.) B. Srinivas (MD)
Secretary



सत्यमेव जयते



आज़ादी का
अमृत महोत्सव



राष्ट्रीय आयुर्विज्ञान आयोग
स्वास्थ्य एवं परिवार कल्याण मंत्रालय
भारत सरकार

National Medical Commission
Ministry of Health & Family Welfare
Government of India

Message from Secretary (NMC)

As we continue our journey to improve the mental health and well-being of our medical students, I am filled with immense gratitude for your unwavering commitment and contributions to the National Task Force. Your dedication and passion are the driving forces behind our collective success.

Our medical students are the future of healthcare, and their mental health is of paramount importance. Together, we can create an environment that supports their academic growth and nurtures their emotional and psychological well-being. By doing so, we can empower them to bring about positive changes in society, including preventing suicide and reducing the treatment gap for mental illness.

On a personal note, I am reminded of my own days as a medical student. The long hours, intense pressure, and relentless pursuit of excellence often took a toll on many students. I vividly remember moments of self-doubt and the struggle to maintain a balance between my academic responsibilities and personal life. It was the support from my mentors and peers that helped me navigate those challenging times. This personal journey has fueled my passion for ensuring that today's medical students receive the support they need to thrive academically, professionally, and personally.

The input from the task force report is invaluable as we finalize our strategies and implement our plans. Let us strive to make a lasting positive impact on the lives of our medical students.


(Dr. B. Srinivas)

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1. Definitions

- a. **Attempted Suicide:** A non-fatal, self-directed, potentially injurious behavior with the intent to end one's own life through actions that may cause harm, but it doesn't always result in injury.
- b. **Deliberate Self-Harm:** Deliberate self-harm, also known as self-injury behavior or self-mutilation, refers to the intentional and direct injuring of one's body tissue without suicidal intent. It is often used as a coping mechanism or to express distress.
- c. **Mental Health** - A state of well-being in which an individual realizes their own abilities, can cope with the everyday stresses of life, can work productively, and can contribute to their community. Mental health is not just the absence of mental disorders but encompasses emotional, psychological, and social well-being. It is an essential component of overall health
- d. **Medical Students** - This term encompasses undergraduate students (pursuing MBBS and interns), postgraduate medical students, super-specialization medical students, and physicians-in-training.
- e. **Risk Factor** - A characteristic, condition, or behavior that increases the likelihood of getting a disease or injury
- f. **Suicide:** Intentionally ending one's own life
- g. **Suicidal ideation:** Any thoughts about ending one's own life. It may be active, with a clear plan for suicide, or passive, with thoughts about wishing to die.
- h. **Suicide Spectrum** - Refers to a range of thoughts, behaviors, and actions related to suicide. It encompasses suicidal ideation (thoughts about taking one's own life), suicide attempts (non-fatal self-harm with intent to die), and completed suicide (death resulting from self-inflicted injury).
- i. **Well-being** - A state in which individuals realize their own potential, can cope with the normal stresses of life, can work productively and fruitfully, and can contribute to their communities. It encompasses physical, mental, and social dimensions and is influenced by various factors, including socioeconomic status, education, employment, and access to healthcare.

2. Language Guidelines to Avoid Stereotypes and Stigma

When discussing suicide, it is crucial to use sensitive language. Whether engaging in conversations, supporting individuals with personal experiences, or addressing the topic professionally, our choice of words goes beyond mere correctness; it can significantly impact lives. As healthcare providers, we must carefully consider the language we use to avoid stigma. By using non-stigmatizing language, we can create an environment where individuals feel more at ease seeking help during their most vulnerable moments.

Our language can also offer hope and have a positive impact. (Table 2.1) It is important to note that discussing suicide with someone does not cause or worsen suicidal thoughts, nor does it prompt individuals to act on such thoughts. Instead, exploring suicidal behaviors or ideation presents an opportunity for intervention and harm prevention. Therefore, it is crucial to inquire about suicidal thoughts and plans, as this approach can help alleviate feelings of isolation and fear.

Table 2.1: Recommended Terminology and Terms to Avoid in Mental Health.

Avoid following terms	Use these words	Reason
Committed suicide	Death by suicide/ Died by suicide	"Commit" in relation to suicide implies that it is a sin or a crime, which reinforces the stigma that it is a selfish act and a matter of personal choice.
Successful suicide/ Completed Suicide	Death by suicide/ Died by suicide	The notion of a "successful" is inappropriate because it frames a very tragic outcome as an achievement or something positive
Suicide prone	At risk of suicide	It is not the individual but the circumstances
(Name) is suicidal	(Name) is thinking of suicide / experiencing suicidal ideas	We don't want to define someone by their experience with suicide
He is schizophrenic She is bipolar He is mentally ill She is Psycho	People/persons with mental illness	We cannot equate someone's identity to their diagnosis People aren't their illness. They have an illness.
He is addict He is junky	Person/people addicted to (substance)	The illness does not define them

Remaining hopeful is key, as people can and do improve. Encouraging individuals to seek help is vital, as suicidal thoughts, ideas, plans, and attempts are signs of a desperate cry for help and indicate a need for assistance.

As a care provider, it is important to choose words thoughtfully and avoid anything that increases stereotypes, bias, or discrimination against individuals with mental illness and suicidal thoughts. Refrain from labelling individuals based on their diagnosis (e.g., "He is bipolar," "She is schizophrenic," "He is suicidal," etc.). It is essential to avoid using terminology that can stigmatize, incentivize, or glorify suicide.

Executive Summary

3. Executive Summary

Medical education is the mother of a country's healthcare system. The primary objective of a medical college is to provide education, knowledge, and skills. The provision of healthcare services is however a secondary function. This distinction is crucial, as the true essence of a medical college lies in its commitment to nurturing the next generation of compassionate and skilled healthcare professionals.

Pursuing a career in medicine is a challenging yet rewarding endeavour. It requires early commitment, continuous perseverance, intense dedication, and significant emotional and financial investments. Aspiring physicians face high stakes and significant responsibilities, navigating the stringent expectations of medical colleges, society, their families, and themselves. Despite these challenges, this path is essential for shaping the future of healthcare.

Given the pervasive stressors involved in medical training, it is not surprising that medical students and doctors are at an increased risk of psychological distress and mental ill health relative to the general population. This is not merely a national phenomenon but a global one. Existing global literature consistently recognizes that 30-40% of medical students report mental health problems. There is high prevalence of anxiety, depressive disorders, suicidal ideation, substance use disorders, as well as stress and burnout in this population. Hence, a national task force was set up to assess the mental health and well-being of medical students in India and to suggest remedial measures.

Initially, the Task Force conducted a comprehensive review of scientific literature, which revealed a significant gap in systematic research on the risk factors and effectiveness of interventions for medical students who attempt or complete suicide. Currently, recommendations can be informed by valuable insights from broader research, including studies on the general population, high-risk groups, and individuals with pre-existing mental health conditions. Given the paucity of literature on risk factors and intervention-based studies concerning medical students, the task force employed three crucial methods to gather comprehensive data. *First*, in-person visits to various medical colleges were conducted, where focused group discussions were held with stakeholders such as medical college administrators, heads of departments, and students. These discussions aimed to identify best practices and challenges in providing mental health support to medical students. *Second*, an online survey targeting undergraduate and postgraduate medical students, as well as faculty members, was conducted to collect a broad range of perspectives and insights on mental health and well-being. A total of 25,590 undergraduate students, 5,337 postgraduate students, and 7,035 faculty members responded to the online survey. *Third*, the task force engaged and interacted with the representatives of Federation of Resident Doctors Association India (FORDA), Resident Doctors Association (RDA) and Association of Doctors and Medical students (ADAMS) for suggestions. Additionally, the task force integrated insights from several pivotal documents and engagements, including the Parliamentary Standing Committee's Report on the Quality of Medical Education in India 2024 (Report 157), the Mental Health Policy (2014), the National Suicide Prevention Strategy (2022), the National Crime Records Bureau (2023), Medical Council of India (MCI) rules, National Medical Commission (NMC) regulations, best practices from various medical colleges, and other relevant government documents.

3.1 Recommendations that are Universally Applicable Across Medical Colleges and Institutions

The environment of medical colleges is vital for fostering a healthy academic and work culture for students, faculty, and staff. A proactive and compassionate approach from the administration can significantly impact the mental health of medical students. By prioritizing mental well-being, institutions contribute to the success and resilience of future healthcare professionals.

- 3.1.1 **Orientation Program at Joining:** A comprehensive orientation program within four weeks for undergraduate students and two weeks for postgraduate students upon joining is essential for new entrants. This program should introduce students to the medical profession, campus resources, and the importance of physical, mental, and spiritual health. By prioritizing mental health and familiarizing students with available support systems, this initiative aims to create a supportive and well-informed environment from the outset of their medical education.
- 3.1.2 **Involving Family Members:** Involving family members during the induction program and periodically, at least once a year, would help them understand the expectations and stressors faced by medical students. This understanding would enable families to provide effective support and enhance the ability of students to cope with academic and clinical demands.
- 3.1.3 **Anti-Ragging Measures:** Strict implementation of the National Medical Commission (NMC) regulations on ragging is mandatory. Medical colleges should have active anti-ragging cells with strict penalties for offenders to mitigate the stress induced by ragging.
- 3.1.4 **Awareness Campaigns and Education:** Regular programs should educate students and faculty about mental health issues and available resources. Mental health education should be integrated into undergraduate (UG) and postgraduate (PG) curricula through lectures, workshops, and seminars. It is recommended that medical teachers, students, and administration should undergo regular training in mental health, either through periodic in-person sessions or online via the Swayam portal. The training modules should cover mental health, stress management, building resilience, prevention of substance use, gatekeeper training, and basic counselling techniques. Specific emphasis should be placed on handling confidentiality matters concerning individuals with mental illness.
- 3.1.5 **Counselling Services:** Implementing a 24/7 support system, such as the Tele-MANAS initiative by the Union Ministry of Health & Family Welfare, is advisable. Medical colleges should have plans for referral, evaluation, management, and follow-up for students with mental illnesses. Confidential, accessible counseling services must be widely promoted. Medical colleges should consider appointing at least two counsellors for every 500 students. These counsellors should report directly to the Dean to ensure that preventive and promotive measures are actively implemented. Psychiatric referrals should only occur when the counsellors determine that a student requires psychiatric care.

- 3.1.6 **Staff/Students Clinic:** Medical colleges should provide free diagnostics and treatment, including medicines, for physical and mental health issues within the campus. Establishing separate wards, clinics, and investigation facilities for students ensures easy access to healthcare services.
- 3.1.7 **Work Environment:** Proper infrastructure and amenities are essential for maintaining the physical health and safety of medical students. This includes well-maintained hostels, clean washrooms, safe drinking water, quality food, security measures, recreational facilities, and reasonable fees.
- 3.1.8 **Hostel Mess:** To accommodate diverse cultural, religious, and dietary preferences, hostel messes should involve students in menu planning and quality control.
- 3.1.9 **Regulation of Duty Hours:** The National Task Force recommends, based on feasibility, resources, and relevance, that residents work no more than 74 hours per week, with no more than 24 hours at a stretch. This includes one day off per week, a 24-hour duty, and 10-hour shifts for the remaining five days. Ensuring 7-8 hours of daily sleep for medical students is crucial for their mental and physical health. Collaborative planning of duty hours by HODs, faculty, senior residents and residents, needs to be done. *It is imperative to recognize that post-graduates and interns primarily serve educational purposes rather than filling gaps in healthcare staffing.* Requests for leave should be judiciously considered and not unreasonably declined. If there is an increased clinical workload, the hospital/medical college should hire more senior residents and medical officers.
- 3.1.10 **Safe and Supportive Environment:** Medical students should have appropriate conditions during duty hours, such as comfortable rest areas, nutritious meals, and hydration facilities. Hospitals should provide regular breaks and ensure food availability in duty rooms.
- 3.1.11 **Supporting Families and Childcare:** Medical colleges could consider providing on-site childcare facilities, family accommodation for married students, and daycare services. Supporting pregnant and postpartum students with academic accommodations, aligning with the Maternity Benefit (Amendment) Act 2017, is also beneficial.
- 3.1.12 **Evaluation and Assessment Methods:** A fair and unbiased evaluation system is essential. Institutions may offer a mix of grading systems to reduce stress and promote a collaborative learning environment.
- 3.1.13 **Communication Feedback and Work Environment:** Regular feedback from faculty and students enhances trust and fosters a healthy work environment. Addressing issues related to workload, hierarchy, or mistreatment is important to maintain inclusivity and respect.

- 3.1.14 **Transparent and Responsive Grievance Redressal:** Clear grievance redressal systems should address harassment and psychological stress. Training faculty and administrators on mentorship, accountability, and anti-harassment policies is essential. A feedback and complaint box should be available in both the Director/Dean's office and the warden's office.
- 3.1.15 **E-Complaint Portal of NMC:** The NMC should establish a national portal for grievance redressal, enabling secure and efficient complaint handling. A dedicated grievance redressal cell within the NMC should manage the workflow and ensure timely resolutions.
- 3.1.16 **Mentor-Mentee Program:** Mentor-mentee programs, as per NMC regulations, provide guidance and professional development opportunities. These programs should involve regular meetings, training for mentors, and support for mentees to promote mental health and resilience.
- 3.1.17 **Removing Fees for Repetition of Semesters:** Abolishing fees for repeating semesters reduces economic burdens and stress. Transparent and standardized grading systems and an independent appeals process is essential.
- 3.1.18 **Teachers' Apprehension:** Creating a supportive environment for teachers is crucial. Clear protocols for handling student complaints, promoting professionalism, and addressing false complaints can enhance teacher engagement and satisfaction.
- 3.1.19 **Uniform PayScale, Retirement, Pension, and Rotational Headship (UPRPR):** Standardizing pay scales, retirement and rotational headship policies across institutions ensures equity and attracts high-quality faculty. Prohibiting private practice for medical teachers and providing non-practicing allowances can maintain the quality & integrity of education.

Uniform PayScale for Medicos (UPS for Medicos): In alignment with UGC pay scales and AICTE pay scales regulations, we propose AIIMS, New Delhi pay scale for all medicos. A uniform AIIMS, New Delhi pay scale structure for interns, postgraduate students, super-specialty students, and medical college teachers ensures equity and fairness in compensation, promoting job satisfaction and attracting high-quality faculty and students.

Uniform Retirement Policy (URP): The current retirement policy for medical faculty is inconsistent and disorganized. A standardized retirement policy nationwide, adopting the AIIMS, New Delhi retirement policy to be implemented.

Uniform Pension Scheme for all Medical Teachers: The implementation of a Uniform Pension Scheme for all medical teachers is essential to ensure their financial security post-retirement. Such a scheme will enable them to dedicate their efforts towards teaching, mentoring, and research without concerns about

their future. Therefore, it is imperative to introduce a New Pension Scheme across all medical colleges.

Uniform Policy of Rotation of Headship (URH): Implementing a rotational headship system for department heads is essential to introduce new ideas and practices, and prevent toxic environments under inefficient leadership.

- 3.1.20 **Reducing Access to Means for Suicide:** Implementing measures to limit access to dangerous means can prevent impulsive self-harm. Evaluating high-risk areas and enhancing security measures are essential.
- 3.1.21 **Family Vacation:** Medical colleges could consider granting a ten-day vacation at least once a year to both undergraduate and postgraduate medical students on a rotational basis. This vacation would allow students to meet their family members and foster family bonding.
- 3.1.22 **Gate-Keeper Training Program:** A Gatekeeper Training Program in medical colleges aims to establish a proactive network for identifying at-risk individuals and connecting them with professional help. This program involves comprehensive training for participants to recognize warning signs and refer students to mental health services. With the support of the Department of Psychiatry, local protocols should be developed, and the gatekeeper training program should be initiated across the campus, involving all stakeholders. This initiative is crucial for fostering a supportive environment and enhancing mental health awareness within the medical college community
- 3.1.23 **Increasing the Number of Postgraduate and Super-speciality Seats:** Expanding postgraduate medical seats addresses healthcare needs, enhances specialist care, and reduces student migration.
- 3.1.24 **Employing Adequate Number of Senior Residents:** Medical colleges should hire more senior residents based on workload and patient care demands.
- 3.1.25 **Policy Adjustments Regarding Bonds:** Abolishing seat leaving fees/bonds and a compulsory rural service bond is imperative. Medical students who abandon their seats after admission should be prohibited from applying to medical colleges for twenty-four months from the date of leaving. Additionally, medical colleges can fill the vacated seat (UG/PG) in the same category (Government/Management Seat) as the student belonged to in the next upcoming calendar year.
- 3.1.26 **Trial Observership/Externships/Residency:** A trial observership or residency period provides firsthand experience of the college and department environment, helping students make informed decisions about their choice of field and institution.

- 3.1.27 **Use of Technology in Training Medical Students:** Integrating technology, such as Virtual Reality (VR), Augmented Reality (AR), Artificial Intelligence (AI), and Machine Learning (ML), into medical training enhances learning experiences and prepares students for technological advancements in healthcare.
- 3.1.28 **Library Facilities:** Digitizing library facilities and creating online access systems support academic development. Establishing reading rooms in hostels and extending library hours accommodate diverse study preferences.
- 3.1.29 **Value-added Optional Courses:** Introducing optional courses in various subjects allows students to explore diverse interests and develop multidisciplinary skills, thereby enhancing their academic and professional growth. These courses can be credited or non-credited and may be accredited by the medical college, university, State Medical Council, or NMC, New Delhi. This approach aligns with the principles of the New Education Policy.
- 3.1.30 **Invited Guest Faculty:** Inviting part-time faculty from various fields enriches the educational experience by providing diverse perspectives and mentorship without administrative burdens.
- 3.1.31 **Clinical Linguistic Language Proficiency Policy:** A comprehensive policy for linguistic proficiency ensures effective communication with local clinical populations, enhancing patient care and professional development.
- 3.1.32 **Supplementary Exams:** Introducing supplementary exams reduces academic pressure and anxiety, providing a fairer assessment system and supporting student well-being.
- 3.1.33 **Announcing Exam Results Using Roll Numbers:** Using roll numbers to announce exam results enhances privacy, reduces stress, and promotes a fair academic environment.
- 3.1.34 **Addressing the 'Ghost Faculty' Problem:** Enhanced verification processes, regular inspections, and stringent penalties can address the ghost faculty issue, ensuring the integrity of medical education.
- 3.1.35 **Centre for Training of Medical Teachers (CTMT):** A comprehensive teacher training centre at both the national and regional levels is essential to elevate medical faculty into exemplary educators proficient in pedagogy, andragogy, online teaching, and various methods of imparting skills. Training medical teachers in stress management, mental illness, substance use, mental health first aid, and basic counselling techniques is essential.
- 3.1.36 **Career Counselling and Campus Recruitment:** Expanding career counselling to include diverse professional guidance and facilitating campus recruitment ensures medical students are well-prepared for various career paths.

- 3.1.37 **Establishing Health Universities:** Dedicated health universities or departments within general universities can ensure the effective implementation of NMC regulations and address the unique needs of medical education.
- 3.1.38 **Establishment of the Centre for ICARED:** A Centre for Innovation, Collaboration, Accelerator, Research, Entrepreneurship, and Medical Device Development (ICARED) fosters a culture of innovation and practical learning, preparing students for leadership in healthcare.
- 3.1.39 **Liaison with Local Organizations:** Medical colleges should liaise with professional organizations and community groups to develop a support network for students, enhancing their academic, professional, and personal development.
- 3.1.40 **Yoga in Promoting Mental Health:** Integrating yoga into students' lives can reduce stress, prevent mental illness, and develop resilience, promoting overall well-being.
- 3.1.41 **Specific Suggestions for Medical Students, Families, and Faculty:** Effective time management, social support, self-awareness, mindfulness, regular exercise, healthy habits, and seeking professional help are essential for maintaining good mental health. Family involvement and faculty support play crucial roles in student well-being.
- 3.1.42 **Mental Health and Wellbeing Committee** - At the national level, the Permanent Member of the National Medical Commission's (NMC) Ethics and Medical Registration Board (EMRB) should serve as the nodal person. At the medical college level, the Mental Health and Well-Being Committee needs to be structured as follows: the Dean must serve as the Chair, the Head of the Department (HOD) of Medicine, Surgery, Obstetrics and Gynaecology (OBG) to be designated as the Co-Chairs (three co-chairs), and the HOD of Psychiatry to act as the Member Secretary. Additionally, the HODs of each department should be members of this committee to ensure the implementation of these recommendations.
- 3.1.43 **Enhancing Physical Fitness and Sports Activities:** It is recommended that the college organize and maintain diverse sports activities, overseen by a sports Committee, with dedicated time allotted for physical activities.
- 3.1.44 **Sāmājika Sanskriti Campus Council:** The Sāmājika Sanskriti Campus Council aims to reduce social isolation and enhance well-being by supporting diverse social groups and activities within medical colleges. Headed by senior faculty and student representatives, it allocates resources for various cultural, recreational, and festival events. Regular evaluations and a quarterly newsletter foster community, making the educational environment more inclusive and engaging.

3.2 . Recommendation for High-Risk Group Identification and Referral

Implementing periodic faculty training and informal methods for early detection of at-risk students ensures timely intervention and support, enhancing student well-being and academic success.

- 3.2.1 **Peer Support System:** Task force proposes a comprehensive Peer Support Model in medical colleges, leveraging senior students to support juniors, aiming to improve mental health, provide academic and emotional support, and prevent suicide. The program includes safe spaces, anonymous reporting, professional support integration, mental health awareness campaigns, and suicide prevention workshops. Regular feedback and evaluations will ensure effectiveness and inform adjustments.
- 3.2.2 **Deaddiction Services:** Students dependent on substances should be encouraged to seek help while maintaining confidentiality rather than be reprimanded. This policy focuses on health and recovery, acknowledging that substance dependence is a health issue requiring professional intervention. Ensure that de-addiction services are readily accessible to students on campus will help address the problem in its initial stages.

3.3 Recommendation for Students with Mental Illness or Attempted Suicide

- 3.3.1 **Supportive and Inclusive Environment:** Every medical college must establish a Department of Psychiatry with sufficient psychiatrists, counsellors, nurses, and support personnel. A crisis intervention strategy shall be in place to inform and involve immediate family members during mental health crises such as attempted suicide and mental health emergencies. Creating a supportive environment with accessible mental health services, family involvement, and academic accommodations promotes the recovery and well-being of students with mental health issues. Offer necessary academic accommodations and support structures to assist students with mental health challenges.
- 3.3.2 **Fitness to Practice Protocol: Medical Students with Mental Illness:** Establishing a clear protocol for evaluating fitness to practice for medical students with mental illness ensures, patient safety and supports student well-being. An evaluation Committee should be formed to assess fitness to practice. The committee should comprise the following members: the Dean (as Chair), a psychiatrist, a faculty member from forensic medicine, the Head of the Department (HOD) of the concerned department, and a female faculty member. An appeal panel also needs to be established. There should be an aim to balance the rights and well-being of medical students with mental health issues against the imperative to maintain patient safety and quality care at the medical college.
- 3.3.3 **Mandatory Reporting of Suicidal Attempts and Death by Suicide:** Enforcing mandatory reporting of suicide attempts and deaths by suicide ensures data collection, accountability, and the development of targeted interventions for mental health support.

By implementing these recommendations, medical colleges can create a supportive, inclusive, and effective environment that enhances the mental well-being and academic success of medical students, ensuring a healthier future workforce.

Introduction

4. Introduction - Mental Health Continuum

Mental health exists on a spectrum, ranging from optimal mental wellness to severe mental illness, with varying degrees of mental distress in between. Understanding the distinctions between these concepts is crucial for promoting mental well-being and providing appropriate support and treatment for those in need. At one extreme of the spectrum lies mental wellness, while at the opposite end lies mental illness, as shown in figure no-5.1. Mental health means a state of well-being in which an individual realizes their own abilities, can cope with the everyday stresses of life, can work productively, and can contribute to their community(1). Mental health is the absence of mental disorders and encompasses emotional, psychological, and social well-being. It is an essential component of overall health. Mental health is affected by biological characteristics, social and economic circumstances, cultural gender norms, and the broader environment of individuals. Exposure to risk factors or stressors can result in a range of mental health problems.

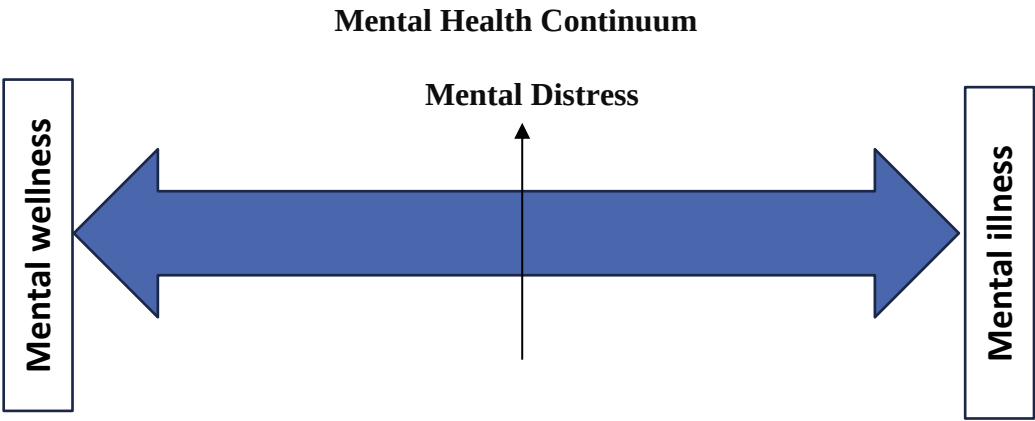


Figure 5.1: The Mental Health Continuum

Mental distress is a term used to describe a temporary state of emotional or psychological discomfort, which is often a normal response to stressful life events, such as loss, trauma, exams, failure, or significant life changes. Mental illnesses are conditions that are clinically diagnosable and have a significant impact on an individual's biological, social, occupational, academic, emotional, or behavioral functioning, often necessitating professional intervention.

The global prevalence of mental illness is a significant public health concern with a substantial impact on individuals, families, and societies. According to the World Health Organization (WHO), approximately 1 in 4 people across the globe will experience a mental health condition at some point in their lives (2).

In India, the National Mental Health Survey 2015-16 undertaken in 12 states reported that the overall weighted prevalence for any mental morbidity was 13.7% lifetime and 10.6% current mental health morbidity(3). The treatment gap for any mental disorder was reported to be as high as 83% in the general population(3). As per the Global Burden of Disease Study 1990–2017, one in seven Indians was affected by mental disorders of varying severity in 2017(4).

At any given time, an estimated 1 in 10 individuals in India will grapple with a diagnosable mental health condition

The National Survey on Extent and Pattern of Substance Use in India (2018), conducted by the Ministry of Social Justice & Empowerment, highlighted the significant problem of drug abuse in the country. The survey found that a large number of individuals were affected, with 2.9 crore people dependent on alcohol, 25 lakh dependent on cannabis, 28 lakh dependent on opioids, and 8.5 lakh children dependent on inhalants(5). These statistics underscore the importance of addressing mental health issues comprehensively and effectively.

4.1 Suicide

Globally, close to 800,000 people die by suicide each year, with about a third of these deaths occurring among young individuals. Suicide is the second leading cause of death among 15–29-year-olds(6). The World Health Organization estimates that one out of every 100 deaths are due to suicide. Additionally, it reports that globally, there may be 20 suicide attempts for every death by suicide(7, 8). However, under-reporting of suicide and attempted suicide is a significant issue worldwide due to stigma, legal and religious concerns, and incomplete or inaccurate reporting. This underestimation is also influenced by limited access to health care, restrictions on health insurance coverage, and refusal of life insurance policies(7).

Suicide is a complex interplay of personal, social, and biological factors, which is rarely caused by a single circumstance or event.

In India, which accounts for about 18% of the global population with its 1.4 billion inhabitants, suicide is a significant national public health concern, with 1.71 lakh suicides recorded in 2022 and a suicide rate of 12.4 per one lakh population as per National Crime Record Bureau Report 2023.

While suicide is not considered a disease, suicidal behavior encompasses a broad spectrum of actions and thoughts related to self-harm and death. This spectrum includes suicide, suicide attempts, deliberate harm, and wishes for death, both active and passive. Despite its prevalence, suicide remains a taboo topic in many societies, leading to stigma, misinformation, and inadequate support for those at risk (1).

Suicide is a complex issue with multifactorial causes, often resulting from a combination of biological, psychological, social, and environmental factors. Mental health disorders like depression, bipolar disorder, and substance abuse are major risk factors. However, suicide typically arises from a complex interplay of various factors, including genetics, social, cultural, economic, gender, and environmental influences. Trauma, sudden loss, broken families, relationship issues, financial loss, or significant life changes can also elevate the risk (9, 10). Addressing these multifaceted factors requires a comprehensive and holistic approach to suicide prevention(11, 12).

Addressing the array of biological, social, financial, environmental, and stress-related factors that contribute to suicide requires a comprehensive and multi-faceted approach.

In this regard, a few landmark initiatives have been undertaken by the government of India to shape mental health care in the country. Key initiatives like the Mental Health Policy in 2014, Mental Healthcare Act in 2017, Nasha Mukta Bharat Abhiyaan in 2020, Mental health and prevention of substance services have been added in the package of services under Comprehensive Primary Health Care under Ayushman Bharat at Health and Wellness Centres in 2021, National Suicide Prevention Strategy in 2022, The launch of the Tele-Mental Health Assistance and Networking Across States (Tele-MANAS) initiative on 10th October 2022 to provide access to mental health care services to all through a centralized, toll-free helpline (14416 or 1800-891-4416). Above initiative demonstrates the government's dedication to enhancing mental health services across the country.

The World Health Organization estimates that globally, there may be 20 suicide attempts for every death by suicide.

Recent preliminary reports and media coverage have highlighted the escalating mental health issues and increasing suicide rates in higher educational institutions, including medical colleges. Given their pivotal role in medical education, medical colleges should also serve as centers for awareness, education, wellness, and mental health care. The Government of India has taken proactive steps by forming the National Task Force on Mental Health and Well-being of Medical Students. The primary objective is to address the mental health and well-being of medical students, which will have a ripple effect in raising awareness about mental health among the general population, reducing the treatment gap, and preventing suicides. This initiative represents a crucial opportunity to develop healthier doctors, healthier citizens, and ultimately, a healthier nation.

Objectives

5. Objectives of the Task Force

5.1 Background: The journey of medical professionals is both arduous and profound, starting from the moment they decide to pursue a career in medicine, often influenced by personal ambition or familial pressure. The rigorous process of gaining admission into medical school demands exceptional dedication and marks just the beginning of a challenging career path. Upon entering medical school, students not only take on the role of future healers but also bear the expectations of their families. This transition can lead to an identity crisis as they move from being top achievers to competing among equally skilled peers.

Medical training demands, clinical responsibilities, financial burdens, and personal obligations, place significant stress on students. Rather than being an endpoint, graduation leads to the next challenge of postgraduate entrance exams, which are highly competitive and pivotal for their future roles as doctors. For postgraduate students, particularly women, the struggle extends beyond academics to balancing societal expectations of marriage against professional ambitions, often leading to severe personal conflicts and, tragically for some, to suicide. After postgraduate studies, the journey does not ease; further specialization deepens the commitment to a demanding medical career. As practicing doctors, they face a professional world fraught with corruption, fierce competition, and the ever-present risk of medical malpractice. While many doctors continue to push forward, overcoming these obstacles with resilience and dedication to the greater good, others find the pressures overwhelming and choose to step back.

This career trajectory for medical professionals is marked by continuous tests of endurance and sacrifice, reflecting a path of valor amid adversity. While many succeed and thrive, the journey remains a formidable challenge with significant personal sacrifices. In response to the importance of addressing mental health challenges among medical students, the National Medical Commission has established the National Task Force on Mental Health and Well-being of Medical Students. This task force aims to address the mental health needs of medical students and promote their overall well-being.

Suicide prevention, grounded in the principle that "Every Life Matters," begins with the efforts of medical colleges. However, the obligation to prevent such tragedies is a collective responsibility that extends to every member of society.

5.2 The Objective of this National Task Force: The Task Force will comprehensively review existing literature and data on mental health and suicide among medical students. It will analyse the contributing factors to these challenges and develop evidence-based strategies aimed at improving mental health and preventing suicides within this population. The objective is to provide recommendations that could be implemented to address these critical concerns

Embedded within the fabric of medical education is a profound creed: “Every Life Matters.” This principle forms the bedrock of our approach to mental health, well-being, and suicide prevention among medical students. Addressing mental health and wellbeing among medical students offers a twofold benefit: it not only reduces needless tragedies within this group but also equips them to navigate the profound emotional challenges they will confront in their future medical careers. Implementing prevention strategies and nurturing the well-being of medical students is far from self-serving. It empowers them to become champions for mental health in their communities. As future doctors, they can be powerful advocates for early intervention, destigmatizing mental illness, and promoting overall well-being. This creates a ripple effect, fostering healthier communities, reducing treatment gap in mental illness and suicide rates. Thus, medical colleges shoulder a profound responsibility: to cultivate resilience in their students and shape them into advocates for of mental health and suicide prevention within society as a whole.

The task force is dedicated to identifying risk factors by reviewing the available literature and evaluating effective intervention strategies used worldwide in medical colleges. With a commitment to addressing systemic issues in healthcare and medical education, the task force prioritizes promoting wellness, preventing mental illness, and reducing deaths by suicide. These efforts aim to enhance the learning environment and foster a healthier atmosphere in medical colleges.

The National Task Force for Mental Health and Wellbeing is committed to creating a nurturing environment for medical students, fostering resilience, reducing stigma, and promoting mental health awareness to ensure their holistic development and success in both their personal and professional lives. Our mission extends beyond the academic halls to prevent suicide, decrease the mental health treatment gap for the public at large, and build a strong, holistic, and compassionate healthcare system for the country.

Scientific Background

6. Mental Health in Medical Students from a Global Perspective:

During medical education, students undergo a crucial transition from teenage to young adults, facing increasing responsibilities and societal, familial, and self-imposed expectations. This period of transformation involves self-discovery and identity formation, contributing significantly to stress. Medical training presents various challenges, including intense competition, emotional stress, financial burdens, interpersonal conflicts, ethical dilemmas, heavy workloads, limited personal time, and inadequate support, creating an environment conducive to mental health issues. (13-15). In a comprehensive systematic review and meta-analysis, researchers aimed to determine the prevalence of professional burnout among medical students. The prevalence rates varied significantly, ranging from 7.0% to 75.2%, influenced by factors specific to each country, the choice of assessment tools, and the criteria used to define burnout symptoms (16)

A meta-analysis conducted by Rotenstein et al. in 2016, which included 167 cross-sectional studies (n = 116,628) and 16 longitudinal studies (n = 5,728) from 47 countries, found that approximately 27% of medical students experienced depression during their medical education(17). Another meta-analysis, pooling data from 62,728 medical students and 1,845 non-medical students across 77 studies, reported a global prevalence of depression among medical students to be 28% (18). Similarly, a systematic review and meta-analysis of 41 studies (n = 36,608) from various regions worldwide reported a pooled prevalence of depression of 38%(19).

The prevalence of mental illness among medical students exceeds that of the general population. According to international literature, one out of three medical students have a diagnosable mental illness.

Jahrami and colleagues conducted an umbrella review involving 32 meta-analyses to ascertain the prevalence rates of self-reported psychological and behavioral symptoms among medical students. The combined analysis revealed an overall pooled prevalence rate of 30.3%. Among these symptoms, sleep problems had the highest reported prevalence at 42.0%, followed by stress at 41.7%, burnout at 35.8%, anxiety, and depression both at 32.5%, internet addiction at 26.0%, substance use at 25.2%, eating disorders at 9.8%, and suicidal thoughts/gestures/ acts at 8.9%. This evidence indicates that approximately one-third of medical students experience at least one of these problematic psychological and behavioral symptoms(20). Additionally, several studies have highlighted a high prevalence of depression, anxiety, and sleep disorders among medical students (21). Another systematic review analyzed data from 31 cross-sectional studies and 23 longitudinal studies, encompassing a total of 17,560 resident physicians, to estimate the prevalence of depression or depressive symptoms. The overall pooled prevalence

among resident physicians was 28.8%, varying from 20.9% to 43.2% based on the assessment tool. The prevalence showed an upward trend with each passing year (22).

A meta-analysis encompassing ten cross-sectional studies from China(23), which included a total of 30,817 Chinese medical students, was conducted. The findings revealed prevalence rates of 29% for depression, 21% for anxiety, 11% for suicidal ideation, and 2% for eating disorders. Subgroup analyses indicated no significant differences in the prevalence of depression and suicidal ideation across genders, nor were there significant differences in the prevalence of depression among different age groups. Similarly, another meta-analysis (24) focusing on Chinese medical students indicated a depression prevalence of 27% within this population. Somatic symptoms such as back pain, neck pain, headaches, sleep disturbances, and functional gastrointestinal disorders appear strongly correlated with mental ill-health in medical students and are likely highly prevalent.(25).

Another systematic review and meta-analysis was aimed at providing a thorough overview of the mental health problems (MHPs) faced by medical students in Brazil(26). The meta-analysis consolidated findings from 59 studies, which reported varying prevalence rates for different mental health problems (MHPs): depression was found in 30.6% of cases from 25 studies, common mental disorders in 31.5% from 13 studies, burnout in 13.1% from three studies, problematic alcohol use in 32.9% from three studies, stress in 49.9% from six studies, low sleep quality in 51.5% from four studies, excessive daytime sleepiness in 46.1% from four studies, and anxiety in 32.9% from six studies. Additionally, the analysis highlighted several factors contributing to these MHPs, including a lack of motivation, inadequate emotional support, and academic overload(26). Another meta-analysis, which included fourteen original studies, found that the pooled prevalence rate of Common Mental Disorders (CMDs) among undergraduate students at Brazilian medical schools was 43%(27). A meta-analysis from Brazil also reported that medical courses are associated with poor quality of life for medical students in the physical and psychological domains(28). The primary predictors of diminished Quality of Life (QoL) were consistently linked to being female gender and the duration of academic pursuit(29).

In light of the Internet's pivotal role in modern education and recreation, a meta-analysis was conducted to estimate the prevalence of Internet Addiction among medical students across diverse countries(30). The analysis encompassed 3651 medical students and revealed a pooled prevalence of 30% Internet Addiction, approximately five times higher than the general population. This underscores the urgency for medical educators and administrators to identify and intervene with students grappling with Internet Addiction. Along with this, the frequent occurrence of poor sleep quality among medical students is notable, correlating with numerous adverse health implications for students and potentially compromising patient care within medical colleges. A meta-analysis encompassing 57 studies involving 25,735 medical students unveiled a pooled prevalence of 52.7% for poor sleep quality, as assessed by the Pittsburgh Sleep Quality Index(31). Notably, poor sleep quality was most prevalent in Europe, trailed by the Americas, Africa, Asia, and Oceania across continents.

A systematic review involving 14 studies and 13,111 participants sought to explore mental health challenges among Asian medical students. The pooled prevalence of anxiety disorder was found to be 7%, depression was noted at 11.0%, and suicidal ideation was 3%(32). The low prevalence of mental health issues among Asian medical students can be attributed to several factors. Firstly, cultural stigma surrounding mental health may lead to underreporting,

as students may be reluctant to disclose their challenges. Secondly, students' exposure to psychiatry and medical psychology during clerkships equips them with knowledge for self-management. Lastly, proactive efforts by medical schools, such as enhanced mental health education and access to psychological counselling services, likely contribute to the low prevalence by providing robust support systems for students(32).

International studies reveal that medical students worldwide face numerous challenges that lead to stress, significantly contributing to mental health issues. Reports indicate that approximately 27% to 38% of medical students experience high prevalence rates of burnout, depression, anxiety, insomnia and other psychological symptoms. These findings underscore the urgent need for enhanced mental health support in medical education settings

6.1 Mental Health in Medical Students from India

Gaining admission into medical colleges in India is an intensely competitive process that demands significant commitment. Upon entering these institutions, students not only face the responsibility of future healers but also carry the burden of familial expectations, a pressure particularly pronounced in government medical colleges. These colleges, while providing extensive clinical exposure through large patient volumes, also introduce formidable challenges that can precipitate mental health issues (33). Research has shown an increase in mental health morbidity during medical training in India, with a jump from 2% pre-admission to 12% post-admission diagnoses. The first year is characterized by change and uncertainty, while the final year is marked by exam pressure and expectations(34).

A regional study from South India reported that 37% of medical students experienced depression, 51% anxiety, and 33% stress(35). Another study from North India found that 21.5% of students had a provisional diagnosis of depressive disorder, with 7.6% qualifying for major depressive disorder using the Patient Health Questionnaire (PHQ-9) (36). A systematic review was conducted to assess the prevalence of depression, anxiety, and stress among medical students in India, incorporating data from 44 studies. The prevalence of depression varied widely, from 8.5% to 71%, which can be attributed to variations in study methodology, assessment tools, cultural influences, stigma, and the unique challenges faced by this population(37). However, the pooled prevalence rates derived from a subset of these studies provided more focused estimates: depression was found to be 39% based on 16 studies with 3882 participants; anxiety was 35% from four studies including 686 participants; and stress was 51.3% from 28 studies encompassing 5354 students(37).

Recent meta-analyses further emphasize the high prevalence of depression among Indian medical students, with findings of 50% in one analysis of 5944 students (38) , and 40% in another, covering 7046 students (39). Despite this high prevalence of various mental illnesses, there is a notable treatment gap, driven by preferences for informal consultations, concerns about confidentiality, lack of time, a preference for self-diagnosis, fear of unwanted intervention, stigma, discrimination, potential career impact, and lack of awareness(40-43). Enhancing access to mental healthcare for medical students entails clarifying the information displayed on academic records, debunking prevalent myths surrounding mental healthcare, and fostering awareness about available resources. Additionally, students often seek care externally

due to concerns about their provider potentially being an academic preceptor within their institution(43).

The attitudes towards mental illness among medical students and interns remain largely negative, which could hinder their future roles as empathetic healthcare providers.(44-46). Please refer to Table No-1. Addressing these attitudes is critical, particularly during training, which offers a prime opportunity for fostering positive changes. Programs to overcome barriers to seeking mental health care are suggested to start early in training and persist throughout (47). This implies that certain barriers start and persist throughout medical school. Therefore, orientation programs that address these concerns must be initiated at the beginning of training and continued throughout medical school to result in a meaningful impact. A good time to have these programs would be within the first few weeks of every new academic session. Initiatives such as having separate student clinics by the psychiatry department in medical colleges to ensure confidentiality need to be strongly considered by the administration to optimize service utilization(33).

Despite the higher prevalence of depression and anxiety disorders among medical students, many are reluctant to seek treatment, contributing to a significant treatment gap. Studies suggest that up to 70-80% of medical students with mental health issues do not seek help or receive adequate treatment.

Integrating psychiatry into the MBBS curriculum is vital, not just for enhancing mental health care and averting suicide among medical students but also for its central role in providing comprehensive, holistic health care to the general public(48). This integration aids in diminishing stigma, facilitating early detection of mental health concerns, enhancing doctor-patient communication, tackling public health issues such as suicide, drug use, and depression, and nurturing the personal and professional growth of medical students(49).

Table 6.1. The Perceived Barriers Medical Students Face in Seeking Help.

Perceived Barriers by Medical Students to Seek Help
1) Stigma about seeking help for mental illness
2) Perceived weakness in personality
3) Preference for informal consultations
4) Concerns about confidentiality
5) Lack of awareness
6) Fear of unwanted intervention
7) Time constraints
8) Lack of convenient access to treatment
9) Preference to manage problems on their own

7. Attempted Suicide and Death by Suicide in Medical Students from a Global Perspective

Suicide research among medical students is a sensitive and often taboo subject, yet critical insights have been gained from various studies examining the spectrum from suicidal ideation to completed suicide. Research involving 4287 U.S. medical students across seven schools, including longitudinal data from five, found that approximately 50% of students experienced burnout, with 10% reporting suicidal ideation. A clear association was noted between burnout and an increased likelihood of subsequent suicidal ideation(50). Further, a systematic review including articles from 2011 identified 17 studies with 13,244 medical students globally, showing suicidal ideation prevalence ranging from 1.8% to 53.6%(51).

Meta-analytic methods have been utilized to evaluate the prevalence of suicidal attempts with greater accuracy. A meta-analysis incorporating 14 research articles worldwide reported a one-year prevalence of suicide attempts among medical students at 1.64%, and a lifetime prevalence at 2.19%. Notably, the prevalence of suicidal attempts was higher in medical studies conducted in low and middle-income countries compared to those in high-income countries(52). Another meta-analysis concerning 8585 African medical students across 14 studies revealed lifetime rates of 18.7% for suicidal ideation, 3.8% for making plans, and 5.5% for actual attempts(53). An umbrella review encompassing 32 meta-analyses reported a combined prevalence of 9% for suicidal thoughts, gestures, and acts among a host of psychological symptoms with a pooled prevalence of 30% (20). Another meta-analysis, which included 24 cross-sectional studies with 21,002 participants from 15 countries, found an overall suicidal ideation prevalence of 11.1% (17).

The prevalence of suicidal thoughts among medical students shows a wide range, from 6.0% to 43.0%, with annual suicide attempts at 1 to 5%. The rate of suicide is between 0.3 to 3 times higher than that of the general population.

Globally, suicidal ideation rates in medical students have been reported as varying broadly, with studies indicating a range from 6.0% to 43.0% (54, 55). Suicide attempt rates also vary significantly by region, as highlighted by research findings of 7.4% in Ethiopia (56), 5.5% in Africa(53), 6.4% in Turkey(57), 2.2% in Austria(57), 1.9% in the United States of America(58), and 1.4% in Norway(55). Such variability can be attributed to differences in medical training systems, course durations, and student demographics. The diversity in methodological approaches and definitions used to describe suicidal behavior across studies further complicates comparisons. Further, underreporting in suicidality complicates the

accuracy of these statistics(59). In summary, global data highlights that suicide and related behaviors are significant concerns among medical students. Studies reveal varying rates of suicidal ideation, attempts, and completions, with factors like stress, academic pressure, burnout, and mental health issues playing substantial roles.

Although suicide and suicidal behaviour are not diseases, they are important symptoms of a larger systemic issue that requires a comprehensive systemic overhaul

7.1 Attempted Suicide and Death by Suicide in Indian Medical Students

India faces significant challenges in obtaining accurate suicide statistics for medical students and physicians from the National Crime Records Bureau (NCRB) due to its reliance on passive surveillance data, which lacks comprehensiveness. The difficulty in collecting precise information about suicides among medical students stems from various factors, including limited resources, fear of litigation, concerns about the reputation of medical schools, inadequate record-keeping, and privacy issues. Currently, there is no robust method for collecting suicide-related data, leaving us reliant on secondary sources.

The National Medical Commission (NMC) has reported that in the past five years, 122 medical students (64 undergraduate and 58 postgraduate students) have died by suicide. This translates to an estimated 25-26 medical student suicide per year. However, when comparing NMC data with NCRB data for the general population, the suicide rate among medical students appears lower. According to the NCRB data for 2022, the suicide rate in India was approximately 12.4 per lakh population. Applying this rate to the medical student population of 600,000 (including undergraduate, postgraduate, and DNB students), we would expect about 74 deaths by suicide annually among medical students. Yet, the NMC data suggests only 24-25 medical student suicides per year. These discrepancies highlight the limitations of current data collection methods. The lack of a comprehensive and systematic data reporting system means that we often rely on secondary sources, such as media reports and internet sources, for information.

An interesting study on suicide was conducted by Chahal et al. (2022), which examined completed suicides within the allopathic medical community by analysing data from online news portals and other publicly accessible internet sources. This study covered the period from January 2010 to December 2019 and identified a total of 358 suicide deaths. Among these, 125 were medical students, 105 were residents, and 128 were physicians. The analysis revealed that academic stress was the predominant cause of suicide among medical students (45%) and residents (23%), while marital discord was more prevalent among physicians (26.7%). Additionally, mental illness was a significant contributing factor, accounting for 24% of medical student suicides and 20% of physician suicides (60). Estimating the suicide rate from the study data of 230 suicides over 10 years (125 undergraduate and 105 postgraduate students) indicates an average of 23 suicides per year. This rate is significantly lower than the expected rate of 74 deaths by suicide per year, based on the NCRB data, if we apply the general population's suicide rate of 12.4 per lakh to the medical student population of 600,000.

An exploratory study conducted using retrospective news content analysis from 2010 to 2014 identified 16 cases of medical student suicides, with 7 of them linked to actual or perceived poor academic performance⁽⁶¹⁾. A similar retrospective study based on media reports spanning a decade (2009 to 2018) revealed a total of 196 reported cases of medical student suicides in India. Among these, 134 (69%) involved undergraduate students and 61 (31%) involved postgraduates. In both the first year and final year of MBBS, the rate of death by suicide was 30%, indicating a high-risk period for students (62).

A recent study involving 787 medical students found that 37% reported having suicidal thoughts, 11% planned suicide, 3% attempted suicide, and 7% assessed the future risk of suicidal behavior (63). Another cross-sectional study conducted among medical students in North India over two months in early 2021 gathered data from 531 participants using a self-administered questionnaire. It revealed that 19.6% of respondents exhibited suicidal behavior. The lifetime rates of suicidal ideation, plan, and attempt were 20.3%, 10.3%, and 2.3% respectively, with a 1-year prevalence of suicidal ideation at 33%. Factors significantly associated with higher suicidal behavior included depression, dissatisfaction with academic performance, and coping with mental disengagement (64).

The evidence from Indian studies on medical student suicides, primarily based on public records such as obituaries, police reports, and newspaper articles, is restricted to publicly available information. This approach may miss cases where causes of death are undetermined or suicides are not disclosed due to privacy, legal, or insurance reasons, leading to significant gaps in understanding suicide rates, risk factors, and intervention targets. However, the available data on suicide and mental health issues in medical students indicate that these are significant concerns worldwide. Studies show that medical students experience high levels of stress, burnout, and depression, which can increase their risk of suicidal ideation and behavior. Aligned with our core value that 'every life matters', addressing this issue can have broader implications for public health policy in preventing suicide. Hence, it is crucial to recognize the varying rates of suicidal attempts and completions among medical students. Understanding these variations is essential for developing targeted interventions and support systems to address the specific needs of at-risk medical students.

After a first suicide attempt, one in five individuals is at risk of making another attempt. The risk of repeat attempts is higher in the first 1 to 3 years.

8. Risk Factors for Mental Illness and the Suicidal Spectrum

Understanding the diverse risk factors impacting mental health and well-being is paramount. These factors span across biological, psychological, social, and environmental domains, each contributing uniquely to the overall mental health landscape. Recognizing these multifaceted influences is essential for developing effective interventions and support systems that foster psychological resilience and promote overall mental health. There is considerable overlap in the risk factors for mental health and well-being, mental distress, mental illness, attempted suicide, and death by suicide. Recognizing and addressing these multifaceted risk factors is essential for developing effective interventions and support systems that promote psychological resilience and overall mental health.

Mental health and well-being and suicide represent a complex interplay of biological, behavioral, environmental, and social factors and is a leading cause of death among adolescents and young adults. Timely intervention through the identification of these risk factors is crucial for prevention and management (65, 66). A comprehensive understanding of these factors is essential for addressing suicide effectively (67). However, the lack of systematic studies in medical students also gives us an opportunity in investing for more systematic studies examining the risk factors predicting mental illness and suicidal tendencies among medical students. Consequently, we are leveraging valuable evidence from studies conducted on the general population and high-risk populations.

There is considerable overlap in the risk factors for mental health and well-being, mental distress, mental illness, attempted suicide, and death by suicide. These interconnected factors underscore the complexity of mental health challenges and highlight the urgent need for comprehensive strategies.

The vulnerability to mental illness and suicide arises from an interaction between biological and environmental influences. Adverse conditions during early developmental phases, such as pregnancy and childhood, can lead to dysregulated gene expression, impacting neuronal networks and behavioral responses. This can increase susceptibility to mental health issues, addiction, and risky behaviors, thereby elevating suicide risk. It is imperative to grasp the complexities of these interactions to devise effective prevention strategies (68).

The risk factors for mental illness and suicide can be categorized into: –

- a) Predisposing Biological Factors,
- b) Environmental Factors, and
- c) Immediate Triggering Factors (Precipitating Factors).

However, this classification is for our understanding only, as the interplay between these factors is complex and not always clearly defined in a water-tight compartment. Please refer Figure no-8.1 to learn more about the interaction of these risk factors.

8.1 Predisposing Biological Factors

Genetics: Increased understanding of how genetic alterations, expression, or suppression, along with regulatory systems, affect brain structure and function, can, directly and indirectly, predispose individuals to suicide risk through mental disorders, disruptions in higher mental functioning, and impulsive behavior (69-71)

Family History of Suicide: Research indicates that the risk of suicide among individuals with a family history of suicide is significantly higher compared to those without such a history. Exposure to suicide within the family creates a complex interplay of genetic predisposition and learned behaviors(70).

Personality Traits: Impulsivity, low frustration tolerance, impaired reward-seeking, and aggression can make stress responses difficult to manage, potentially leading to suicidal thoughts and actions(72, 73)

Disabilities: Disabilities can contribute to feelings of isolation, frustration, stress, systematic barriers, stigma, discrimination, socioeconomic disadvantages, and lowered self-esteem, contributing to a heightened risk of suicide among individuals with disabilities(74).

Major Physical Illnesses: Chronic pain, diminished functioning, and the emotional toll of serious illnesses can lead to depression or hopelessness. Suicide risk is notably increased due to a complex blend of psychological, physiological, and social factors (75, 76).

Existing Mental Disorders: Existing mental health disorders are strongly linked to an increased risk of suicide. Mental health conditions, especially major depression, bipolar disorder, anxiety disorders, certain personality disorders, and substance abuse, are among the strongest predictors of suicide. Effective intervention strategies typically involve a combination of medication, psychotherapy, and support systems to reduce symptoms and build coping strategies.(77-79).

8.2 Environmental Factors

Trauma or Abuse: Experiences of physical, sexual, or emotional abuse have profound, long-lasting negative effects on mental health, increasing suicide risk. Exposure to trauma often results in persistent psychological distress, challenges in managing emotions, the development of negative thought patterns about oneself and the world, and engagement in risky behaviors. These effects deeply penetrate the individual's overall well-being(80, 81).

Cultural and Religious Beliefs: Cultural and religious beliefs, norms, and values can shape individuals' perceptions of life, death, suffering, and the afterlife, impacting their attitudes toward suicide. They also play an essential role in planning interventions. (82-84)

Family Factors: Dysfunctional family environments marked by conflict, lack of support, and poor communication can contribute to emotional distress and suicide (85)

Social Isolation and Rejection: Feeling lonely, disconnected, and unsupported can create despair, especially for those with mental health vulnerabilities (86, 87)

Challenges with Sexual Orientation/Gender Identity: Discrimination, internal conflict, and lack of acceptance can lead to significant psychological stress (88, 89).

Bullying and Peer Conflict: Experiencing bullying, whether in person or online, is a major risk factor for suicidal thoughts and behaviors(85, 90).

Poor Coping Skills: Without healthy strategies for managing stress and difficult emotions, individuals may feel overwhelmed, increasing vulnerability (91-93).

Stigma and Barriers to Mental Health Care: Societal or internalized stigma can discourage adolescents from seeking help, and systemic barriers like lack of access to services can be detrimental (94).

Academic Pressure and Expectations: Intense pressure to excel academically, coupled with fear of failure, often self-imposed or disappointing parents and teachers, can lead to significant distress (15, 95).

Past History of Mental Illness and/or Suicide Attempts: A previous history of mental illness and past history of suicidal attempt is a strong predictor. The robust findings comes from that the history of past attempts predicts future attempts and completed suicides (96). People who have had an earlier suicide attempt are 20-30% more likely to reattempt. The increased risk of death by suicide is higher in the first 1 to 3 years after their first suicide attempt (97, 98)

There is a lack of systematic studies examining the risk factors predicting mental illness and suicidal tendencies among medical students. As a result, we are leveraging valuable evidence from studies conducted on the general and high-risk population

8.3 Immediate Triggers/Precipitating Factors

Financial Loss: Economic hardship can bring about overwhelming stress, especially for adolescents who may already feel burdened (99).

Sudden Loss or Grief: The death of a loved one, a breakup, or other significant relationship loss can trigger acute emotional pain and a sense of hopelessness (99)

Media Exposure: The media can play a complex role in shaping attitudes and behaviors related to suicide. However, sensationalized or irresponsible media reporting can also have adverse effects, such as glorifying suicide or providing detailed descriptions of suicide methods, which can increase the risk of copycat suicides, known as the "contagion effect."(100).

Mental Health Crisis: An exacerbation of an existing disorder or the onset of new symptoms or post-discharge from the hospital can lead to suicidal thoughts and behaviors (99).

Adverse Life Events: Experiences such as failing examinations, unemployment, legal trouble, or public humiliation can feel insurmountable, especially with limited coping skills and support (92).

To summarize, mental health & wellbeing and suicidal spectrum is a complex issue significantly affecting adolescents and young adults, primarily driven by a combination of biological, behavioral, environmental, and social risk factors. These factors include genetic predispositions, personality traits, family history, and existing mental disorders such as depression, anxiety, and substance abuse. Environmental influences such as trauma, cultural beliefs, family dynamics, and societal barriers also play critical roles in increasing suicide risk. Immediate triggers like financial stress, personal losses, and acute mental health crises can precipitate suicidal actions. Understanding and addressing these multifaceted risk factors are crucial for effective suicide prevention and intervention strategies.

8.4 Risk Factors Specific to Medical Students

The factors that heighten the risk of Mental illness and suicide among medical students can be divided into academic-related factors, such as failing grades, exam stress, and burnout, and non-academic factors, which include financial hardships, mental health challenges, and relationship issues (101). A recent systematic review and meta-analysis of 25 studies evaluating the risk factors for suicidal ideation and suicide attempts among medical students was conducted. The strongest risk factors for both suicidal ideation and suicide attempts among medical students were poor mental health outcomes, including depression, burnout, comorbid mental illness, and stress (102). Another meta-analysis and systematic review (21) evaluated the global prevalence and risk factors for mental health issues among medical students during the COVID-19 pandemic. Identified risk factors included being female, junior student, exposure to COVID-19, academic stress, history of psychiatric or physical disorders, economic trouble, fear of educational impairment, difficulties with online learning, fear of infection, loneliness, low physical activity, low social support, problematic internet or smartphone use, and young age. The findings emphasize the need for mental health services to support high-risk students and inform targeted interventions by colleges and health authorities.

A narrative review examined suicidality in medical students worldwide, highlighting the high rates of psychiatric disorders among this population and their correlation with elevated suicide rates. This review identified the following factors

- a) structural aspects of medical schools (e.g., curricula, accommodation, social support),
- b) interpersonal factors (e.g., social isolation, academic pressures),
- c) unique aspects of medical training (e.g., simulation training, exposure to trauma) and
- d) socio-cultural factors such as ragging and gender role expectations also play a role (15).

A web-based survey conducted by Marcon and his colleagues (149) aimed to identify factors linked to a history of suicide attempts among medical students. The study identified several significant risk factors, including female gender, homosexuality, low income, bullying by university peers, childhood or adult trauma, family history of suicide, recent suicidal ideation, daily tobacco use, and severe risk for alcohol abuse. On gender comparison, high-risk female medical students were more likely to feel worried, irritable, and stressed. In contrast, high-risk male medical students were more prone to having suicidal thoughts, intense anger, excessive drinking, and using recreational drugs or prescription medications without appropriate follow-up. Both genders showed no difference in their help-seeking behaviors (150)

A study conducted in an Indian medical college using a web-based survey questionnaire found that significant predictors of suicide ideation among students included being female, alcohol use, a history of facing abuse, academic stress, family-related stress, and relationship-related stress. Additionally, half of the students identified academic stress as a significant life stressor (103). Scientific evidence shows that medical students who attempt suicide are associated with poor academic performance, burnout, and mental health problems such as depression, anxiety, and other mental health problems (101, 104, 105). However, the paucity of global and national literature makes it challenging to comprehensively identify and address these risk factors, underscoring the need for more extensive research to develop effective prevention and intervention strategies that promote mental health and resilience.

The limited evidence regarding factors that heighten the risk of mental illness and suicide among medical students can be categorized into academic and non-academic factors. Academic-related factors include failing grades, exam stress, clinical work and burnout. Non-academic factors encompass financial hardships, family stress, and relationship issues.

8.5 Protective Factors

Social, family, and school connectedness, characterized by perceived caring, support, and quality communication, stands as a significant protective element against suicidal ideation and behavior in young individuals. (106). These close relationships with family, friends & community members can provide a sense of belonging and emotional support, reducing feelings of isolation and hopelessness. Religious or spiritual beliefs can offer solace, optimism, and a sense of purpose for specific individuals, thereby lowering the likelihood of suicide (82). McKinley and colleagues systematically reviewed the existing literature on factors influencing resilience among medical doctors. After reviewing and applying inclusion criteria, 24 studies were selected for a narrative synthesis. The analysis pinpointed several critical factors that contribute to resilience in medical professionals. These include demographic variables, personality traits, organizational and environmental influences, social support networks, leisure activities, experiences of overcoming past adversities, and targeted interventions designed to bolster resilience(107)

While most published studies on mental illness and suicide focus on identifying the socio-demographic and psychosocial characteristics risk factors, there is a notable absence of systematic research examining protective factors across populations. There is a lack of systematic, published studies among medical students. Additionally, there are no systematic studies investigating protective factors against mental illness, suicide risk, specifically in medical students. Therefore, investing in exploring these protective and resilient factors is crucial for preventing mental illness and reducing suicide rates in medical students. Therefore, it is necessary to extrapolate data from studies conducted in the general population. For risk factors, please see Figure no-8.1

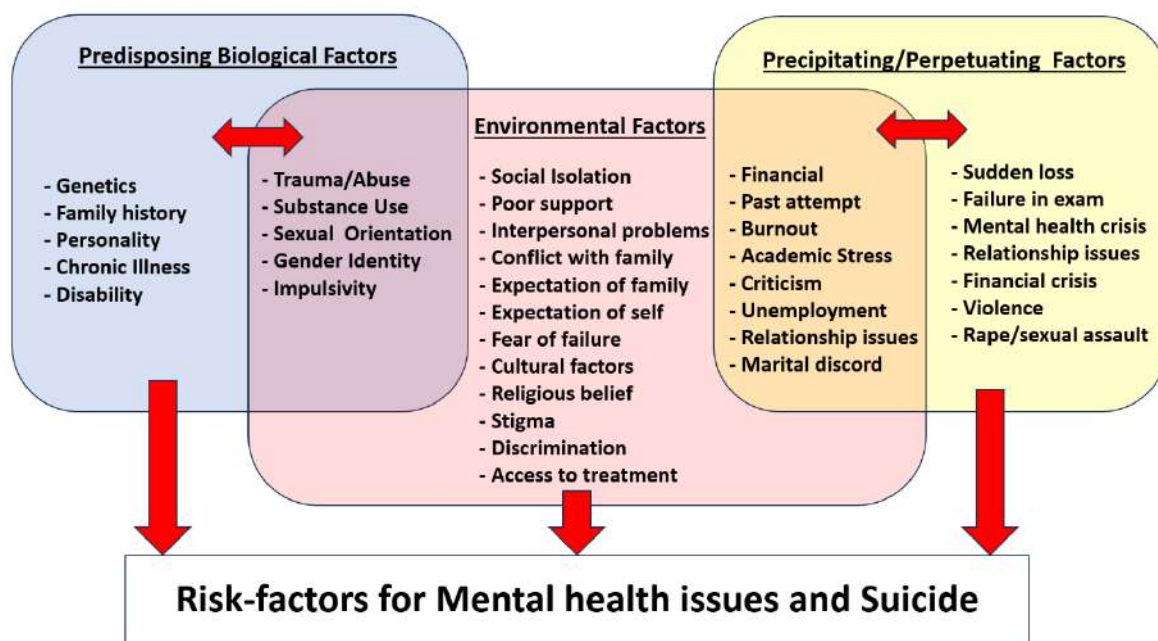


Figure 8.1: The Risk Factors for Mental Health Issues and Suicide, demonstrating that these Risks Arise not from a Single Factor but from a Complex Interplay of Various Elements

Understanding the risk factors for mental health, well-being, and suicide is crucial; they include mental health disorders, substance abuse, a history of trauma or abuse, past-history, significant life changes, and a lack of social support. Recognizing these factors will enable us to develop a comprehensive mental health care plan.

9. Evidence-Based Interventions

Interventions to Improve the Mental Health and Well-being of Medical Students

The literature on interventions that enhance medical students' mental health and well-being is relatively sparse. Most studies predominantly focus on a specific set of interventions, with no systematic evaluations of their overall effectiveness. Consequently, we have reviewed the available literature on these specific interventions only. The studies in medical students predominantly examined a specific set of interventions are: Mindfulness-Based Interventions (MBIs)(108, 109), physical activity and exercise regimens(110, 111), resilience training programs(112, 113), peer support systems(114, 115), and stress management strategies(116, 117). The attention to the mental health of medical students as a significant area of academic inquiry is a relatively recent development, and consequently, empirical studies focusing on mental health well-being intervention-based approaches are limited and need further exploration(118).

There is a significant gap in systematic research specifically addressing the effectiveness of mental health promotion and suicide prevention measures for medical students globally. The available evidence primarily stems from studies conducted on the general population, high-risk groups, and individuals with mental illness. However, these findings could potentially provide valuable insights for interventions aimed at medical students.

A systematic review aimed to uncover effective interventions within undergraduate medical education (UME) that enhance students' emotional well-being(119). Analysing twenty-eight articles encompassing 8224 participants, the review revealed limited evidence supporting several practices: adoption of Pass/Fail grading systems, implementation of mental health programs targeting stigma reduction and enhancing accessibility, integration of mind-body skills education/training programs, structuring the curriculum to include more clinical contact hours and problem-based learning, and establishment of small group-based faculty advisor/mentor programs. However, the study concluded that there is a need for high-quality medical education research to improve the emotional well-being of medical students.

9.1 Mindfulness-Based Interventions

McConville and colleagues (2017)(120) conducted a systematic review analyzing the impact of mindfulness interventions on health profession students through both randomized and non-randomized controlled trials, incorporating a total of 10 studies specifically focusing on medical students. The inclusion criteria were limited to studies that reported quantitative outcomes. Their findings indicate that mindfulness-based interventions significantly reduce stress, anxiety, and depression while enhancing mindfulness and mood among health

profession students compared to predominantly passive controls in the control groups. However, the results were not separately detailed for medical students. Another study by the Cochrane Review (121) encompassed randomized controlled trials examining mindfulness interventions aimed at medical students and junior doctors in their first three postgraduate years. The review specifically targeted psychological interventions primarily focused on teaching mindfulness principles for preventive purposes. The primary outcomes measured were anxiety and depression, while secondary outcomes included stress, burnout, academic performance, suicidal ideation, and quality of life. The review analyzed data from 10 studies involving a total of 731 participants. The findings revealed no significant evidence supporting the effectiveness of mindfulness-based interventions in reducing symptoms of anxiety or depression. Nonetheless, these interventions demonstrated a modest beneficial impact on reducing stress and alleviating burnout. A systematic review published in 2023(109) reported that students who engaged in mindfulness training experienced perceptible improvements in stress levels and symptoms of psychological distress. Additionally, these students noted enhanced perceptions of their health and overall psychological well-being.

A recent systematic review by Kaisti and his colleagues (2024)(108) aimed to collate and analyze the quantitative outcomes of mindfulness-based interventions (MBIs) on medical students by reviewing 31 articles that met specific inclusion criteria. Over half of the included studies were randomized controlled trials (RCTs), with interventions typically ranging from 4 to 10 weeks and based on established programs like Mindfulness-Based Stress Reduction or Mindfulness-Based Cognitive Therapy or their modifications. The findings revealed high satisfaction levels with the interventions and significant improvements in the intervention groups regarding reduced stress and distress symptoms and enhanced mindfulness compared to controls. These positive effects were maintained over follow-ups lasting months or years. Additionally, both controlled and uncontrolled studies showed statistically significant outcomes, reinforcing the potential of MBIs to improve medical students' well-being significantly. Further, recently, studies looked into the online delivery of MBIs for medical students(122).

9.2 Stress Management

The meta-analysis conducted by Yusoff Bahri (117) aimed to assess the impact of stress management interventions on the psychological health of medical students, specifically targeting general psychological distress, stress, anxiety, and depression symptoms. Only 13 articles met the inclusion criteria and were analyzed. The results from the meta-analysis indicated that stress management interventions have a moderate, statistically significant positive effect on the psychological health of medical students. Additionally, subgroup analyses revealed significant interactions based on the duration of the intervention and the research design used. Specifically, brief to medium-length interventions were more effective than those of longer duration, and randomized controlled trials (RCTs) yielded larger effects than non-RCTs. A systematic review of predominant interventions aimed at alleviating burnout among healthcare workers were predominately enhancements in communication skills, teamwork dynamics, participatory initiatives, and psychological interventions such as Yoga, meditation, and mindfulness(123). A systematic review suggests that yoga interventions

effectively manage stress among healthcare workers. Additionally, within the same review, medical students demonstrated enhanced emotional self-regulation and self-compassion scores following an 11-week yoga program(124).

9.3 Resilience Training

Resilience training programs are designed to enhance the ability of individuals, including medical students, to effectively manage and recover from stress, challenges, and adversities, which is particularly crucial given the high-stress nature of medical training. These programs initiate with educational workshops that focus on imparting knowledge about the science of stress and resilience, including the underlying neuroscience and identification of personal stress triggers, which is supported by studies showing the impact of education on improving resilience outcomes(125). Skill development is a core component of these programs, targeting essential areas such as problem-solving, emotional regulation, interpersonal communication, behavior modification, mindfulness and meditation, cognitive restructuring to alter maladaptive thought patterns, and effective goal-setting strategies. These skills are practiced through role-playing, simulations, and other practical exercises in a structured environment, which research has shown to enhance both the learning experience and the application of these skills in real-world settings(126). To ensure the longevity and adaptability of these benefits, resilience training programs incorporate follow-up sessions and continuous access to supportive resources, such as mobile apps. While resilience training programs have been implemented and supported by a growing body of literature highlighting their potential benefits, it is important to acknowledge that systematic, large-scale, longer-duration prospective studies proving their efficacy conclusively are still limited(127).

9.4 Online Interventions

Recent studies on online interventions for medical students have yielded initially promising outcomes(128). These online intervention programs offer significant advantages for mental health support. They are inherently flexible, providing access to resources and support anywhere and anytime. This especially benefits medical students who often face demanding schedules and high-pressure environments. This accessibility ensures that help is available when it's most needed, whether late at night or during breaks in a busy day. Moreover, the online format of these interventions can also enhance confidentiality and privacy, which are critical factors for individuals who may hesitate to seek face-to-face counselling due to stigma or fear of professional repercussions. A recent systematic review by Ungar and colleagues (2022)(128) included 11 studies and categorized them based on their focus areas: mental health literacy, mindfulness, Cognitive Behavioral Therapy, and peer support. Key findings include significant reductions in perceived stress from two programs, reduced burnout levels from another, and significant improvements in mindfulness, empathy, and resilience from one program. Additionally, two studies reported enhancements in coping strategies. Despite these positive outcomes, many reviewed studies lacked control groups, and only a few online programs demonstrated limited evidence of effectiveness. Further, medical students have identified digital mental health interventions as promising tools for preventing stress and

facilitating early intervention. However, they have expressed reservations about the effectiveness of these digital tools in managing severe mental disorders(129).

9.5 Yoga Intervention for Mental Health Promotion and Well-being

Yoga was developed primarily as a tool for self-mastery and spiritual progress. However, over the past few decades, the therapeutic applications of yoga in mental healthcare have been explored with promising results. Studies have also demonstrated biological mechanisms of action of yoga such as downregulation of HPA axis, enhanced vagal tone, better autonomic modulation, enhanced neuroplasticity and GABAergic tone (151). A recent systematic review and meta-analysis assessed the effects of yoga interventions on participants with major depressive disorder (MDD). This review included 34 randomized controlled trials (RCTs) involving 2,341 participants, 48.4% of whom were women. The duration of the yoga interventions ranged from 2 weeks to 28 weeks, with an average duration of 10.57 weeks. The authors concluded that yoga can improve depression and anxiety in patients with MDD and is safe, with wide patient acceptance (152). Similarly, another meta-analysis involving 38 RCTs evaluated the utility of yoga in alleviating anxiety symptoms. This analysis found that yoga practice had a large and statistically significant effect on anxiety symptoms compared to controls (153). Additionally, another meta-analysis included 42 RCT studies to assess the effect of yoga on stress and physiological markers of stress. The authors concluded that interventions including yoga, particularly yogasanas, were associated with reduced evening cortisol, waking cortisol, ambulatory systolic blood pressure, resting heart rate, high-frequency heart rate variability, fasting blood glucose, cholesterol, and low-density lipoprotein levels compared to active control (154).

One major limitation identified by systematic reviews of yoga studies is the heterogeneity of the interventions. Various schools of yoga emphasize different components, complicating the generalizability and scalability of these interventions. To address this issue, the Departments of Psychiatry, Telemedicine Centre, and Department of Integrative Medicine at the National Institute of Mental Health and Neurosciences (NIMHANS) have developed evidence-based generic yoga and tele-yoga programs for specific mental health conditions (155). The creation of these specific yoga modules involves a rigorous scientific process of validation and efficacy testing through clinical trials (156). During the validation process, traditional and scientific yoga literature is thoroughly reviewed, and the developed content is validated through interviews with yoga experts from various schools, including Art of Living, Isha Yoga, Patanjali Yoga, and Iyengar Yoga. Once content validation is complete, the module is tested for feasibility and efficacy (157-161). The tele-yoga modules are developed following the tele-yoga advisory issued by the Central Council for Research in Yoga and Naturopathy (CCRYN), Ministry of AYUSH, Government of India. Please see **Appendix-6** Yoga module prepared by the Department of Integrative Medicine at the National Institute of Mental Health and Neurosciences (NIMHANS), Bangalore.

The literature review highlighted individual-level, mindfulness-based interventions for enhancing medical students' resilience, overlooking the impact of structural and systemic

stressors within the medical education system. While mindfulness-based interventions have shown efficacy in promoting mental health, focusing on individual interventions neglects significant organizational stressors. Medical training exposes students to organizational-level stressors, including those deeply ingrained in the system and others resulting from preventable failures, such as fostering a competitive culture and tolerating intimidation and bullying. Interventions targeting these organizational stressors are crucial for enhancing mental well-being among medical students. Thus, a comprehensive approach addressing individual and systemic factors is necessary for effective intervention.

There is a significant opportunity for more studies on risk factors for mental illness and suicide prevention among medical students. Consequently, we can utilize valuable data from studies conducted on the general population and high-risk populations.

9.6 Designing Interventions for Mental Health and Well-being

There is considerable literature documenting both the presence of mental health disorders and risk factors in young adults. The worldwide literature suggests numerous interventions, even though evidence on proven interventions specifically for medical students remains limited. The lack of scientific literature on evidence-based interventions to improve the mental health and well-being of medical students compels us to extrapolate evidence from studies on high-risk populations. In the absence of strong evidence-based data, the task force believes that suicide intervention studies from the general population offer valuable insights for planning interventions encompassing prevention, promotion, early identification, treatment, and rehabilitation. These elements are crucial, which is why this framework was chosen.

The World Health Organization (WHO) has spearheaded endeavours to address this concern, advocating for tailored national strategies across diverse cultural, economic, and social landscapes. Preventing suicide is one of the central parts of the WHO's operational program aimed at decreasing suicide rate across the globe. This commitment is exemplified by WHO's initiatives such as the "Health for All Strategy," "Global Trends in Suicide Prevention," SUPRE campaign (SUicide PREvention), and "LIVE LIFE Initiative for Suicide Prevention." (6, 8, 130). In the quest for effective suicide prevention initiatives, no single strategy stands above the others. Combinations of evidence-based strategies at the individual level, high-risk populations, and population levels should be tried.

Interventions for preventing suicide are categorized as

- 1) Universal,
- 2) Selective, and
- 3) Indicated strategies.

In simpler terms, these interventions are collectively called the **USI model**. (131). Please refer to Figure No-9.1

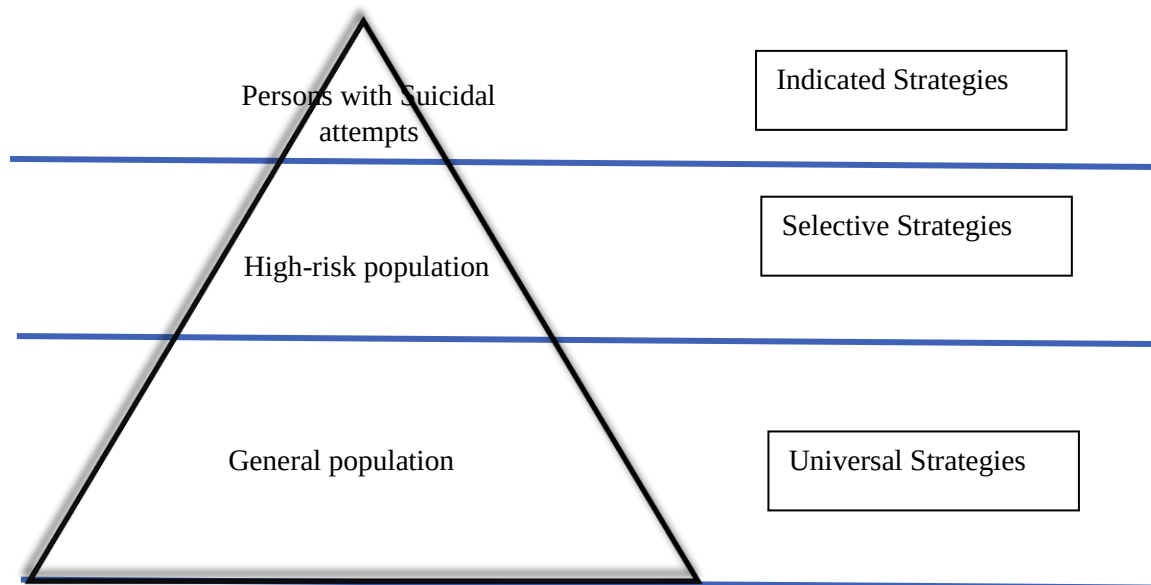


Figure 9.1. The USI Model (131)

Universal strategies encompass entire populations, aiming to boost awareness, remove barriers to care, and enhance social support. Selective strategies focus on high-risk groups, like individuals with mental health issues, substance abuse issues, past attempters, and recent life events, to minimize the likelihood of suicidal behavior by applying tailored interventions. Indicated interventions are proposed for those who have attempted suicide or exhibit suicidal ideation, providing crisis interventions and ongoing support (131)

Transposing the USI model to evidence-based mental health and wellbeing and suicide prevention interventions for medical students, these interventions can be formulated across three levels:

Universal Strategies - those encompassing the entire medical students' community,

Selective Strategies - those at risk (determined by critical time points or transitions - entry/ exam/ exit; adaptation/ adjustment challenges/ impaired coping/ re-evaluating course continuation, past history of suicide attempt, substance use), and

Indicated Strategies for those with mental illness or a recent history of attempted suicide.

The USI model provides a robust framework for structuring suicide prevention interventions tailored to the unique needs of medical students. This multi-tiered approach is particularly well-suited to the medical student community, where varying levels of stress and risk are prevalent.

9.6.1 For all Medical Students – Universal

Interventions at this level encompass the entire medical student fraternity. They aid in reducing suicide risk through various methods, such as restricting access to lethal means, conducting awareness campaigns and institutional programs to address bullying and support mental health, providing accessible mental health resources and care, organization staff sensitization, evolving pathways/systems of care and encouraging responsible media coverage of suicides(130).

Interventions to promote well-being are important among medical students to prevent suicide. This can be achieved through institutional changes, such as modifications in grading and classification systems, anti-ragging measures, group-based approaches focusing on stress management, mindfulness therapy, relaxation techniques, and psychoeducation (132). When examining research on suicide prevention among medical students, a meta-analysis indicated that the efficacy of relatively brief, individually focused, mindfulness-based interventions may exhibit greater effectiveness in reducing levels of anxiety, depression, and stress in medical students in the short term, potentially leading to a decrease in suicidal ideation and behavior (133).

Another meta-analysis highlighted the preventive benefits of in-class psychoeducation in reducing suicide rates in educational settings (134). Communication & mental health awareness programs are crucial in addressing stigma related to mental illness and promoting improved help-seeking behaviors among medical students(132). Thus, organization-led proactive initiatives mitigate overall suicide risk by creating awareness and enhancing help-seeking.

9.6.2 For Medical Students at Risk - Selective

Medical students with a potentially higher risk of suicide include individuals with mental illness and/or substance use, those from marginalized sections of society, those who have poor financial resources, those belonging to gender minorities, and those having interpersonal relationship issues and academic difficulties.

Early detection initiatives, especially screening programs, play a critical role in identifying individuals at risk(135). Providing access to mental health resources, such as counselling services, support groups, peer support interventions, and hotlines, is essential for improving and preventing suicide in students at risk (132, 136, 137). Targeted psychological interventions for students experiencing high levels of stress, academic pressure, or personal challenges play an important role(138). Mentorship programs such as PREVAIL and LET's CONNECT have demonstrated effectiveness in preventing suicide among people at risk and those with social problems (136, 139). Similarly, Gatekeeper training, as evidenced by several studies, has been shown to significantly enhance the competence and confidence of staff and teachers in managing suicidal students (140, 141).

9.6.3 For Medical Students with Attempted Suicide and/ or Mental Illness – Indicative

Medical students who have attempted suicide or have mental illness often require resources for intensive psychosocial and pharmacological interventions provided by the psychiatry department of medical colleges. Long-term psychosocial interventions, such as cognitive behavioral therapy (CBT), dialectical behavioral therapy (DBT), collaborative assessment and management of suicidality (CAMS), acceptance and commitment therapy (ACT), mentalization, and interpersonal psychotherapy, aim to address underlying mental health issues and improve coping skills over an extended period. In contrast, brief interventions like no suicide contracts, safety planning interventions, crisis response planning, attempted suicide short intervention programs (ASSIP), involving family members, and volitional help sheets focus on providing immediate support and resources during times of crisis (137, 142-145)

Additionally, pharmacological agents with potential effects on suicidal behavior, such as lithium, clozapine, ketamine, selective serotonin reuptake inhibitors (SSRIs), and buprenorphine, may be considered as part of a comprehensive treatment plan, particularly for individuals with severe psychiatric conditions(137). Implementing strict follow-up strategies, supervised medication, and family members' support, including regular monitoring of medical students with mental illness, plays a significant role in preventing suicide or suicide reattempts. Studies have shown that follow-up support, such as phone calls, crisis cards, emails, and postal cards after discharge, can significantly decrease the risk of suicide(146).

Currently, there is a lack of systematically conducted research assessing the efficacy of suicide prevention measures specifically tailored for medical students. Existing evidence stems from studies conducted within the general population, high-risk population, and persons with mental illness. However, the conclusions drawn from these studies may apply to medical students, encompassing all students, those identified as being at risk, as well as individuals with a history of attempted suicide or mental health concerns. Please refer to Table no-2, which outlines the applicability of the study findings in medical students. Additionally, the systematic review indicated evidence for various suicide prevention strategies according to the Oxford Centre for Evidence-Based Medicine (OCBEM) levels of evidence working Group. Levels of Evidence is published by OCBEM (2010).

9.7 Level of Evidence: Extrapolating from General Population Studies, High-risk Populations and Persons with Mental Illness

At present, there is a lack of systematic research on the effectiveness of mental health promotion, prevention of mental illness, and suicide prevention measures specifically for medical students worldwide. This gap in targeted research forces us to extrapolate findings from studies conducted on the general population. Although there is a lack of systematic research specifically in medical students, there are high-quality studies available on suicide prevention in the general population. These robust studies provide valuable evidence, compelling us to use their findings to inform our efforts in supporting medical students. By leveraging these well-established research insights, one can develop more effective strategies to address the unique challenges faced by medical students and improve their mental health outcomes.

The glaring absence of intervention studies to prevent mental illness and suicide in medical colleges across the globe highlights a severe neglect of medical students' health. This significant gap calls for immediate and substantial investment in research and resources to effectively tackle the mental health challenges faced by medical students, ensuring their well-being and success.

A systematic review conducted by Zalsman and his colleagues (12) assessed the effectiveness of suicide prevention strategies globally. The review highlighted evidence for measures such as restricting access to lethal means like analgesics, anesthetics, and hot spots for jumping, implementing school-based awareness programs to reduce suicide attempts and ideation, and pharmacotherapy such as clozapine and lithium, along with pharmacological and psychological treatments for depression, potential benefits of screening in primary care, general public education, and media guidelines for suicide prevention. The review noted encouraging preliminary findings but suggested further investigation was warranted for strategies like gatekeeper training, physician education, and internet and helpline support due to the paucity of randomized control trials.

Table 9.1 - Level of Evidence for Mental Health & Well-being and Suicide Prevention Strategies Extrapolating from General Population Studies to Medical Students (12)

Level of Evidence	Intervention
1. For all Medical Students	
Level 2a, 2c, 3b	Restriction on Access to Suicide Firearm restrictions Erection of barriers at jumping hot-spots for suicide Restriction to Pesticide/Regulation on Pesticide Restrictions on access to charcoal (Carbon Monoxide) Restrictions on barbiturate and caffeine tablet sales Restriction measures on hanging
Level 2a, 2c	Media Role in Reporting of Suicide Media reporting Media Blackout on Suicide Reporting
Level 2b	Availability of Safety net of Mental Health Services Means ensuring universal access to services, offering crisis intervention, implementing early screening and intervention, providing ongoing treatment, fostering community support, and raising awareness about mental health.

Level 1b, 2a, 2b, 2c	School-based Awareness Programs for Adolescents Awareness programs on Mental illness and suicide prevention
Level 2c	Primary Care Physician Education on Mental illness and suicide prevention
Level 2c, 2b	Public Awareness Campaigns Community-based Screening and Follow-up
2. For Medical Students at Risk:	
Level 1a, 3b	Psychosocial interventions Group therapy
Level 1b	Brief psycho-education for parents Assertive outreach intervention
Level 1a, 1b, 2a, 2b	Screening adolescents
Level 1b, 2a, 2b, 2c	Gatekeeper training program
Level 2b, 4	Crisis Helpline
Level 1b, 2b	Mobile Phone & Telephone Interventions
Level 2b	Internet chats-based interventions
Level 4	Collaborative assessment and management
Level 2b	Family crisis intervention
3. For Medical Students who have Attempted Suicide and/or have a Mental Illness	
Level 1a, 1b	Lithium Clozapine Quetiapine and atypical antipsychotics Ketamine SSRI Psychosocial interventions Brief intervention in the emergency room and follow-up contact Group therapy Integrative psychotherapy Intensive community-based management
Level 1b, 2b	Lithium and Valproic acid Antiepileptics and Lithium Management of mental illness at the primary care level Dialectical behavioral therapy Parental involvement therapy Brief parent-adolescent intervention Brief psycho-education for parents Integrative program (outreach, problem-solving, adherence, continuity) Postcard intervention
Level 1b, 2a	Cognitive Behavior Therapy

Level 1a, 1b, 2b, 4	Psychodynamic therapy Group DBT Family-based intervention Follow-up meeting Aftercare programme Chain of care intervention Collaborative intervention in primary care Management of depression in primary care
Level 1a, 2a, 2c	Community-based screening and intervention
Level 1b, 2b, 3a	Cognitive psychotherapy
Level 4	Collaborative assessment and management
Note: Oxford criteria (Centre for Evidence-Based Medicine, 2010)	
Level	
1a: Systematic review (with homogeneity) of RCTs,	
1b: Individual RCT (with narrow confidence intervals),	
1c: All or none study,	
2a: Systematic review (with homogeneity) of cohort studies,	
2b: Individual Cohort study (including low-quality RCT),	
2c: “Outcomes” research; Ecological studies,	
3a: Systematic review (with homogeneity) of case-control studies,	
3b: Individual Case-control study,	
4: Case series and poor-quality cohort and case-control study,	
5: Expert opinion without an explicit critical appraisal, based on bench research or “first principles”	

In another systematic review published by Mann John and his colleagues in 2021(147), the researchers emphasize that effective suicide prevention interventions include a broad array of strategies designed to mitigate risk and enhance safety. Key among these strategies are Awareness and education efforts focused on improving the knowledge and skills of general practitioners, educating young individuals, and training gatekeepers who are pivotal in identifying and responding to signs of suicidal behavior. Screening for individuals at high risk is crucial for early intervention. Therapeutic interventions include pharmacotherapy to manage underlying mental health conditions, various forms of psychotherapy such as Cognitive Behavioral Therapy (CBT) for individuals and groups, brain stimulation techniques like electroconvulsive therapy, and collaborative care models that ensure coordination between multiple healthcare providers. School-based and internet-based interventions extend the reach of preventive measures into educational settings and digital platforms, respectively. Follow-up care post-crisis involves contact interventions and active outreach to provide continued support. Additionally, restricting access to common means of suicide serves as a vital preventive measure. These comprehensive strategies are fundamental to effectively reducing the incidence of suicide.

Based on the above review, to effectively adapt suicide prevention strategies for medical students, it is crucial to implement a comprehensive approach that includes educational interventions, regular mental health screenings, easily accessible therapeutic options, and brief suicide prevention interventions for people at risk(142, 147).

Additionally, ensuring diligent post-crisis care and restricting access to potential means of suicide are essential. These targeted strategies address medical students' distinct challenges and bolster their overall mental health resilience.

In the absence of strong evidence-based data, the task force believes that suicide intervention studies from the general and high-risk populations provide valuable insights for planning interventions encompassing prevention, promotion, early identification, treatment, and rehabilitation. The evidence base for these interventions is limited in both size and quality. Most current interventions focus on training general practitioners, students, and staff in awareness, restricting access to potential means, identifying those at risk, implementing brief suicide prevention interventions, and ensuring post-crisis care.

The potential of digital interventions in the prevention of depression and suicide has been extensively explored. Self-guided digital interventions are gaining recognition as valuable tools for reaching individuals at risk of suicide who may not engage in traditional face-to-face therapy. Studies show that up to 70% of individuals contemplating suicide do not seek professional help. Digital platforms, whether web-based or app-based, offer a promising avenue to encourage help-seeking behaviors and provide earlier intervention, potentially diminishing the frequency and intensity of suicidal thoughts. A meta-analysis conducted by Torok Michelle and colleagues in 2020 (148) assessed the efficacy of these interventions, both direct (targeting suicidality) and indirect (addressing depression), in reducing suicidal ideation and behaviors. The findings suggest that directly targeted, self-guided digital interventions can significantly contribute to suicide prevention efforts and should be actively promoted across the internet and digital distribution platforms like app stores. While the individual effect size of these interventions may be small, their broad implementation could substantially impact the population level if widely adopted.

The critique of current research on suicide prevention underscores significant shortcomings, particularly in terms of statistical power, study duration, ethical challenges, and evidence quality. Given the complex and multifactorial nature of suicide, which often results in small effect sizes for interventions, there's a pressing need for more robust research designs, including randomized controlled trials (RCTs) with well-chosen comparator interventions(145). Furthermore, the absence of studies exploring integrated, multifaceted approaches is a critical gap. Comprehensive strategies are necessary to address the diverse factors contributing to suicidal behavior effectively. Another vital consideration is the lack of data on ancillary outcomes such as acceptability, attitudes, and adherence to interventions, which are crucial for ensuring that preventive measures are practical and sustainable. Additionally, including economic evaluations in these trials is essential to assess the cost-effectiveness and feasibility of interventions, facilitating their broader implementation and sustainability. Overall, enhancing the methodological rigor, extending follow-up periods, and broadening the scope of suicide prevention research to include economic and practical viability assessments will be

vital to developing more effective, acceptable, and implementable suicide prevention strategies.

Essentially, there is no one-size-fits-all solution for suicide prevention. Therefore, each community needs to tailor suicide prevention programs that are culturally sensitive, locally relevant, based on empirical evidence, and tailored intervention programs in India to mitigate suicide risk among medical students. Figure No-9.2 provides details of the suicide prevention interventions that can be delivered as well as the resource requirement at each level, i.e., for all medical students, those at-risk, and those having attempted suicide and /or with mental illness or substance use. By equipping medical educators and staff with the skills and confidence to identify and support at-risk students, these initiatives could create a safer and more supportive environment for medical students, thereby reducing suicide rates.

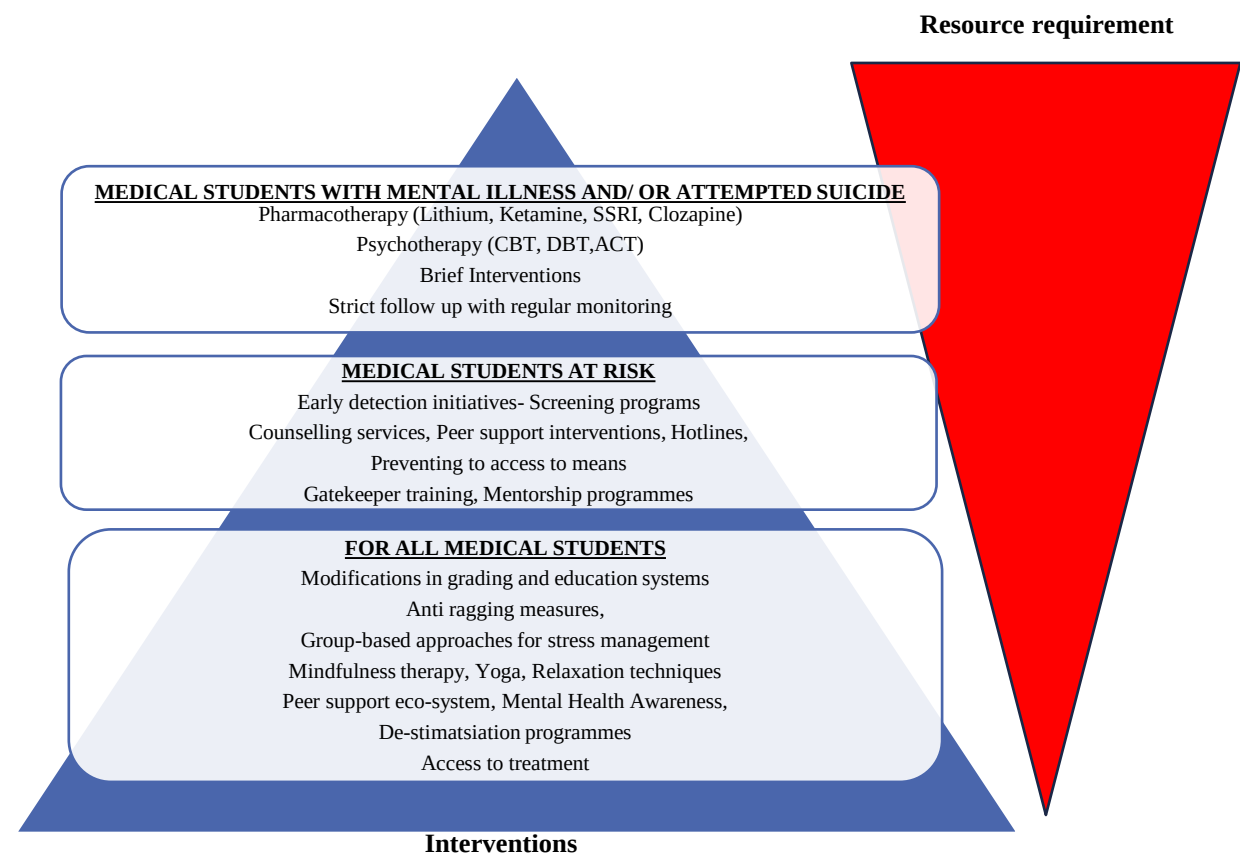


Figure 9.2 Mental Health & Well-being and Suicide Prevention Interventions; Resource Requirements for Medical Students

SSRI: selective serotonin reuptake inhibitors, CBT: Cognitive behavior therapy, DBT: Dialectical behavioral therapy, ACT: Acceptance commitment therapy

Survey and Interactions with Stakeholders

10. Survey and Interaction with Stakeholders: Observations and Results

Because of the paucity of literature regarding risk factors and intervention-based studies on medical students, the task force employed three important methods to gather comprehensive data.

First, the task force engaged in in-person visits to various medical colleges and held focused group discussions with various stakeholders, including medical college administrators, heads of departments, and students. These discussions aimed to identify best practices and challenges in providing mental health support to medical students.

Second, the task force conducted an online survey targeting undergraduate and postgraduate medical students, as well as faculty members, to collect a wide range of perspectives and insights on mental health and well-being. These combined approaches provided a thorough understanding of the current landscape and informed the development of effective interventions and support systems.

Third, the task force interacted with students, the medical students' associations, the junior resident's organization, and parents of medical students.

In-Person Visit to the Medical College by the Taskforce

The Task Force employed a comprehensive and interactive methodology to gather insights into the mental health and well-being of medical students nationwide. Task force members visited various medical colleges, engaging directly with administrators and heads of departments through focused group discussions (FGDs) to understand their best practices and challenges in supporting students' mental health. These discussions provided a detailed perspective on institutional efforts and identified areas needing improvement.

To further understand the mental health and well-being of medical students, FGDs were conducted with small groups of students from various years, under the guidance of a skilled moderator. Additionally, individual discussions were held to ensure confidentiality. The objective was to gather diverse perspectives and in-depth information on the student's experiences and challenges. Participants were randomly selected to represent different demographics within the medical student population. The moderator, experienced in facilitating discussions, used a specially designed discussion guide with open-ended questions to prompt conversation. The FGDs were held in a comfortable, neutral setting within the medical college, ensuring a distraction-free environment. Each session began with an introduction by the moderator, explaining the purpose of the discussion and assuring confidentiality to encourage open and honest sharing. Ice-breaker questions were used to make participants comfortable before delving into the main discussion.

During the discussions, students were encouraged to share their thoughts and experiences regarding their mental health and well-being. The moderator asked open-ended questions and used probing techniques to explore responses in more detail, ensuring a comprehensive understanding of the issues faced by the students. Important notes were taken by the moderator and other task force members. The FGDs provided rich, detailed information and multiple perspectives on the mental health challenges faced by medical students. This method proved

valuable in capturing the complex and varied experiences of students, highlighting areas for intervention and support to enhance their well-being.

In addition to undergraduate students, the task force also engaged with postgraduate students from various departments through FGDs. When a more private setting was deemed necessary, individual task force members conducted one-on-one interviews with postgraduate students to ensure confidentiality and gather in-depth insights. To encourage broader participation and input, the task force invited students to share their views and experiences via email. This approach ensured that students who might not feel comfortable speaking in groups could still contribute valuable information.

The task force's visits were thorough, including inspections of hostels, duty rooms, cafeterias, libraries, and other key areas within the medical colleges. This allowed the task force to gain a holistic understanding of the physical environments where students live and study, which are integral to their mental well-being. This multifaceted approach ensured a comprehensive assessment of the mental health support systems in place and identified opportunities for enhancing student well-being across medical institutions.

Online Survey

The National Task Force conducted an online survey aimed at understanding the mental health and well-being of undergraduate (UG) and postgraduate (PG) medical students, as well as faculty members of medical colleges. The primary objective of this survey was to gather comprehensive insights into the various stressors and challenges faced by medical students in their academic and personal lives. Recognizing the sensitive nature of the topic, the survey assured participants of complete confidentiality and provided the option to remain anonymous, encouraging honest and open feedback without fear of repercussions. A total of 25,590 undergraduate students, 5,337 postgraduate students, and 7,035 faculty members responded to the online survey.

The stress and reasons for stress experienced by undergraduate (UG) and postgraduate (PG) medical students vary considerably. To capture these differences, separate questionnaires were devised for UG and PG students. This approach helped us understand the distinct stressors and challenges faced by each group. Additionally, a separate questionnaire was drafted to invite faculty and administrators to share their perceptions of medical students' stress. This multifaceted approach provided a comprehensive understanding of the stress landscape in medical education from both student and faculty perspectives.

The survey was meticulously designed to cover a wide range of domains that are crucial to the mental health and well-being of medical students. These domains included academics, exams, hostel living conditions, food quality, financial issues, family dynamics, relationship issues, experiences of ragging, and mental health concerns. By addressing these diverse areas, the survey aimed to capture a holistic view of the factors influencing the mental health of medical students.

The questionnaire incorporated a variety of question types to ensure comprehensive data collection. Closed-ended questions required respondents to choose from predefined options, enabling the collection of quantitative data and facilitating easy analysis. Open-ended questions allowed respondents to provide detailed, qualitative feedback, offering deeper insights into their personal experiences and concerns. Range responses used scales, such as Likert scales, to

measure the intensity or frequency of specific experiences or feelings, providing nuanced data on student well-being. Qualitative responses encouraged narrative answers, allowing participants to elaborate on their experiences and provide context to their answers

The survey was disseminated online, inviting participation from both UG and PG medical students, as well as faculty members. This inclusive approach ensured that perspectives from different stages of medical education and from those involved in teaching and mentoring were captured, providing a comprehensive understanding of the mental health landscape in medical colleges.

Meeting with Stake Holders

In addition to other efforts, the Task Force conducted online/in-person meetings with various associations and stakeholders to gather comprehensive insights and feedback. These meetings were attended by the representatives of Federation of Resident Doctors Association India (FORDA), Resident Doctors Association (RDA) and Association of Doctors and Medical students (ADAMS). Engaging with medical students' associations allowed the task force to understand the collective concerns, suggestions, and needs of the student body from their representatives. This provided valuable insights into the challenges faced by medical students and potential areas for improvement in their educational and support systems. Meetings with junior residents' organizations provided the task force with valuable insights into the experiences and perspectives of postgraduate students in medical colleges across the country. Their feedback was crucial in understanding the practical challenges and stresses of residency, including duty hours, work-life balance, and mental health support. Involving parents in these discussions provided a holistic view of the students' experiences from a familial perspective. Parents offered insights into the support systems needed at home and how institutions can better communicate and collaborate with families to support student well-being. Direct interaction with students was paramount. These meetings facilitated an open dialogue where students could voice their concerns, share their experiences, and suggest improvements. This direct feedback was invaluable in ensuring that the recommendations developed are student-centered and address the real issues faced by the student population. Additionally, the Task Force invited students to provide feedback via email. This approach allowed students who were unable to participate in online meetings to contribute their thoughts and experiences at their convenience. It also ensured that the Task Force received a wide range of perspectives and could address specific concerns raised by individual students. By incorporating feedback from these diverse groups, the Task Force ensured that the recommendations are comprehensive and consider the views of all relevant stakeholders. This multi-faceted approach to gathering input helped us develop a 360-degree comprehensive perspective and effective strategies to enhance the educational environment and support systems in medical colleges.

10.1 Group Discussion with Various Stake-Holders During the In-Person Visit and Online Consultation by the Task Force Members.

By adopting the aforementioned methodology and visiting numerous medical colleges, we discovered the following themes in various stakeholder meetings. Theme saturation indicates comprehensive coverage of the relevant issues. These themes highlight critical areas affecting the mental health and well-being of medical students

10.1.1 Under-graduate Students Reported

Mess: The quality and hygiene of food in the mess were significant concerns. Students emphasized the importance of nutritious and hygienic food for their overall well-being. Additionally, they highlighted the need for a 24/7 cafeteria within the campus, especially during exam periods when access to food at all hours is crucial. In some colleges, the mess was mandatory even for day boarders, restricting students' freedom to choose based on their dietary preferences and schedules. This compulsion imposed a financial burden on many students. They requested more flexibility in dining options, which they believed would have a positive impact on their mental health.

Hostel Rooms / Sharing Rooms: The condition of hostel rooms, the experience of sharing accommodations and lack of privacy were recurring themes. Overcrowded or poorly maintained rooms contributed to stress, while well-kept, private spaces were seen as beneficial.

Library (Space, Table, Online Access at Hostel): The availability of adequate study spaces, tables, and online resources within the campus and also in the hostel rooms was highlighted. Students valued quiet, well-equipped libraries and the ability to access online materials from their hostels.

Packed Academic Sessions: Jam-packed academic classes in the first year of MBBS are a common occurrence, often resulting in significant pressure and stress for first-year students. While this rigorous schedule aims to establish a solid foundation in medical knowledge, it can also lead to burnout if not properly managed. Balancing the demanding coursework with adequate rest and mental health support is essential for student well-being.

Teaching Ability of Medical Teachers: The poor teaching abilities of medical teachers were highlighted, with many relying on PowerPoint presentations that they merely read aloud during classes. There was a lack of interaction and discussion, leading students to question the value of such sessions and the effectiveness of the teachers. Many teachers did not even make eye contact with students during classes.

Auditorium: Many students noted the importance of having access to well-maintained auditoriums for academic and extracurricular events. These spaces contribute to a sense of community and provide venues for stress-relieving activities.

Sports Facilities: The availability and quality of sports facilities were frequently mentioned. Lack of dedicated time for sports/gym and not giving permission to attend for regular exercise was also a recurring theme. Students emphasized the need for adequate sports infrastructure to support physical fitness, which in turn benefits mental health.

Language Learning Policy - Weekly Class: The lack of inclusion of weekly local language learning classes was highlighted, particularly for students from diverse linguistic backgrounds. This policy can reduce language barriers and improve clinical performance of the students.

Assignments Issues: The management of assignments, such as logbook, case submission, including deadlines and workload, was frequently discussed. Students requested more balanced and realistic expectations to avoid undue stress.

No Break Between Exams: A recurring theme among many students was the lack of breaks between exams. This limited time for rest and study often adds to their stress and hampers their overall performance. As a result, they have requested at least a one-day break between exams to alleviate some of this pressure. Few students also mentioned the urgent need for provision of vacations (2weeks) immediately after exams was seen as a critical factor in allowing students to recuperate and reduce burnout.

Supplementary Exam: The management of supplementary exams, including scheduling and support for students who need to retake exams, was a recurring theme. Students called for more supportive policies.

Confidentiality for Accessing Mental Healthcare: Ensuring confidentiality when accessing mental health services was paramount. Students expressed the need for discreet and non-stigmatizing access to mental health resources.

Staff/Student Clinic: The availability of a staff/student clinic providing free diagnostic, treatment and medicine was important. Access to free or affordable healthcare within the campus was seen as a significant support system.

Psychiatrist Availability Within the Campus: The presence of a psychiatrist on campus was frequently mentioned. Immediate access to professional mental health care was considered crucial for timely support.

Hotline Contact: The establishment of a dedicated hotline for mental health crises was highlighted. This provided an immediate resource for students in distress.

Sensitivity Towards Students' Needs: A recurring theme was the overall insensitivity of the administration and faculty towards students' mental health needs. Students valued empathetic and responsive institutional practices and requested a change in the attitudinal perspective of the concerned administrators.

Career Options: Guidance and support for career planning and options were important. Students expressed the need for career counselling services to navigate their professional paths effectively.

10.1.2 Post-graduate Students Reported

Long and Multiple 24-Hour Duties: The demanding schedules, including long and multiple 24-hour duties (sometimes 3-5 consecutive duties), were significant stressors among the most PGs. These extended hours without adequate rest led to physical and mental exhaustion, negatively impacting their performance and health.

Non-Availability of Cafeteria During Night Duty Hours: The lack of a cafeteria accessible during working long duty hours was a major concern. Postgraduates often found it difficult to access nutritious meals during their shifts, impacting their health and ability to perform their duties effectively.

Stipend: The adequacy and timely disbursement of stipends were critical issues for postgraduate students. Financial stability is essential to reducing stress and enabling students to focus on their studies. Delays or inadequacies in stipends exacerbated financial strains, and seeking help from family members for financial support induced feelings of guilt, significantly impacting their mental well-being and academic performance.

Excessive Workload for Junior Students: Junior postgraduates were often subjected to excessive workloads and inhumane working conditions. They were frequently assigned menial tasks such as pushing trolleys, raising investigation requests, collecting reports, cleaning and bandaging wounds, making beds, and catheter insertion. This left them with little time for academic pursuits and reading.

Senior PG Students Bullying Junior PGs: Bullying by senior PG students was a recurring issue. This toxic environment hindered the professional and personal growth of junior students, creating a hostile and stressful working atmosphere.

Inadequate Time for Self-study: The hectic clinical workload left postgraduate students with little to no time for academic reading and research. This hindered their academic progress and professional development.

Faculty Insensitivity Towards PGs' Needs and Workload: Faculty insensitivity towards the needs and workload of postgraduates was a significant concern. There was a lack of understanding and support from the faculty regarding the immense pressures faced by PG students. Requests for leave were often refused, and PGs were looked down upon for making such leave requests. This lack of empathy and flexibility in granting leave further exacerbated their stress and burnout.

Poor Infrastructure and Facilities in Duty Rooms: Postgraduates reported poor infrastructure and facilities in duty rooms. Substandard living conditions during on-call hours made it difficult for them to rest and recuperate, further contributing to their stress levels.

Inadequate Family Rooms within the Campus: Many postgraduates highlighted the lack of adequate family rooms on campus. This inadequacy made it challenging for students with families to balance their personal and academic lives, adding to their stress and affecting their overall well-being.

Non-Availability of Faculty: A significant issue was the non-availability of faculty members, many of whom were reportedly engaged in private practice or were ghost faculty. The absence of clinical supervisors for guiding students negatively impacted the quality of medical education and support available to postgraduate students.

Thesis: Many students raised concerns about transparency in guide selection. They also highlighted the stress caused by insufficient time to draft their synopsis, collect data, and write their thesis. Some students questioned the guiding capabilities of their supervisors and requested dedicated and flexible time for thesis work, with a few even suggesting the possibility of eliminating the thesis requirement altogether.

10.1.3 Administrators and Faculty Reported

Faking Mental Health Issues by Students: Faking mental illness, stress, and suicidal ideas was a recurring theme noted by the faculty. Some students reportedly used these claims to avoid clinical and academic responsibilities, raising concerns about the authenticity of their issues and the resulting impact on their peers and staff. Some students exaggerate minor issues and present themselves as experiencing "stress with suicidal ideas and mental health issues" to avoid clinical and academic workload, such as postponing thesis synopsis submission, thesis

submission, seminars, case conferences, journal club, and avoiding taking cases. They have requested a protocol for assessing and accommodating such students from the Department of Psychiatry or administration.

Inadequate Faculty and Paramedical Staff: A recurring theme was the inadequate human resources available for clinical work and academic activities. This shortage exacerbates the workload on existing faculty, senior residents, and students, impacting the overall quality of education, research and patient care. They requested that the existing vacancies be filled and more senior residents be hired based on the department's workload. This autonomy should be granted to the Heads of Departments (HODs) to balance training medical students, transferring knowledge, imparting skills, and mentoring them effectively. A few of them suggested NMC to look into this matter seriously.

Inadequate Pay Scale: A recurring theme was concerns about the inadequate pay scales for teachers, senior residents, and postgraduate stipends. They emphasized that better compensation is crucial for attracting and retaining qualified professionals, ensuring quality education, and maintaining motivation among staff and students. Additionally, some faculty members have highlighted the issue of varying retirement ages across the country.

Stress Among Faculty: Another recurring theme was the perpetual stress among faculty members. They emphasized that while students come and go, faculty face continuous stress due to the demands of clinical work, academic activities, guiding students in thesis research, the need for publications, administrative tasks, medical negligence cases, violence from patients and their families, the threat of medico-legal cases, complaints by students, and other institutional responsibilities. Faculty reported experiencing burnout and a gradual loss of interest in teaching over time. They highlighted the lack of incentives for good teachers and the need for proper recognition of their contributions.

Rotational Headship: Some of the faculty raised the need for rotational headship, highlighting that a sense of toxicity and stagnation can develop in departments with perpetual Heads of Department (HODs). Rotational headship can provide several benefits, including bringing fresh perspectives, new leadership development, and new ideas to the department, which can enhance the overall academic and clinical environment. Faculty members advocating for rotational headship also emphasized the importance of mentorship and succession planning. By rotating leadership roles, experienced faculty can mentor emerging leaders, ensuring a smooth transition and continuity in departmental management.

Stress from Family Members of the Students: Many family members approach the department when their ward is not allowed to take exams due to insufficient attendance or when they fail exams. At times, they complain about the excessive workload. Many family members are unaware of the rigorous training, clinical responsibilities, and academic requirements of postgraduate students.

These themes collectively provide a comprehensive understanding of the multifaceted challenges and needs of medical students. Addressing these areas can significantly enhance their mental health and overall well-being, fostering a more supportive and nurturing educational environment.

10.2 Online Survey

The online survey results are organized into three distinct sections. Initially, we present the analysis of undergraduate (UG) students, followed by the analysis of postgraduate (PG) students, and finally, the analysis of faculty responses. This structured approach allows for a clear and comprehensive understanding of the experiences and perceptions of each group, providing valuable insights into the stress and challenges faced by medical students at different stages of their education, as well as the perspectives of faculty and administrators. A total of 25,590 undergraduate students, 5,337 postgraduate students, and 7,035 faculty members responded to the online survey.

Stakeholder	n
Undergraduate students	25,590
Post-graduate students	5,337
Faculties, Administrators and Wardens	7,035
Total Online Survey Responses Received	37,962

The online survey results were analysed using simple descriptive statistics. The results are presented as follows: initially, responses from undergraduate (UG) students are presented, followed by those from postgraduate (PG) students, and finally, responses from faculty members

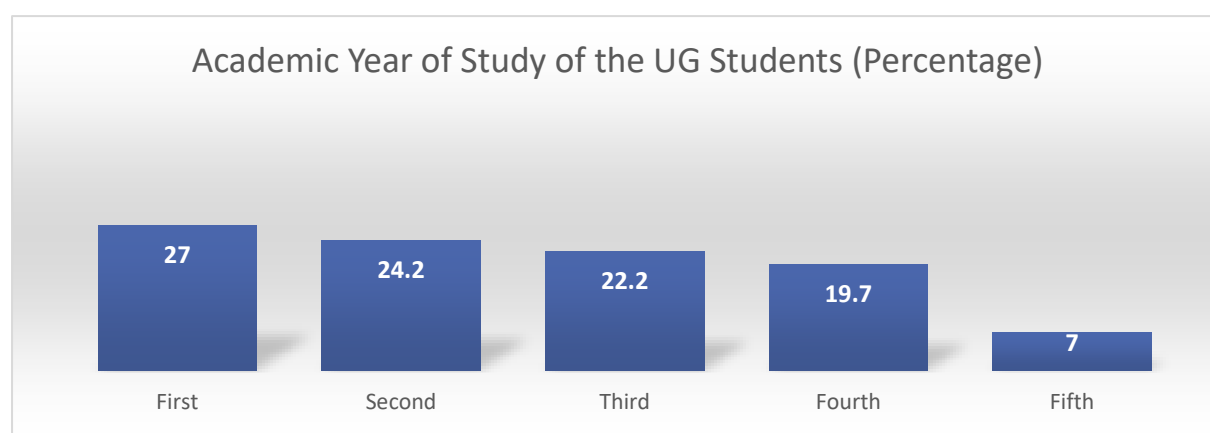
10.2.1 Analysis of Online Survey Responses from Undergraduate Students

Table 10.1: Demographic Characteristics of UG Medical Students

Socio-demographic parameters	Frequency (n) n=25590	Percentage (%)
Is your medical college located in the same state you belong to?		
No	5778	22.6%
Yes	19812	77.4%
Type of Residence:		
Hostel/Dormitory	19483	76.1%
Own Apartment/Shared Accommodation	1716	6.7%
Parents	3940	15.4%
Relatives/Extended Family	268	1%
Others	183	0.7%
Family Income (per annum):		
1-20L	22019	86%
21-40L	2456	9.6%

>40L	1115	4.3%
Family Structure:		
Joint Family	4218	16.5%
Single parent with joint family	363	1.4%
Single-parent Household	1842	7.2%
Two-parent Household	19013	74.3%
Others	154	0.6%
Where did you complete the majority of your school education?		
Rural Area	4067	15.9%
Semi-Urban Area	4770	18.6%
Urban Area	16753	65.5%
What was the primary medium of language in your school?		
English	21643	84.6%
Hindi	1328	5.2%
Other	2619	10.2%

Total 25,590 undergraduate medical students responded to the online survey. A significant proportion are in their early years of study, with 6,907 (27%) in the first year, 6,187 (24.2%) in the second year, 5,670 (22.2%) in the third year, 5,033 (19.7%) in the fourth year, and 1,793 (7%) in the fifth year. A majority of students, 19,812 (77.4%), attend medical colleges within their home state, while 5,778 (22.6%) study in different states. Regarding residence, 19,483 (76.1%) live in hostels or dormitories, 1,716 (6.7%) in their own or shared apartments, 3,940 (15.4%) with parents.



The majority come from families with an annual income of 1-20 lakhs (22,019, 86%) and two-parent households (19,013, 74.3%). Educational background of the UG indicate that 16,753 (65.5%) completed their schooling in urban areas, 4,770 (18.6%) in semi-urban areas, and 4,067 (15.9%) in rural areas. Finally, the primary medium of instruction in school was English for 21,643 (84.6%) students, Hindi for 1,328 (5.2%), and other languages for 2,619 (10.2%).

Table 10.2: Environmental Parameters for UG Medical Students

Environment related parameters	Frequency (n)	Percentage (%)
Overall supportiveness of Family Environment:		
Extremely Unsupportive	1151	4.5%
Neutral	2550	10%
Supportive	8865	34.6%
Extremely Supportive	13024	50.9%
Within your home environment: Academic Pressure from Family:		
Always and Often	3960	15.5%
Sometimes	7735	30.2%
Supportive	7489	29.3%
Extremely Supportive	6406	25%
Financial Strain in the Family:		
Always and Often	4744	18.5%
Sometimes	8194	32%
Supportive	6860	26.8%
Extremely Supportive	5792	22.6%

Environmental support parameters indicate that the family environment is predominantly supportive, with 13,024 (50.9%) rating it as extremely supportive, 8,865 (34.6%) as supportive, and 1151 (4.5%) rating it unsupportive. Academic pressure from family is reported always or often by 3,960 (15.5%) students, sometimes by 7,735 (30.2%), while remaining feel supported and extremely supported in their home environments. Financial strain is experienced always or often by 4,744 (18.5%) students and sometimes by 8,194 (32%), while remaining feel supported and extremely supported regarding financial matters.

Table 10.3: Academic Parameters of UG Medical Students

Academic related parameters	Frequency (n)	Percentage (%)
How would you rate your overall academic workload?		
Light and too light	391	1.5%
Manageable	5410	21.1%
Manageable but heavy	14487	56.6%
Too heavy	5302	20.7%
On average, how many hours per week do you spend on studying and attending classes (outside of personal study)?		
Less than 20 hours	5000	19.5%
20-40 hours	9280	36.3%
40-60 hours	9381	36.7%
More than 60 hours	1929	7.5%
Exams adequately assess my knowledge and skills:		
Strongly disagree and Disagree	5866	22.9%
Neutral	9544	37.3%
Agree	8158	31.9%
Strongly agree	2022	7.9

The fear of failure negatively impacts my academic performance:		
Strongly Disagree	1305	5.1%
Disagree	3475	13.6%
Neutral	7606	29.7%
Agree and strongly agree	13204	51.6%
I feel constant pressure to achieve top grades		
Strongly Disagree	1482	5.8%
Disagree	4036	15.8%
Neutral	9689	37.9%
Agree and Strongly agree	10383	40.6%
I struggle to balance my academic work with my personal life and wellbeing		
Strongly Disagree	826	3.2%
Disagree	2734	10.7%
Neutral	7638	29.8%
Agree and strongly agree	14392	56.3%
Do you feel the present curriculum contribute to your stress?		
Extremely and significantly stressful	11186	43.7%
Moderately stressful	9664	37.8%
Slightly stressful	3982	15.2%
Not stressful	848	3.3%
Difficulty of Study material :		
Extremely and significantly stressful	8419	32.9%
Moderately stressful	10611	41.5%
Slightly stressful	5094	19.9%
Not stressful	1466	5.7%
Frequency of exams:		
Extremely and significantly stressful	9134	35.9%
Moderately stressful	9563	37.6%
Slightly stressful	4962	19.5%
Not stressful	1784	7%
Does the fear of failure lead to any of the following behaviours?		
Considering leaving the medical course	738	2.9%
Excessive perfectionism	1539	6%
Procrastination (avoiding or delaying tasks)	13448	52.5%
Skipping classes/assignments	1934	7.6%
Thoughts of self-harm	330	1.3%

The majority of students, 14,487 (56.6%), find their academic workload manageable but heavy, while 5,302 (20.7%) consider it too heavy, and only 391 (1.5%) find it light or too light. The fear of failure is a significant issue in UG, with 13,204 (51.6%) agreeing or strongly agreeing that it negatively impacts their performance. Furthermore, 10,383 (40.6%) students feel constant pressure to achieve top grades. Balancing academic work with personal life is a

struggle for 14,392 (56.3%) students. Medical curriculum-induced stress is a significant factor, with 11,186 (43.7%) finding it extremely or significantly stressful and 9,664 (37.8%) moderately stressful. The frequency of exams is extremely or significantly stressful for 9,134 (35.9%) and moderately stressful for 9,563 (37.6%).

Lastly, the fear of failure leads to various negative behaviors, including procrastination in 13,448 (52.5%) students, skipping classes or assignments in 1,934 (7.6%), excessive perfectionism in 1,539 (6%), considering leaving the course in 738 (2.9%), and thoughts of self-harm in 330 (1.3%). These findings underscore the significant academic pressures and stresses faced by medical students.

Table 10.4: Hostel and Library Parameters of UG Medical Students

Hostel related parameters	Frequency (n)	Percentage (%)
Overall condition of your hostel facilities (cleanliness, maintenance, etc)		
Very and moderately dissatisfied	10645	41.6%
Neutral	7926	31%
Moderately satisfied	5109	20%
Very satisfied	1920	7.5%
Do you have adequate privacy and personal space within your hostel room?		
No	8613	33.7%
Somewhat	6507	25.4%
Yes	10470	40.9%
Mess/Food Quality:		
Very and moderately dissatisfied	14294	55.9%
Neutral	6795	26.6%
Moderately satisfied	3371	13.2%
Very satisfied	1130	4.4%
Library Access and Resources:		
Very and moderately dissatisfied	5570	21.8%
Neutral	7832	30.6%
Moderately satisfied	7542	29.5%
Very satisfied	4646	18.2%

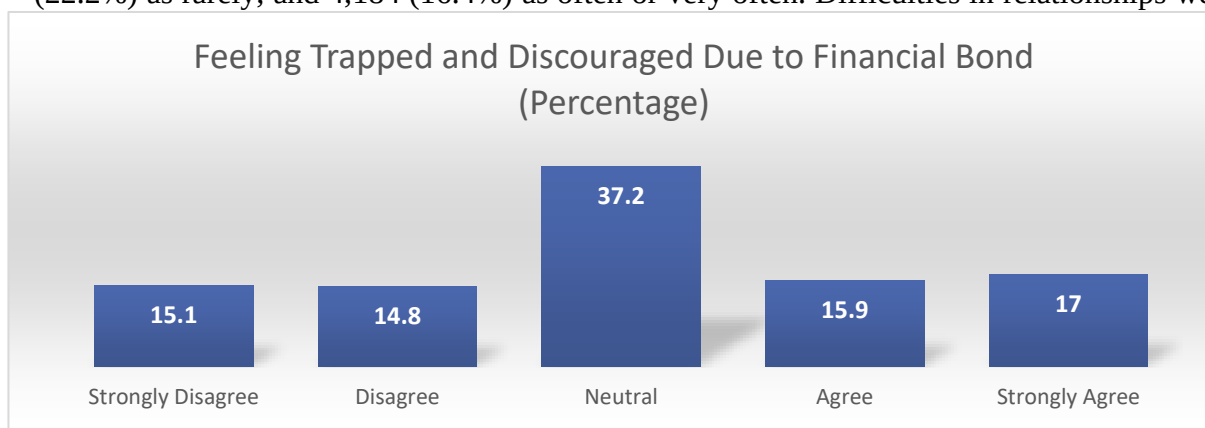
A significant portion of students, 10,645 (41.6%), are very or moderately dissatisfied with the overall condition of their hostel facilities, including cleanliness and maintenance. Regarding privacy and personal space within hostel rooms, 8,613 (33.7%) feel they do not have adequate privacy. The quality of food provided in the hostel mess is a major concern, with 14,294 (55.9%) students very or moderately dissatisfied.

Financial stress is a significant issue, with 8,663 (33.9%) students finding their finances extremely or significantly stressful and 6,971 (27.2%) moderately stressful. Educational loans or debt are held by 6,958 (27.2%) students, and among them, 5,416 (32.7%) feel extreme or significant pressure about repayment. Additionally, 10,445 (40.8%) students have financial dependents. The existence of a financial bond for leaving the medical course makes 8,412 (32.9%) students feel trapped and discouraged from leaving if unhappy.

Table 10.5: Financial Stress Related Parameters of UG Medical Students

Financial stress related parameters	Frequency (n)	Percentage (%)
How stressful are your finances (tuition, living costs, hostel etc.)?		
Extremely and significantly stressful	8663	33.9%
Moderately stressful	6971	27.2%
Slightly stressful	5176	20.2%
Not stressful	4780	18.7%
Do you have any educational loans or debt?		
No	18632	72.8%
Yes	6958	27.2%
If yes, how much pressure do you feel about repayment?		
Extreme and significant pressure	5416	32.7%
Moderate pressure	3663	22.1%
Slight pressure	2236	13.5%
No pressure	5266	31.8%
Do you have financial dependents (family members you support)?		
No	15145	59.2%
Yes	10445	40.8%
How frequently have you thought about leaving the MBBS course so far?		
Never	8797	34.4%
Rarely	5685	22.2%
Often and very often	4184	16.4%
Sometimes	6924	27.1%
Do you currently have any difficulties in the following relationships?		
Classmates	1256	4.9%
Family	2363	9.2%
Friends	3417	13.4%
Romantic Partner	3229	12.6%
Roommates	1234	4.8%

Thoughts of leaving the MBBS course was reported by 6,924 (27.1%) as sometimes, 5,685 (22.2%) as rarely, and 4,184 (16.4%) as often or very often. Difficulties in relationships were

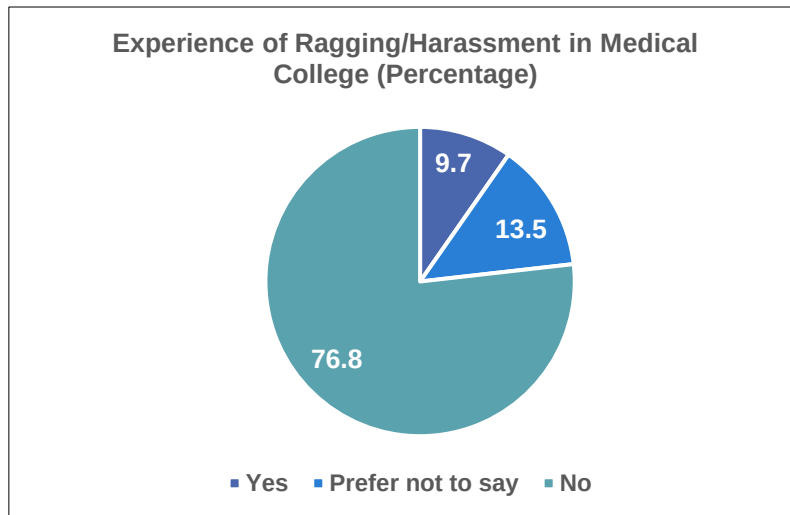


reported by 3,417 (13.4%) with friends, 3,229 (12.6%) with romantic partners, 2,363 (9.2%) with family, 1,256 (4.9%) with classmates, and 1,234 (4.8%) with roommates. These findings

highlight significant areas of stress and challenges faced by medical students, including financial pressures, feelings of entrapment, and relational difficulties.

Ragging

The analysis of ragging and stress-related parameters for 25,590 undergraduate medical students provides significant insights into their experiences and stress levels. A majority, 19,655 (76.8%), reported not experiencing or witnessing any form of ragging or harassment, while 2,486 (9.7%) confirmed such experiences.



Regarding institutional measures, 17,932 (70.1%) students believe their college has adequate measures to prevent and address ragging, while 3,618 (14.1%) disagree, and 4,040 (15.8%) are unsure. In terms of familial emotional support, only 1,232 (4.8%) extremely unsupportive. Regarding the friend-based emotional support, UG students reported that 2,602 (10.2%) extremely unsupportive. Feelings of loneliness or social isolation are common, with 8,962 (35%) experiencing them always or often and 9,995 (39.1%) sometimes. Social connectivity is an issue for many, as 8,265 (32.3%) find it difficult to make or maintain social connections and 6,089 (23.8%) somewhat difficult. When dealing with personal difficulties, 14,796 (57.8%) students have someone to confide in and 6,539 (25.6%) reported that they do not have any one.

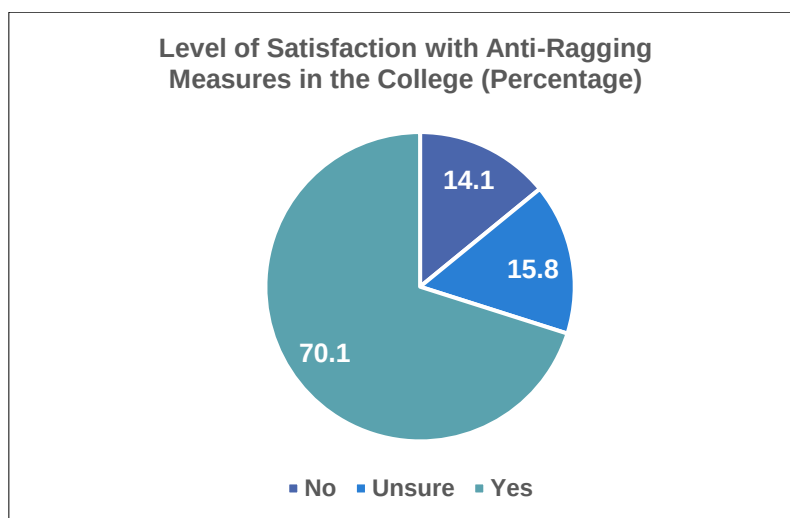
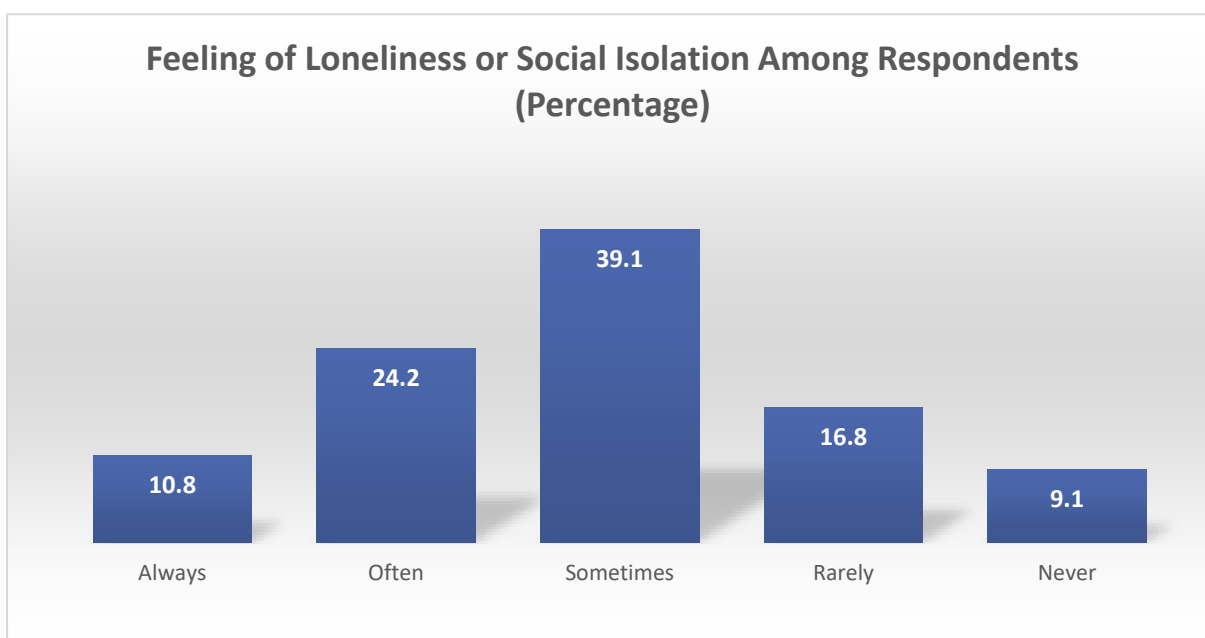


Table 10.6: Emotional Support and Thoughts-Related Parameters of UG Medical Students

Emotional support and thoughts related parameters	Frequency (n)	Percentage (%)
How would you describe the level of emotional support you receive from your family?		
Extremely Unsupportive	1232	4.8%
Neutral	4164	16.3%
Supportive	8626	33.7%
Extremely supportive	11568	45.2%
How would you describe the level of emotional support you receive from your friends?		
Extremely Unsupportive	2602	10.2%
Neutral	7907	30.9%
Supportive	9823	38.4%
Extremely supportive	5258	20.5%
Do you find it difficult to make friends or maintain social connections at medical college/hostel?		
No	11236	43.9%
Somewhat	6089	23.8%
Yes	8265	32.3%
Do you feel you have someone you can discuss in when you experience personal difficulties?		
No	6539	25.6%
Sometimes	4255	16.6%
Yes	14796	57.8%
How comfortable would you feel seeking help from a mental health professional (like a counsellor or therapist) if you needed it		
Somewhat and very Uncomfortable	5362	21%
Neutral	10696	41.8%
Somewhat Comfortable	6106	23.9%
Very Comfortable	3426	13.4%
When facing stress, what do you usually do?		
Self-harm	110	0.4%
Use substances (alcohol, drugs, etc.)	104	0.4%
Do you feel you have adequate knowledge and skills for managing stress in a healthy way?		
No	9319	36.4%
Yes	16281	63.6%
Rate the level of support you feel from: Family		
Extremely Unsupportive	903	3.5%
Neutral	3564	13.9%
Supportive	8648	33.8%
Extremely Supportive	12475	48.7%
Friends:		
Extremely Unsupportive	2339	9.1%
Neutral	7686	30%
Supportive	10091	39.4%

Extremely Supportive	5474	21.4%
Faculty/Mentors:		
Extremely Unsupportive	4664	18.2%
Neutral	10576	41.3%
Supportive	7504	29.3%
Extremely Supportive	2846	11.1%
How comfortable are you seeking support from the following people during times of stress or difficulty: Very and somewhat uncomfortable		
Parents/family	3139	12.3%
Friends/peers	3339	13%
Faculty/Mentors	7693	31.1%

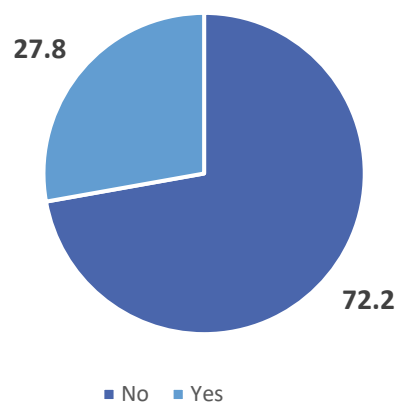
Mental health conditions have been diagnosed in 7,115 (27.8%) students, with 3,780 (14.8%) having one condition, 1,851 (7.2%) having two, and 1,045 (4.1%) having three conditions.



Thoughts of self-harm or suicide in the last 12 months were reported by 4,139 (16.2%) students, with 1,305 (5.1%) seeking professional help. Comfort in seeking mental health professional support varies, with 3,426 (13.4%) feeling very comfortable, 6,106 (23.9%) somewhat comfortable, 10,696 (41.8%) neutral, and 5,362 (21%) somewhat or very uncomfortable.

Regarding adequate knowledge and skills for managing stress, 9,319 (36.4%) reported that they lack knowledge and skills to manage stress. Faculty or mentors are seen as extremely unsupportive by 4,664 (18.2%). Comfort in seeking support during stress from parents or family is somewhat or very uncomfortable for 3,139 (12.3%) students, from friends or peers for 3,339 (13%), and from faculty or mentors for 7,693 (31.1%).

Response to "Have you ever been diagnosed with any mental health conditions?" (Percentage)



Experience of Thoughts of Self-Harm or Suicidal Ideation in the Last 12 Months (Percentage)

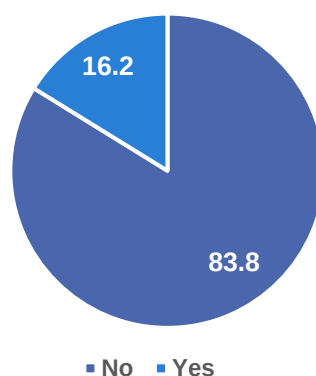


Table 10.7: Mentor-Mentee Program-Related Parameters of UG Medical Students

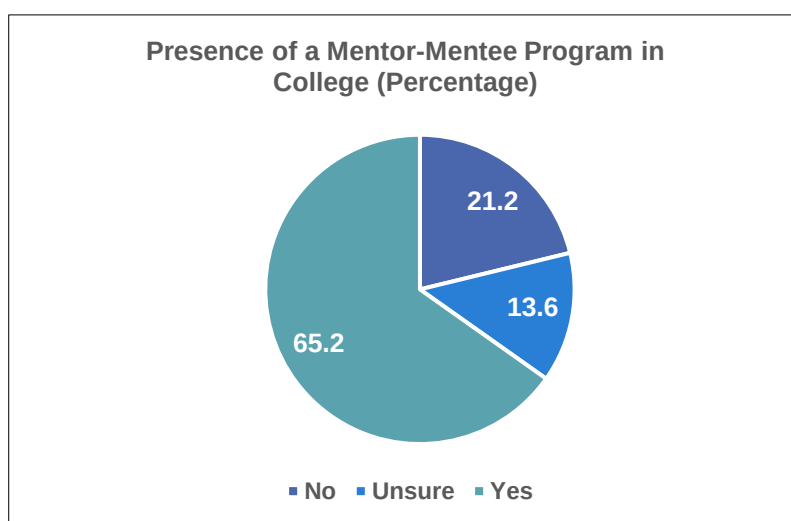
Mentor-mentee programme related parameters	Frequency (n)	Percentage (%)
If yes, have you been assigned a faculty mentor?		
No	4221	16.5%
Yes	15540	60.7%
How frequently do you meet or interact with your mentor?		
Every few months	3052	11.9%
Monthly	4858	19%
Weekly	2106	8.2%
Rarely	4951	19.3%
Never	5766	22.5%

How would you rate the effectiveness of your mentor-mentee relationship		
Very Effective	2511	9.8%
Somewhat Effective	4325	16.9%
Neutral	7381	28.5%
Very and somewhat Ineffective	5644	22%
Do you feel comfortable seeking mental health support (counselling, therapy, mentor support) if needed		
Very comfortable	3381	13.2%
Somewhat comfortable	7017	27.4%
Neutral	10140	39.6%
Somewhat and very uncomfortable	5052	19.8%
Are you aware of any mental health support services available within your medical college		
No	9341	36.5%
Unsure	5157	20.2%
Yes	11092	43.3%
If yes, how would you rate the following aspects of those services: Accessibility of mental health services		
Very and somewhat Inaccessible	3648	18.6%
Neutral	8438	43%
Somewhat Accessible	4205	21.4%
Very Accessible	3350	17.1%
Quality of mental health services:		
Very poor and poor	4808	18.8%
Average	11677	45.6%
Good	6927	27.1%
Excellent	2178	8.5%

A significant majority, 16,680 (65.2%), report that their college has a formal mentor-mentee program, while 5,420 (21.2%) state there is no such program, and 3,490 (13.6%) are unsure.

Among those whose colleges have a program, 15,540 (60.7%) have been assigned a faculty mentor, while 4,221 (16.5%) have not. Interaction frequency with mentors varies, with 5,766 (22.5%) never interacting, 4,951 (19.3%) interacting rarely, 3,052 (11.9%) every few months, 4,858 (19%) monthly, and 2,106 (8.2%) weekly. The effectiveness of the mentor-mentee relationship is rated as very effective by 2,511 (9.8%) students, somewhat effective by 4,325 (16.9%), neutral by 7,381 (28.5%), and very or somewhat ineffective by 5,644 (22%).

Awareness of mental health support services within their medical college is reported by 11,092 (43.3%) students, while 9,341 (36.5%) are unaware, and 5,157 (20.2%) are unsure. Accessibility of these mental health services is rated as very or somewhat inaccessible by 3,648 (18.6%) students and the quality of these services is perceived as very poor or poor by 4,808 (18.8%).



10.2.2 Analysis of Online Survey Responses from Postgraduate Students

The analysis based on the inputs provided by postgraduate students will be presented and discussed in the following order. A brief description of the socio-demographic profile, followed by family and academic concerns and perceptions about the facilities in the college and ecosystem there; a deep dive into perceived stress levels; mental health concerns and coping. 5,337 postgraduate students participated in the online survey. Among them, 2,623 were females, 2,576 were males, 6 identified as other genders, and 132 chose not to disclose their gender. The data distribution indicates a relatively balanced representation across the three years of the PG study: 1st year comprises 35%, 2nd year constitutes 29.6%, and 3rd year accounts for 32%. Additionally, 2.5% of the data was from students specializing in super-specialty fields. The majority of PG students were unmarried (57%), with notable proportions representing married (30%) and in-relationship statuses (12%). A majority of 85% of the students come from families with annual income of less than 20 lakhs.

Table 10.8 Demographic Characteristics of PG students

Variable	Frequency n=5337	Percent
Gender		
Female	2623	49.1%
Male	2576	48.3%
others	136	2.6%
Year of Study		
1st Year	1918	35.9%
2nd Year	1578	29.6%
3rd year	1705	31.9%
Other	136	2.5%
Marital Status		
Single	3051	57.2%
In a relationship	629	11.8%

Married	1624	30.4%
Separated	16	0.3%
Divorced	17	0.3%
Total Family Income		
1-20 lakh rupees per annum	4519	84.7%
21-30 lakh rupees per annum	446	8.4%
31-40 lakh rupees per annum	160	3.0%
41-50 lakh rupees per annum	78	1.5%
51 lakh and above rupees per annum	134	2.5%

Clinical and Academic Work: Regarding academic stress, 1095 (20%) of PG students find the current academic workload frequently challenging, 505(9.5%) too intense, while 1721(32%) report manageable academic stress levels. Close to half the PG students 2432(45%) expressed working for more than 60 hours a week with over 3020(56%) not getting their weekly offs. 42% of them attributed the source of their problems to be due to the college administration which could include patients and families while the remaining 50% were equally divided in the source of problems between faculty and seniors. 56% of them reported academic concerns due to the load and while 62% felt that the support that they got from their guide or teacher was adequate, 88% of them felt more support from faculty would help improve the academic experience. Tailored support strategies can help address the diverse needs of students and promote their overall well-being during their postgraduate studies. 38% of the PGs reported not having adequate time to rest, while 57% stated that they were denied their weekly off from duty as per the National Medical Commission (NMC) regulatory provisions.

A notable proportion of PG students (26%) expressed dissatisfaction with regular teacher attendance at the college, and 17% reported inadequate support by their guide during their thesis, emphasizing the importance of addressing this issue to uphold educational standards and support student learning effectively. The presence of "ghost faculty" in private medical colleges and instances of faculty engaging in private practice during working hours in government medical colleges are significant issues in the medical education sector. While implementing biometric attendance systems has significantly improved the situation, stricter action and more rigorous implementation are necessary to address these concerns effectively. These practices not only compromise the quality of education but also undermine the integrity of the medical profession.

Regarding academics, PG students reported that 20.52% find their academic stress frequently challenging, and 9.5% reported too intense. Discrimination can profoundly impact students' mental health, academic performance, and well-being. However, 68.80% of PG students reported not facing discrimination based on gender, ethnicity, religion, caste, geography, language, or other factors in their academic environment. But at the same time, a substantial percentage (31%) of students reported that they are experiencing discrimination, underscoring the need for institutions to implement more robust policies against discrimination and to foster an inclusive environment.

Exams: A significant majority of the PG students 4657 (87.3%) reported that they have not been asked for unreasonable favors in exchange for passing exams. However, a notable minority 680 (12.7%) indicated that they have encountered such unethical requests,

highlighting a concern about integrity within the academic environment. Even this 12.74% reporting for unfavorable demand can severely undermine the educational institution's integrity and potentially harm students' overall educational experience. They may also lead to long-term detrimental effects on future medical practitioners' professional and ethical standards. This issue highlights the need for stringent policies, transparent grievance mechanisms, and robust anti-corruption measures within academic institutions. It's crucial that students feel supported in reporting these issues without fear of repercussion.

Table 10.9. Problems Related to College and Administration

Variable	Frequency	Percent
Do faculty/teachers come to college regularly and engage in teaching?		
No	1363	25.5%
Yes	3974	74.5%
With whom do students in your hospital / college encounter problems most frequently?		
Admin and Other (Patients/patients relatives etc.)	2262	42.4%
Faculty members	1339	25.1%
Postgraduate seniors	1342	25.1%
Senior residents	394	7.4%
Do students in your institution face frequent problems with any specific aspect?		
Academics load	909	17.0%
Clinical Workload	1995	37.4%
Others	1573	29.5%
Thesis	860	16.1%
How would you describe the current academic workload at your college?		
Frequently challenging	1095	20.5%
Manageable	1721	32.2%
Occasionally challenging	1762	33.0%
Too Intense	505	9.5%
Too light	254	4.8%
Are you getting weekly offs as per the regulatory provisions?		
No	3020	56.6%
Yes	2317	43.4%
NOT answered	1218	22.8%
What are the approximate working hours you spent in a week		
upto 50 hours	773	14.5%
51 to 60 hours	800	15.0%
61 to 70 hours	657	12.3%
71 to 80 hours	652	12.2%

More than 80 hours	1123	21.0%
Don't wish to specify	1332	25.0%
Academic Load - Have you experienced stress due to academic demands?		
No	2319	43.55%
Yes	3018	56.5%
How would you rate the support you receive from your Guide / Teacher?		
Adequate	3358	62.9%
Inadequate	935	17.5%
Needs improvement	1044	19.6%
Would additionally support from colleagues or faculty improve your academic experience?		
No	640	12.0%
Yes	4697	88.0%
Have you ever been asked for unreasonable favours in exchange for passing exams?		
No	4657	87.3%
Yes	680	12.7%

Regarding Thesis-related Challenges: The responses indicate a fairly even split regarding challenges with thesis work, with 2764(51.8%) of the PG students experiencing challenges. This suggests that over half of the students face difficulties in their thesis work, which could encompass a variety of issues from data collection to writing and submission processes. The vast majority of students 4716 (88.4%) reported that their thesis guide did not try to exploit them for signing the thesis. However, there remains a concerning 621 (11.6%) who did experience exploitation, which is a serious issue regarding academic integrity and student treatment.

Table 10. 10. Thesis and Academic Work

Variable	Frequency	Percent
Challenges with Thesis Work-Have you faced any challenges with your thesis work?		
No	2573	48.2%
Yes	2764	51.8%
Additional Thesis Stressors - Would you like to share any specific stressors you encountered during your thesis work?		
No	4334	81.2%
Yes	1003	18.8%
Has your thesis guide tried to exploit you for signing the thesis?		
No	4716	88.4%
Yes	621	11.6%
Has your thesis guide intentionally delayed the submission of your thesis?		
No	4898	91.8%

Yes	439	8.2%
How much stress you felt due to the delayed thesis?		
Severe	1194	29.7%
Less	1860	34.9%
Moderate	2283	42.8%
Have your thesis guide asked you to manipulate thesis data to get standard outcome?		
No	4935	92.5
Yes	402	7.5
Assistance Needed for Thesis - How would you like to receive assistance for your thesis from the administration?		
Extra time	1109	20.8
Faculty guidance	1948	36.5
Financial support	678	12.7
Thesis removal	1249	23.4
Other	353	6.6
Access to Resources - Is obtaining necessary resources from the college library easy?		
No	1683	31.5
Yes	3654	68.5

A significant majority 4898 (91.8%) of the PG students have not experienced intentional delays in their thesis submissions by their guides. Nevertheless, 439(8.2%) reported such delays, which can contribute to increased stress and potentially impact their academic progress. The vast majority 4935 (92.5%) of students reported that they were not asked to manipulate thesis data by their guides, which is a positive indication of academic integrity. However, a small percentage 402 (7.5%) did encounter requests for data manipulation, suggesting ethical concerns within certain thesis supervisory relationships.

PG students expressed diverse needs for assistance with their thesis work. The most common request was for better faculty guidance 1948(36.5%), followed by the desire for thesis removal 1249(23.4%), indicating a significant portion who might prefer alternative evaluation methods. Extra time for thesis completion was also a notable need 1109 (20.8%), and some students sought financial support 678(12.7%), underscoring the varied challenges students face during their thesis phase.

Hostel and Food: A significant proportion of the PG students are not satisfied with the hostel facilities, with nearly 50% rating them as poor or extremely poor. The interaction between the student body and hostel management also needs improvement, with only 16% rating it as good or very good. A slight majority (53%) suggest that changes are needed in hostel management policies. This suggests that nearly half of the students are dissatisfied with their living conditions, potentially impacting their academic performance and overall well-being. Satisfactory living conditions are crucial for quality of life and academic success. Poor ratings

indicate that improvements are necessary to ensure that the hostel environment supports rather than hinders student learning and performance.

Table 10.11 Facilities Related to Hostel

Variable	Frequency	Percent
How satisfied are you with the overall facilities provided by the college?		
Extremely poor	730	13.7%
Poor	1504	28.2%
Satisfied	1858	34.8%
Good	899	16.8%
Very Good	346	6.5%
How satisfied are you with the cleanliness and variety of food items available in the cafeteria?		
Extremely poor	1181	22.1%
Poor	1641	30.7%
Satisfied	1544	28.9%
Good	709	13.3%
Very Good	262	4.9%
What is your opinion on the overall facilities available in the hostel ?		
Extremely poor	1152	21.6%
Poor	1494	28.0%
Satisfied	1672	31.3%
Good	763	14.3%
Very Good	256	4.8%
Are there any arrangements available for the students' families to stay on the campus at the time of their visit?		
No	3635	68.1%
Yes	1702	31.9%
Is there a mechanism for interaction between student and hostel management?		
No	1931	36.2%
Yes	3406	63.8%
How do you rate the kind of interaction exists between the student body and hostel management?		
Extremely poor	1059	19.8%
Poor	1696	31.8%
Satisfied	1729	32.4%
Good	624	11.7%
Very Good	229	4.3%
Do you think the environment of the hostel affects your academic performance?		
No	2106	39.5%
Yes	3231	60.5%

Ragging: A significant number of students 930(18%) reported that ragging was still there and hurt them. This underscores the ongoing issue of ragging within some academic environments. 1425 (27%) reported experiencing harassment from senior PG students in clinical settings, while 1669 (31%) reported similar experiences from faculty and senior residents.

Awareness of anti-ragging regulations is relatively high 4510(84%), but there is still a significant minority (nearly 20%) unaware of these regulations, which suggests the need for increased education and communication efforts. However, these measures alone are not enough, as indicated by the (18%) substantial proportion of students affected by ragging. This suggests a potential gap in the enforcement of these measures or in the effectiveness of the response systems. Educational institutions must maintain anti-ragging policies, actively enforce them, and ensure that students are both aware of and comfortable accessing support systems.

The respondents' analysis of self-care practices and stress management strategies demonstrates a wide range of approaches by PGs. The primary practices identified include conversing with friends or relatives (27.28%), spending quality time with loved ones (26.91%), taking trips (12.09%), pursuing personal hobbies (9.01%), and participating in sports or games (6.56%). Furthermore, additional responses encompass embracing spiritual practices, meditation, journaling, yoga, and undergoing stress management training

Table 10. 12 Harassment and Bullying

Variable	Frequency	Percent
Impact of Ragging or Bullying - How the experiences of ragging or bullying by senior students affected you?		
Not at all	2663	49.9%
Slightly	991	18.6%
Moderately	753	14.1%
Significantly	484	9.1%
Very Significantly	446	8.4%
Awareness of Anti-Ragging Measures - Are you aware of the anti-ragging cell in your institute?		
No	827	15.5%
Yes	4510	84.5%
Support Systems for Addressing Bullying - What support systems should be enhanced to address bullying more effectively?		
Anti-ragging committees	2217	41.5%
Counselling services	1842	34.5%
Hotline numbers	924	17.3%
Other	354	6.6%
Harassment in Clinical Settings - Do you experience harassment from senior PG students in clinical settings?		
No	3912	73.3%
Yes	1425	26.7%

Harassment from Faculty or Residents - Do you experience harassment from faculty or senior residents regarding clinical work?		
No	3668	68.7%
Yes	1669	31.3%

Family Stress: A considerable proportion of respondents, 2173 (41%), noted that family issues have impacted their focus on studies, highlighting the significant disruptive potential of familial challenges on academic performance. While 41% who are married or are in a relationship feels that the presence of a significant other in their lives helps them cope, (11%) of postgraduates reported that marital conflicts have worsened their stress levels. While the majority, 3902 (73%), do not perceive the necessity for additional support regarding family stress, a substantial minority, 1435 (27%), seek assistance, indicating a gap in existing support structures. Nevertheless, nearly half of the respondents, 2552 (48%), recognize the advantages of having family counselling services available on campus, underscoring the potential benefits of such provisions in alleviating stress and enhancing mental well-being.

Table 10. 13. Family Stress and Other Variables

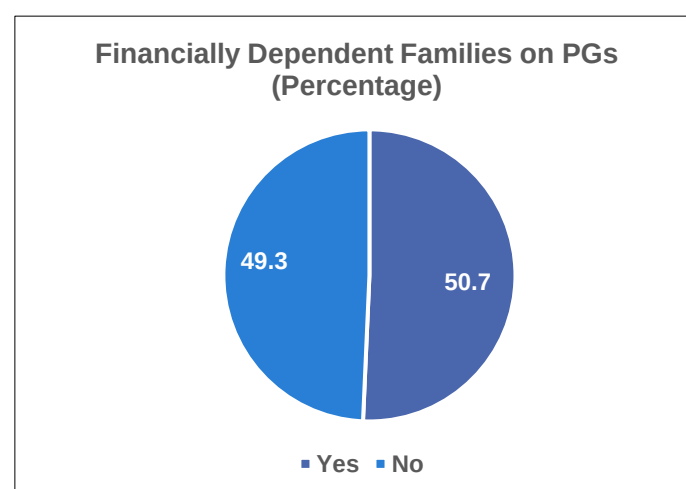
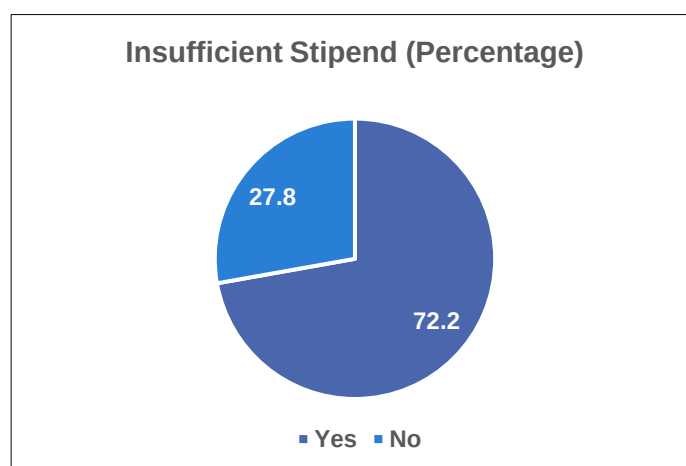
Variable	Frequency	Percent
Impact of Family Issues on Studies - Have family issues ever affected your ability to focus on your studies and clinical work?		
No	3164	59.3%
Yes	2173	40.7%
Need for Support with Family Stress- Do you need help managing stress related to family responsibilities?		
No	3902	73.1%
Yes	1435	26.9%
Need for Family Counselling on Campus - Would family counselling on campus be beneficial to you?		
No	2785	52.2%
Yes	2552	47.8%
Impact of Marital or Relationship Status - How has your marital or relationship status impacted your stress levels as a postgraduate student?		
Adversely	569	10.7%
Helps me cope	2194	41.1%
Not applicable (unmarried)	2574	48.2%

Financial Concerns: Most PG students fall into the lower to middle-income bracket (<20lakh Rs income per annum) 4519(84%), reflecting the economic background of a significant portion of the student body. A majority 3206 (60.1%) feel their stress and well-being are impacted by financial concerns, highlighting the need for increased support. A large majority 3851 (72.2%) find their stipend insufficient, pointing to a critical need for review and adjustment of stipend policies. While a majority 3115 (58.4%) receive their stipends regularly, a significant proportion 2222 (41.6%) do not, indicating potential areas for improvement. Nearly half 2708

(50.7%) of the PG students have financially dependent families, adding to their financial stress. Invariably, most of the PG students in the age group 25-29yrs had their families who were looking for financial assistance from the PGs, adding burden to them.

Table 10. 14. Finances Including Stipend

Variable	Frequency	Percent
Sufficiency of Stipend- Is the stipend you receive sufficient?		
No	3851	72.2%
Yes	1486	27.8%
Regularity of Stipend Payment-Is your stipend paid regularly by the institute?		
No	2222	41.6%
Yes	3115	58.4%
Family Financial Dependency-Is your family financially dependent on you?		
No	2629	49.3%
Yes	2708	50.7%



Perceived Stress Levels: Most students experience moderate to very high-stress levels (84%). However over 40% of them feel that this high perceived stress levels are a way to have the workload reduced. This underscores the need for effective stress management and mental health support structures within medical institutions. A significant majority of postgraduates, 3419 (64%), reported that workload adversely affected their mental health and well-being. Furthermore, 905 (17%) of postgraduates felt overwhelmed by their workload, while 1951 (37%) perceived it as challenging. They cited factors such as long daily working hours, continuous duty for 2-5 days, and inadequate infrastructure and support at their duty places as contributing stressors. Additionally, 1034 (19%) of postgraduates expressed the need to alleviate stress through substance use, including tobacco, alcohol, cannabis, and other drugs. Moreover, 1409 (26%) of PG students recognized a strong association between stress and substance use among postgraduates. Substance use as a coping mechanism is prevalent among a significant portion, with many acknowledging the link between stress and substance use. While 70% acknowledged that they do share their challenges with their family members, 69% also reported that they were concerned about how their family members would react to their challenges. A significant 36% of them felt that peer relationships did contribute to their stress levels though a lesser 21% acknowledged the need for support from their authorities in resolving relationship issues with their peers. Hence, there is an urgent need to take measures to educate the PGs and also implement measures to curtail the stress.

Table 10. 15. Stress and Workplace

Variable	Frequency	Percent
Is there a perception that some postgraduates claim excessive stress to reduce their workload?		
No	3186	59.7%
Yes	2151	40.3%
Sharing Challenges with Family or Spouse - Do you share academic or departmental challenges with your family or spouse?		
No	1481	27.7%
Yes	3856	72.3%
Concerns About Family Reaction - Are you concerned about how your family or spouse might react if you shared your problems with them?		
No	1669	31.3%
Yes	3668	68.7%
Peer Relationships - Have relationships with peers contributed to your stress levels?		
No	3437	64.4%
Yes	1900	35.6%
Need for Support in Resolving Interpersonal Issues - Do you need support from authorities to resolve interpersonal relationship issues?		
No	4235	79.4%
Yes	1102	20.6%

Mental Health & Suicide: The survey results reveal that 4518 (84.7%) of postgraduate students have not been diagnosed with any mental health condition, while 819 (15.3%) have been diagnosed with one. A notable percentage of the students suffer from mental illness 819 (15.3%), which could be exacerbated by the high levels of stress reported.

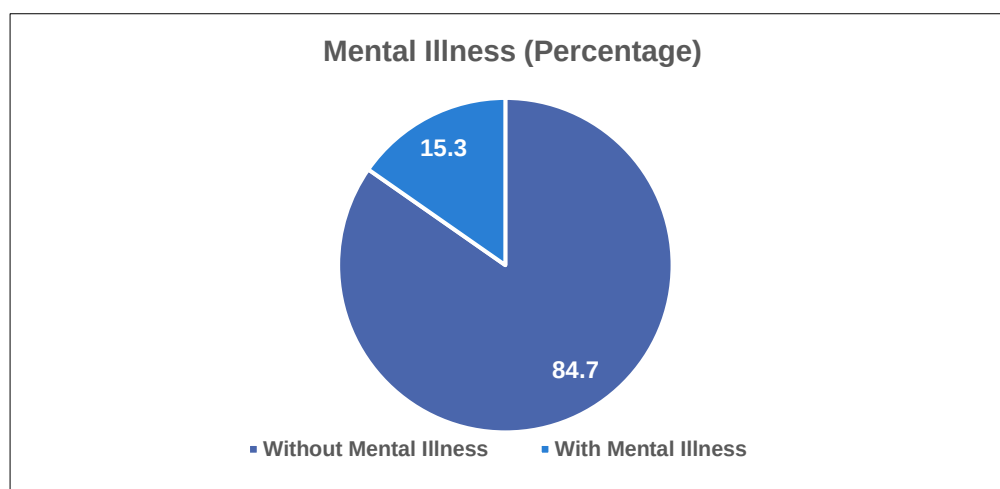
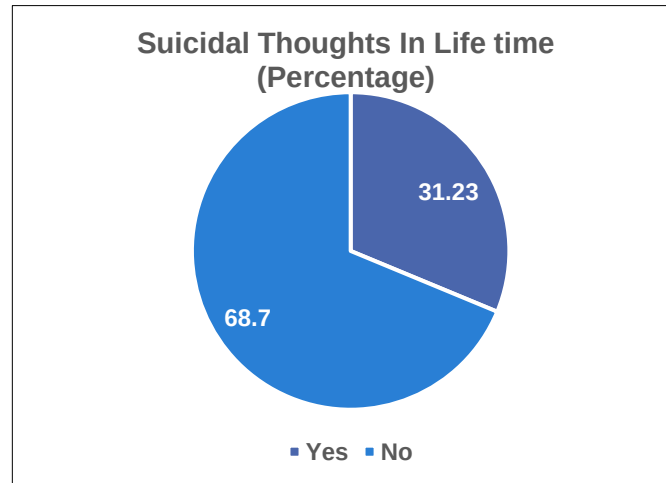


Table 10. 16. Mental Health and Suicide

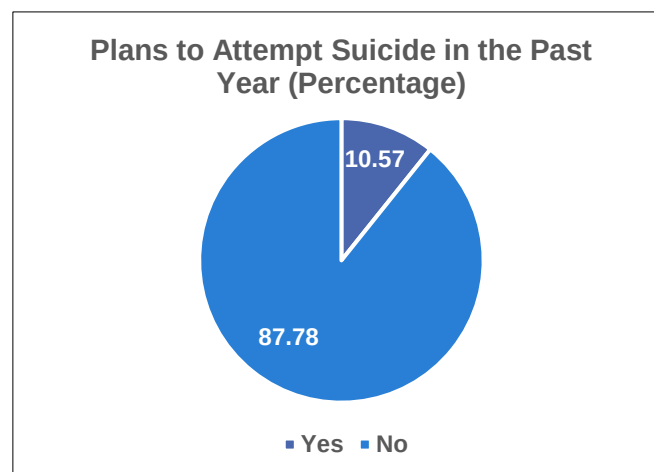
Comfort in Seeking Mental Health Help-Are you comfortable seeking help within your hospital for mental health-related issues?		
No	2222	41.6%
Yes	3115	58.4%
Challenges in Seeking Mental Health Help-What challenges might you face if you seek help for mental health issues within your hospital?		
Confidentiality concerns	2333	43.7%
Discrimination	575	10.8%
Impact on future job prospects	455	8.5%
Licensing issues	42	0.8%
Other	847	15.9%
Stigma	1085	20.3%
Experience with Suicidal Thoughts - Have you experienced thoughts of suicide in the past?		
No	3670	68.8%
Yes	1667	31.2%
Suicidal Plans -Have you made any plans to attempt suicide in the past year?		
No	4685	87.8%
Yes	564	10.6%
Don't wish to Specify	88	1.6%
Suicide Attempts-Have you attempted suicide in the past year?		
No	5100	95.6%
Yes	237	4.4%
Mental Illness Experience-Do you suffer from any mental illness?		

No	4518	84.7%
Yes	819	15.3%

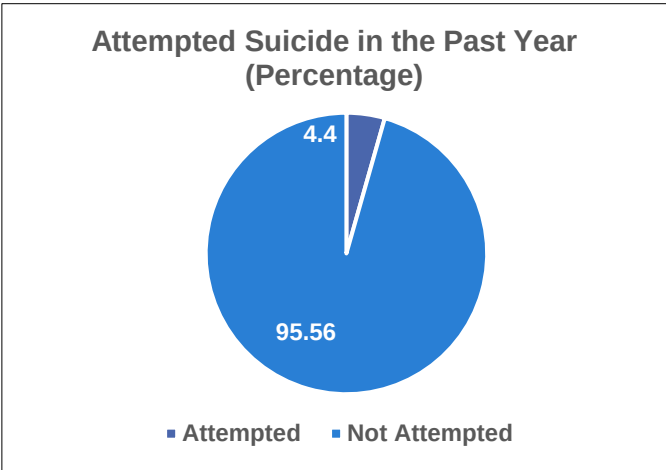
Among the respondents, 1,667 (31.23%) disclosed experiencing suicidal ideation in the past, with 3,670 (68.7%) reporting no such thoughts.



Moreover, 564 (10.57%) PG students indicated making plans to attempt suicide within the last year, while 4,685 (87.78%) did not report such plans.



Additionally, 237 (4.44%) PG students admitted to attempting suicide in the past year, while the majority, 5,100 (95.56%), did not report any suicide attempts during that period.

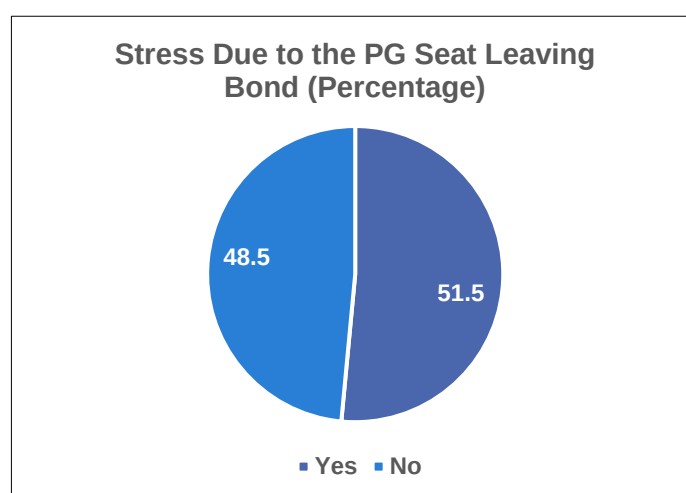


Seeking Help: More than half of the students are comfortable seeking mental health help, which is positive 3115 (58.37%). However, the relatively high percentage of students uncomfortable seeking help 2222 (41.63%) highlights potential barriers, such as stigma or lack of trust in the available services, which must be addressed to ensure all students can receive the support they need. On examining the landscape of seeking mental health assistance, several challenges emerge. Foremost among these are confidentiality concerns, cited by 43.71% of respondents, highlighting the pervasive fear of privacy breaches and its deterrent effect on seeking help. Stigma remains a significant barrier, with 20.33% expressing apprehension due to societal judgment and misunderstanding of mental health issues. Additionally, 15.87% of PG students cited unspecified challenges, indicative of various obstacles not explicitly categorized. Discrimination, accounting for 10.77%, underscores the persistent social biases faced by individuals seeking mental health support. Furthermore, concerns about the impact on future job prospects (8.53%) and licensing issues (0.79%) demonstrate the intricate interplay between mental health-seeking behaviors and professional livelihoods. If these are the concerns faced by future health care professionals themselves, their potential in influencing patients to seek help becomes a question that needs to be thought through.

Regarding PG Seat Leaving and Rural Service Bond: About half of the PG students 2747(51.5%) report stress due to the PG seat leaving bond, indicating a potential area for policy adjustments and less than half 1998 (37.4%) of the PG students report stress due to the rural service bond, affecting a substantial number.

Table 10. 17. Stress about Bond

Variable	Frequency	Percent
Do you feel stressed about the PG seat leaving bond in your college?		
No	2590	48.5%
Yes	2747	51.5%
Do you feel stressed about the rural service bond in your college?		
No	3339	62.6%
Yes	1998	37.4%



10.2.3 Analysis of Online Survey Responses from Faculty and Administrators

Total number of faculty who responded to the online survey were 7035 with a fairly even distribution between male 3395 (50.37%) and female 3282 (48.69%) respondents, with a small percentage preferring not to disclose their gender 57 (0.85%) and very few identified as others 6(0.09%). The data also reveals that predominance of faculty members 5816 (86.29%) in the survey, with a smaller representation from administrative roles 904 (13.41%) and wardens 20 (0.30%). This distribution highlights that the survey results are predominantly influenced by faculty viewpoints mainly.

Table 10. 18: Description of Socio-Demographic Characteristics of Faculty.

Socio-demographic parameters	Frequency (n)	Percentage (%)
Gender:		
Female	3282	48.7%
Male	3395	50.4%
Others	6	0.08%
Prefer not to say	57	0.85%
Position:		
Administrator	904	13.4%
Faculty	5816	86.3%
Warden	20	0.3%
Do you think students should be given protected leisure time or leave periods to relax?		
Not at all	359	5.4%
Moderate	1422	21.1%
Mostly	4959	73.5%
Do you think the academic schedule/atmosphere of your college is stressful for students?		
Not stressful	3254	48.3%
Moderately stressful	2066	30.7%
Very stressful	1420	21.1%

Do you feel that sometimes faculties themselves are responsible for avoidable mental stress to students?

No	3290	48.8%
Yes	3450	51.2%

Challenges Dealing Depressed Students: Majority 5302 (78.66%) of respondents feel they have not encountered significant challenges in managing depression among students. However, there is still a significant minority 1438 (21.34%) who have faced difficulties. Qualitative data responses highlight several recurring themes: a) Reluctance and Denial: Students often do not want to discuss their issues or deny having problems, making it difficult for faculty to provide appropriate support, b) Non-compliance with Treatment: Some students do not follow through with recommended treatments or interventions, c) Academic Pressures: Depression linked to anxiety over exams and performance in studies is a significant concern, and d) Communication Barriers: A general lack of openness or communication about mental health issues.

A substantial proportion of respondents 2875 (42.66%) believe that their institutions lack a clear system for addressing depression among students.

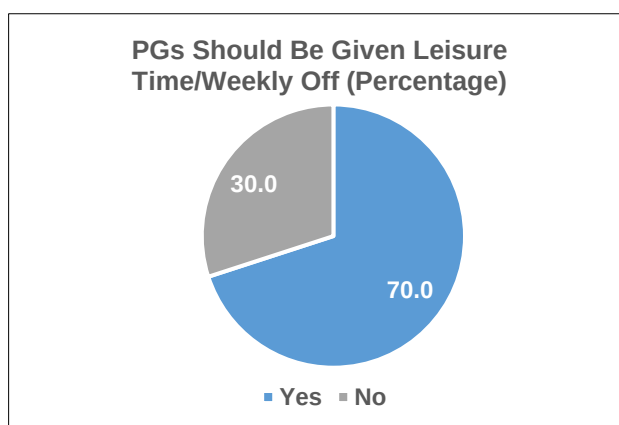


Table 10.19: Description of Challenges Faced by Faculty

Challenges faced by faculty	Frequency (n)	Percentage (%)
Have you faced any challenges in managing cases of depression among medical students?		
No	5302	78.6%
Yes	1438	21.4%
Do you share some examples of overcoming challenges with your students?		
No	2227	33.1%
Yes	4513	66.9%
Is there a clear system in place to address or tackle cases of depression among students in your college		
No	2875	42.7%
Yes	3865	57.3%

Stress Faced by the Faculty (educators): The distribution of responses to the question about how respondents rate their stress levels at their workplace revealed that the most common response is a moderate level of stress, with a rating of 5 (16.57%). Higher stress levels (ratings

of 7, 8, and above), which indicate more significant concerns, collectively account for a substantial proportion (29.66%). Lower stress levels (ratings of 1-4) collectively make up approximately 39.35%, indicating that a significant portion of the respondent's experience low to relatively manageable stress levels.

Volunteering Mentor-Mentee Program: The distribution of responses by the educators to the question about whether respondents would volunteer to be a mentor in a mentor-mentee program reveals a strong inclination towards volunteering as a mentor, with a remarkable 3062 (45.43%) of respondents choosing the highest commitment level. When considering the higher end of the scale (responses 8, 9, and 10), which indicate a strong likelihood of volunteering 69%, showcasing a widespread enthusiasm for participating in mentorship. At the other end of the spectrum relatively low numbers of educators (8%) showed resistance or reluctance towards mentoring,

Misuse of Mental Stress Label: The responses to the question about whether respondents think that students use mental stress as an excuse to get away from work or to avoid responsibilities. A significant proportion of respondents 3489(51.76%) believe to some extent that students might use mental stress as an excuse, while others 3251(48.17%) believe that these issues are genuine and not used as excuses. This clearly indicates that there is a clear need for enhanced awareness and training on mental health issues for faculty and administrators, alongside the development of clear guidelines for handling claims of mental stress. Institutions should also bolster their mental health support systems, encourage open dialogues about mental health to reduce stigma, and regularly assess student well-being.

Role of Stress in Medical Training: Regarding the whether respondents think a hectic schedule and mental stress are important for the proper training of medical professionals. A significant portion of respondents (22.88%) firmly believe that such stress is not important at all for training, which is the single most common response. However, there were (24.96%) believe that a hectic schedule and mental stress are considered important for the proper training of medical professionals. The data suggests that while a significant number of educators see some value in maintaining stress level optimal for training.

Improving Mental Health and Wellness of UG students: The survey results regarding measures to improve mental wellness in UG students, the educators believed that the most valued measure is focusing on good communication with faculty 4788(12.94%), closely followed by the provision of counselling services with 4759(12.87%). These top preferences highlight the critical role of direct support and open communication channels between students and faculty. Additionally, organizing cultural or sports events was highly regarded 4534 (12.26%), reflecting the significance of balancing academic work with recreational activities for mental well-being. Mentor-mentee programs and ensuring access to healthy food on campus also received substantial support, with responses just under 12%, emphasizing the benefits of guidance, mentorship, and physical health on mental wellness.

Other important factors include improving residential facilities 3999(10.81%), providing spaces for sports 3978 (10.75%), and offering financial support 2634(7.12%), each of which addresses different aspects of student life that contribute to overall mental health. Measures like a less intensive academic schedule and more off days, although supported to a lesser extent, still show a recognition of the need for rest and reduced pressure in the academic environment 1980(5.35%).

Table 10.20: Faculty Perception of Various College Activities

Various activities college	Frequency (n)	Percentage (%)
Do you think extracurricular events, wellness workshops, or recreational activities should be organized regularly at your college?		
Not at all	212	3.1%
Some times	931	13.3%
Mostly	5597	79.6%
Do you have a conversation about mental wellness and stress in college with your students?		
No	1389	20.6%
Yes	5351	79.4%
Are you able to express good ideas to improve the wellness and learning experience of your students to your superiors?		
Never	538	8%
Mostly	1512	22.3%
Always	4690	69.6%
Is there a clear system to address discrimination/bias that students may face due to their financial, social, cultural, or academic background etc.?		
No	3102	46.1%
Yes	3638	53.9%
How would you rate your stress levels at your workplace		
No/mild stress	2104	31.2%
Moderate	2300	32.7%
Extreme	2336	33.2%
Do you think you are in a position to impact the mental well-being of your students?		
Not at all/Occasionally	687	10.2%
Sometimes	1833	26%
Mostly	4220	60.1%
Do you think you have support from your superiors to initiate activities to promote mental wellness in your students?		
Not at all/Occasionally	854	4.5%
Sometimes	1684	23.9%
Mostly	4202	59.7%
Would you volunteer to be a mentor to a student as part of a mentor-mentee program?		
Not at all/Occasionally	565	8.4%
Sometimes	1023	15.2%
Mostly	5152	76.3%
Do you think students use mental stress to get away from work or as an excuse to shun work?		
Not at all/Occasionally	1410	20.9%
Sometimes	2599	38.5%
Mostly	2731	40.5%
Do you think a hectic schedule and mental stress are important for the proper training of medical professionals?		
Not at all/Occasionally	2589	38.4%
Sometimes	1893	26.9%
Mostly	2258	32.1%

Improving Mental Health and Wellness of PG Students: The survey results regarding measures to enhance mental wellness in PG students of various specialties the educators believed and endorsed, emphasizing good communication with faculty 4721(13.70%), underscoring the critical role of open dialogue and support between students and educators. Facilities that enhance daily living, such as good residential amenities 4062 (11.78%) and access to healthy food 4000 (11.60%) also ranked highly, reflecting the importance of a conducive living environment in supporting mental health. Counselling services are equally pivotal, receiving 4015 responses (11.65%), indicating a strong need for direct psychological support. The mentor-mentee program, favored by 3609 (10.47%), along with cultural and sports events, which received 3356 (9.74%), highlight the value of community and extracurricular engagement in fostering a balanced and supportive educational experience. Additionally, practical measures like post-night duty offs 3275 (9.50%) and less intensive schedules 1475(4.28%) are recognized for their role in preventing burnout, emphasizing the need for workload management in maintaining student well-being.

Table 10.21: Faculty Perception of Measures to Improve Mental Wellness

Which of the following measures do you feel will help improve mental wellness in UG students?		
Ensuring good healthy food on campus	553	8.2%
Financial support/special scholarships for students with limited resources	11	0.2%
Focus on good communication with faculty	225	6.7%
Good residential facility in the college	157	2.3%
Less intensive academic schedule	1980	29.4%
Mentor-mentee program	177	2.6%
Organization of cultural or sports events	2769	41.1%
Provision of counselling services	398	5.9%
More off days	401	5.9%
Others	69	1%
Which of the following measures do you feel will help improve mental wellness in PG students of your specialty?		
Ensuring good healthy food on campus	581	8.6%
Financial support/special scholarships for students with limited resources	17	0.3%
Focus on good communication with faculty	350	5.2%

Good residential facility in the college	177	2.6%
Less intensive academic schedule	1475	21.9%
Mentor-mentee program	143	2.1%
Organization of cultural or sports events	1152	17.1%
Provision of counselling services	314	4.7%
Post night duty offs	2241	33.3%
Others	290	4.3%

Recommendations

11. Recommendations to Improve Mental Health and Wellbeing

The task force has developed these recommendations with a dedicated commitment to enhancing mental health and preventing suicide among medical students. There is considerable literature documenting both the presence of mental health disorders and risk factors in young adults but limited in medical students. There are also numerous interventions suggested in the worldwide literature, although studies on proven interventions are limited. The scientific literature reveals a critical gap in systematic research on the effectiveness of interventions for medical students who attempt or complete suicide. Similarly, there is a scarcity of studies examining protective factors aimed explicitly at mitigating suicide risk among medical students. To fill the gap the national task force undertook various initiatives and deliberations to draft the following recommendations

- A) National task force deliberations included integrating insights from several pivotal documents and engagements, including The Parliamentary Standing Committee's Report on the Quality of Medical Education in India 2024 (Report 157), The Mental Health Policy (2014), The National Suicide Prevention Strategy (2022), The National Crime Records Bureau (2023), Medical Council of India (MCI) rules, National Medical Commission (NMC) regulations, best practices from various medical colleges, and other relevant government documents.
- B) To formulate the recommendations, the task force engaged in a multi-step, methodology. Initially, the Task force conducted formal meetings both in-person (face to face) and virtual (remote) and arrived at common grounds when-ever there was disagreement. Next, held focused group discussions with various stakeholders, including faculty, students, and college administration.
- C) The task force carried out an online survey of stakeholders. A total of 25,590 undergraduate students, 5,337 postgraduate students, and 7,035 faculty members responded to the online survey.
- D) In addition to other efforts, the Task Force conducted online and in-person meetings with various associations and stakeholders to gather comprehensive insights and feedback. These meetings were attended by the representatives of the Federation of Resident Doctors Association India (FORDA) and Resident Doctors Association (RDA). Engaging with associations medical students allowed the task force to understand the collective concerns, suggestions, and needs of the student body from their representatives. This provided valuable insights into the challenges faced by medical students and potential areas for improvement in their educational and support systems. Meetings with resident organizations helped the task force gain perspectives from postgraduate students who were directly involved in 24/7 clinical duties. Their feedback was crucial in understanding the practical challenges and stresses of residency, including duty hours, work-life balance, and mental health support.

Involving parents in these discussions provided a holistic view of the student's experiences from a familial perspective. Parents offered insights into the support systems needed at home and how institutions can better communicate and collaborate with families to support student

well-being. Direct interaction with students was paramount. These meetings facilitated an open dialogue where students could voice their concerns, share their experiences, and suggest improvements. This direct feedback was invaluable in ensuring that the recommendations developed are student-centered and address the real issues faced by the student population. Additionally, the Task Force invited students to provide feedback via email. This approach allowed students who were unable to participate in online meetings to contribute their thoughts and experiences at their convenience. It also ensured that the Task Force received a wide range of perspectives and could address specific concerns raised by individual students. By incorporating feedback from these diverse groups, the Task Force ensured that the recommendations were comprehensive and considered the views of all relevant stakeholders.

Online survey results were consistent with the global literature, an alarmingly high 27.8% of UG students and 15.3% of PG students voluntarily indicated having a diagnosed mental health disorder, and 16.2% UG students and 31.2% PG students reported having had suicidal ideation. This degree of MH disorders, and suicidal ideation combined with students with risk factors calls for an aggressive and rapid implementation of interventional programs.

Given the individualized nature of mental health issues and suicidality, a one-size-fits-all solution for suicide prevention is impractical. Addressing this complex challenge requires a sophisticated, multi-faceted approach tailored to meet the unique needs and circumstances of medical students in India. The recommendations include implementing comprehensive mental health programs, enhancing access to mental health services, promoting protective factors, and encouraging systematic studies focused on mental health improvement and suicide prevention specifically for medical students. The formulated set of recommendations is designed to be dynamic and responsive. Recognizing the evolving nature of the academic landscape and medical student needs, this document is intended to serve as a living guideline. It will be periodically updated based on new research findings and ongoing feedback from the medical community. This approach ensures that the recommendations remain relevant and are based on the most current evidence and best practices, thereby enhancing their effectiveness in addressing the complex issues of mental health and suicide prevention among medical students.

In case of any conflict with these recommendations and the NMC Act, 2019, Rules, and Regulations, it is imperative that the NMC Act, rules, and regulations prevail over these recommendations.

The Core Recommendations and Suggestions are Organized into Three Sections.

Section	Title
11.1	Universal Recommendations a) Medical Colleges b) Medical Students c) Family Members of Medical Students d) Faculty Members
11.2	Identification of High-Risk Groups and Referral
11.3	Persons with Mental Illness and Attempted Suicide

SECTION 11.1 - Universal Recommendations

i. MEDICAL COLLEGES

The environment in medical colleges is vital to building a healthy academic and work culture for students, faculty, and other staff. A proactive and compassionate approach from the administration can significantly impact the mental health of medical students. By prioritizing mental well-being, institutions can contribute more to the success and resilience of future healthcare professionals.

1. Orientation Program at Joining

A comprehensive five-day orientation program within four weeks for undergraduate students and two weeks for postgraduate students upon joining would greatly help the new entrants in setting expectations and helping prepare for the journey ahead. The orientation program could be done for a period of five days. Colleges could prepare a comprehensive orientation program focusing on, an introduction to the medical profession, access to various resources both within the campus and outside and the importance of nurturing physical, mental, and spiritual health. This can assist them in prioritizing their mental health and well-being from the beginning of their journey. It can also assist in familiarizing them with campus resources, and encourage them to seek help when needed. A guidebook created by students for students can serve as an 'Induction Manual,' providing a comprehensive overview of the campus, medical school, and hostel life, along with essential contact details such as the anti-ragging cell, helpline, resource centers, and counseling services. This resource would be invaluable for new students and can be distributed during the induction or orientation program.

2. Involving Family Members During the Induction Program and also Periodically at Least Once a Year

Involving family members of postgraduate (PG) and undergraduate (UG) medical students during the one-day induction program within their respective departments for PGs and at the

institute level for UGs is crucial. This approach would help family members understand the expectations, stressors, and support required by students to successfully navigate their courses. By gaining a comprehensive understanding of the academic and clinical demands, family members can provide more effective support from the home front. Recognizing the stressors faced by students enables families to create a supportive environment that mitigates stress and promotes well-being. Addressing both academic and personal needs through family involvement leads to a holistic approach to the education and well-being of medical students. These meetings can be conducted in-person or online to ensure broad participation. These parent-faculty meetings should be held at least once a year.

3. Anti-Ragging Measures

The stress induced by ragging must be mitigated. All medical colleges should strictly monitor the implementation of the National Medical Commission, Prevention and Prohibition of Ragging in Medical Colleges and Institutions Regulations, 2021. The UGC Anti-Ragging Cell, which provides assistance to victims of ragging needs to be in place. It operates a 24x7 toll-free helpline (1800-180-5522) and an online anti-ragging portal (www.antiragging.in) where students can confidentially report incidents of ragging would help the students. This information needs to be widely publicized in all medical colleges. Please refer Appendix -7 for more information.

4. Awareness Campaigns and Education

Medical colleges should consider organizing regular programs to educate students and faculty about mental health issues and available resources on campus, based on available resources. It is also recommended to consider integrating psychiatry as a compulsory subject in the undergraduate (UG) curriculum. As it is norm in medical colleges, that every PG Medical Student and Medical Teacher Should undergo training, in Basic Course in Biomedical Research (BCBR), Similarly every faculty and medical student should undergo training, Basics in Mental Health & Wellbeing. It is recommended that medical teachers, PG students, and administration undergo regular training in mental health, either through periodic in-person sessions or online such as the Swayam portal. The NMC will develop comprehensive modules covering mental health, mental illness, stress management, building resilience, prevention of substance use, gatekeeper training, suicide prevention, and basic counselling techniques. Specific emphasis should be placed on handling confidential matters concerning individuals with mental illness. Cultivating a culture that destigmatizes help seeking is paramount. Several days during the year offer an opportunity for colleges to enhance awareness of mental health and building resilience among students and staff.

a. National Doctor's Day – National Doctor's Day is celebrated in India on July 1 each year. Starting this year, the National Medical Commission (NMC) will annually select a theme for Doctor's Day celebrations, to be observed in all medical colleges. The theme for this year will be 'Mental Health and Well-being of Medical Students.' The celebration's focus can encompass various aspects, including resilience building, stress management, soft skills training, leadership development, entrepreneurship, medical innovation, spirituality, community service, yoga, and career advancement. Activities may include workshops and seminars led by mental health professionals and medical leaders, stress management techniques like mindfulness and relaxation exercises, and resilience training utilizing scenario-based learning.

b. World Mental Health Day - Observed on October 10th each year, it serves as an opportunity for medical colleges to engage in raising awareness about mental health issues and to mobilize efforts towards better mental health. Medical colleges can organize events, seminars, poster competitions, mass media competitions, and workshops focusing on various aspects of mental health, including early signs of mental illness, strategies for prevention, and available treatments.

c. World Suicide Prevention Day - World Suicide Prevention Day on September 10 is an opportunity for medical colleges to advance suicide awareness and prevention through seminars, campaigns, training, public engagements, and support initiatives.

d. Drug Prevention Day - It is a United Nations international day observed on June 26. Medical colleges have the opportunity to hold activities to raise awareness against the menace of drug abuse. It will help spread awareness and reduce stigmatization of those struggling with drug abuse and associated mental illnesses.

e. Anti-Ragging Day: It is celebrated on 12th August, and the emphasis can be on raising awareness about the detrimental effects of ragging and promoting a zero-tolerance policy. Educational sessions can cover laws and regulations against ragging, its psychological impact, and the importance of reporting incidents. Interactive workshops can educate students on handling and reporting ragging incidents, and awareness campaigns can utilize posters, videos, and social media content.

5. Counselling Services

A 24/7 Support System should be implemented across the campus. This can be done quickly by implementing the Tele Mental Health Assistance and Networking Across States (Tele-MANAS) initiative by the Union Ministry of Health & Family Welfare, New Delhi, using the toll-free number (14416) in all medical colleges. Extensive promotion of this number across campuses will allow more students to access the online counselling services provided by the MoHFW, New Delhi.

Medical colleges can consider appointing two counsellors for every 500 students, depending on available resources. Ideally, these counsellors would report directly to the Dean to ensure that preventive, promotive, and redressal measures are effectively implemented. Psychiatric referrals should only occur when the counsellors determine that a student requires psychiatric care. Every medical college should have a clearly formulated plan for referral, evaluation, management, and follow-up for students who suffer from mental illnesses. The mechanisms for referral and care should be widely disseminated and known to all faculty and administrators. A local 24X7 helpline is recommended to assist students in acute distress. Such services should be created in all medical colleges with the active participation of the Department of Psychiatry. The services created should create an environment to encourage students to seek help when needed and most importantly ensure confidentiality and easy accessibility. There should be a firewall (confidentiality) between counselling service providers and the medical college faculty and Admin. However, it is encouraged to have outside providers, outside clinics and hospitals in town.

6. Staff/Students Clinic

All medical students, both undergraduate (UG) and postgraduate (PG), should be provided free treatment including medicines for their physical and mental health issues within the medical college campus. Establishing separate wards, clinics, and investigation facilities specifically for students ensures easy access to healthcare services. Government medical colleges should offer these services without any charges, while private medical colleges should provide them for free or at a subsidized rate. This approach ensures that students receive the necessary healthcare without financial burdens, promoting their well-being and academic performance. It also fosters a supportive environment where charity and professional courtesy begin at home, emphasizing the institution's commitment to the health and success of its students. By addressing health issues promptly and effectively, medical colleges can help students maintain their physical and mental health, ultimately leading to better educational outcomes and a healthier future workforce.

7. Work Environment

It is of paramount importance that all medical institutions have proper infrastructure and amenities for medical students. These basic amenities are critical to maintain proper physical health, feel safe and secure and focus on the intense and demanding medical curriculum. The following table lists a few of these basic amenities that could be provided to all medical students.

Basic Amenities or Facilities to be Provided to Medical Students

- Proper hostels facility with preferably single occupancy
- Well-structured and maintained hostels with adequate ventilation, lighting and furnishings
- Proper clean washrooms
- Safe drinking water
- High food safety and quality standards with regular review of quality
- CCTV monitoring and proper security measures
- Establish common rooms, gyms, sports, and other recreational facilities
- Family quarters or suitable housing for married students
- Consider providing guest houses or rooms for visiting family members
- Reasonable fees for hostels
- No compulsory hostel or mess fees for day-boarders
- 24/7 cafeteria accessible to all hostel residents and duty doctors

8. Hostel Mess

Given the diverse cultural, religious, community, and dietary habits of students from various parts of the country joining medical colleges, it is recommended to enhance the hostel mess by involving students as prefects in planning their food preparation. Consider forming a mess committee that includes medical students (UG/PG) representing different backgrounds and regions to ensure effective implementation. This initiative can also include establishing multiple messes based on feasibility, students' active participation and economic viability (such as North Indian, South Indian, Vegetarian, Jain, etc.) to cater to various dietary

preferences and nutritional needs. Empowering students to take an active role in menu planning, quality control, hygiene, finance, and resource management can lead to a more inclusive and satisfying dining experience in the hostel mess.

To ease the financial burden on students, it is important to avoid forcing them to join the hostel mess. Allowing students the flexibility to choose whether to participate in the hostel mess or make alternative dining arrangements will help them manage their expenses more effectively. The administration may consider providing common resources such as refrigerators, cooking facilities, microwaves, mixers, stoves, and utensils to enable students to prepare their own meals. This provision will support students' diverse dietary needs and preferences, enhancing their overall living experience. This approach also encourages autonomy and respects individual preferences, contributing to a more supportive and inclusive campus environment.

9. Regulation of Duty Hours

Excessive duty hours pose risks to the physical and mental health of medical students and also compromise patient safety. To mitigate this, the government issued guidelines regulating resident doctors' duty hours (Ministry of Health and Family Welfare, Residency Scheme 1992 directive). According to these guidelines, resident doctors should generally not exceed 12 hours of continuous active duty per day and 48 hours per week. However, these guidelines were not implemented due to a shortage of human resources and other logistical reasons.

The National Task Force recommends, based on feasibility, resources, and relevance, that residents work no more than 74 hours per week, with no more than 24 hours at a stretch. This schedule includes one day off per week, one 24-hour duty, and 10-hour shifts for the remaining five days. It is also important for medical students to sleep at least 7-8 hours per day for optimal mental and physical health. Department Heads (HOD), faculty members, senior residents, and Junior Residents (JRs) can collaboratively plan duty hours and roster the duty into three shifts, or two shifts, or one shift based on human resource availability. Additionally, strict adherence to the National Medical Commission (NMC) regulations for a weekly one-day off is crucial. Implementing these measures, where feasible, will help protect the health of medical students and improve patient safety. It is imperative to recognize that post-graduates and interns primarily serve educational purposes rather than filling gaps in healthcare staffing.

10. Regulation of Type of Duty and Teamwork

Healthcare delivery is teamwork. In the West, one main reason for good quality of care is that each team member knows his/her task and responsibility, is well trained, and contributes to the system. Feedback from multiple quarters suggests that residents get an unfair share of work and duties. Many duties that do not fall into anyone's ambit or for which staff is lacking is thrust upon residents. It can include but is not limited to, collecting reports, going to blood banks, moving patient trolleys, filling various forms, arranging for free medications or finances for surgery, nursing care, sample delivery, other clerical work, and data entry.

Each medical institution should ideally have a clear policy of work profiles and distribution. Depending on available resources, it is beneficial to employ supportive staff such as phlebotomists, clerical staff, data entry operators, and hospital attendants to manage various supportive tasks. Training paramedical and supportive staff can enhance work quality, public satisfaction, and patient care, enabling medical professionals to concentrate on their primary responsibilities and perform at their best.

11. Safe and Supportive Environment for the Duty Students

The Task Force advises the administration to consider providing medical students with environment-appropriate conditions during their duty hours to ensure their well-being and optimal performance. This includes access to air conditioning, comfortable rest areas, nutritious meals, and proper hydration facilities. For example, well-equipped break rooms with comfortable seating, clean toilets, bathing facilities, changing rooms, and quiet spaces for rest can help students recharge. Additionally, providing healthy meal options in the hospital cafeteria ensures they receive adequate nutrition. Ensuring adequate lighting, ventilation, and ergonomic workspaces in clinical areas can prevent physical strain and fatigue.

If work hours are hectic, the hospital needs to consider providing appropriate support, such as arranging regular breaks and ensuring that food is available at the duty place or duty room. These measures, including access to nutritious meals, tea, and snacks directly in duty rooms, can help alleviate stress, prevent burnout, and support the overall well-being and effectiveness of medical students during their demanding duties. Implementing these supportive actions, where feasible, will enhance the working conditions and health of medical students, ultimately improving patient care.

12. Supporting Families and Childcare

It is important for all medical colleges and institutions with postgraduate students to have adequate infrastructure and policy to support families and childcare especially for the PG students. Medical colleges could consider providing on-site childcare facilities, family accommodation for married students or those with children, and daycare services. These amenities would help students manage both family and professional roles more effectively, reducing stress associated with child-raising and family obligations.

To provide a supportive, fair, and equitable environment that recognizes the unique needs of female medical students during pregnancy and postpartum, enabling them to continue their education while maintaining their health and the health of their babies. This support shall be implemented in line with the Maternity Benefit (Amendment) Act, 2017. Allow female students to postpone examinations and extend deadlines for assignments around their due dates. Provide options to complete missed coursework through alternative means, academic accommodation such as additional assignments, coursework flexibility, or clinical rotation. These provisions should be strictly implemented under the legal framework of the NMC Act, 2019, Rules, and Regulations. It is also important that there should not be any compromise on the quality and quantity (duration) of the training. Any break in the training needs to be compensated to complete the recommended period of training so that patient safety is not compromised in the long term.

13. Evaluation and Assessment Methods in Medical Colleges:

The exam evaluation of medical students should be fair and unbiased. While the traditional grading/marks-based system helps in providing regular feedback to students. It allows for distinctions between high achievers and others. However, it can also create a competitive environment and cause stress. The Pass/Fail System reduces pressure and competition among students. It can create a more collaborative learning environment. However, it may not provide detailed feedback on student performance. Institutions may offer the two systems knowing

their advantages and disadvantages. A mix of both systems can also be tried as it provides flexibility and balance. The National Medical Commission (NMC) must enact amendments to its relevant regulations to facilitate students taking exams in alternative centers, either within the same university or in Diplomate of National Board (DNB) exams.

14. Communication, Feedback, and Work Environment:

Administrative teams should maintain constant communication with faculty and students and encourage regular feedback. This will enhance the exchange of ideas and build trust to foster a healthy work environment. Regular assessments of the work environment should be conducted by gathering feedback from various quarters. It is essential to address any issues related to workload, hierarchy, or mistreatment, as these can foster mistrust and breed discontent among faculty and students. Administrators must ensure that the college atmosphere is inclusive and respects cultural, racial, caste, financial, and social differences. Clear mechanisms should be in place to promptly address any complaints of discrimination or bias. Additionally, a feedback and complaint box should be available in both the Director/Dean's office and the warden's office.

15. Transparent and Responsive Grievance Redressal in the Medical Colleges and Universities

A toxic educational environment, and harassment at medical college, hospital and/or hostel cause undue psychological stress, and negatively impacts the mental health of students. All colleges and institutions should have a clear grievance redressal system in place to address misuse of power, deter unprofessional behavior, and foster a respectful environment. This needs to be accompanied by proper training for faculty, administrators, and seniors on mentorship, accountability, leadership, and anti-harassment policies. Regular evaluations of faculty and seniors based on junior feedback, and third-party mentors may be implemented. For grave violations of ethical standards and personal boundaries like sexual harassment, there should be strict administrative regulatory oversight and a zero-tolerance policy.

16. E-complaint Portal of NMC

The National Medical Commission (NMC) should establish a national portal for grievance redressal called "e-Complaint," enabling students, faculty, and other stakeholders to raise complaints efficiently. This user-friendly portal, accessible via web and mobile applications, should feature secure login, standardized complaint submission forms, and options to upload supporting documents. A dedicated grievance redressal cell within the NMC, supported by adequate staff, will manage the workflow and deal with the complaints. Complaints will be acknowledged within 3 working days, reviewed within 14 working days, and resolved within 30 working days, with regular updates provided to the complainant. A detailed resolution report will be issued. The system will ensure transparency and accountability through periodic reports while maintaining confidentiality. Continuous improvement efforts, including training and awareness programs, will ensure the e-complaint system remains effective and responsive to emerging needs, enhancing trust and accountability within medical institutions.

17. Mentor-Mentee Program

This program was implemented as per Reg 14 of the National Medical Commission (Prevention and Prohibition of Ragging in Medical Colleges and Institutions) Regulations, 2021. Mentor-mentee programs in medical colleges are structured relationships between more experienced individuals (mentors) and less experienced individuals (mentees) designed to provide guidance, support, and professional development opportunities. These programs are crucial for the holistic development of medical students. These programs involve a matching process based on shared interests, regular meetings to discuss goals and challenges, and opportunities for skills development. Mentees benefit from networking opportunities and peer support, while mentors receive training on effective mentoring techniques. Monitoring and support ensure a successful and enriching experience for both parties.

All the mentors shall undergo training in mental wellness, mental health, and illness identification, providing the first line of psychological first-aid, referral, and monitoring the mentees. In post-graduation and super-specialization, the guide and co-guide of PG students could serve as their mentors. This explicit designation ensures that students have a defined and reliable support system, fostering a more structured and supportive academic environment.

18. Removing Fees for the Repetition of Semesters in Medical Colleges

Deliberately failing students to collect fees for semester repetitions is grossly unethical and have been brought to the notice of the Taskforce. There should be strict penalties for medical colleges found guilty of deliberately failing students for financial gain. Removing fees for repeating semesters in medical colleges is a potential strategy to reduce economic burdens on students who need to retake courses. This also helps reduce the stress associated with the financial burdens of repeating courses. Exam assessment shall include enforcing a transparent and standardized grading system, and establishing independent appeals process with external panellists to be considered in respective universities.

19. Teacher's Apprehension

Medical college faculty members are concerned about the potential fallout from student complaints, including harm to their professional standing, career progression, or legal repercussions. They often perceive a lack of backing from college administrations or regulatory bodies, intensifying their anxieties about repercussions from student grievances. The increasing focus on student feedback and satisfaction has heightened teachers' apprehensions about facing disciplinary measures or adverse outcomes due to student complaints. Consequently, teachers are frequently becoming disengaged from teaching and mentoring. This situation needs to be addressed across all medical colleges. Creating a supportive environment where teachers feel appreciated and supported is essential to improve this scenario. Establishing clear protocols for handling student complaints and disciplinary issues can give teachers assurance and clarity. Promoting professionalism and ethical behavior among teachers and students can cultivate a culture of respect and empathy. Instances of false or frivolous student complaints against teachers should be met with strict disciplinary actions.

20. Uniform PayScale, Retirement and Rotational Headship (UPRPR)

In alignment with the UGC pay scale and AICTE regulations, we propose establishing a standardized pay scale, service conditions, non-practicing allowance, education allowance, and qualification requirements for medical college teachers. This standardized pay scale should align with the current Pay Commission recommendations, ensuring uniformity and competitiveness across institutions nationwide. A uniform salary structure for interns, post-graduate students, super-specialty and medical college teachers across the nation ensures equity and fairness in compensation, promoting job satisfaction and attracting high-quality faculty. Standardized salaries simplify administrative processes, enhance transparency, and reduce potential unfair practices like ghost faculty.

Insufficient stipends that don't match living costs or workload, coupled with delays in payments, create significant financial instability for medical students. The lack of a uniform stipend policy leads to disparities between states and types of institutions (government vs. private). There should be a uniform policy for stipends across states and institutions to ensure fair compensation. Timely and regular payment schedules, potentially through direct payment systems for transparency, must be ensured. The stipend should be a living recommendation, adjusted according to market inflation. Implementing this policy is essential and should be done proactively, rather than waiting for students to go on strike to demand fair stipends. Strikes, Delays, and insufficient stipends can have serious consequences on the healthcare of the general population.

Teaching in a medical college is a dedicated profession and a significant responsibility. Faculty are involved in teaching (both undergraduate and postgraduate teaching), clinical work, and research. To ensure the highest quality of medical education, private practice for medical teachers should be prohibited. This measure will prevent any compromise in their teaching duties and maintain the integrity and quality of education provided to students. Hence, a non-practicing allowance should be included to compensate medical teachers who dedicate their time exclusively to teaching and academic duties, thereby enhancing their focus on education and research.

Uniform PayScale for Medicos (UPS for Medicos): Medical teachers should be recognized that they do teaching, clinical work and research and take part in both undergraduate and postgraduate teaching and thus need to be uniformly paid equivalent to the so-called "premier" institutions. To ensure the highest quality of medical education, private practice for medical teachers should be prohibited. Instead, interns, post-graduate students, senior residents, super-specialty students, and medical teachers should be compensated according to the AIIMS, New Delhi pay scale across all medical colleges, regardless of whether they are private, public, state, central, deemed university, or any other type of institution. This measure will prevent any compromise in their teaching duties, maintain the integrity of education, and ensure that educators are adequately rewarded for their commitment to academic excellence.

Uniform Retirement Policy: The current retirement policy for medical faculty across the nation is haphazard and disorganized. Therefore, the retirement policy should be standardized nationwide, adopting the AIIMS, New Delhi policy. This measure will prevent any compromise in teaching duties, maintain the integrity of education, and ensure that educators are adequately rewarded and provided with consistent retirement benefits for their commitment to academic excellence.

Uniform Pension Scheme for all Medical Teachers: The implementation of a Uniform Pension Scheme for all medical teachers is essential to ensure their financial security

post-retirement. Such a scheme will enable them to dedicate their efforts towards teaching, mentoring, and research without concerns about their future. Therefore, it is imperative to introduce a New Pension Scheme across all medical colleges.

Uniform Policy of the Rotation of Headship (HOD): Implementing a rotational headship system for department heads is essential to provide all faculty members with leadership opportunities, introduce new thoughts and practices, and prevent a toxic environment due to inefficient leadership. The Valiathan Committee (2006), Sujatha Rao Committee (2010), Sneha Bhargava Committee (2010), and Dr. M. K. Bhan Committee (2012) have all recommended rotational headship at the departmental level. This practice has been successfully implemented at the National Institute of Mental Health and Neuro Sciences (NIMHANS), Bangalore. Adopting NIMHANS, Bangalore - Rotation of Headship system nationwide will ensure a fair and consistent approach to leadership roles, enhance administrative efficiency, and promote collaborative governance in medical institutions.

21. Family Vacation

Medical colleges could consider granting a ten-day vacation at least once a year to both undergraduate and postgraduate medical students on a rotational basis. This break is aimed at fostering family bonding. Addressing family-related stressors identified in surveys and discussions, this vacation ensures students return refreshed and better able to focus on their academic responsibilities. However, this vacation should not interfere with completing the mandatory syllabus, clinical training, lab work, thesis, and curriculum. Any such interference will result in the mandatory training as per NMC guidelines taking precedence.

22. Reducing Access to Means for Suicide on Medical College Campuses

Implementing measures to limit access to potentially dangerous means, such as medications, sharp objects, and high places, can help prevent impulsive self-harm and support mental health. For instance, installing barriers or fences on rooftops and balconies can restrict access to these high-risk areas. Additionally, creating secure storage areas for medications with limited access and educating staff and students on safe storage and disposal practices can reduce the risk of misuse. Another innovative approach is the installation of ceiling fans with a safety design that includes a spring mechanism. This spring is designed to fail when it encounters excessive weight, causing the fan to lower and preventing potential hanging incidents.

The anti-Ragging Committee established under the NMC regulations will evaluate access points to high-risk areas like doors, windows, and gates. Additionally, it is essential to review current security measures, such as surveillance systems and locks, to ensure they effectively prevent unauthorized access. Assessing the physical environment and considering modifications, such as installing barriers or safety nets in high-risk areas, can also help reduce the risk of self-harm. These simple measures can help prevent impulsive acts of self-harm and promote mental health and well-being on campus.

23. The Gate-Keeper Training Program

The gate-keeper program attempts to reduce the incidence of suicide among medical students by creating a network of individuals who can identify at-risk individuals and connect them with professional help. It is suggested to select a diverse group of gatekeepers, including faculty members, medical students, administrative staff, senior residents, and health professionals within the college. Comprehensive training on the identification of suicide warning signs, communication skills, methods to approach at-risk students, and procedures for referring students to mental health services should be provided. It is important to conduct an initial intensive training session followed by periodic refresher courses. Training can be delivered through workshops, online modules, and scenario-based learning.

24. Increasing the Number of Postgraduate and Super-speciality Seats in India:

Much of the workplace stress comes from a lack of human and material resources. A mismatch between public expectation and health care delivery not only results in stress for providers but also exposes them to abuse and violence. A balance is required between the MBBS seats and post-graduation opportunities. A constant and regular review by the NMC, with blueprinting based on the nation's needs, disease epidemiology, and other inputs, is essential. This approach is crucial for developing specialties and courses to address the public healthcare needs of the country. Expanding opportunities for in-service candidates to pursue postgraduate education in medical fields such as DNB, MD, and MS can significantly enhance the healthcare system. Postgraduate programs should be initiated at various hospitals, including district hospitals, corporate hospitals, nursing homes, community health centers, and other similar facilities. Expanding the number of postgraduate medical seats in India is crucial for several reasons. It addresses the nation's healthcare needs by enhancing specialist care in rural areas, ensures specialized treatment for complex health conditions, and alleviates the workload of postgraduate students in medical colleges. Additionally, it helps mitigate corruption associated with demand and supply imbalances, supports planned research and innovation, and curtails the migration of students seeking medical education overseas. This expansion is vital for strengthening the overall healthcare infrastructure and capacity in India.

25. Employing an Adequate Number of Senior Residents

Medical colleges should evaluate the need for hiring more senior residents based on various critical factors, including workload, patient footfall, the number of operations, emergency cases, labor cases, and teaching responsibilities. For surgical branches, obstetrics and gynaecology, emergency, and other highly demanding departments, the Head of Department (HOD) should request the authorities or management to increase the number of senior residents. By assessing these elements, medical colleges can ensure they have an adequate number of senior residents to handle the demands of patient care effectively. This approach not only improves the quality of medical care provided to patients but also enhances the training and support for postgraduate students, particularly during duty hours and bedside training. Additional senior residents can offer more personalized guidance, reduce the burden on existing staff, and ensure that postgraduate students receive comprehensive, hands-on experience. This leads to better-prepared medical professionals and ultimately improves the overall healthcare system. Furthermore, having sufficient senior residents helps maintain a balanced workload, preventing burnout, and ensuring a sustainable and supportive learning environment.

26. Policy Adjustments Regarding Bonds

The policy requiring students to pay a bond if they vacate their medical college seats (both UG and PG) was implemented when medical seats and doctors were scarce. However, with the current availability of medical seats and doctors for hiring, it is high time to reconsider this policy. The financial pressure imposed by the seat-leaving bond creates a punitive environment that detracts from the overall educational experience. States continue to rely on this compulsory method to compensate for inadequate investment in health resources, playing with the lives of medical students, and public health safety at large. This approach should be avoided as a perpetual solution, as it places undue strain on public health and fails to address the root issue of resource allocation in the healthcare system. States must invest adequately in health infrastructure to sustainably meet public health needs without relying on compulsory service bonds. To alleviate the financial burden on students and foster a more nurturing educational setting, it is proposed to abolish both the seat leaving and compulsory rural service bond.

Removal of Seat Leaving Bond: Abolish the policy that requires students to pay a bond if they vacate their medical college seats (both UG/PG seats), thus alleviating financial pressure and fostering a more nurturing educational setting. Instead, consider implementing a rule prohibiting medical students who abandon their seats after admission from applying to medical colleges for twenty-four months from the date of leaving the medical college. This would serve as a deterrent without imposing financial hardships.

Additionally, medical colleges can fill the vacated seat (UG/PG) in the same category (Government/Management Seat) as the student belongs to in the next upcoming calendar year. This approach maintains fairness while addressing the issue of seat abandonment effectively. If seats are frequently abandoned in a particular institute or department, the NMC should conduct a review to assess the environment of that institution or department. This ensures that systemic issues are identified and addressed, maintaining the quality and attractiveness of medical education. The NMC can take appropriate measures to alleviate such situations

Removal of Compulsory Rural Service Bond: The compulsory rural service bond was initially established to address the shortage of doctors by mandating service in underserved areas. However, with the current adequacy of medical professionals and improved availability of healthcare resources, it is appropriate to reevaluate this policy. Transitioning from compulsory service to a system of positive incentives is recommended. Alternatives include higher pay for service in rural areas, granting grace marks, providing reservations in postgraduate or super-specialization seats for those who complete their rural service, offering adequate incentives, income tax rebates, and excellent facilities. This approach aims to create a more encouraging and supportive environment for fulfilling public health service requirements, moving away from the current compulsory methods that may not effectively motivate medical professionals.

Both the compulsory rural service bond and Seat leaving bonds should be reconsidered and removed at the earliest opportunity. Furthermore, any unethical practices, such as withholding documents or refusing to declare student results due to non-payment of bonds, are not supported by the NMC. Appropriate actions will be taken against entities engaging in such practices.

27. Trial Observership/Externships/Residency

A trial observership (for UGs) or residency (for PGs) period would provide medical aspirants with firsthand experience of the college, medical/speciality field, and department environment. This exposure enables them to make informed decisions about their choice of field, institution, and specialization. By experiencing the day-to-day workings of a medical program, students can gain a realistic understanding of the workload, responsibilities, and challenges they will face, helping them assess their readiness and commitment to the chosen field. This is an optional policy for the students but mandatory for the institutions to offer this program based on the available resources.

During the trial period, students can evaluate their compatibility with the faculty, peers, and overall institutional culture. The trial period may include clinical rotations, interactions with faculty and current residents, participation in academic activities, and exposure to the administrative aspects of the residency program. This comprehensive experience can lead to higher satisfaction and reduced attrition rates, as students are more likely to remain in a program where they feel comfortable and supported. Engaging in a trial residency allows students to familiarize themselves with the academic and clinical expectations of the program, enhancing their preparedness and confidence when they begin their formal residency.

The trial residency could be structured as a short-term program of not more than six weeks per specialty, without any pay for this period (trial residency) or without any pay of fees to the medical college (trial observership) but subject to availability. This duration is sufficient for students to gain meaningful insights about the UG/PG program and the chosen medical specialty.

28. Use of Technology in Training Medical Students

Integrating technology into medical student training involves the adoption of Virtual Reality (VR) and Augmented Reality (AR) simulations, as well as the application of Artificial Intelligence (AI) and Machine Learning (ML). Enhancing e-learning platforms with advanced learning management solutions and incorporating telemedicine modules are also crucial. Furthermore, expanding the use of online learning platforms and Massive Open Online Courses (MOOCs) provides flexible educational opportunities. These initiatives aim to modernize medical education by making it more interactive, personalized, uniform, and efficient, preparing students for future technological advancements in healthcare. These platforms enable medical students to access courses from leading institutions, offering them a wide range of expertise and perspectives. The National Medical Commission (NMC) should develop policies that support integrating these technologies into medical education, including investing in IT infrastructure, training educators for online teaching, and establishing partnerships with technology providers.

29. Library Facilities

Enhancing library facilities for medical students is crucial for supporting their academic and professional development. Consider digitizing the library and creating an online library system that students can access from their hostel rooms, providing easy, round-the-clock access to essential resources. This phased approach to digitization will ensure a smooth transition and continuous availability of up-to-date medical literature, journals, and research databases. Establishing reading rooms in hostels will create dedicated, quiet spaces for students to study

without needing to leave their accommodation. Additionally, extending the working hours of the physical library will accommodate those who prefer traditional study environments, ensuring that all students have ample opportunities to access the materials they need. By implementing these improvements, medical students will have enhanced support for their studies, promoting a more flexible, resource-rich learning environment.

30. Optional Courses

In alignment with the National Education Policy of India, various optional courses can be offered to interested students through in-person, online, or mixed methods. These courses can cover a wide range of subjects, including AI, coding, mechanical engineering, architecture, finance, administration, medico-legal studies, ethics, humanities, history, social media, photography, mass media, journalism, dance, arts, research, yoga, Ayurveda, and more. Such courses can be initiated in collaboration with various institutes, colleges, and other establishments. Importantly, these courses are optional, allowing students to explore diverse interests and enhance their multidisciplinary knowledge and skills.

By offering optional courses for developing acumen provides numerous benefits, including enhanced multidisciplinary knowledge, skill development, career flexibility, personal growth, innovation, interdisciplinary collaboration, lifelong learning, academic and professional networking, and alignment with national educational goals. These courses empower students to explore their interests, develop into holistic cognitive individuals, and thrive in a dynamic and interconnected world.

31. Invited Guest Faculty

All medical colleges are encouraged to invite part-time faculty from various fields, not necessarily doctors. These experts can include engineers, lawyers, policymakers, financial experts, data analysts, sports personalities, philanthropists, spiritual leaders, and more. Part-time faculty members, who are leaders in their respective fields, do not need to fulfil the NMC faculty requirements and will not be counted towards the NMC's student/faculty ratio for full-time teaching faculty. Their primary role will be to guide and handhold students and young faculty, providing valuable insights and expertise to enhance the educational experience and professional development within the institution.

This initiative allows students and young faculty to benefit from the insights and mentorship of established leaders, enhancing the quality of education and research. It broadens students' learning experiences with diverse perspectives and cutting-edge knowledge, while invited faculty focus solely on teaching and mentoring without administrative burdens. Offering an honorary for the expert's time makes this approach cost-effective. Invited guest faculty do not contribute to meeting the National Medical Commission (NMC) norms for student-to-faculty ratios. This program provides valuable networking opportunities, aiding career development and enriching the educational environment.

32. Clinical Linguistic Language Proficiency Policy

Many undergraduate and postgraduate medical students pursue their courses outside their home states and may not be well-versed in the local language of the state where their medical college

is located. This language barrier can pose significant challenges in learning from and interacting with the clinical population. To address this issue, a comprehensive clinical linguistic language proficiency policy will be adopted by all medical colleges. This policy will include instruction in the local language to ensure all UG and PG students achieve the linguistic proficiency necessary for effective clinical practice in OPD and IPD. These Clinical linguistic proficiency classes *will be held on holidays and optional*, but all students (students from other states who cannot speak the local language) will be encouraged to participate to maximize their clinical training and professional development.

These clinical linguistic proficiency classes enable healthcare providers to accurately gather patient information, understand patient histories, symptoms, and concerns, and deliver clear and comprehensible instructions regarding treatments, medications, and follow-up care. Additionally, it enhances patient comfort and trust by allowing providers to communicate in the patient's native language, fostering better engagement and adherence to medical advice. Clinical linguistic proficiency also facilitates improved collaboration with local healthcare staff and colleagues, ensuring efficient and effective clinical operations. Furthermore, it allows healthcare providers to appreciate and integrate cultural and social contexts into patient care, thereby improving the overall quality and relevance of medical services.

33. Supplementary Exams to be Reintroduced at the University Level

To alleviate stress among medical students, universities should introduce supplementary exams. The demanding nature of medical education often leads to heightened stress, anxiety, and mental health challenges. Offering supplementary exams provides students who may not perform well initially with a second chance, thus reducing the academic pressure and anxiety associated with one-time high-stakes testing. These exams encourage deeper learning and knowledge retention, essential for their future practices. Supplementary exams also offer a fairer assessment system, accommodating students who may face extenuating circumstances during the primary exams. Additionally, this approach signals that universities support their students' educational success and well-being, creating a more positive academic environment. Implementing regular supplementary exam periods, providing clear information about these opportunities, and offering additional academic support can further enhance student performance and retention. By integrating supplementary exams into the academic structure, universities can reduce student stress, improve academic outcomes, and support a healthier learning environment, thus promoting overall success in medical education.

34. Announcing Exam Results Using Roll Numbers only

Announcing exam results using roll numbers instead of names is a practice aimed at enhancing privacy and reducing stress among students. By using roll numbers, students' identities are protected, ensuring that their academic performance remains confidential. This prevents potential embarrassment or stigma for those who may not have performed as well as expected. Additionally, it reduces direct peer comparison, alleviating feelings of inadequacy or competition among students. Universities will make all attempts that the results should be published securely, either on notice boards or through digital platforms, using only roll numbers. Using roll numbers also minimizes the risk of bias or discrimination based on students' names, which might reveal their ethnicity, gender, or socio-economic background. This promotes a fair and unbiased academic environment.

35. Centre for Training of Medical Teachers (CTMT)

Establishing a Centre for Training of Medical Teachers (CTMT) at the national level is imperative to enhance medical faculty's capabilities in pedagogy, online teaching, and skill impartation. This program will encompass diverse teaching methods, technology integration, effective assessment, and communication skills. Ethical training covering professional ethics, research ethics, and cultural competence is essential for managing diverse student and patient populations.

The CTMT will centralize resources, offering standardized, high-quality training through workshops, certification courses, and seminars. It will foster collaboration among educators and facilitate research in medical education, elevating the nationwide standard. The focus will extend to online teaching methods, digital video creation, and Learning Management Systems (LMS), enhancing educators' digital instructional proficiency. Additionally, the phased establishment of regional centers nationwide will extend training of teachers in medical colleges. This initiative ensures continuous education and training accessibility, ultimately improving healthcare delivery nationally.

36. Addressing the 'Ghost Faculty' Problem

To tackle the "ghost faculty" issue in medical institutions, the government should implement a multi-faceted strategy that includes enhanced verification processes like biometric attendance linked to a centralized database, regular inspections and audits, and secure reporting mechanisms for transparency. Introduce stringent penalties for institutions found guilty of maintaining ghost faculty. These could range from financial penalties to restrictions on admissions or even loss of accreditation. At the same time, penalizing the 'ghost faculty' by imposing a loss of license to practice. Additionally, policy reforms and regulation support are essential to address underlying systemic issues, complemented by initiatives for capacity building that improve recruitment and retention of genuine faculty by offering better working conditions and professional development opportunities. These measures will ensure the integrity of medical education and uphold educational standards.

37. Career Counselling and Campus Recruitment

Career counselling for medical students should be expanded to include guidance from professionals in diverse sectors, broadening their career horizons. Corporate professionals can teach business skills in healthcare management, while pharmaceutical representatives can highlight opportunities in drug development, clinical trials, and marketing. Policy makers can offer insights into health policy and public health administration, and IAS/IPS officers can discuss roles in public health and safety. MBA leaders can provide knowledge on hospital management and entrepreneurship, and hospital administrators can explain various clinical and non-clinical roles. To facilitate the transition from education to employment, campus recruitment should be encouraged by the State health department and private sectors, highlighting job opportunities in public and private healthcare. Job fairs, workshops, and mentorship programs involving alumni can prepare students for the job market, helping them build networks and explore diverse career paths. This comprehensive approach ensures that medical students are well-prepared for various professional avenues, contributing to a dynamic healthcare workforce.

38. Establish Health Universities

To facilitate the implementation of the National Medical Commission (NMC) recommendations, the following steps are recommended to all States for transitioning from general universities to dedicated medical/health universities or establishing a dedicated department for medical colleges within general universities. This facilitates the implementation of the National Medical Commission (NMC) requirements, recommendations, guidelines, regulations, and other policies and addresses the challenge of universities struggling to keep up with the pace of medical college rules and regulation requirements, a strategic and comprehensive approach is essential. Universities must ensure strict adherence to the NMC Act, rules, and regulations by aligning their charters, policies, and administrative structures with NMC. Especially in the North Eastern States, a collaborative effort to amalgamate resources from several states to form a single, unified health university can be highly beneficial. This regional One Health University would streamline the implementation of medical education regulations, enhance resource sharing, and improve the overall quality of medical training and research in the region.

39. Establishment of the Centre For ICARED

Centre for **I**nnovation, **I**ncubation, **C**ollaboration, **A**ccelerator, **R**esearch, **E**ntrepreneurship, and **M**edical Device Development

In today's rapidly changing healthcare landscape, medical schools must stay abreast of technological advancements and ensure that students can apply their knowledge in practical settings. The proposed center for ICARED at the medical colleges will be a hub for turning new ideas into real-world health solutions and preparing students to be leaders in medical innovation. The healthcare industry is in constant flux, necessitating relentless innovation and the capacity for swift adaptation and learning. Despite these demands, there remains to be a noticeable delay in applying medical research to practical applications. By establishing a dedicated center like ICARED within medical colleges, one can cultivate an environment that encourages innovation and entrepreneurship among medical students and faculty. This center will play a pivotal role in transforming new ideas into effective solutions, thereby significantly contributing to medicine.

Objective of the ICARED

- 1) Cultivate Innovation: Develop a culture of innovation at the medical college to foster creativity and new ideas.
- 2) Enhance Practical Learning: Integrate entrepreneurship into the curriculum to improve the practical learning experiences of students.
- 3) Forge Partnerships: Establish relationships with industry leaders, healthcare providers, and research institutions to enhance learning and collaboration opportunities.
- 4) Create Collaborative Platforms: Provide a platform for students, staff, and faculty to work together on research projects with industry partners.
- 5) Encourage Entrepreneurial Mindsets: Foster entrepreneurial thinking among medical students to prepare them for innovative roles in healthcare.

6) Strengthen Research Collaboration: Facilitate comprehensive research partnerships with medical colleges, engineering colleges, startups, industries, corporates, and pharmaceutical companies.

7) Promote Medical Innovation: Support the creation and development of new medical devices and technologies.

8) Incubate and Accelerate Projects: Provide incubation and acceleration programs to nurture promising projects and help them reach market readiness.

9) Support Early-stage Innovations: Assist early-stage innovations in developing into viable products, providing necessary resources and support

Engaging Stakeholders: The initiative will involve both internal and external stakeholders to foster a comprehensive ecosystem for innovation. Internal stakeholders from the academic community will participate in mentoring and research, while external partners from the healthcare industry, investment sectors, and regulatory bodies will provide the necessary collaboration, funding, and guidance to ensure compliance and commercial viability.

Integration Into the Current Medical College Structure: The centre will be seamlessly integrated into the existing infrastructure of the medical college, with specifically allocated spaces for laboratories and office areas. There will be a curricular integration to provide students with credits for their involvement in the centre's activities, enriching their educational experience. Additionally, faculty members will play a significant role, serving in advisory capacities and actively participating in research and development projects.

Establishing the Centre for ICARED will position medical colleges at the forefront of medical innovation and entrepreneurship. It will provide invaluable resources and support for aspiring innovators and entrepreneurs, driving medical technology and education advancement. Implementing the ICARED program in medical colleges may involve signing a Memorandum of Understanding (MoU) between medical colleges and other disciplinary institutes such as Engineering Colleges, Management Colleges, Indian Institutes of Technology (IITs), Biotechnology Institutes, Law Colleges, Corporates, Pharmaceuticals, and other relevant industries to create a collaborative framework.

ICARED initiative will benefit students and faculty through comprehensive training programs, research opportunities, understanding market needs, and personality development initiatives. Further, it also will provide specialized training to enhance technical, legal, and research skills; fostering interdisciplinary research projects and promoting innovation; arranging internships and industry exposure for students and faculty; organizing workshops, seminars, and guest lectures focused on professional development and leadership.

This innovative concept should be implemented in a phased approach over a period of five to ten years, beginning with institutions of national importance. Following initial implementation and thorough evaluation, the program should be expanded to encompass all medical colleges and universities. If broad implementation proves challenging, establishing regional centers in collaboration with nearby medical colleges would be an effective alternative to ensure widespread access and resource-sharing.

40. Liaison with Local Organizations for Supporting Medical Students

To create a supportive environment for medical students, medical colleges should actively liaise with local branches of professional organizations and community groups such as the Indian Medical Association (IMA), National Medicos Organization (NMO), Local and State Level Psychiatry Associations, Rotary Clubs, Lions Clubs, and other non-governmental organizations (NGOs). The primary objective is to establish a robust support network for medical students, enhancing their academic, professional, and personal development.

Medical colleges can partner with these organizations to develop mentorship programs where experienced medical professionals guide and support students throughout their academic and career journeys. Workshops and seminars on various topics such as career development, stress management, leadership skills, and professional ethics can be organized in collaboration with the National Medicos Organization and the Indian Medical Association. Additionally, engaging students in community service projects and health camps organized by these organizations will provide practical experience and foster a sense of social responsibility. Networking events and forums can be facilitated, allowing students to interact with professionals from different fields and broaden their professional connections. This network not only aids in their academic and professional development but also ensures their overall well-being, preparing them to become competent and compassionate medical professionals.

41. Yoga in Promoting and Preventing Mental Illness and Developing Resilience for Medical Students and Medical Teachers

Yoga is increasingly recognized as an effective practice for promoting mental health, preventing mental illness, and developing resilience among medical students. Regular yoga practice reduces stress and anxiety, enhances mood through the production of endorphins, and improves mindfulness by helping students stay present and focused. Yoga also plays a crucial role in preventing mental illnesses by addressing early signs of mental distress and equipping students with healthy coping mechanisms to manage the pressures of medical education. Its holistic approach integrates physical, mental, and emotional health, promoting a balanced lifestyle that can prevent mental health issues from developing. Furthermore, yoga contributes to resilience by enhancing emotional regulation, physical strength, and mental toughness. It helps students respond to stressors calmly, promotes a healthy body that supports a healthy mind, and encourages introspection and self-awareness.

Medical colleges can integrate yoga into students' lives by organizing regular classes, workshops, and seminars, providing resources for self-practice, including yoga in the curriculum, and creating a supportive environment that emphasizes the importance of self-care. Yoga is a powerful tool for medical students to enhance their emotional well-being, develop resilience, and maintain a balanced and healthy lifestyle. Medical colleges can play a key role in facilitating this integration and ensuring students benefit from yoga practices. In this endeavor, the Departments of Psychiatry, Telemedicine Centre, and Integrative Medicine at the National Institute of Mental Health and Neurosciences (NIMHANS) have developed generic yoga and tele-yoga programs tailored for specific mental health conditions. Please see Appendix - 6 for more details.

42. Enhancing Physical Fitness and Sports Activities

To foster physical fitness, sports, teamwork, and overall well-being among students, it is recommended that the college organize and maintain a diverse range of sports activities. This initiative could be overseen by a sports committee comprising faculty, administrative staff, and student representatives, with support from a dedicated Sports Coordinator. It is essential to regularly maintain and update sports facilities and equipment to ensure safety and quality standards are met. An inclusive sports calendar should offer various activities, encouraging participation from all students and promoting fair play and teamwork. Additionally, dedicated time should be allotted for sports and physical activities within the academic schedule. Annual sports competitions and events should be organized to cultivate a competitive spirit and recognize outstanding performances. Establishing feedback mechanisms is crucial for continuously improving the sports program and ensuring it meets the evolving needs of the student body. This holistic approach will significantly contribute to the overall development and well-being of the students.

43. Sāmājika Sanskriti Campus Council

To mitigate social isolation and enhance the well-being of medical students, it is crucial to implement a policy supporting the establishment of diverse social groups within medical colleges. These groups could cater to various interests, including arts, cultural activities, and academic special interest groups, ensuring every student finds a community. The Sāmājika Sanskriti Campus Council could be headed by two senior faculty members (at least one female senior faculty) and include three representative medical students from all batches of the year. Local and professional organizations such as NMO, IMA, Lions club, Rotary club, and so forth can be involved in organizing these activities.

Dedicated resources and spaces may be allocated for these activities, with funds available for social, recreational, and leisure events such as wellness lectures, movie nights, one-day picnics, drama, singing, dancing, drawing, painting, poster-making, multimedia projects, karaoke, skits, and rangoli. Celebrations of festivals like Ganesh Chaturthi, Deepavali, Dussehra, Holi, Christmas, and so forth should also be organized by this council. These activities help reduce stress and build strong social networks, addressing common causes of suicidal ideation such as feelings of alienation and disconnection.

Additionally, the policy should include regular evaluations and feedback mechanisms to continuously improve social group initiatives. A quarterly newsletter featuring student contributions on various topics such as interests, sports, travels, books read, and movies watched can foster a sense of community and shared interest. By integrating social group participation into the educational framework and adapting to student needs, medical colleges can create a more inclusive and engaging environment that reduces isolation and enhances the overall educational experience.

11.1.2 SPECIFIC SUGGESTIONS FOR MEDICAL STUDENTS

The changing times and newer challenges that healthcare providers face today require that medical students learn to face these challenges and emerge as leaders after their training. This is only possible with adequate attention to mental wellbeing. A few suggestions to develop and maintain good mental health are as follows.

Effective Time Management: Much stress results from unfinished assignments and poor time management. It is suggested that students develop habits that are in keeping with the requirements of their curriculum. They should prioritize tasks, create schedules, and allocate time for study, self-care, and leisure activities.

Avoid Overloading: Many students have very high expectations of themselves and always wish to perform with perfection. Excessive competition can also result in undue stress. It is suggested that students should set realistic expectations and focus on learning rather than perfection.

Social Support: Students should be encouraged to connect with peers, family, and mentors. That way they get emotional support and learn to handle unfamiliar challenging situations. Students should seek guidance from experienced mentors and seniors. They can get coping ideas by discussing challenges and coping strategies with experienced mentors.

Self-awareness: Students should recognize situations that cause stress or anxiety. Identifying triggers allows them to develop effective coping mechanisms

Practice Mindfulness/Meditation: Practicing mindfulness or some form of meditation or prayer is a very effective way to improve emotional well-being. Many studies have shown that mindfulness is an effective stress reduction technique that can promote overall happiness. Inculcating such routines in daily routine can be very helpful.

Regular Exercise, Sports Activity or Yoga: Physical activity improves health, well-being, and improves mental attitude and leaves the student feeling positive. A regular exercise routine can be very useful in improving mental well-being also.

Healthy Sleep and Eating Habits: Students should prioritize restful sleep and a balanced nutrition. They should avoid excessive caffeine and irregular eating patterns.

Other Relaxing Activities: students should take time to prioritize self-care activities such as reading, listening to music, or spending time outdoors with friends.

Seeking Professional Help: Medical students should seek professional help to tide over difficult periods and also if they find it difficult to cope with the demands of the course.

Enhanced Civic Responsibility of Students Towards Infrastructure and Resources: It is essential to recognize that medical students, who will be responsible for the health and lives of many patients in the future, also need to develop a strong sense of civic responsibility and accountability towards the proper utilization of infrastructure and resources provided to them. They must take equal responsibility in maintaining the cleanliness of the premises and shared spaces, a practice successfully inculcated in developed countries. This sense of civic duty towards fellow students will aid in better integration with peers from diverse backgrounds and contribute to their development as more competent professionals and responsible citizens.

11.1.3 SPECIFIC SUGGESTIONS FOR FAMILIES

Families play a significant role in contributing to mental health of medical students. Knowing what medical students go through helps families provide empathetic support during their tenure.

Educating about the Stress: Parents need to be respectfully and sensitively educated on the pressure their child may feel from their expectations (academic achievement, choice of specialty, financial contribution, marriage and so forth etc). Some strategies that families can adopt to support the student include the following;

Communication: It is vital for families to maintain regular and open communication. While meeting parents of medical students', medical teachers should emphasize that family support is essential to help students cope with stress. Regular conversations with trusted family members can help them feel supported and valued.

Support system: Families should encourage the student to connect with peers and mentors. If possible, they can facilitate interactions and support introvert students to socialize. A supportive environment at home is crucial for the mental health of students.

Self-development: Families should encourage and support students to form good habits. These include a regular routine of exercise, prayer, yoga, meditation, good food habits, sleep, leisure activities among others. Families can also help the student plan and prioritize tasks to manage their workload.

Proactive collaboration: Collaboration between the families of medical students and medical teachers is vital for the holistic education and professional development of the students. Establishing a liaison allows for open communication regarding the student's progress, challenges, and goals. By working together, families and teachers can provide comprehensive support to the students, addressing both academic and personal needs. This partnership fosters a supportive learning environment that nurtures the students' growth and success in their medical careers.

Professional help: Families should keep an eye on adverse situations and symptoms that suggest poor coping and need for professional help.

Families Should be Aware of Signs of Distress. Some of these may Include:

Withdrawal: If a student withdraws from social interactions.

Behavioural changes: Drastic changes in mood, eating habits, or sleep patterns.

Difficulty in Academics: Difficulty coping with academics or academic decline.

Absenteeism: Unexplained absenteeism

Substance Use: Using alcohol or drugs to cope.

Warning thoughts: Any suggestion of self-harm or suicidal ideation.

11.1.4 SUGGESTION FOR FACULTY

Faculty members are in a unique position to positively impact students' mental health. By promoting a supportive and positive environment, they contribute significantly to students' overall well-being. Here are some strategies they can adopt:

Guide: Medical faculty should be approachable and accessible so that students know that they can seek guidance or discuss their concerns. Such an open-door policy helps students voice their concerns and relieve their stress.

Curriculum and Academics: A regular review and feedback system of academic curriculum can help faculty identify stressors. Faculty should also keep an oversight on duty distribution and workload on students under their supervision. They can help them design a curriculum and reduce unnecessary stress in student's schedule. When required academic feedback should be provided in a constructive manner. Offer feedback that highlights strengths and areas for improvement. Faculty need to set realistic expectations from students. Faculty should focus on learning and growth rather than unattainable theoretical standards.

Role Model: Faculty can model healthy coping behaviors for students to learn. Model resilience to challenges and share personal experiences of overcoming challenges with students.

Grant of Leave: Leave should not be unreasonably denied. Many students experience anxiety about not being granted leave even when they genuinely need it, which can lead to increased frustration and a sense of suffocation

Encourage Self-development in Students: Medical teachers should encourage and support students to form good habits. They can raise awareness about the importance of regular routine of sleep, healthy eating, exercise, prayer, meditation, leisure activities among others. They can volunteer for the gate-keeper program and also assist in regular organization of wellbeing promotion activities. Faculty are in the best position to teach students how to plan and prioritize tasks to manage their workload.

Empowering Medical Teachers: In India, medical college teachers often lack training in managing student stress and understanding psychiatric disorders. They must undergo training in counselling, recognizing mental illness, assessing suicide risk, and stress management. This training should include stress management techniques, counselling skills, mental health first aid, identifying mental illness and substance use, and assessing for suicidal risk. Equipping teachers with these skills is vital for early detection and intervention, ultimately promoting the mental well-being of medical students. The mechanisms of providing counselling Services in collaboration with the Department of Psychiatry services should be in place and used as required. Faculty should ensure tackle any stigma and normalize help-seeking in students in distress.

Teacher's Well-being: In today's world, medical teachers face immense pressure from juggling various roles such as teaching, training, clinical work, research, and administrative duties. Consequently, prioritizing their mental health and well-being becomes paramount. Regular training sessions aimed at stress management, self-care practices, mental health awareness, and incorporating yoga are crucial for ensuring their overall wellness. By investing in their well-being and acquiring the necessary skills, medical educators can effectively support their students and cultivate a healthier academic environment.

SECTION 11.2 - High-Risk Groups Identification and Referral

To enhance the well-being and academic success of medical students, it is imperative to implement a comprehensive policy for periodic faculty training focused on identifying students at risk. With the help of the Department of psychiatry, local protocols should be prepared and integrated into the gatekeeper program for all the stakeholders to be done so that proper identification of high-risk students is done. The section on highlight risk factors that predispose a medical student to mental illness and suicide is presented in figure-8.1.

This protocol should mandate regular workshops and training sessions for faculty members, equipping them with the skills to recognize and address early signs of distress among students. Informal methods for early detection of at-risk students should be implemented to avoid discrimination. The focus should be on indirect parameter monitoring. Faculty training should emphasize recognizing critical risk factors, including academic decline, frequent absenteeism, changes in behavior, financial struggles, coping with the sudden death of a family member, relationship issues, substance use, violence, deliberate self-harm attempts, and behavioral problems within the college, campus, or hostel environment. Training programs for faculty should be comprehensive, including role-playing scenarios to practice identifying and responding to distressed students, expert talks from mental health professionals on common issues and effective intervention strategies, and analysis of case studies to understand the complexities of student distress.

Teachers should be mindful that medical students experiencing difficulties in any of the following areas (**5A's**) should be kept under close observation:

1. Academic decline or difficulty
2. Addiction (Substance and non-substance)
3. Actions (Behavioural changes)
4. Absenteeism &
5. Asocialization (withdrawal from social activities)

The role of the Head of Department (HOD) is crucial in overseeing the implementation of this policy. The HOD should ensure that faculty members and also himself/herself attend training sessions, facilitate communication between faculty and support services, and monitor the effectiveness of the intervention strategies. Additionally, the HOD should provide guidance and support to faculty in handling sensitive situations involving student distress.

To maintain the privacy and confidentiality of students, it is critical to establish an effective and confidential reporting system. This system should enable faculty to discreetly refer students to relevant support services including referral to the psychiatry department, while ensuring that student privacy is maintained throughout the referral and support process.

Accommodative measures should also be considered to support at-risk students. This might involve offering flexible academic schedules, providing additional academic resources or tutoring, and allowing for temporary adjustments to attendance requirements. It is essential to create an environment where students feel comfortable seeking help and where their needs are met without fear of judgment or repercussions. To ensure the policy's effectiveness, it is important to continuously assess and improve the training programs and support services. This

can be achieved through feedback loops, where feedback is collected from faculty and students to refine the training sessions and support systems, and periodic reviews of the policy to reflect current best practices and emerging needs. Engaging stakeholders, including faculty, students, mental health professionals, and administrative staff, in the development and implementation process is crucial for the policy's success.

Initiating mentor-mentee programs with high-risk medical students can provide additional support and guidance, which may be crucial for their well-being and success. These programs can offer personalized attention, help navigate challenges, and provide a supportive environment to promote mental health and resilience. All faculty who volunteers for the mentor-mentee program should also be trained to identify the high-risk student.

11.2.1 Medical Students Dealing with Substance Abuse

Students dependent on substances shall be encouraged to seek help rather than face reprimand. The focus of this policy is on health and recovery, acknowledging that substance dependence is a health issue requiring professional intervention. Ensure that deaddiction services are readily accessible to students within the campus. Additionally, providing access to confidential support services, such as counselling and rehabilitation programs, can help students manage their substance use disorders effectively. Organize regular educational programs and workshops to raise awareness among the student body, faculty, and staff about substance use disorders, the importance of seeking help, and the support systems available.

The administration and treating team should encourage the involvement of family members in the treatment, where appropriate, to provide a network of support that is often critical in recovery. Provide resources and guidance to families on supporting their loved ones during recovery.

Medical students struggling with substance use may experience impaired judgment, decreased motor skills, and compromised decision-making abilities, which can jeopardize the quality of care they provide to patients in the medical college. If any concerns are raised regarding the fitness to clinical practice by supervisors or fellow students, Fitness to Practice Protocol: Medical Student with Mental Illness shall be followed as mentioned in the following section.

11.2.2 De-addiction Services

Medical colleges should establish outpatient (OP) and inpatient (IP) de-addiction clinics to provide comprehensive care and support for students dealing with addiction. The OP clinic, conveniently located on campus, should be equipped with consultation and counselling rooms, and staffed by a multidisciplinary team, including psychiatrists, counsellors, social workers, and nurses. It should offer services such as assessment, counselling, therapy, medication management, and educational workshops on addiction prevention. A robust referral system for internal and external resources should be in place, ensuring holistic care for students.

The IP clinic of 5 to 10 beds should be housed in a dedicated ward within the medical college hospital, offering comfortable accommodations and recreational facilities. These facilities may be housed separately from the psychiatry ward to avoid stigmatization. It should provide round-the-clock medical support, including detoxification, therapy, holistic treatments, educational programs, and family involvement in the treatment process. Structured follow-up care and reintegration support are essential components, helping students transition back to academic

and social life while preventing relapse. These clinics will enhance the educational environment, equip future healthcare professionals with practical addiction treatment skills, and create a supportive, stigma-free atmosphere for students to seek help, ultimately leading to better recovery outcomes and improved overall well-being.

11.2.3 Peer Support System

To establish a structured peer support system in medical colleges, leveraging the experience and insights of senior students to support juniors, we propose a comprehensive Peer Support Model. This model aims to improve mental health, provide academic and emotional support, and prevent suicide among medical students. The core of this model is a Peer Support System, where senior students with empathy and strong communication skills are selected and trained. These senior students receive training on mental health awareness and basic counselling skills. Junior students are paired with senior students based on shared interests, academic backgrounds, and personal preferences, facilitating regular meetings to discuss academic progress, personal challenges, and overall well-being.

Training and workshops are integral, covering mental health training, recognizing signs of distress, providing emotional support, and developing skills in active listening and stress management. Additionally, creating a supportive environment includes safe, non-judgmental spaces for juniors to share concerns and an anonymous reporting system to express issues without fear of stigma.

Professional support integration involves a clear referral system for senior students to connect juniors with professional counselling services when necessary. Collaboration between peer support and mental health services ensures comprehensive support. Regular mental health awareness campaigns, seminars, and activities will reduce stigma and promote seeking help, alongside specific suicide prevention workshops. Feedback and evaluation are essential. Regular feedback from both senior and junior students will assess effectiveness and inform adjustments. Periodic evaluations of the program's impact on well-being and academic performance will be conducted using surveys and mental health assessments.

Implementation begins with planning and design, forming a committee of faculty members headed by the dean, faculties of the department of psychiatry, head of the departments and student representatives to develop guidelines and protocol. A pilot phase will test feasibility with a small group, gathering data and feedback to refine the model. Full implementation across all departments and batches will follow, with continuous support and supervision from faculty and psychiatry department. Ensuring sustainability involves securing long-term funding and regularly updating training materials and protocols.

Expected outcomes include improved mental health and well-being of juniors, reduced stress-related issues and burnout, enhanced academic performance and personal development, and a lowered risk of suicide. This model aligns with the New Education Policy's emphasis on holistic education and well-being, providing a structured framework to foster a supportive and nurturing environment in medical colleges.

SECTION 11.3 - Persons with Mental Illness and Attempted Suicide

11.3.1 Supportive and Inclusive Environment

To Foster a Supportive and Inclusive Environment that Encourages Recovery and Well-Being among Students with Mental Illness.

This policy is committed to creating a supportive and inclusive environment that promotes the recovery and well-being of students experiencing mental health issues. Recognizing families' vital role, this policy facilitates access to treatment and family involvement in the treatment process in alignment with the Mental Healthcare Act 2017.

Provide Accessible Mental Health Services: Ensure mental health services are readily available and accessible on campus. Ensure every medical college has a fully functional Department of Psychiatry dedicated to providing quality psychiatric care to medical students and patients at associated hospitals. These services shall be free of cost to the medical students (UG/PG).

Mental Health Services: Every medical college must establish a Department of Psychiatry with sufficient psychiatrists, counsellors, nurses, and support personnel. Staffing levels should be based on the student body's size and the associated hospital's patient population to ensure adequate care availability. The Department of Psychiatry will offer a comprehensive range of psychiatric services, including but not limited to diagnosis, treatment, counselling, and ongoing management of mental health conditions. Particular emphasis will be placed on student mental health, including preventive services, awareness programs, workshops, crisis intervention, drug abuse prevention, counselling, and wellness programs.

Mental Health and Wellbeing Committee: At the national level, the Permanent Member of the National Medical Commission's (NMC) Ethics and Medical Registration Board (EMRB) will serve as the nodal person. At the medical college level, the Mental Health and Well-Being Committee will be structured as follows: the Dean will serve as the Chair, the Heads of the Department (HOD) of Medicine, Surgery, Obstetrics and Gynaecology (OBG) will be designated as the Co-Chairs (three co-chairs), and the HOD of Psychiatry will act as the Member Secretary. Additionally, the HODs of each department will be members of this committee to ensure the implementation of these recommendations.

Support Academic Success: Offer necessary academic accommodations and support structures to assist students with mental health challenges. There will be a straightforward process in which the Head of the Department (HOD) of Psychiatry or the senior faculty of the psychiatry department will evaluate the student's mental health progress and recommend their application for academic accommodations based on mental health conditions. These requests will be made in accordance with the rules & regulations established by the National Medical Commission (NMC) regulations.

Family Involvement in Treatment: Encourage and facilitate the involvement of family members in the treatment process. A crisis intervention strategy shall be in place to inform and involve immediate family members during mental health crises such as attempted suicide and mental health emergencies. Offer counselling sessions to guide family members on effectively and respectfully supporting their loved ones.

Confidentiality: Strict adherence to confidentiality and protecting the personal information of all individuals receiving care per the Mental Healthcare Act 2017. Disclosures of a student's mental health status to administration should only occur under specific conditions:

1. **Patient Safety:** If the student's mental health condition might compromise the safety of patient care within a clinical setting.
2. **Student Safety:** If the student's mental health directly threatens their safety or well-being.

In this regard, the HOD of Psychiatry is tasked with evaluating whether a student's mental health condition may compromise patient care in a clinical setting or pose a direct threat to the student's own safety. All disclosures must be justified based on a qualified mental health professional's clear, current, and documented assessment. Ensure that all actions taken under this policy comply with the Mental Healthcare Act 2017. Provide specific training for college administration who might receive mental health information about the student. Educate administration on the procedures and responsibilities involved in receiving and handling disclosures, emphasizing the importance of confidentiality as per the Mental Healthcare Act of 2017

11.3.2 Fitness to Practice Protocol: Medical Student with Mental Illness

This protocol aims to balance the rights and well-being of medical students with mental health issues against the imperative to maintain patient safety and quality care at the medical college. Hence, these guidelines help to balance the risk.

1. *Evaluation Committee Composition:* An evaluation panel will be formed when concerns about a student's fitness to practice arise. The committee will comprise the following members: the Dean (as Chair), a psychiatrist (within the institute), a faculty member from forensic medicine, the Head of the Department (HOD) of the concerned department, and a female faculty member.
2. *Family Involvement:* The involvement of a family member in the evaluation process is considered essential, as it can significantly support the student's welfare and recovery. They will provide care, follow-up, rehabilitation, and recovery.
3. *Sources of Information:* The evaluation will consider multiple sources, including self-reports, faculty observations, academic and clinical performance, and professional mental health assessments, ensuring a comprehensive understanding of the student's situation. If the treatment has occurred outside the medical college, all medical records and fitness to rejoin medical education certificate by the treating psychiatrist will be submitted by the student to the Evaluation Committee.
4. *Decision-Making Process:* Decisions regarding a student's fitness to practice will be reached by consensus within the panel, with a balanced focus on both the student's well-being and the safety of patients. Possible outcomes include no action, therapeutic interventions, adjustments to academic or clinical duties, or, if necessary, temporary suspension from patient-related activities. Students who require support will receive a personalized plan, including mental health therapy, modifications to academic and clinical responsibilities, and ongoing assessments to monitor progress. Adjustments will be made to ensure they are reasonable and do not significantly hinder the student's educational progress.

5. *Worst Case Scenario:* In instances where a student's illness is characterized by severe mental illness, frequent relapses, poor treatment adherence or potential for violence, with substantial concerns about patient safety, these issues must be documented. Based on this documentation, there may be a decision to temporarily or permanently suspend the student from engaging in patient-related clinical activities. Temporary suspension aims to safeguard patient and student safety while allowing students time to seek treatment and manage their condition. In cases where permanent suspension is deemed necessary, the student may complete their education and receive their degree, but they will not be eligible to practice medicine. This ensures ongoing safety while still allowing the student to achieve academic completion.
6. *Confidentiality:* All aspects of the fitness to practice evaluations will be handled with strict confidentiality. Disclosure of information will be limited to individuals directly involved in the evaluation or the implementation of accommodations.
7. *Appeal Process:* Students retain the right to appeal any decisions about their fitness to practice. The appeals process will be transparent and timely, conducted by an alternative panel consisting of different members, except for the assessing psychiatrist, to maintain continuity in understanding the student's medical background. This alternative panel will include the Dean, the HOD of Forensic Medicine, the three HODs from any clinical department, a senior female faculty member, an advocate, a social worker, and a faculty member from the SC/ST community.

11.3.3 Mandatory Reporting of Suicidal Attempt and Death by Suicide:

Mandatory reporting of suicide attempts (requiring hospitalization) and deaths by suicide involving medical students and faculty of medical colleges should be enforced through regulations by the National Medical Commission (NMC). This measure aims to ensure that such incidents, whether occurring within or outside the campus, are promptly reported to the NMC with detailed accounts of possible causes. Integrating mandatory reporting into NMC regulations will enable the collection of accurate data, facilitating the identification of patterns and risk factors associated with these tragic events. This data is crucial for developing targeted interventions and preventive strategies. The reporting requirements will also promote accountability and transparency, ensuring that institutions are held responsible for the well-being of their community members.

Report Submission on Attempted Suicide:

- The head of the institution should be accountable for accurate reporting. The medical college must submit a brief report within 2 weeks of any attempted suicide, whether it occurs within or outside the campus, to the NMC.

Report Submission on Death by Suicide:

- Within 2 weeks of a death by suicide, occurring within or outside the campus, the medical college is required to submit a brief report to the NMC.
- The NMC may conduct an official visit to the medical college within two weeks of receiving the report of death by suicide.
- A psychological autopsy will be conducted by the HOD of Psychiatry and HOD of Forensic Medicine or their designated representatives. The resulting report must be submitted to the NMC within a timeframe of 3 months.
- A national-level suicide registry for medical students and medical professionals should be initiated by the National Medical Commission (NMC) in a phased manner. This critical initiative aims to systematically collect and analyse data on suicides within these high-risk groups. The registry will serve as a comprehensive database, capturing demographic details, academic pressures, mental health histories, and other relevant factors contributing to suicides. A well-maintained suicide registry can save lives by providing the data needed to implement evidence-based prevention programs and support services tailored to the needs of medical students and professionals.

To facilitate implementation, the NMC may develop a regulatory framework outlining reporting procedures and timelines, establish a standardized reporting mechanism, and ensure the confidentiality and sensitivity of handled information.

The recommendations provided by the Task Force, if implemented in their true spirit, will extend beyond ensuring the successful completion of medical school and residency training for young doctors. The objective is to cultivate professionals who are morally and ethically grounded, emotionally intelligent, flexible, adaptable, and resilient. Additionally, it aims to promote cultural competence by valuing diversity and inclusion, fostering spiritual awareness and compassion, encouraging a willingness to embrace vulnerability, and dedicating efforts to character building that transcends medical education, ultimately contributing to the upliftment of society.

"A difficult medical student is simply a student in a difficult situation who needs assistance and care from the teacher. By adopting this perspective, we can approach them with a non-judgmental attitude, compassion, kindness, understanding, and empathy"

12. Summary and Concluding Remarks

The comprehensive recommendations aimed at improving the mental health and well-being of medical students in India. Key areas of focus include creating a supportive academic and work environment, involving family members in student induction programs, implementing strict anti-ragging measures, and conducting regular mental health awareness campaigns. It also emphasizes the importance of accessible counselling services, proper infrastructure, and amenities in medical colleges. Additionally, it highlights the need for a balanced workload, fair compensation, and support systems for students with mental health issues.

12.1 Conclusions

The well-being of medical students is paramount to ensuring they can effectively transition into compassionate and competent healthcare professionals. Addressing the mental health challenges faced by medical students requires a multi-faceted approach that involves proactive measures from medical college administrations, structured support systems, and active involvement of families. Implementing these recommendations will not only enhance the educational experience of medical students but also contribute to the overall improvement of the healthcare system by fostering a resilient and well-supported future workforce.

12.2 Way Forward

Medical education is the foundation of a country's healthcare system. The future of medical education requires a concerted effort to address the mental health and well-being of medical students.

- **Establish Centralized Reporting Systems:** Develop a robust, centralized system for reporting and monitoring suicides.
- **Implement Regular Training Programs:** Conduct regular training sessions for faculty to identify and support students at risk. Emphasize the importance of early detection and intervention for mental health issues.
- **Enhance Mental Health Services:** Expand mental health services, including 24/7 counselling support and easily accessible de-addiction clinics within medical colleges. Utilize telemedicine services like Tele-MANAS to provide widespread mental health support.
- **Promote a Supportive Environment:** Create an inclusive, respectful, and safe environment in medical colleges by implementing strict anti-ragging measures, providing proper infrastructure, and offering flexible academic schedules for students in distress.
- **Family Involvement:** Actively involve families in the support system of medical students, particularly during induction and crisis situations, to provide a strong emotional support network.
- **Regulate Work Hours and Fair Compensation:** Ensure fair distribution of duty hours and provide adequate compensation through uniform stipend policies based on AIIMS,

New Delhi pay scale. This will help reduce stress and financial burden on medical students. Hire an adequate number of Senior Residents to meet the demands of clinical work.

- **Policy Adjustments Regarding Bonds:** Abolishing seat leaving fees/bonds and a compulsory rural service bond is imperative. The government should offer positive incentives that can reduce financial pressure and encourage public health services.
- **Leverage Technology:** Integrate advanced technologies like Virtual Reality (VR), Augmented Reality (AR), and Artificial Intelligence (AI) into medical education to enhance learning experiences and prepare students for future healthcare challenges.
- **Foster Innovation and Career Development:** Establish centers like ICARED to promote innovation and entrepreneurship among medical students. Enhance career counselling and campus recruitment efforts to broaden students' career horizons.
- **Address Systemic Issues:** Increase postgraduate medical seats, employ adequate senior residents, and implement policies to address the 'ghost faculty' problem such as uniform pay scale, uniform retirement policy based on AIIMS, New Delhi, Rotational Headship and New Pension Scheme. Inviting honorary faculty from various fields enriches the educational experience at the medical college. This will improve the overall quality of education and healthcare services.
- **Continuous Evaluation and Improvement:** Regularly assess the implementation and effectiveness of these recommendations through feedback from students, faculty, and stakeholders. *At the national level* - The Permanent member of the NMC's EMRB will serve as the nodal person, and *at the medical college level* - the Dean will be designated as the nodal officer, and HOD of Psychiatry as a member secretary for implementing these recommendations at each medical college. Continuously refine strategies to meet emerging needs and best practices.

The core mission of every medical college is education. While providing healthcare services and conducting research are important, these activities should primarily serve the purpose of training and educating students, not filling gaps caused by a lack of resources in the public healthcare system. By addressing both systemic and risk factors, medical colleges can create a healthier, more supportive environment that promotes the well-being of their students and reduces the risk of suicide. These efforts should focus on enhancing the learning experience and fostering a healthier environment in medical colleges. By adopting the recommended comprehensive measures, medical colleges can create a healthier, more supportive environment for medical students, ultimately leading to better mental health outcomes and a stronger healthcare system in India.

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Annexure -1

Building Resilience After Tragedy

When a tragic event like suicide occurs within the confines of a medical college, the repercussions ripple far beyond the immediate circle of the individual involved. The aftermath demands a delicate and compassionate approach towards the emotional well-being of other students. This event can profoundly impact the emotional well-being of students, and may even cast a shadow over their studies and future careers. Recognizing this, the debriefing process becomes not just a reactionary measure, but a crucial intervention aimed at addressing the emotional fallout and equipping future doctors with the coping mechanisms they will undoubtedly need in their professional lives.

One of the key elements in managing such a situation is prompt response. Initiating debriefing sessions as soon as possible after a suicide can provide timely support to students, helping them process their emotions and begin the healing process. These sessions should be led by mental health professionals, such as psychiatrists, who are experienced in handling such delicate situations. Their guidance can ensure that the debriefing process is conducted with care and sensitivity. During these sessions, it is important to provide accurate information about the circumstances of the suicide, thereby dispelling rumours and fostering clarity amidst confusion. Acknowledging and validating students' feelings of shock, grief, confusion, and any other emotions they may be experiencing is essential. Creating a safe and comfortable environment where students feel free to express their thoughts and emotions is paramount.

Sl No	Building Resilience after the Tragedy: An Opportunity to Intervene
1	After the legal procedures is over, form a debriefing team (including psychiatrist, forensic HOD, dean, HOD and other administrators., who are well versed in grief and debriefing) and plan for a debriefing session with students.
2	Organize group debriefing sessions for affected individuals to express their thoughts and feelings, so that it helps them to process their emotions and begin the healing process
3	Provide accurate information about the circumstances of the suicide, thereby dispelling rumours and fostering clarity amidst confusion
4	Validate the emotions student's community such as denial, shock, anger, sadness, frustration and so forth
5	Provide information about available support services. Provide resources for coping with grief and loss like helpline and counselling services.
6	Offer individual grief counselling for those who are affected severely.
7	Plan gatekeeper training program (if not done) by developing peer support system. Review the current support system inside the campus
8	Normalize help seeking behaviour

Encouraging peer support can also be beneficial. Facilitating opportunities for students to share their experiences and provide support to each other can help create a sense of solidarity and community. It is also important to normalize help-seeking behavior, emphasizing the importance of seeking professional help if students are struggling to cope with their emotions. Providing information about available mental health resources on campus can be helpful in this regard.

Additionally, educating students on healthy coping strategies and self-care techniques can empower them to manage their emotions and stress levels effectively. Follow-up support should also be provided for students who may need additional help coping with the loss. Keeping an eye on the mental health of students in the weeks following the suicide and offering additional support as needed is crucial.

In conclusion, debriefing sessions following a suicide in a medical college should be conducted with great care and sensitivity. They not only provide support to students in their time of need but also serve as an opportunity to teach and inculcate coping mechanisms that will serve them well in their future careers as doctors.

Annexure-2

Legal Considerations of Suicide Attempts - Enhancing Support for Individuals in Crisis

Teachers at medical colleges confront a significant dilemma when a student reveals thoughts of self-harm, suicide attempts, or mental health problems. Medical faculty lack training in psychiatry, leading to uncertainty about how to address these situations. They may also experience their own anxiety and emotional challenges in dealing with these issues and determining the best way to support their students. While they are eager to assist, they are also aware of the limitations of their role and the potential legal implications if any untoward incident occurs.

Attempted suicide was considered a crime in India under Section 309 of the Indian Penal Code. However, this provision was decriminalized by the Mental Healthcare Act, 2017. The Sec 115 (1) of the Act say that “Notwithstanding anything contained in section 309 of the IPC any person who attempts to commit suicide shall be presumed, unless proved otherwise, to have severe stress and shall not be tried and punished under the said Code” This section clearly states that, they will not be prosecuted or punished under the IPC 309 Code, emphasizing a shift towards recognizing attempted suicide as a sign of distress rather than a criminal act.

The Sec 115 (2) of Mental Healthcare Act, 2017 further mentions that “the appropriate Government shall have a duty to provide care, treatment, and rehabilitation to a person, having severe stress and who attempted to commit suicide, to reduce the risk of recurrence of attempt to commit suicide.” So, it is the duty and responsibility of the concerned government to provide appropriate treatment for those who attempt suicide.

The ongoing discourse on the Bharatiya Nyaya Samhita Act, 2023 (BNS Act, 2023) reflects a broader understanding of suicide as a mental health issue rather than a criminal act. The offense of 'attempt to commit suicide' has been removed in the BNS Act, 2023. Efforts are being made to align legal frameworks with contemporary Mental Healthcare Act, 2017 perspectives, emphasizing support, treatment, and prevention over punishment.

However, the BNS Act, 2023, retains few sections and have introduced a new provision regarding abetment of suicide.

Retained sections are –

- a) Section 86 addresses the abetment of suicide by a husband driving his wife to commit suicide.
- b) Sections 107 and 108 cover general abetment of suicide.

New Section introduced is -

- a) Section 226 introduces penalties for attempting to commit suicide with the intent to compel or restrain any public servant from discharging their official duties.

As mentioned above, several critical points require consideration for providing care and registering medico-legal case. Hence, following shall be kept in mind:

a) Prioritizing emergency healthcare is paramount.

b) Involving family members in the treatment of attempted suicide is crucial.

c) Medico-Legal Case Registration – In instances of attempted suicide involving foul play, abetment, or medical instability, it is necessary to register a Medico-Legal Case. The table below can assist in determining when to register an MLC

Foul play (suspiciousness)	Capacity to consent	Medically Stable	MLC registration
Not Known	Present	Yes	Based on the person's report
Not Known	Present	No	Register MLC
Not Known	Absent	No	Register MLC
Present	Not applicable	Not applicable	Register MLC
In Case of any Doubt Register MLC			

Annexure -3

Common Myths of Attempted Suicide and Death by Suicide

	Myths	Facts
1	Asking someone directly about their suicidal thoughts may potentially trigger a suicidal attempt.	Inquiring about suicidal thoughts is beneficial as it offers individuals a valuable opportunity to share their feelings and provides a window of opportunity for intervention.
2	People who talk about suicide are often not severe and are unlikely to attempt it	People who discuss suicide are experiencing profound distress, so it is crucial to take them seriously.
3	Someone who has attempted suicide will never try again.	A previous suicide attempt is a recognized risk factor and will increase with each subsequent attempt.
4	If a person is serious about killing themselves, then there's nothing you can do	Suicidal ideation is often temporary; support and understanding can make a critical difference.
5	You have to be mentally ill or weak to think about suicide	Suicidal thoughts can arise due to life's challenges or stress
6	People who express suicidal thoughts are not severe and are only seeking attention.	Most individuals experiencing suicidal thoughts are seeking relief from their pain rather than a desire for death itself.
7	Asking about suicide is not advisable as it might plant the idea in someone's mind to attempt it.	Open discussions about suicide can provide relief and offer an opportunity for intervention.
8	It is not always easy to recognize when someone is feeling suicidal.	People may show signs of suicide risk, which can vary widely; being observant is crucial.
9	People who die by suicide are selfish or weak.	Suicide often stems from intense emotional pain, a sense of hopelessness, and a cry for help

Annexure-4

Five-Day Orientation Program on Mental Health Education and Training

Day 1: Introduction and Overview

- Introduction to Mental Health and Illness
- Common Mental Health Disorders
- Understanding Mental Distress: Causes and Symptoms
- Differentiating Normal Stress and Mental Distress
- Promoting Mental Wellness: Self-Care and Resilience
- Techniques for Maintaining Mental Wellness
- Workshop: Self-Care Techniques (Relaxation and Mindfulness)

Day 2: Stress Management and Coping Mechanisms

- Understanding Stress: Types and Impact
- Physiological and Psychological Impact of Stress
- Stress Management Techniques
- Time Management and Organizational Skills
- Cognitive-Behavioral Strategies
- Workshop: Practical Stress Management (Role-Playing Scenarios)
- Group Discussion: Sharing Stress Management Strategies

Day 3: Suicide Prevention and Gatekeeper Training

- Recognizing Suicide Risk: Warning Signs and Risk Factors
- Assessing Suicidal Ideation
- Intervention Strategies for Suicide Prevention
- Approaching and Communicating with At-Risk Individuals
- Safety Planning and Referral
- Gatekeeper Training: Role of Gatekeepers in Mental Health
- Active Listening and Empathetic Communication
- Workshop: Role-Playing Interventions

Day 4: Mental Health First Aid and Peer Support Systems

- Principles of Mental Health First Aid
- Assessing Risk
- Listening Non-Judgmentally
- Mental Health First Aid
- Steps to Provide Immediate Support
- Building Peer Support Networks
- Establishing and Maintaining Support Groups
- Training Peer Supporters
- Group Activity: Developing Peer Support Strategies

Day 5: Practical Applications and Wrap-Up

- Implementing Mental Health Programs
- Strategies for Integrating Mental Health Initiatives into Curricula
- Best Practices from Various Institutions
- Evaluation and Continuous Improvement
- Assessing the Effectiveness of Mental Health Programs

Feedback Mechanisms and Continuous Improvement
Workshop: Developing an Action Plan for Mental Health Initiatives
Closing Session: Reflections and Future Directions
Participant Reflections on the Program

This schedule ensures a comprehensive and balanced approach to mental health education, addressing key topics and practical applications each day to equip participants with essential knowledge and skills. However, the above curriculum can be modified as per the local requirements.

Annexure - 5

Indian Suicide Prevention Resources

Organization	Description	Contact Details
Tele Manas (National Helpline)	A national tele-mental health program providing psychological support across India. Help Available 24/7	Phone: 14416
Suicide Prevention India Foundation (SPIF)	Offers training programs, workshops, and social media outreach for suicide prevention.	Website: www.spif.in
I Call Helpline (Mumbai)	Provides emotional support and counselling, operational Monday to Saturday from 8 am to 10 pm.	Phone: 022-25521111
Roshni Helpline (Telangana)	Offers free and confidential support from 9 am to 11 pm, known for volunteer training.	Phone: 040-66202000
Sneha Suicide Prevention Helpline (Tamil Nadu)	Available nationwide, providing 24/7 emotional support and the option for anonymity.	Phone: 044-24640059

Global Suicide Prevention Resources

Resources	Description	Website
World Health Organization (WHO)	Promotes coordinated global efforts in suicide prevention, emphasizing the LIVE LIFE approach.	www.who.int
International Association for Suicide Prevention (IASP)	Facilitates international collaboration and evidence-based actions to reduce suicide incidents.	www.iasp.info
National Institute of Mental Health (NIMH)	Leads suicide research initiatives and provides resources aligned with the National Strategy for Suicide Prevention.	www.nimh.nih.gov
Samaritans	Focuses on the importance of language and communication in suicide prevention, providing resources for supportive conversations.	www.samaritans.org
The Lifeline Canada Foundation	Lists mental health centres and suicide prevention initiatives in Canada, emphasizing targeted support.	thelifelinecanada.ca
The National Suicide Prevention Conference (UK)	Brings together professionals and communities in the UK to share insights and strategies on suicide prevention.	nspconference.co.uk
CDC Guidance for Community Response to Suicide Clusters	Offers guidelines for addressing suicide clusters, emphasizing proactive preparation and community engagement.	www.cdc.gov

Annexure-6

Brief Yoga Modules for Mental Health & Well-being

The Departments of Psychiatry, Telemedicine Centre, and Integrative Medicine at the National Institute of Mental Health and Neurosciences (NIMHANS), Bangalore have developed evidence-based generic yoga and tele-yoga programs tailored for specific mental health conditions. Below are YouTube links for specific yoga practice modules. Please find the YouTube Links for Specific Yoga Practices for Medical Students.

- 1) Brief Yoga Intervention for Stress Management for daily practice: duration 30 minutes

Link: https://youtu.be/AnaG04oq4k8?si=J9_HSVCr_3QxVuEs

- 2) Yoga Intervention for Stress Management – Longer version for weekly practice: duration 50 minutes

Link: <https://youtu.be/ro3-znvPVYY?si=T5CEkSJ4WYFidb-6>

- 3) Brief Yoga intervention for overcoming low mood: duration 30 minutes

Link: https://youtu.be/lv0yLTcU4z0?si=I_TzKM_zz3DEQxF2&t=4

- 4) Brief Yoga intervention for managing anxiety and improving quality of sleep: duration 30 minutes

Link: https://youtu.be/PQApWqEM-4I?si=cpKGGKck5K-g_217O

- 5) Brief Yoga intervention for physical fitness: duration 30 minutes

Link: https://youtu.be/lmBhBEPQDYw?si=maekXo-746n6fU_2

Annexure-7

National Medical Commission, Prevention and Prohibition of Ragging in Medical Colleges and Institutions Regulations, 2021

The National Medical Commission (NMC) enacted the Prevention and Prohibition of Ragging in Medical Colleges and Institutions Regulations, 2021, to create a safe and conducive environment for medical students across India. These regulations are designed to eradicate the practice of ragging and ensure that medical institutions foster an atmosphere of respect, dignity, and mutual understanding among students.

The regulations mandate proactive measures for preventing ragging, including the establishment of anti-ragging committees and squads, conducting awareness programs, and promoting a culture of inclusivity and respect. Institutions are required to provide robust support systems, such as counselling services, a 24x7 helpline, and a dedicated anti-ragging cell to handle complaints and provide immediate assistance.

The regulations stipulate stringent disciplinary actions against those found guilty of ragging, including suspension, expulsion, and legal proceedings, while ensuring transparency and fairness in disciplinary processes. Medical institutions must submit regular compliance reports to the NMC, detailing measures taken to prevent ragging and outcomes of reported incidents. The NMC monitors these reports to ensure adherence to the regulations.

For more information visit this website:

<https://www.nmc.org.in/ActivitiWebClient/open/getDocument?path=/Documents/Public/Portal/NmcGazette/231281.pdf>

The UGC Anti-Ragging Cell

The Anti-Ragging Cell of the University Grants Commission (UGC) is a dedicated entity established to combat and prevent the menace of ragging in higher education institutions across India. This cell operates under the guidelines set by the UGC and the Supreme Court of India, aiming to create a safe and secure environment for students.

The UGC Anti-Ragging Cell, which provides assistance to victims of ragging.

- a) It operates a 24x7 toll-free helpline - **1800-180-5522**
- b) An online anti-ragging portal: **www.antiragging.in**

where students can confidentially report incidents of ragging. This information needs to be widely publicized in all medical colleges.

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National Tele Mental Health Program of India

“Supporting Healing Hands & Hearts”

Mental Health Support for Healers
Call Tele MANAS

TOLL FREE 14416



to know more about Tele MANAS



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

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

राष्ट्रीय आयुर्विज्ञान आयोग National Medical Commission

No. 47/10/2024-PGMEB-NMC-
Part(1)

Dated :

To
The Dean/Principal,
Medical Colleges/Institutions in India

**Subject: Implementation of Nasha Mukh Bharat Abhiyan in
Medical Colleges/Institutions**

Dear Sir/Madam,

Secretaries in the Department of Social Justice & Empowerment and the Department of Higher Education, Government of India in a joint DO Letter dated August 6, 2024 to Chairman, National Medical Commission has requested for implementation of Nasha Mukh Bharat Abhiyan (Drug-Free India Campaign) in the Medical Colleges. This initiative aims to combat the menace of substance abuse through mass awareness, counseling, treatment, and care in educational institutions, as well as the formation of a Nasha Mukh Hostel Committee in all colleges/institutions (copy enclosed).

2 . In this regard, the medical colleges/institutions are requested to undertake the following actions:

Part I: Formation of Nasha Mukh Hostel Committees

Part II: Formation of annual schedule of Activities under the Abhiyan

Part III: Awareness programme for students, faculty and other staff of the college

Part IV: Submission of Comprehensive Report/Action Taken Report to Department of Social Justice & Empowerment, Department of Higher Education and National Medical commission

3. The detailed guidelines regarding composition of the committee, the roles and responsibilities of its members, the list of activities under the Abhiyan, the structured approach for continuous support to students in hostels, and the requirements for the submission of comprehensive reports/action taken reports are provided in the enclosed DO Letter.

4. In light of the above, all Deans/Principals of medical colleges/institutions are requested to take proactive steps to implement the Nasha Mukta Bharat Abhiyan in their respective medical colleges/institutions and submit the action taken report to Sh Aujender singh , Memb secy, Anti Ragging cell

Yours sincerely,

Dr.(Prof) B.Srinivas
Secy NMC

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

पॉकेट -14, सेक्टर-8, द्वारका, फेस1-, नई
दिल्ली77-
Pocket- 14, Sector-
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Yours sincerely,

Signed by B Srinivas

Date: 14-08-2024 14:27:32

Dr.(Prof) B.Srinivas
Secy NMC

C. Sanjay Murthy
Secretary
Department of Higher
Education



Amit Yadav
Secretary
Department of Social
Justice and
Empowerment

D.O. No. DP/7/2023-DP-I

August 6, 2024

The Department of Social Justice & Empowerment (DoSJE) launched the **Nasha Mukh Bharat Abhiyaan (NMBA)** in August 2020 to combat the menace of substance use through mass awareness, counselling and providing treatment and care. Since its launch in the year 2020, the Abhiyaan has transformed into a Jan Aandolan through the participation of 11.22+ Crore citizens of the country including 3.55 + crore youth. Now, Nasha Mukh Bharat Abhiyaan is extended to all the districts of the country with special focus on the youth, Students and educational institutions.

2. The Hon'ble Home Minister and Minister of Cooperation chaired the 7th Apex Level Meeting of Narco-Coordination Centre (NCORD) on 18th July, 2024, in New Delhi, and reviewed the progress of Nasha Mukh Bharat Abhiyaan. While appreciating the efforts of all the stakeholders of the Abhiyaan including the states and UTs, Hon'ble Home Minister encouraged all to take up activities in mission mode for successful nationwide execution of the Abhiyaan. Hon'ble Home Minister also desired that Nasha Mukh Bharat Abhiyaan activities be carried out in the hostels of the educational institutions, to aid the young students in the fight against substance use, and to cope with factors like academic stress, peer influences etc., and promote the abilities in students to make good choices of life.

3. With this vision, it is requested of all the hostels in Central Universities, Indian Institutes of management (IIMs), Indian Institutes of Technology (IITs), All India Institute of Medical Sciences (AIIMS) medical colleges, engineering colleges, polytechnic colleges, Industrial Training Institutes (ITIs) and hostels of other Higher Educational Institutions to implement the following measures:

3.1. Formation of a Nasha Mukh hostel committee in all educational institutions. The composition, roles and responsibilities of this committee are attached in the Concept Note (Part I) attached as Annexure I.

3.2. Formation of an annual schedule of activities to ensure sensitisation and awareness of the student community, faculty and residents of the hostel. Training and sensitisation of all the counsellors, shall be done with the help of NIMHANS/ AIIMS, New Delhi and National Institute of Social Defence (NISD). A non exhaustive list of awareness activities is also attached in the Concept Note (Part II).

3.3. Universities should have a collaborative mechanism with the enforcement agencies to ensure that supply of narcotic drugs from neighbouring boundary areas/slums/hotspot etc., is curbed. Sensitization efforts in university campuses should be conducted with various stakeholders to ensure the student population remains in a safe and drug-free environment. This collaborative approach aims to create a vigilant community, effectively combating drug peddling and illegal trafficking.

3.4. Proper referral & networking systems may be evolved through the following helpline numbers:

- a. National Toll-free de-addiction helpline: 14446 - This helpline is to provide confidential psychosocial support and counselling by trained counsellors is supported by the Department of Social Justice and Empowerment (DoSJE).
- b. Tele Manas: 14416 - provide free tele-mental health services is supported by the Ministry of Health & Family Welfare
- c. MANAS (Madak Padarth Nisedh Asuchna Kendra): 1933 - Citizens of the country can anonymously share information on drug supply, peddlers and illegal drug trafficking. This helpline is supported by Ministry of Home Affairs (MHA) and Narcotics Control Bureau (NCB) where identity of callers is kept confidential.

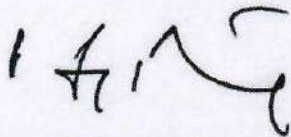
3.5. As you are aware, newly admitted students (hostel residents as well as day scholars) are at higher risk of substance use due to peer pressure, academic stress, lack of supervision and mental health issues among others. The absence of structured routines and easy access to substances also contribute to this risk. First-year students also face emotional challenges due to transitioning to independence, loneliness, and homesickness, which can further lead to substance use as a coping mechanism. Therefore, NMBA activities in hostels may put special focus on sensitising and training 1st year students and parents through a sustainable plan of action.

3.6. A structured approach has to be implemented to provide students with continuous support throughout their academic journey, ensuring they receive assistance as explained in the Concept Note (Part III).

4. An Action Taken Report (ATR) may be submitted by Vice Chancellors/dean/head of the institutes of the concerned higher educational institutions to Department of Social Justice and Empowerment (DoSJE) with a copy to Department of Higher Education (DoHE) as per proforma attached in the Concept Note (Part IV). The names and contact details of nodal officer of the Nasha Mukh Hostel Committee may be provided so that login access to NMBA mobile application may be provided by DoSJE for uploading the activities in upcoming academic years.

Your prompt action in this regard is much appreciated.

Yours sincerely,



K. Sanjay Murthy
Secretary
Department of Higher
Education



Amit Yadav
Secretary
Department of Social
Justice and Empowerment

Copy to:

1. The Chairman, University Grants Commission
2. The Chairman, All India Council for Technical Education
3. The Chairman, National Medical Commission
4. Directors of IITs (23) and Council of Indian Institute of Technology
5. Directors of IIMs (21)
6. Heads of Medical Colleges (Government and Private) (706) ✓
7. Heads of Universities (1016), Colleges (17453) and Stand Alone Institutions (SAls) (6203) ✓ (as mentioned in Annexure V)



ANNEXURE I:

CONCEPT NOTE FOR EXPANDING NASHA Mukht BHARAT ABHIYAAN IN HOSTELS OF HIGHER EDUCATIONAL INSTITUTIONS

NASHA Mukht BHARAT ABHIYAAN

The Department of Social Justice and Empowerment being the nodal agency for drug demand reduction launched its flagship mass awareness campaign 'Nasha Mukht Bharat Abhiyaan' (NMBA) on 15th August 2020 in the 272 identified districts. It has successfully evolved into a Jan Andolan covering all the districts of the country since 15 August 2023, and is now entering its fifth year. In the past four years, a wide range of activities under the banner of NMBA have been undertaken across the country with the participation of youth, children, educational institutions, women and the community. With the active participation of all the stakeholders, NMBA has been able to sensitize, educate & inform 11.22+ crore people including 3.55+ lakh youth, 2.35+ lakh women, 3.39+ lakh educational institutions and 9000+ master volunteers through 3.91 lakh activities conducted at various levels across the country. Recognising the exemplary efforts of the states and districts under NMBA, the Hon'ble Prime Minister also appreciated the abhiyaan activities in his Mann Ki Baat episode on 30 July 2023.

BACKGROUND

Young students in hostels are at an increased risk of substance use disorders due to several key factors including peer pressure, stress and academic pressure, lack of supervision, mental health issues, and experimental curiosity among others. The absence of structured routines and the ready availability of substances further elevates this risk. Additionally, the emotional challenges of transitioning to independence, loneliness and homesickness, can drive students to use substances as a coping mechanism. To address this issue, Nasha Mukht Bharat Abhiyaan aims to strategically sensitise and train hostel students, teachers, parents and other stakeholders through a sustainable plan of action.

PART I: COMPOSITION, ROLES AND RESPONSIBILITIES OF NMBA HOSTEL COMMITTEES

FORMATION OF NASHA MUKT HOSTEL COMMITTEES

The hostels of all the central universities/institutions and hostels of DoSJE, would be required to form Nasha Mukta Hostel committees in the hostels constituting member representatives from the university, student representatives, and hostel staff. More members may be added on a need and relevance basis.

COMPOSITION OF THE COMMITTEE

1. Nodal officer appointed by the university Vice-Chancellor (1)
2. Warden of the hostel (2)
3. Counsellor deployed in the higher educational institution (1).
4. Resident student representatives in the hostel (6)

ROLES AND RESPONSIBILITIES OF THE COMMITTEE MEMBERS

I. NODAL OFFICER

- a. Overseeing the workings of the hostel committee.
- b. Dealing with grievances presented by the parents, resident students and other beneficiaries.
- c. Planning the schedule of activities in the hostel. A non exhaustive list of activities is attached. (Part II)
- d. Ensuring regular updation of activities in NMBA mobile application
- e. Submission of quarterly ATR (proforma attached as Part IV) to the Department of Social Justice and Empowerment.

II. WARDEN

- a. Monitor hostel activities and behaviours of the residing students to identify any signs of substance use or risky behaviour.
- b. Report/deal with the grievances of the hostel residents with regards to the availability, consumption and distribution of narcotics in and around the educational institutions.
- c. Establish effective confidential referral systems in collaboration with campus health services/ counselling centres/helpline numbers to assist resident students with available treatment facilities and services in the district.

III. COUNSELOR

- a. Establish a mechanism for substance use related counselling service within hostels.
- b. Visiting the hostel two days a week to counsel students on priority basis on their struggle and vulnerabilities.
- c. Group counselling of 1st year hostellers every month.
- d. Awareness creation workshop on substance use disorders/consequence of substance use etc.

IV. STUDENT REPRESENTATIVES

- Establish peer support groups or networks within the hostel to provide a supportive environment.
- Serve as role models by demonstrating responsible behaviour and healthy choices, influencing peers positively.
- Participate in NMBA-related activities, such as discussions, workshops, and seminars, to deepen understanding and engagement in substance use prevention efforts.

PART II: LIST OF ACTIVITIES THAT CAN BE DONE UNDER THE ABHIYAAN (NON – EXHAUSTIVE)

S.N O	LIST OF ACTIVITIES THAT CAN BE DONE UNDER THE ABHIYAAN (NON – EXHAUSTIVE)
1	Training and awareness generation activities with children, adolescents, youth and master volunteers.
2	Sports and physical activities
3	Seminars, Webinars or Workshops for awareness generation
4	Nukkad Natak, Skits and Play
5	Flash mobs, drives and Rallies
6	NMBA pledge (including e-pledge) in educational institutions, hotspots and public places
7	Walkathons and marathons
8	Wall Paintings/Graffiti and art competitions
9	Slogan writing or jingle making
10	Video-making or short film making
11	Yoga and Meditation Activities
12	Documentaries/Film Screenings on substance use and discussions
13	Awareness generation through NMBA vehicles
14	Distribution of IEC Material available on the NMBA website
15	Organise Inter/Intra University Debate/Essay/Painting/Drawing Competitions (online/offline,any)
16	Identifying influential alumnis from the colleges to advertise the Abhiyaan.
17	Focus Group Discussions with various stakeholders in high risk areas (online and offline).

18	Social Media Campaigns
19	Celebration of international/national days of importance (for ex: celebrating World Aids Day and spreading awareness about AIDS and how Injecting drug users increase the chances of getting AIDS)
20	Formation of support groups and initiating counselling networks to address the issues related to substance use.
21	A sub-campaign to increase awareness about the ban of licit/ illicit substances near college areas with the help of police/competent authority

PART III: Structured approach for continuous support to students in hostels

Sr. No.	Stages	Activities
1.	Admission	• Anti-Drug Declaration • A seminar on awareness against substance use for the fresh batch as a part of their orientation
2.	During the Course (special focus on first year students)	• Formation of anti drug committee • Workshops and seminars at regular interval every month for 1st year hostellers • Group counselling of 1st year hostellers twice a month • Provision for individual counselling twice a week • Messenger/Representative from 1st year students of every course for smooth communication between the hostellers and authorities • Awareness activities (as attached in Annexure II) • Clubs aimed at drug free campus in the institute for both hostellers and day-scholars
3.	Final Semester	• Valedictory Session showcasing achievements and motivating students to lead a drug free life

PART IV: ACTION TAKEN REPORT PROFORMA

1.	Institution Details • Name of Institution: • Location: • Academic Year:
2.	Formation of Anti-Drug Hostel Committee

	● Whether Anti-Drug Hostel Committee has been formed: ● Name, Designation & contact of Nodal Officer: ● No. of Committee trainings held: ● No. of activities undertaken: ● No. of people reached out:
3.	Sensitization of neighbouring boundary areas: ● Whether the hostel has sensitised neighbouring boundary: ● Indicate the number of people reached out in community:
4.	Referral & Networking Systems: ● Whether proper referral & networking systems evolved: ● No. of resident students referred:
5.	Structured Support for 1st year Resident Students: ● No. of Students who signed Anti-Drug Declaration form: ● No. of workshops/training/Seminars conducted: ● No. of individual Counselling Sessions held: ● No. of group Counselling Sessions held: ● Total No. of residents reached out: ● Whether messenger/representative selected:
6	Structured Support for 1st year Day-scholar Students: ● No. of Students who signed Anti-Drug Declaration form: ● Whether any club has included drug-free campus as one of its agenda: (Specify the name of the club) ● No. of awareness activities conducted by the club: ● Total no. of people reached out:

Feedback:

Feedback from students:

Challenges Faced:

Recommendations for Improvement



CDN-20011/218/2024-Coord-NMC
Government of India
National Medical Commission
Policy and Coordination Division



Pocket- 14, Sector- 8,
 Dwarka, Phase-1, New Delhi-77
 Dated the 16-08-2024

PUBLIC NOTICE

Sub: Establishment of Tobacco Cessation Centers in All Medical Colleges.

In accordance with the Operational Guidelines launched on May 31, 2024, on World No Tobacco Day, the Ministry of Health and Family Welfare, in collaboration with the National Medical Commission, is initiating the establishment of Tobacco Cessation Centres (TCCs) in all medical colleges across India. These centres will be critical in advancing public health by assisting individuals in quitting tobacco use and thus reducing tobacco-related diseases.

2. As part of the Tobacco Free Youth Campaign 2.0, the National Medical Commission mandates that all medical colleges under its jurisdiction must establish a Tobacco Cessation Center. The centres should be operationalized as soon as possible, with comprehensive guidance provided via a scheduled webinar.

Key Points:

- i. A webinar will be held on **August 20, 2024**, from **02:00 PM to 03:30 PM** to orient all medical institutes regarding the setup and management of these centres.
 - ii. Participation in the webinar is **mandatory** for all medical institutes to ensure effective implementation of the TCCs.
 - iii. The Tobacco Cessation Centres are to be officially launched virtually by the Hon'ble Health Minister during the Tobacco Free Youth Campaign 2.0.
 - iv. All medical colleges must comply with the guidelines and ensure that their Tobacco Cessation Centres are fully operational in a timely manner.
3. Detailed programme of the webinar is enclosed. Link for the aforementioned webinar will be shared in due course.
4. This issues with the approval of competent authority.

DR B SRINIVAS
 SECRETARY
 srinivas.b@nic.in

Webinar with all medical institutes to orient them on setting up Tobacco Cessation Centres (TCC) at their institutes

The Ministry of Health and Family Welfare is organizing a webinar with all medical institutes to orient them on setting up Tobacco Cessation Centres (TCC) at their institutes. This initiative is in preparation for the launch by the Hon'ble Health and Family Welfare Minister during the Tobacco Free Youth Campaign 2.0.

The webinar is scheduled for **20 August 2024, from 02:00 PM to 03:30 PM.**

Webinar Link: https://echo.zoom.us/webinar/register/WN_LDhJqivMQC6bU4MXks0fOA



**No. NMC/PG/Legal/2023/(22827)
(8286827)
Government of India
National Medical Commission
(O/o Secretary)**

Sector-8, Dwarka
New Delhi-110075
Dated the August, 2024

To,

Directors/ Principals/ Deans & HoDs
All Medical Colleges/ Institutions under NMC

Subject: PGMEB's directions for compliance of NHRC's Order dtd 12-06-2024, 29-01-2024 and 03-08-2024 in Case No. 343/11/13/2023 –reg.

Madam/Sir,

I invite reference to the Post Graduate Medical Education Board's (PGMEB) letter dated 01-07-2024 (copy enclosed) to all medical institutions/ colleges directing them for compliance of NHRC's Order dated 12-06-2024, 29-01-2024 and 03-08-2024 in Case No. 343/11/13/2023, which is concerning the implementation of the provisions of the Sexual Harassment of Women at Work Place (Prevention, Prohibition and Redressal) Act, 2013 (PoSH Act, 2013) and the contents of the letter are self explanatory. All concerned medical colleges are requested to strictly adhere to the same.

Encl.: As above

Yours sincerely,

Signed by B Srinivas

Date: 22-08-2024 07:20:10

(B. Srinivas)
Secretary

Copy to:

- i. ACS/ PS/ Secretaries/ Department/s of Medical Education in all States/ Union Territories
- ii. PPS to Chairman, NMC
- iii. PPS to President(PGMEB)
- iv. DMMP-I System Integrator- for uploading of NMC Website
- v. Guard File

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

File No. NMC/PG/Legal/2023/(22827) / 026368

Date- 01.07.2024

To,
All Dean & HoD
All Health Institutions/Medical Colleges under NMC

Sub: Compliance of NHRC's Order dt 12.06.2024, 29.01.2024 and 03.08.2023 in Case No. 343/11/13/2023-reg.

Madam/Sir,

National Medical Commission (NMC) vide letter No. CDN-20011/28/2023/Coord-NMC dt. 28.06.2023, has communicated to all Health Institutions/Medical Colleges to comply with directions of the Hon'ble Supreme Court of India vide Judgment dt 12.05.2023 passed in Civil Appeal No. 2482/2014 filed by Shri Aureliano Fernandes Vs. State of Goa & Ors. All the Medical Institutions/Organization have to implement the provision of Sexual harassment of Women at work Place (Prevention, Prohibition and Redressal) Act, 2013 (PoSH Act, 2013) and to constitute the Internal Complaint Committees (ICCs), Local Committees (LCs), Internal Committees (ICs) at appropriate level and same should be displayed on the website of the Organization.

2. However, the NHRC in its order dated 12.06.2024 in the Case No. 343/11/13/2023, has observed that the websites of the Medical Colleges do not display information about the composition of the ICC/LCs/ICs, the details of the email IDs, the contact numbers of the designated persons, nor the procedure prescribed for submitting an online complaint. This omission is contrary to the directives contained in paragraphs 77 (i) & (ii) of the judgment dated 12.05.2023 (attached herewith) passed by the Supreme Court of India in Civil Appeal No. 2482/2014 filed by Shri Aureliano Fernandes vs. State of Goa & Ors. The relevant directives are as follows:

"(i) The Union of India, all State Governments and Union Territories are directed to undertake a timebound exercise to verify as to whether all the concerned Ministries, Departments,

राष्ट्रीय आयुर्विज्ञान आयोग National Medical Commission

स्नातकोत्तर चिकित्सा शिक्षा बोर्ड

Post Graduate Medical Education Board (PGMEB)

Government organizations, authorities, Public Sector Undertakings, institutions, bodies, etc. have constituted ICCs/LCs/ICs, as the case may be and that the composition of the said Committees are strictly in terms of the provisions of the PoSH Act.

(ii) It shall be ensured that necessary information regarding the constitution and composition of the ICCs/LCs/ICs, details of the e-mail IDs and contact numbers of the designated person(s), the procedure prescribed for submitting an online complaint, as also the relevant rules, regulations and internal policies are made readily available on the website of the concerned Authority/Functionary/ Organisation/Institution/Body, as the case may be. The information furnished shall also be updated from time to time.

3. All health institutions and medical colleges are once again directed to adhere to the directions provided by the Hon'ble Supreme Court of India, failing which punitive action as per the regulations may be taken by the NMC.

4. This issues with the approval of the competent authority.

Encl.: As Above

Yours faithfully,



(Aujender Singh)
Director, PGMEB.

National Medical Commission

Copy to,

The Assistant Registrar (Law), National Human Rights Commission, Manav Adhikar Bhavan,
Block-C, GPO Complex, INA, New Delhi – 110023.

Email Id:-cr.nhrc@nic.in

**IN THE SUPREME COURT OF INDIA
CIVIL APPELLATE JURISDICTION**

CIVIL APPEAL NO. 2482 of 2014

AURELIANO FERNANDES		APPELLANT
Versus		
STATE OF GOA AND OTHERS		RESPONDENTS

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JUDGEMENT

HIMA KOHLI, J.

A. SCOPE OF THE APPEAL

1. A challenge has been laid by the appellant to the judgment dated 15th March, 2012, passed by the High Court of Judicature at Bombay Bench, at Goa, dismissing a writ petition¹ preferred by him against an order² passed by the Executive Council³ of Goa University (Disciplinary Authority) accepting the Report⁴ of the Standing Committee for Prevention of Sexual Harassment at Work Place⁵ and imposing upon him, a major penalty of dismissal from services and disqualification from the future employment under Rule 11(X) of the Central Civil Services (Classification, Control and Appeal) Rules, 1965⁶ which was duly upheld by the Governor and the Chancellor of Goa University, being the Appellate Authority⁷.

B. SEQUENCE OF EVENTS

(a) PROCEEDINGS BEFORE THE FIRST COMMITTEE:

2. The factual matrix of the case needs to be placed in a chronological sequence. The appellant commenced his career in the respondent no. 2 – Goa University as a Temporary Lecturer in the Department of Political Science, in the year 1996. He was

¹ W.P. No. 602 of 2011

² Dated 10th May, 2010

³ For short 'EC'

⁴ Dated 05th June, 2009

⁵ For short 'The Committee'

⁶ For short the CCS (CCA) Rules

⁷ Vide Order dated 19th April, 2011

appointed as the Head of the said Department, in the year 2003. It is the appellant's version, which is strongly refuted by the other side, that aggrieved by the passing of a resolution by the Departmental Council of the Department of Political Science against them, two girl students along with their friends submitted a complaint to the respondent no.2 – University, alleging physical harassment at his hands. The said complaints⁸ were the starting point of an inquiry initiated by the Committee on receiving complaints by the Registrar of the respondent no. 2 – University⁹. The Committee served a notice¹⁰ on the appellant calling upon him to explain the charges levelled against him in nine complaints and to appear before it for a personal hearing on 24th April, 2009, a date that was subsequently changed to 27nd April, 2009. Contemporaneously, the Registrar of the respondent no. 2 – University directed the appellant to hand over charge and proceed on leave till the conclusion of the inquiry.

3. The appellant furnished a detailed reply to the Committee, running into fifty-three pages wherein he raised some preliminary objections to the inquiry being conducted by the Committee, alleged a well-organized conspiracy against him by some wayward students in connivance with the members of the faculty and refuted the contents of fourteen depositions of girl students forwarded to him by the Committee. He concluded by stating that the charges of sexual harassment levelled against him were completely false and baseless. The appellant also addressed a letter to the Registrar seeking

⁸ Complaint dated 11.03.2009 & 17.03.2009

⁹ Under cover of letter dated 08.04.2009

¹⁰ Dated 17th April, 2009

removal of two Members of the Committee on the ground of bias and on a plea that being his subordinates, they were prone to bias.

4. The Committee called the appellant for a hearing on 27th April, 2009. It was alleged by the appellant that the deposition of all the complainants including the witness named by him were recorded while he was made to wait outside the Committee room. He was called later on and the Committee recorded his statement. Even on the next hearing, on 28th April, 2009, a similar procedure was adopted by the Committee. On 30th April, 2009, the appellant received a notice from the Committee enclosing therewith another complaint of sexual harassment received against him to which he was directed to respond and present himself on 6th May, 2009. *Vide* letter 2nd May 2009, the appellant sought more time to submit a reply to the additional complaint and permission to engage an Advocate to appear for him before the Committee.

5. The appellant submitted his reply to the notice on 8th May, 2009. On 6th May, 2009, the request of the appellant to engage a lawyer was declined by the Committee. On the same day, a corrigendum was issued by the Committee to the earlier letter¹¹ informing him that the next date fixed for filing his reply should be read as "12th May, 2009" instead of "12th June, 2009" and the date for further deposition should be read as "14th May, 2009" instead of "12th June, 2009".

¹¹ Dated 5th May, 2009

6. Vide letter dated 8th May, 2009, the appellant objected to the inquiry being conducted by the Committee on a complaint¹² received from an ex-student of the respondent no. 2 – University on the ground that she was neither a student nor an employee of the University. Additionally, he asked for a copy of the said complaint, besides the statement of deposition that had already been furnished to him.

7. On 12th May, 2009, the appellant forwarded an affidavit of a witness to refute some of the allegations levelled against him by the complainants. Vide letter of even date, the Committee forwarded an additional deposition of a member of the Faculty, Dr. Rahul Tripathi, who had stepped down from the Committee constituted to look into the complaints against the appellant and deposed as a witness.

8. The appellant wrote a letter dated 13th May, 2009 to the Committee seeking some time to appear before it on a plea that he was admitted in the hospital with a severe back-ache. Vide notice dated 14th May, 2009, the Committee directed the appellant to appear before it on 19th May, 2009 for recording his deposition and for submitting his written reply to the fresh deposition of the other complainant. Further extension of time, as requested, was however declined by the Committee.

9. In the meantime, vide letter dated 13th May, 2009, the appellant applied to the respondent no.2 – University seeking voluntary retirement on health grounds. However, the said application was withdrawn by him on 18th May, 2009. On the same date, an advocate engaged by the appellant's brother issued a notice to the respondents no.2 and

¹² Signed on 27th April, 2009

3 seeking extension of time by one month for the appellant to appear before the Committee.

10. In its letter dated 20th May, 2009, the Committee noted that though the appellant had failed to appear before it on 19th May, 2009 for recording his further deposition, he was being granted one last opportunity to present himself on 23rd May, 2009, for completing his deposition and for cross-examining the witness including the complainants. Alongside, six more depositions were forwarded to the appellant, seeking his reply by 22nd May, 2009.

11. The appellant addressed yet another letter¹³ to the Committee expressing his inability to attend the proceedings on 23rd May, 2009, on health grounds and requested for postponement of the proceeding by 3-4 weeks. However, his request was turned down by the Committee on the very same day and the appellant was directed to remain present on 23rd May, 2009, failing which, he was informed that the Committee would proceed further with the inquiry. A second request¹⁴ made by the appellant for seeking postponement of the proceedings of the Committee, met the same fate.

12. After about ten days, the appellant sent a letter¹⁵ to the Chairperson of the Committee stating *inter alia* that he had partially recovered from his ailment and was in a position to depose. He sought fresh dates to enable him to furnish a reply to the additional depositions received by him. However, by then the Committee had proceeded

¹³ Dated 22nd May, 2009

¹⁴ Dated 23rd May, 2009

¹⁵ Dated 4th June, 2009

ex-parte against the appellant and submitted its Report¹⁶ to the Registrar of the respondent no. 2 – University stating that 18 meetings had taken place in connection with the inquiry that had established sexual harassment of the complaints by the appellant which act amounted to a grave misconduct and was in gross violation of Rule 3(1)(III) of the CCS Conduct Rules and consequently, recommended termination of his services.

(b) PROCEEDINGS BEFORE THE EXECUTIVE COUNCIL

13. The EC held a meeting on 13th June, 2009 wherein the Report submitted by the Committee was accepted and the appellant was placed under suspension with immediate effect. *Vide* Memorandum dated 8th September, 2009, the Chairman of the EC informed the appellant that the EC proposed to conduct an inquiry against him under Rule 14 of the CCS (CCA) Rules. Enclosed with the said Memorandum, was the statement of the Articles of Charge, statement of the imputation of the misconduct in support of each Article of Charge, list of documents and a list of witnesses for sustaining the said charges. The appellant was given ten days' time to submit a written statement of his defence and state whether he desired to be heard in person.

14. The appellant submitted a detailed reply to the aforesaid Memorandum, running into twenty pages and also demanded several documents and information relating to the complaints of sexual harassment made against him, on the plea that they were relevant

¹⁶ Dated 5th June, 2009

for submitting his written statement which was turned down by the Vice Chancellor of the respondent no. 2 – University¹⁷ and he was granted twenty days to respond.

15. On 15th October, 2009 the EC appointed a former Judge of the Bombay High Court to conduct an inquiry into the charges framed against the appellant and he was informed that the Inquiry Officer will hold a preliminary inquiry into the charges framed against him on 9th November, 2009. The first sitting of the Inquiry Committee conducted on 9th November, 2009, was duly attended by the appellant and his Advocate. The second meeting was scheduled on 7th December, 2009 on which date when the Presenting Officer appearing on behalf of the respondent no. 2 – University referred to the judgment dated 26th March, 2004, passed by this Court in the case of **Medha Kotwal Lele and Others v. Union of India and Others**¹⁸ and the amendment¹⁹ to the *proviso* to Rule 14(2) of the CCS (CCA) Rules that provides that where there is a complaint of sexual harassment within the meaning of Rule 3C of the Central Civil Services (Conduct) Rules, 1964²⁰, the Complaints Committee shall be deemed to be the inquiring authority for the purpose of imposing major penalties, the Inquiry Officer decided to keep the inquiry in abeyance, so as to ascertain as to whether any further directions had been issued by the Supreme Court in **Medha Kotwal's** case (*supra*).

16. On 15th December, 2009, the Registrar of the respondent no. 2 - University informed the appellant that the disciplinary proceedings initiated against him on the

¹⁷ vide letter 17th September, 2009

¹⁸ (2013) 1 SCC 297

¹⁹ Dated 1st July, 2004

²⁰ CCS (Conduct) Rules

recommendations made by the EC in its meeting held on 12th December, 2009, stood terminated and the order appointing the Inquiry Officer had also been withdrawn in the light of the order dated 26th April, 2004, passed by the this Court in Medha Kotwal's case holding that the report of the Complaints Committee for Prevention of Sexual Harassment of Women at Workplace shall be deemed to be an Inquiry Report under the CCS (CCA) Rules which shall be binding on the disciplinary authority for initiating disciplinary action against the government servant. Describing the decision taken by the EC on 14th June, 2009 of appointing an Inquiry Officer to inquire into the charges framed against the appellant as inadvertent, the Registrar informed the appellant that the disciplinary authority will decide the further course of action against him under the extant rules.

C. DECISION OF THE DISCIPLINARY AUTHORITY AND THE APPELLATE AUTHORITY

17. This was followed by issuance of a Memorandum²¹ by the Vice-Chancellor of the respondent no. 2 – University on behalf of the EC informing the appellant that in its meeting conducted on 28th January, 2010, the EC had accepted the report of the Committee and decided that he was unfit to be retained in service in view of the gravity of the charges levelled against him. Proposing to impose a major penalty of dismissal

²¹ Dated 17th February, 2010

thereby disqualifying him from future employment as contemplated under the Rules²², the appellant was granted two weeks to submit his representation.

18. The appellant submitted his reply on 13th March, 2010. After examining his reply, the disciplinary authority dismissed the appellant from service *vide* order dated 10th May, 2010. The appeal²³ preferred by the appellant against the said dismissal order was rejected by the order²⁴ of the Appellate Authority²⁵.

D. DECISION OF THE HIGH COURT

19. The said orders were challenged before the Bombay High Court. The High Court observed that the Committee had granted ample opportunities to the appellant to cross-examine the complainants and the witnesses, but he had deliberately elected not to appear before it. In such circumstances, the Committee could not be blamed for proceeding *ex-parte* against him and submitting its Report. It was also held that the Committee was justified in discarding the medical certificates submitted by the appellant as he kept on making flimsy excuses to stay away from the enquiry proceedings. The plea of the appellant that the Committee was improperly constituted or its composition was questionable as it comprised of persons who were junior to him in the Department, was rejected as meritless. Further, the contention that the enquiry had been conducted with undue haste, without giving a

²² Rule 11 (IX) CCS CCA, 1965

²³ Appeal dated 25th June, 2010

²⁴ Dated 19th April, 2010

²⁵ Governor of Goa and Chancellor of Goa University

fair and reasonable opportunity to the appellant to defend himself, was also turned down. As a result, the High Court did not see any merits in the said writ petition which was dismissed holding that there was no breach of the principles of natural justice and the Service Rules in the case.

E. ARGUMENTS ADVANCED BY COUNSEL FOR THE PARTIES :

(a) COUNSEL FOR THE APPELLANT

20. Arguing on behalf of the appellant, Mr. Bishwajeet Bhattacharya, learned Senior counsel has assailed the impugned judgment on several counts. The main thrust of his arguments is that the dismissal order²⁶ passed by the Disciplinary Authority and upheld by the Appellate Authority is based solely on the Report submitted by the Committee which was nothing more than a fact-finding proceeding that had commenced on 17th March, 2009 and concluded on 5th June, 2009; that though the inquiry had purportedly commenced on 17th March, 2009, the first hearing had actually taken place only on 27th April, 2009 and the entire proceedings were hurriedly closed within a span of thirty-nine days, by relying on forty-eight documents and forty-three depositions in the course of eighteen meetings without affording the appellant adequate opportunity to defend himself and present his case. It was argued that though the Committee had acceded to the request of the appellant for extension of time²⁷ and had granted him time till 12th June, 2009, the period was abruptly curtailed by almost one month and the date was advanced to 14th May, 2009, without any justification and unmindful of the appellant's indisposition,

²⁶ Order dated 10th May, 2010

²⁷ Vide Letter dated 5th May, 2009

as was conveyed. Only when the appellant wrote to the Committee seeking a new date for his further deposition and for conducting further proceedings, did he come to know that the Committee had concluded its proceeding and submitted its Report on 5th June, 2009 itself. It is thus contended that the principles of natural justice have been grossly violated by the respondents and the appellant has been deprived of a reasonable opportunity of a fair trial, before passing the order of dismissal from service thereby causing him serious prejudice.

21. Citing the decision of this Court in Union of India and Another v. Tulsiram Patel²⁸, learned Senior counsel argued that none of the three clauses to the second proviso to Article 311(2) of the Constitution of India that mandates that no person employed by the Union or the State shall be dismissed or removed from the service except after an inquiry, could have been resorted to by the respondents for having elected not to conduct a proper inquiry before proceeding to dismiss the appellant. It was vehemently contended that contrary to the procedure prescribed under the CCS (CCA) Rules, no proper inquiry was conducted by the respondents and no charges were framed by the first Committee till the date it had submitted its Report²⁹ and that the Articles of Charge that were framed by the respondents vide Memorandum dated 8th September, 2009, were subsequently dropped and the inquiry ordered was abandoned in favour of the Report submitted by the first Committee which was only a fact finding report that could not have been relied on as a final inquiry, particularly when it entailed serious

²⁸ (1985) 3 SCC 398

²⁹ Vide letter dated 5th June, 2009

consequences. Learned Senior counsel cited a decision of a learned Single Judge of the Delhi High Court in Sandeep Khurana v. Delhi Transco Ltd. And Others³⁰ and of a Single Judge of the Karnataka High Court in Professor Giridhar Madras v. Indian Institute of Science represented by Chairman and Others³¹ to urge that the Report of the Committee could not be equated with the report of an Inquiry officer, as contemplated in the procedure prescribed in Rule 14 of the CCS (CCA) Rules. This non-adherence to the procedure prescribed has caused grave injustice to the appellant, it being a serious infraction of the principles of natural justice. Allegations of bias were also levelled by the appellant against some members of the first Committee.

22. Learned counsel further argued that none of the three clauses appended to the second proviso of Article 311(2) of the Constitution of India have been pressed against the appellant to justify the impracticability of holding a proper inquiry and that failure on the part of the Committee to follow the procedure as prescribed in the CCS (CCA) Rules itself vitiates the entire proceedings. In fact, it is the case of the appellant that at no stage was he informed by the Committee that the proceeding being conducted by it were disciplinary proceedings and therefore, the report submitted by the said Committee could not have been treated by the respondents as an Inquiry Report under CCS (CCA) Rules.

(b) COUNSEL FOR THE RESPONDENTS NO. 2 AND 3

23. On the other hand, Ms. Ruchira Gupta, learned counsel appearing for the respondents no.2 and 3 strongly refuted the arguments advanced on behalf of the

³⁰ ILR 2006 (11) Del 1313

³¹ (2019) SCC Online Kar 3508

appellant. She submitted that the appellant having failed to challenge the decision taken by the respondent no.2 – University of dispensing with the inquiry contemplated in the Memorandum dated 8th September, 2009 at the appropriate stage, he is precluded from doing so belatedly. To substantiate this submission, she referred to the preliminary objections taken by the appellant in his letter dated 18th April, 2009 where he had raised five preliminary objections relating to the reconstitution of the Committee and its composition, the prejudice allegedly harboured against him by two members of the Committee and the fact that he was denied access to the records sought by him. But the grievance subsequently sought to be raised about the competence or jurisdiction of the Committee to conduct the inquiry and the procedure adopted by it, was never questioned by the appellant.

24. Referring to the correspondence exchanged between the Committee and the appellant, learned counsel submitted that the appellant was granted at least three opportunities to submit his reply and eighteen hearings were conducted by the Committee but he did not participate in the proceedings on several dates. Only after the appellant failed to turn up and made flimsy excuses of indisposition and repeatedly sought adjournments, did the Committee proceed *ex parte* against him and submitted its Report to the Registrar on 5th June, 2009. It was thus sought to be argued that the situation would not have changed in any manner had another opportunity been afforded to the appellant, as requested by him *vide* letter dated 4th June, 2009. In this context, the attention of the Court was drawn to the *proviso* to Rule 14(2) of the CCS (CCA)

Rules, which enjoins the Complaints Committee to hold an inquiry into the complaint of sexual harassment, "*as far as practicable*", in accordance with the procedure laid down in the Rules. The decision of the Division Bench of the Delhi High Court in **Avinash Mishra v. Union of India**³² has been cited to justify the stand of the respondents that the expression "*as far as practicable*" itself indicates that the Committee is vested with the discretion not to strictly follow the entire procedure as long as the officer charged has been afforded adequate opportunity to explain his stand in respect of the complaint and the relevant material has been disclosed to him.

25. Learned counsel for respondents no. 2 and 3 went on to state that the Committee had afforded adequate opportunities to the appellant to cross-examine the witnesses, produce his witnesses and complete his own deposition but he kept on delaying the proceedings under one pretext or the other. Referring to the Report, she stated that it shows that the Committee had taken note of the detailed reply submitted by the appellant on 25th April, 2009 and had dealt with the same at considerable length. Reliance has also been placed on the decisions of this Court in **Hira Nath Mishra and Others v. Principal, Rajendra Medical College, Ranchi and Another**³³ and **P.D. Agrawal v. State Bank of India and Others**³⁴ to argue that principles of natural justice is not an inflexible doctrine and the facts and circumstances of each case have to be examined to see whether the requirements of natural justice stand satisfied. In the present case,

³² 2014 SCC Online Del 1856

³³ (1973) 1 SCC 805

³⁴ (2006) 8 SCC 776

having regard to the sensitivity of the matter where no less than seventeen students of the respondent no. 2 – University had submitted complaints of sexual harassment against the appellant, the Committee exercised its discretion by keeping a balance and conducted the proceedings without violating the principles of natural justice, which is amply borne out from a perusal of the Report itself.

26. Learned counsel also refuted the submission made by the other side that failure on the part of the Committee to frame Articles of Charge before conducting the inquiry had caused serious prejudice to the appellant. She submitted that the sum and substance of the complaints were well known to the appellant from the very beginning and all the relevant depositions of the complainants and other witnesses were duly furnished to him. He was afforded ample opportunity to respond to the said complaints, cross-examine the witnesses and produce his own witnesses in defence. Explaining the decision of the respondent no.2 – University to terminate the subsequently constituted inquiry proceedings against the appellant by virtue of the Memorandum dated 8th September, 2009, learned counsel alluded to the order dated 26th April, 2004, passed by this Court in **Medha Kotwal's case** (supra), which had clarified that the Complaints Committee as contemplated in **Vishaka and Others v. State of Rajasthan and Others**³⁵, will be the Inquiry Authority for the purposes of the CCS (CCA) Rules and the report of the said Committee will be deemed to be an Inquiry Report on which the Disciplinary Authority shall act in accordance with the Rules. It was submitted that the EC

³⁵ (1997) 6 SCC 241

had made a *bona fide* error by appointing an Inquiry Authority to inquire into the charges framed against the appellant and the said decision to recall the order dated 15th October, 2009 was duly communicated to the appellant on 15th December, 2009. Only thereafter, did the EC issue a fresh Memorandum³⁶ to the appellant calling upon him to submit his representation on the decision to accept the Report submitted by the Committee and impose on him, a major penalty of dismissal from service.

27. It was thus submitted that no prejudice was caused to the appellant and the Committee had observed the principles of natural justice "*as far as was practical*", in the given facts and circumstances of the case. Adequate opportunity was afforded to the appellant not just by the Committee, but also by the Disciplinary Authority and the Appellate Authority before taking any action against him. Therefore, this was not a case of "no opportunity" or "no hearing" but a case of "adequate opportunity" and "fair hearing" afforded to the appellant before imposing a major penalty of dismissal from service on him, as specified in Section 11 (9) of the CCS (CCA) Rules.

F. THE TRIAD : ARTICLES 309, 310 AND 311 OF THE CONSTITUTION OF INDIA

28. Services under the Union and the States are governed under Part XIV of the Constitution. Article 309 of the Constitution that provides for recruitment and conditions of service of persons serving the Union or a State, Article 310 that refers to the tenure of office of persons serving the Union or a State and Article 311 that deals with dismissal,

³⁶ dated 17th February, 2010

removal or reduction in rank of persons employed in civil capacities under the Union or a State are inter-linked and "form an integrated whole, there being an organic and thematic unity running through them"³⁷.

(a) **ARTICLE 309: CONDITIONS OF SERVICE**

29. Article 309 does not by itself provide for recruitment or conditions of service of Government servants, but confers this power on the appropriate legislature to make the laws and on the President and the Government of a State to make rules relating to these matters. The expression "*conditions of service*" in Article 309 takes in its sweep all those conditions that regulate holding of a post by a person which begins from the time he enters the service till his retirement and even post-retirement, in relation to matters like pension, pending disciplinary proceedings, etc. This expression also includes the right to dismiss such a person from service³⁸. A Statute can be enacted by the appropriate Legislature or Rules can be made by the appropriate Executive under Article 309 for prescribing the procedure and the authority who can initiate disciplinary action against a Government servant³⁹. It has further been held that any Act or Rule that violates the rights guaranteed to a government servant under Article 311, would be void⁴⁰. Similarly, such an Act or Rule would be treated as void if it violates any of the fundamental rights guaranteed under Part III of the Constitution.

³⁷ Union of India and Another v. Tulsiram Patel, (1985) 3 SCC 398

³⁸ State of Madhya Pradesh and Others v. Shardul Singh, (1970) 1 SCC 108

³⁹ Bk. Sardari Lal v. Union of India and Others, (1971) 1 SCC 411

⁴⁰ Moti Ram Deka v. The General Manager, North East Frontier Railway, (1964) 5 SCR 683

(b) **ARTICLE 310: DOCTRINE OF PLEASURE**

30. Article 310 embodies the "**Doctrine of Pleasure**" and in the context of Government servants, relates to their tenure of service. Article 310(1) makes the tenure of Government servants subject to the pleasure of the President or the Governor of a State except as expressly provided for by the Constitution. This Article is analogous to the rights of the Crown in England where all public officers and servants of the Crown are appointed at the pleasure of the Crown and their services can be terminated at will, without assigning any cause⁴¹. That is the reason why the tenure of the Government servant is subject to the pleasure of the President or the Governor of a State, except as expressly provided for under the Constitution. All members of such services who receive their stipend from the public exchequer, whether at the top of the hierarchy or at the very bottom, are finally answerable to the public and expected to discharge their duties responsibly, efficiently, effectively and above all, for the higher good of the public. It can, therefore, be seen that though the origin of Government servants may be contractual, once appointed to the post or office, they acquire a status and their rights and obligations are no longer determined by the consent of both the parties, but are governed by the Statute or Statutory Rules⁴².

⁴¹ Union of India and Another v. Tulsī Ram Patel, (1985) 3 SCC 398

⁴² Roshan Lal Tandon v. Union of India, (1968) 1 SCR 185

(c) **ARTICLE 311 : A MANIFESTATION OF THE PRINCIPLES OF NATURAL JUSTICE**

31. This Court has held that in matters of dismissal, removal or reduction in rank of public servants, Article 311 of the Constitution is a manifestation of the essential principles of natural justice. It imposes a duty on the Government to ensure that any such decision against the public servant is preceded by an inquiry that contemplates an opportunity of hearing to be granted to the public servant, who is also entitled to make a representation against such a decision⁴³. Article 311 reads as under :

"311. Dismissal, removal or reduction in rank of persons employed in civil capacities under the Union or a State.—(1) No person who is a member of a civil service of the Union or an all India service or a civil service of a State or holds a civil post under the Union or a State shall be dismissed or removed by an authority subordinate to that by which he was appointed.

(2) No such person as aforesaid shall be dismissed or removed or reduced in rank except after an inquiry in which he has been informed of the charges against him and given a reasonable opportunity of being heard in respect of those charges:

Provided that where it is proposed after such inquiry, to impose upon him any such penalty, such penalty may be imposed on the basis of the evidence adduced during such inquiry and it shall not be necessary to give such person any opportunity of making representation on the penalty proposed:

Provided further that this clause shall not apply—

(a) where a person is dismissed or removed or reduced in rank on the ground of conduct which has led to his conviction on a criminal charge; or

(b) where the authority empowered to dismiss or remove a person or to reduce him in rank is satisfied that for some reason, to be recorded by that authority in writing, it is not reasonably practicable to hold such inquiry; or

(c) where the President or the Governor, as the case may be, is satisfied that in the interest of the security of the State it is not expedient to hold such inquiry.

(3) If, in respect of any such person as aforesaid, a question arises whether it is reasonably practicable to hold such inquiry as is referred to in clause (2), the decision thereon of the authority empowered to dismiss or remove such person or to reduce him in rank shall be final."

⁴³ Nisha Priya Bhatia v. Union of India and Another, (2020) 13 SCC 56

32. To provide a sense of security of tenure to Government servants, the Framers of the Constitution have incorporated safeguards in respect of the punishment or dismissal or removal or reduction in their rank as provided for in Clauses (1) and (2) of Article 311. At the same time, being mindful of the very same public interest and public good which does not permit that Government servants found to be corrupt, dishonest or inefficient be continued in service, a remedy is provided under the second *proviso* to Clause (2) of Article 311 whereunder their services can be dispensed with, without conducting a disciplinary inquiry.

33. Thus, the golden thread that weaves through Articles 309, 310 and 311 is public interest, directed towards larger public good. Together, they form a triad and symbolize the overarching Doctrine of Public Policy.

G. ARTICLE 14 : BEDROCK OF THE PRINCIPLES OF NATURAL JUSTICE

34. Principles of natural justice that are reflected in Article 311, are not an empty incantation. They form the very bedrock of Article 14 and any violation of these principles tantamounts to a violation of Article 14 of the Constitution. Denial of the principles of natural justice to a public servant can invalidate a decision taken on the ground that it is hit by the vice of arbitrariness and would result in depriving a public servant of equal protection of law.

35. Article 14, often described as the 'Constitutional Guardian' of the principles of natural justice, expressly forbids the State, as defined in Article 12, from denying to any person, equality before the law or equal protection of the laws. Article 14 provides an

express guarantee of equality before the law to all persons and extends a protection to them against discrimination by any law. Article 13(3)(a) defines law to include any ordinance, order, bye-law, rule, regulation, notification, custom or usages having in the territory of India, the force of law. Thus, principles of natural justice guaranteed under Article 14, prohibit a decision-making adjudicatory authority from taking any arbitrary action, be it substantive or procedural in nature. These principles of natural justice, that are a natural law, have evolved over a period of time and been continuously refined through the process of expansive judicial interpretation.

H. THE TWIN ANCHORS : NEMO JUDEX IN CAUSA SUA AND AUDI ALTERAM PARTEM

36. The twin anchors on which the principles of natural justice rest in the judicial process, whether quasi-judicial or administrative in nature, are *Nemo Juxed In Causa Sua*, i.e., no person shall be a judge in his own cause as justice should not only be done, but should manifestly be seen to be done and *Audi Alteram Partem*, i.e. a person affected by a judicial, quasi-judicial or administrative action must be afforded an opportunity of hearing before any decision is taken.

37. How deeply have Courts internalised and incorporated the principles of natural justice into the Constitution can be perceived from the seven Judge Bench decision in the case of *Maneka Gandhi v. Union of India and Another*⁴⁴. In this case, where a challenge was laid to the order of impounding the passport of the appellant, which was

⁴⁴ (1978) 1 SCC 248

silent on the reasons for such an action and the respondent—State had declined to furnish the reason therefor, it was held that life and liberty of a person cannot be restricted by any procedure that is established by law, but only by procedure that is just, fair and reasonable. Quoting the *audi alteram partem* rule and equating it with “fair play in action”, Justice P.N. Bhagwati (as he then was) had authored the judgment for the majority and had observed that:

“14.The *audi alteram partem* rule is not cast in a rigid mould and judicial decisions establish that it may suffer situational modifications. The core of it must, however, remain, namely, that the person affected must have a reasonable opportunity of being heard and the hearing must be a genuine hearing and not an empty public relations exercise. That is why Tucker, L.J., emphasised in **Russel v. Duke of Norfolk**⁴⁵ that “whatever standard of natural justice is adopted, one essential is that the person concerned should have a reasonable opportunity of presenting his case”. What opportunity may be regarded as reasonable would necessarily depend on the practical necessities of the situation. It may be a sophisticated full-fledged hearing or it may be a hearing which is very brief and minimal : it may be a hearing prior to the decision or it may even be a post-decisional remedial hearing. The *audi alteram partem* rule is sufficiently flexible to permit modifications and variations to suit the exigencies of myriad kinds of situations which may arise.....”

38. In the captioned case, citing the judgment of a Constitution Bench of this Court in **Rustom Cavasjee Cooper v. Union of India**⁴⁶, wherein it was held that fundamental rights are not a water tight compartment, the Court observed as under:-

“The principle of reasonableness, which legally as well as philosophically, is an essential element of equality or non-arbitrariness pervades Article 14 like a brooding omnipresence and the procedure contemplated by Article 21 must answer the test of reasonableness in order to be in conformity with Article 14”

The emphasis was on the Court's attempt to expand the reach and ambit of the fundamental rights guaranteed in the Constitution rather than attenuate their meaning

⁴⁵ 1949 1 ALL ER 109

⁴⁶ (1970) 1 SCC 248

and content by a process of judicial construction. Relying on the minority judgment rendered by Justice Fazal Ali in the case of A.K. Gopalan v. State of Madras⁴⁷, this Court went on to hold in Maneka Gandhi's case (supra) that the procedure required to be prescribed under Article 21 must include four essentials namely, notice, opportunity to be heard, impartial tribunal and ordinary course of procedure. It was observed that even on principle, having regard to the impact of Article 14 on Article 21, the concept of reasonableness must be projected in the procedure contemplated by Article 21.

39. In Delhi Transport Corporation v. D.T.C. Mazdoor Congress and Others⁴⁸, a five-Judge Bench of this Court highlighted how essential it is to afford a reasonable opportunity to an employee to put forth his case in a domestic inquiry and the requirement of an employer to comply with the principles of natural justice and fair play, in the following words :

"202.It is now well settled that the 'audi alteram partem' rule which in essence, enforces the equality clause in Article 14 of the Constitution is applicable not only to quasi-judicial orders but to administrative orders affecting prejudicially the party-in-question unless the application of the rule has been expressly excluded by the Act or Regulation or Rule which is not the case here. Rules of natural justice do not supplant but supplement the Rules and Regulations. Moreover, the Rule of Law which permeates our Constitution demands that it has to be observed both substantially and procedurally..... Rule of law posits that the power is to be exercised in a manner which is just, fair and reasonable and not in an unreasonable, capricious or arbitrary manner leaving room for discrimination....."

[emphasis added]

XXX XXX XXX

⁴⁷ 1950 SCC 228

⁴⁸ (1991) Supp (1) SCC 600

316. Thus it could be held that Article 14 read with Article 16(1) accords right to an equality or an equal treatment consistent with the principles of natural justice. Any law made or action taken by the employer, corporate statutory or instrumentality under Article 12 must act fairly, justly and reasonably. Right to fair treatment is an essential inbuilt of natural justice. Exercise of unbridled and uncanalised discretionary power impinges upon the right of the citizen; vesting of discretion is no wrong provided it is exercised purposively judiciously and without prejudice. Wider the discretion, the greater the chances of abuse. Absolute discretion is destructive of freedom than of man's other inventions. Absolute discretion marks the beginning of the end of the liberty. **The conferment of absolute power to dismiss a permanent employee is antithesis to justness or fair treatment. The exercise of discretionary power wide off the mark would breed arbitrary, unreasonable or unfair actions and would not be consistent with reason and justice. The provisions of a statute, regulations or rules that empower an employer or the management to dismiss, remove or reduce in rank of an employee, must be consistent with just, reasonable and fair procedure. It would, further, be held that right to public employment which includes right to continued public employment till the employee is superannuated as per rules or compulsorily retired or duly terminated in accordance with the procedure established by law is an integral part of right to livelihood which in turn is an integral facet of right to life assured by Article 21 of the Constitution. Any procedure prescribed to deprive such a right to livelihood or continued employment must be just, fair and reasonable procedure. In other words an employee in a public employment also must not be arbitrarily, unjustly and unreasonably be deprived of his/her livelihood which is ensured in continued employment till it is terminated in accordance with just, fair and reasonable procedure. Otherwise any law or rule in violation thereof is void."**

[emphasis added]

40. The significant role played by procedural fairness in the backdrop of internalising the principles of natural justice into the Constitution cannot be overstated. This aspect has been highlighted by a Division Bench of this Court of which one of us, [Hima Kohli, J], was a member, in **Madhyamam Broadcasting Limited v. Union of India & Others**⁴⁹.

Speaking for the Bench, Chief Justice D. Y. Chandrachud stated :

"53. The judgment of this Court in **Maneka Gandhi** (supra) spearheaded two doctrinal shifts on procedural fairness because of the constitutionalising of natural justice. Firstly, procedural fairness was no longer viewed merely as a means to secure a just outcome but a requirement that holds an inherent value in itself. In

⁴⁹ (2023) SCC Online 366

view of this shift, the Courts are now precluded from solely assessing procedural infringements based on whether the procedure would have prejudiced the outcome of the case. Instead, the courts would have to decide if the procedure that was followed infringed upon the right to a fair and reasonable procedure, independent of the outcome. In compliance with this line of thought, the courts have read the principles of natural justice into an enactment to save it from being declared unconstitutional on procedural grounds. Secondly, natural justice principles breathe reasonableness into the procedure. Responding to the argument that the principles of natural justice are not static but are capable of being moulded to the circumstances, it was held that the core of natural justice guarantees a reasonable procedure which is a constitutional requirement entrenched in Articles 14, 19 and 21. **The facet of *audi alterum partem* encompasses the components of notice, contents of the notice, reports of inquiry, and materials that are available for perusal. While situational modifications are permissible, the rules of natural justice cannot be modified to suit the needs of the situation to such an extent that the core of the principle is abrogated because it is the core that infuses procedural reasonableness.** The burden is on the applicant to prove that the procedure that was followed (or not followed) by the adjudicating authority, in effect, infringes upon the core of the right to a fair and reasonable hearing."

- [emphasis supplied]

41. In **A.K. Kraipak and Others v. Union of India and Others**⁵⁰ quoting with approval the judgment **In re: H.K. (All Infant)**⁵¹, this Court held that :

"20. The aim of the rules of natural justice is to secure justice or to put it negatively to prevent miscarriage of justice. These rules can operate only in areas not covered by any law validly made. In other words they do not supplant the law of the land but supplement it. The concept of natural justice has undergone a great deal of change in recent years. In the past it was thought that it included just two rules namely: (1) no one shall be a judge in his own case (*Nemo debet esse iudex propria causa*) and (2) no decision shall be given against a party without affording him a reasonable hearing (*audi alteram partem*). Very soon thereafter a third rule was envisaged and that is that quasi-judicial enquiries must be held in good faith, without bias and not arbitrarily or unreasonably. But in the course of years many more subsidiary rules came to be added to the rules of natural justice. Till very recently it was the opinion of the courts that unless the authority concerned was required by the law under which it functioned to act judicially there was no room for the application of the rules of natural justice. The validity of that limitation is now questioned. **If the purpose of the rules of natural justice is to prevent miscarriage of justice one fails to see why those rules should be made inapplicable to administrative enquiries. Often times it is not easy to draw the line that demarcates administrative enquiries from quasi-judicial enquiries. Enquiries which were considered administrative at one time are now being considered as quasi-judicial in**

⁵⁰ (1969) 2 SCC 262

⁵¹ (1967) 1 All ER 226

character. Arriving at a just decision is the aim of both quasi-judicial enquiries as well as administrative enquiries. An unjust decision in an administrative inquiry may have more far reaching effect than a decision in a quasi-judicial inquiry....."

- [Emphasis supplied]

I. FAIR ACTION AND IMPARTIALITY IN SERVICE JURISPRUDENCE:

42. In the context of service law, it is, therefore mandatory to afford a Government servant or an employee, a reasonable opportunity of being heard before an order is passed. In Mangilal v. State of M.P.⁵², this Court declared that even if a Statute is silent and there are no positive words in the Act or the Rules made thereunder, principles of natural justice must be observed. This is what the Court has held:

"10....Where the statute is silent about the observance of the principles of natural justice, such statutory silence is taken to imply compliance with the principles of natural justice where substantial rights of parties are considerably affected. The application of natural justice becomes presumptive, unless found excluded by express words of statute or necessary intendment. (See Swadeshi Cotton Mills v. Union of India⁵³) Its aim is to secure justice or to prevent miscarriage of justice. Principles of natural justice do not supplant the law, but supplement it. These rules operate only in areas not covered by any law validly made. They are a means to an end and not an end in themselves....."

43. In Tulsiram Patel's case (supra), observing that violation of the rules of natural justice would result in arbitrariness which would amount to discrimination, the Constitution Bench made the following observations :

"95. The principles of natural justice have thus come to be recognized as being a part of the guarantee contained in Article 14 because of the new and dynamic interpretation given by this Court to the concept of equality which is the subject-matter of that article. Shortly put, the syllogism runs thus: violation of a rule of natural justice results in arbitrariness which is the same as discrimination; where discrimination is the result of State action, it is a violation of Article 14:

⁵² (2004) 2 SCC 447

⁵³ (1981) 1 SCC 664

therefore, a violation of a principle of natural justice by a State action is a violation of Article 14. Article 14, however, is not the sole repository of the principles of natural justice. What it does is to guarantee that any law or State action violating them will be struck down. **The principles of natural justice, however, apply not only to legislation and State action but also where any tribunal, authority or body of men, not coming within the definition of State in Article 12, is charged with the duty of deciding a matter. In such a case, the principles of natural justice require that it must decide such matter fairly and impartially.**

96. The rule of natural justice with which we are concerned in these appeals and writ petitions, namely, the *audi alteram partem* rule, in its fullest amplitude means that a person against whom an order to his prejudice may be passed should be informed of the allegations and charges against him, be given an opportunity of submitting his explanation thereto, have the right to know the evidence, both oral or documentary, by which the matter is proposed to be decided against him, and to inspect the documents which are relied upon for the purpose of being used against him, to have the witnesses who are to give evidence against him examined in his presence and have the right to cross-examine them, and to lead his own evidence, both oral and documentary, in his defence. The process of a fair hearing need not, however, conform to the judicial process in a Court of law, because judicial adjudication of causes involves a number of technical rules of procedure and evidence which are unnecessary and not required for the purpose of a fair hearing within the meaning of *audi alteram partem* rule in a quasi-judicial or administrative inquiry. If we look at clause (2) of Article 311 in the light of what is stated above, it will be apparent that that clause is merely an express statement of the *audi alteram partem* rule which is implicitly made part of the guarantee contained in Article 14 as a result of the interpretation placed upon that article by recent decisions of this Court. **Clause (2) of Article 311 requires that before a government servant is dismissed, removed or reduced in rank, an inquiry must be held in which he is informed of the charges against him and given a reasonable opportunity of being heard in respect of those charges....."**

- [emphasis supplied]

At the same time, a note of caution was added in the captioned case and the Court observed that the rules of natural justice are neither statutory rules nor are they cast in stone. They are flexible and can be adapted and modified by statutes, depending on the exigencies of different situations, the facts and circumstances of the case and the framework of the law⁵⁴.

⁵⁴ Also refer : A.K.Kraipak and others v. Union of India and Others, (1969) 2 SCC 262 and Union of India v. Col. J.N. Sinha and Another, (1970) 2 SCC 458

44. In Swadeshi Cotton Mills v. Union of India⁵⁵, in his dissenting judgment, Justice O. Chinnappa Reddy, had made the following pertinent observations :-

"106. The principles of natural justice have taken deep root in the judicial conscience of our people, nurtured by **Dr. Bina pani**⁵⁶, **A.K. Kraipak**⁵⁷, **Mohinder Singh Gill**⁵⁸, **Maneka Gandhi**⁵⁹. They are now considered so fundamental as to be "implicit in the concept of ordered liberty and, therefore, implicit in every decision-making function, call it judicial, quasi-judicial or administrative. **Where authority functions under a statute and the statute provides for the observance of the principles of natural justice in a particular manner, natural justice will have to be observed in that manner and in no other. No wider right than that provided by statute can be claimed nor can the right be narrowed. Where the statute is silent about the observance of the principles of natural justice, such statutory silence is taken to imply compliance with the principles of natural justice.** The implication of natural justice being presumptive it may be excluded by express words of statute or by necessary intendment. Where the conflict is between the public interest and the private interest, the presumption must necessarily be weak and may, therefore, be readily displaced....."

- [emphasis supplied]

45. Thus, ordinarily, courts interpret statutory provisions in sync with the aforesaid principles of natural justice on a premise that no statutory authority would violate the fundamental rights enshrined in the Constitution. When it comes to authorities that are expected to discharge judicial and quasi-judicial functions, the rule of *audi alteram partem* applies with equal force. Reasonableness infuses lifeblood in procedural matters, be it elements of the notice, the contents of the notice, the scope of inquiry, the material available or an adequate opportunity to rebut such material. All of this is to avoid

⁵⁵ (1981) 1 SCC 664

⁵⁶ AIR 1967 SC 1269

⁵⁷ (1969) 2 SCC 262

⁵⁸ (1978) 1 SCC 405

⁵⁹ (1978) 1 SCC 248

miscarriage of justice at any stage. This is of course fluid and subject to adapting to the demands of a situation in the given facts of a case.

J. THE STATUTORY REGIME

(a) GOA UNIVERSITY STATUTE

46. In the above background, we may now proceed to examine the relevant Rules that govern the conditions of service of the appellant herein. The Statutory regime in respect of teachers employed in the respondent no. 2 – University is governed by the Goa University Statute SSB-1 (XXVI). SC-6(i) of the Statute contemplates as follows–

"For disciplinary and departmental action, the teachers shall be governed under the CCS (CCA) Rules, 1965, Fundamental Rules and Supplementary Rules as applicable to the employees of the Goa Government".

(b) CCS (CCA) RULES :

47. The CCS (CCA) Rules mentioned above, have been enacted by the President of India in exercise of the powers conferred by the proviso to Article 309 and Clause 5 of Article 148 of the Constitution of India. Part VI of the CCS (CCA) Rules lays down the procedures for imposing penalties. Rule 3(C) has been incorporated in the CCS (CCA) Rules *vide* GSR 49 dated 7th March, 1998 and subsequently, *vide* GSR 823 (E) dated 19th November, 2014. The said provision states as follows: -

"3C. Prohibition of sexual harassment of working women

(1) No Government servant shall indulge in any act of sexual harassment of any women at any work place.

(2) Every Government servant who is incharge of a work place shall take appropriate steps to prevent sexual harassment to any woman at the work place.

Explanation – (1) For the purpose of this rule –

(a) "sexual harassment" includes any one or more of the following acts or behaviour (whether directly or by implication), namely –

- (i) physical contact and advances; or
- (ii) a demand or request for sexual favours; or
- (iii) making sexually coloured remarks; or
- (iv) showing pornography; or
- (v) any other unwelcome physical, verbal or non-verbal conduct of a sexual nature."

(c) **PRAGMATIC APPLICATION OF THE "AS FAR AS IS PRACTICABLE" RULE**

48. Rule 14 of the CCS (CCA) Rules stipulates the procedure for imposing major penalties and is extracted below :

"14. Procedure for imposing major penalties

- (1) No order imposing any of the penalties specified in clauses (v) to (ix) of Rule 11 shall be made except after an inquiry held, as far as may be, in the manner provided in this rule and rule 15, or in the manner provided by the Public Servants (Inquiries) Act, 1850 (37 of 1850), where such inquiry is held under that Act.
- (2) Whenever the disciplinary authority is of the opinion that there are grounds for inquiring into the truth of any imputation of misconduct or misbehaviour against a Government servant, it may itself inquire into, or appoint under this rule or under the provisions of the Public Servants (Inquiries) Act, 1850, as the case may be, an authority to inquire into the truth thereof.

Provided that where there is a complaint of sexual harassment within the meaning of rule 3 C of the Central Civil Services (Conduct) Rules, 1964, the Complaints Committee established in each Ministry or Department or Office for inquiring into such complaints, shall be deemed- to be the inquiring authority appointed by the disciplinary authority for the purpose of these rules and the Complaints Committee shall hold, if separate procedure has not been prescribed for the Complaints Committee for holding the inquiry into the complaints of sexual harassment, the inquiry as far as practicable in accordance with the procedure laid down in these rules."

- ***[emphasis supplied]***

49. As can be seen from the above, when the misconduct relates to a complaint of sexual harassment at the work place, the Complaints Committee constituted by the respondent no.2-University to examine such a complaint, dons the mantle of the inquiring authority and is expected to conduct an inquiry in accordance with the procedure

prescribed in the rules, as far as may be practicable. The use of the expression "as far as is practicable" indicates a play in the joints available to the Complaints Committee to adopt a fair procedure that is feasible and elastic for conducting an inquiry in a sensitive matter like sexual harassment at the workplace, without compromising on the principles of natural justice. Needless to state that the fact situation in each case will vary and therefore no set standards or yardstick can be laid down for conducting the inquiry in complaints of this nature. However, having regard to the serious ramifications with which the delinquent employee may be visited at the end of the inquiry, any discordant note or unreasonable deviation from the settled procedures required to be followed, would however strike at the core of the principles of natural justice, notwithstanding the final outcome.

K. JOURNEY FROM "VISHAKA" CASE TO THE PoSH ACT

(a) VISHAKA GUIDELINES : FILLING IN THE VACUUM :

48. The occasion to amend Rule 14 (2) of the CCS (CCA) Rules and append a *proviso* thereto was a direct consequence of judicial intervention by this Court in the case of Vishaka (supra), where the powers vested under Article 32 of the Constitution of India were exercised by a three-Judge Bench to enforce the fundamental rights of women to "gender equality and right to life and liberty", bestowed under Articles 14, 15, 19(1)(g) and 21 of the Constitution of India. Treating a set of writ petitions filed by some social activists and NGOs, who were agitating the brutal gang rape of a social worker in a

village of Rajasthan as a class action, this Court worked towards filling in the vacuum in the existing legislation. Noting the absence of any Statute enacted to provide for effective enforcement of the basic human right of gender equality and guarantee against sexual abuse, particularly against sexual harassment at work places, the Court drew strength from several provisions of the Constitution of India including Article 15⁶⁰, Article 42⁶¹ and Article 51(A)⁶² and with the aid of the relevant International Conventions and norms including the General Recommendations of the CEDAW⁶³ that had passed a Resolution on 25th June, 1993, resolving that an effective complaint mechanism be put in place to address sexual harassment in the work place, laid down a set of Guidelines and norms with a direction that they would be strictly adhered to at all work places and shall be binding and enforceable in law till the vacuum was filled and a legislation was enacted to occupy the field. The Guidelines directed creation of a complaints mechanism to ensure time bound treatment of complaints, constitution of a Complaints Committee and recommended, disciplinary action where such conduct amounted to misconduct in employment 'as defined by the relevant service rules'. The momentous judgment in Vishaka's case (supra) was delivered on 13th August, 1997 and the Guidelines declared by the Court continued to hold the field till the Sexual Harassment of Women at

⁶⁰ Article 15: The State shall not discriminate against any citizen on grounds of religion, race, caste, sex, place of birth of any of them.

⁶¹ Article 42: The State shall make provisions for securing just and humane conditions of work and for maternity relief.

⁶² Article 51(A): (e) It shall be the duty of every citizen of India to, amongst others, renounce practices derogatory to the dignity of women.

⁶³ The Convention on the Elimination of All Forms of Discrimination Against Women

Workplace (Prevention, Prohibition and Redressal) Act, 2013⁶⁴ was enacted on 22nd April, 2013.

(b) MEDHA KOTWAL LELE'S CASE : FOLLOW UP THROUGH CONTINUING MANDAMUS :

49. After Vishaka's case (supra), came the case of Medha Kotwal Lele and Others v. Union of India and Others⁶⁵ (supra) where a grievance was raised by several petitioners that the Complaints Committees directed to be constituted in terms of the Guidelines laid down by this Court, had not been established to deal with cases of sexual harassment. Treating the said petition as a Public Interest Litigation, notices were issued to several parties including the Union of India and the State Governments and the following directions were issued :

"2....."Complaints Committee as envisaged by the Supreme Court in its judgment in Vishaka case SCC at para 53, will be deemed to be an inquiry authority for the purposes of the Central Civil Services (Conduct) Rules, 1964 (hereinafter called the CCS Rules) and the report of the Complaints Committee shall be deemed to be an inquiry report under the CCS Rules. Thereafter the disciplinary authority will act on the report in accordance with the Rules."

A similar amendment was also directed to be carried out in the Industrial Employment (Standing Orders) Rules.

⁶⁴ For short 'PoSH Act'

⁶⁵ (2013) 1 SCC 311

50. On 17th January, 2006, in the very same case of Medha Kotwal Lele⁶⁶, noting that there was no information available regarding implementation of the directions issued in Vishaka's case (supra), this Court issued the following directions :

"2. It is not known whether the committees as suggested in Vishaka case have been constituted in all the departments/institutions having members of staff of 50 and above and in most of the district-level offices in all the States, members of the staff working in some offices would be more than 50. It is not known whether the committees as envisaged in Vishaka case have been constituted in all these offices. The number of complaints received and the steps taken in these complaints are also not available. We find it necessary to give some more directions in this regard:

2.1. We find that in order to coordinate the steps taken in this regard, there should be a State-level officer i.e. either the Secretary of the Women and Child Welfare Department or any other suitable officer who is in charge and concerned with the welfare of women and children in each State. The Chief Secretaries of each State shall see that an officer is appointed as a nodal agent to collect the details and to give suitable directions whenever necessary.

2.2. As regards factories, shops and commercial establishments are concerned, the directions are not fully complied with. The Labour Commissioner of each State shall take steps in that direction. They shall work as nodal agency as regards shops, factories and commercial establishments are concerned. They shall also collect the details regarding the complaints and also see that the required committee is established in such institutions."

51. Exercising its powers of a writ of continuing mandamus, the aforesaid petition was again taken up after the passage of over six years, on 19th October, 2012⁶⁷ when this Court examined the affidavits filed by each State Government to satisfy itself on the compliance of the Guidelines laid down in Vishaka's case (supra). On examining the position regarding amendments required to be carried out in the CCS(CCA) Rules and the Standing Orders as also the establishment and composition of the Complaints

⁶⁶ (2013) 1 SCC 312

⁶⁷ (2013) 1 SCC 297

Committees, the Court noted with great dismay that several State Governments had failed to make compliances. Extracted below are the observations made in this regard:

"43. As the largest democracy in the world, we have to combat violence against women. We are of the considered view that the existing laws, if necessary, be revised and appropriate new laws be enacted by Parliament and the State Legislatures to protect women from any form of indecency, indignity and disrespect at all places (in their homes as well as outside), prevent all forms of violence—domestic violence, sexual assault, sexual harassment at the workplace, etc.—and provide new initiatives for education and advancement of women and girls in all spheres of life. After all they have limitless potential. Lip service, hollow statements and inert and inadequate laws with sloppy enforcement are not enough for true and genuine upliftment of our half most precious population—the women.

44. In what we have discussed above, we are of the considered view that guidelines in **Vishaka** should not remain symbolic and the following further directions are necessary until legislative enactment on the subject is in place:

44.1. The States and Union Territories which have not yet carried out adequate and appropriate amendments in their respective Civil Services Conduct Rules (by whatever name these Rules are called) shall do so within two months from today by providing that the report of the Complaints Committee shall be deemed to be an inquiry report in a disciplinary action under such Civil Services Conduct Rules. In other words, the disciplinary authority shall treat the report/findings, etc. of the Complaints Committee as the findings in a disciplinary inquiry against the delinquent employee and shall act on such report accordingly. The findings and the report of the Complaints Committee shall not be treated as a mere preliminary investigation or inquiry leading to a disciplinary action but shall be treated as a finding/report in an inquiry into the misconduct of the delinquent.

44.2. The States and Union Territories which have not carried out amendments in the Industrial Employment (Standing Orders) Rules shall now carry out amendments on the same lines, as noted above in para 44.1 within two months.

44.3. The States and Union Territories shall form adequate number of Complaints Committees so as to ensure that they function at taluka level, district level and State level. Those States and/or Union Territories which have formed only one committee for the entire State shall now form adequate number of Complaints Committees within two months from today. Each of such Complaints Committees shall be headed by a woman and as far as possible in such committees an independent member shall be associated.

44.4. The State functionaries and private and public sector undertakings/organisations/ bodies/institutions, etc. shall put in place sufficient mechanism to ensure full implementation of Vishaka guidelines and further provide that if the alleged harasser is found guilty, the complainant victim is not forced to work with/under such harasser and where appropriate and possible the alleged harasser should be transferred. Further provision should be made that harassment and intimidation of witnesses and the complainants shall be met with severe disciplinary action.

44.5. The Bar Council of India shall ensure that all Bar Associations in the country and persons registered with the State Bar Councils follow **Vishaka** guidelines. Similarly, the Medical Council of India, Council of Architecture, Institute of Chartered Accountants, Institute of Company Secretaries and other statutory institutes shall ensure that the organisations, bodies, associations, institutions and persons registered/affiliated with them follow the guidelines laid down by **Vishaka**. To achieve this, necessary instructions/circulars shall be issued by all the statutory bodies such as the Bar Council of India, Medical Council of India, Council of Architecture, Institute of Company Secretaries within two months from today. On receipt of any complaint of sexual harassment at any of the places referred to above the same shall be dealt with by the statutory bodies in accordance with **Vishaka** and *Others v. State of Rajasthan and Others* (1997) 6 SCC 241, guidelines and the guidelines in the present order."

(c) **ENACTMENT OF THE PoSH ACT AND RULES :**

52. After the passage of fifteen years from the date of the verdict delivered in **Vishaka's case** (*supra*), the PoSH Act, was legislated on 22nd April, 2013 and finally notified on 9th December, 2013. The Act lays down a comprehensive mechanism for constitution of Internal Complaints Committee, Local Committee and Internal Committees, the manner of conducting an inquiry into a complaint received, duties of an employer, duties and powers of the District Officer and others, penalties for non-compliance of the provisions of the Act, etc. Accompanying the Act are the Rules, 2013⁶⁸ that have been framed in exercise of powers conferred under Section 29 of the PoSH Act and amongst others, lays down the manner in which an inquiry into a complaint of sexual harassment ought to be conducted (Rule 7), the interim reliefs that can be extended to the aggrieved women during the pendency of the inquiry (Rule 8), the manner of taking action for sexual harassment (Rule 9) etc. It is noteworthy that sub-rule (3) of Rule 7

⁶⁸ The Sexual Harassment of Women at Work Place (Prevention, Prohibition and Redressal) Act, 2013

provides that the respondent shall file his reply to the complaint within a stipulated time along with the relevant documents and give details of the witnesses and sub-rule (4) stipulates that the Complaints Committee shall make an inquiry into the complaints "*in accordance with the principles of natural justice*".

(d) **BREATHING REASONABLENESS INTO THE PROCEDURAL REGIME :**

53. Thus, it can be seen that the journey from Vishaka's case (supra) that acted as a springboard and sowed the seeds of future legislation by structuring Guidelines to deal with cases of sexual harassment, blossomed into a comprehensive legislation with the enactment of the PoSH Act and Rules. At the same time, however, women centric the Guidelines and the Act may have been, they both recognize the fact that any inquiry into a complaint of sexual harassment at the workplace must be in accordance with the relevant rules and in line with the principles of natural justice. The cardinal principle required to be borne in mind is that the person accused of misconduct must be informed of the case, must be supplied the evidence in support thereof and be given a reasonable opportunity to present his version before any adverse decision is taken. Similarly, the concerned employer is also expected to act fairly and adopt a procedure that is just, fair and reasonable. The whole purpose is to breathe reasonableness into the procedural regime. But, the test of reasonableness cannot be abstract. It has to be pragmatic and grounded in the realities of the facts and circumstances of a case. When conducting an inquiry, it is the duty of the Inquiring Authority to proceed in a manner that is visibly free

from the taint of arbitrariness, unreasonableness or unfairness. An inquiry that can culminate into imposition of a major penalty like termination of service of an employee, must doubly conform to a just, fair and reasonable procedure. Any displacement of the principles of natural justice can only be in exceptional circumstances, as contemplated in the proviso to Article 311(2) of the Constitution of India and not otherwise. Wherever the rules are silent, principles of natural justice must be read into them and a hearing be afforded to the person who is proposed to be punished with a major penalty⁶⁹.

54. The four predominant purposes sought to be achieved by reading the principles of natural justice into law and into the conduct of judicial and administrative proceedings to achieve the underlying object of securing fairness have been concisely expressed by this Court as an assurance of a fair outcome by following the procedural Rules, an assurance of equality in the proceedings, legitimacy of the decision and decision-making authority thereby preserving the integrity of the system and finally, with the idea of preserving the dignity of individuals where citizens are treated with respect and the dignity they deserve in a society governed by the Rule of Law⁷⁰.

L. ANALYSIS AND DISCUSSION :

55. In the present case, the incidents in question relate to the period when the **Vishaka Guidelines** were in place and it had been clarified in **Medha Kotwal Lele** (supra) that the Complaints Committee will be deemed to be an inquiry authority for the

⁶⁹ State Bank of India and Others v. Ranjit Kumar Chakraborty and Another, (2018) 12 SCC 807

⁷⁰ Madhyamam Broadcasting Limited v. Union of India decided on 5th April 2023

purposes of the CCS Rules. Keeping this in mind, we may now proceed to ascertain as to whether the procedure adopted by the respondents No. 2 and 3 herein violated the principles of natural justice and thereby caused prejudice to the appellant, as has been alleged, for this Court to interfere in the impugned judgment.

(a) **SCOPE OF INTERFERENCE BY THE HIGH COURT IN JUDICIAL REVIEW :**

56. It may be clarified at the outset that to satisfy itself that no injustice has been meted out to the appellant, the High Court was required to examine the decision-making process and not just the final outcome. In other words, in exercise of powers of judicial review, the High Court does not sit as an Appellate Authority over the factual findings recorded in the departmental proceedings as long as those findings are reasonably supported by evidence and have been arrived at through proceedings that cannot be faulted on account of procedural illegalities or irregularities that may have vitiated the process by which the decision was arrived at.

57. The purpose of judicial review is not only to ensure that the individual concerned receives fair treatment, but also to ensure that the authority, after according fair treatment, reaches, a conclusion, which is correct in the eyes of law⁷¹. Notably, in **Apparel Export Promotion Council vs. A.K. Chopra**, a matter related to sexual harassment at the workplace⁷² where, aggrieved by the decision taken by the Disciplinary Authority of accepting the report of the Inquiry Officer and removing the

⁷¹ [1999] 1 SCC 759

⁷² Chief Constable of the North Wales Police v. Evans, [1982] 3 All ER 143 HL. Also refer : B.C. Chaturvedi v. Union of India, [1995] 6 SCC 749.

respondent therein from service on the ground that he had tried to molest a lady employee, this Court had set aside the order of the High Court that had narrowly interpreted the expression "sexual harassment" and held that in departmental proceedings, the Disciplinary Authority is the sole judge of facts and once findings of fact, based on appreciation of evidence are recorded, the High Court in its writ jurisdiction should not normally interfere with those factual findings unless it finds that the recorded findings were based either on no evidence or that the findings were wholly perverse and/or legally untenable. The Court is under a duty to satisfy itself that an inquiry into the allegations of sexual harassment by a Committee is conducted in terms of the service rules and that the concerned employee gets a reasonable opportunity to vindicate his position and establish his innocence⁷³.

(b) EXTENT OF ADHERENCE TO THE "AS FAR AS PRACTICABLE" NORM

58. Assuming as correct, the submission made by learned counsel for the respondents no.2 and 3 that the Committee was not bound to strictly follow a step by step procedure for conducting an inquiry having due regard to the *proviso* to Rule 14(2) of the CCS (CCA) Rules that permits a Committee to enquire into a complaint of sexual harassment '*as far as practicable*', in accordance with the procedure laid down in the Rules, the question that would still beg an answer is

⁷³ Dr. Vijaykumaran C.P.V. v. Central University of Kerala and Others, (2020) 12 SCC 426

whether the inquiry conducted by the Committee in the instant case, would meet the '*as far as practicable*' norm?

59. Rule 14 prescribes the procedure required to be followed for conducting an inquiry by a Public Authority which entails issuance of a charge sheet, furnishing details of the Articles of Charge, enclosing statements of imputations in respect of each article of charge, forwarding of a list of witnesses and the documents sought to be relied upon by the Management/employer. The said procedure may not have been strictly followed by the Committee in the present case, but it is not in dispute that all the complaints received from time to time and the depositions of the complainants were disclosed to the appellant. He was, therefore, well aware of the nature of allegations levelled against him. Not only was the material proposed to be used against him during the inquiry furnished to him, he was also called upon to explain the said material by submitting his reply and furnishing a list of witnesses, which he did. Furthermore, on perusing the Report submitted by the Committee, it transpires that depositions of some of the complainants were recorded audio-visually by the Committee, wherever consent was given and the appellant was duly afforded an opportunity to cross-examine the said witnesses including the complainants. The charges levelled by all the complainants were of sexual harassment by the appellant with a narration of specific instances. Therefore, in

the given facts and circumstances, non-framing of the Articles of Charge by the Committee cannot be treated as fatal. Nor can the appellant be heard to state that he was completely in the dark as to the nature of the allegations levelled against him and was not in a position to respond appropriately. So far, so good.

(c) THE COMMITTEE'S UNDERSTANDING OF ITS MANDATE :

60. As noted above, when the Registrar of the respondent No. 2—University addressed a letter to the Chairperson of the Committee, he forwarded nine complaints of sexual harassment that had been received by the Vice Chancellor of the University. The process of the inquiry was set into motion on 17th March 2009 when the appellant was informed that on receiving complaints of sexual harassment against him, the Committee had conducted a preliminary verification of the complaints by recording the statements of the concerned students. Till then, no specific Articles of Charge were framed by the Committee and no imputation of charges were forwarded to the appellant. At the same time, copies of all the complaints received and the statements recorded were forwarded directly to the appellant calling upon him to explain the charges levelled against him.

61. The plea of the appellant that the Committee understood the remit of its inquiry as a 'fact-finding proceeding', can be discerned from the contents of the letters dated 17th March 2009 and 20th April 2009 addressed to the appellant. The

impression carried by the Committee that it was only required to submit a fact-finding report to the University was no different for the EC as is borne out from a perusal of the Memorandum dated 8th September 2009, issued by the Chairman of the EC who, after receiving the Committee's Report, informed the appellant that an inquiry was proposed to be conducted against him under Rule 14 of the CCS (CCA) Rules. This was the first time when the respondents informed the appellant that the EC had decided to follow the procedure prescribed under the rules of drawing up a Statement of Articles of Charge, imputation of misconduct in support of each Article of Charge and other documents and had granted the appellant time to submit his reply in defence. The appellant did submit a reply. But it is an admitted position that the said inquiry proceedings were aborted at the initial stage itself and it was the Report of the Committee submitted earlier, that was acted upon by the EC in terms of a decision taken on 28th January 2010. We are of the opinion that when the Committee itself was unclear as to the scope of its inquiry, the appellant cannot be blamed for harbouring an impression that the remit of the Committee was confined to fact finding alone and it was not discharging the functions of a disciplinary committee, as contemplated under the service Rules.

(d) WHIRLWIND PROCEEDINGS

62. On examining the records, it emerges that the point at which the Committee fell into an error was when it attempted to fast forward the entire proceedings after the first few hearings and declined to grant a reasonable time to the appellant to effectively participate in the said proceedings. It is noteworthy that the proceedings of the Committee had commenced on 16th April 2009 and stood concluded on 5th June, 2009. During this period, 18 meetings were conducted by the Committee. Following is the month-wise details of the dates on which the meetings of the Committee were conducted :

- (i) April 2009 – On 16th, 27th and 29th
- (ii) May 2009 – On 6th, 12th, 13th, 14th, 19th, 20th, 22nd, 23rd, 25th, 27th, 28th and 29th
- (iii) June, 2009 – On 3rd, 4th and 5th

63. It is also noteworthy that the time span prescribed under the CCS (CCA) Rules for concluding an inquiry is ordinarily within a period of six months from the date of receipt of the order of appointment. But, here, the entire process was wrapped up in flat 39 days. This shows the tearing hurry in which the Committee was to submit its Report. One such glaring instance of the over anxiety to conclude the proceedings is apparent from the letter dated 5th May 2009, addressed by the Committee to the appellant informing him that the next date for filing his reply and for recording further depositions was 12th June 2009. Surprisingly, on the very

next day, the Committee issued yet another letter advancing the said dates by claiming that an error had crept into the previous letter and informing the appellant that the date for filing his reply should be read as '12th May 2009' and the date for recording further depositions should be read as '14th May, 2009', thus moving the dates back by a whole month. Another egregious example of the hurry and scurry shown by the Committee can be gathered from the fact that on 20th May 2009, the Committee had written to the appellant giving him a last opportunity to present himself on 20th May 2009, not only to complete his deposition, but also to cross-examine the complainants and other witnesses. Simultaneously, the Committee forwarded six more depositions to the appellant and directed him to furnish his reply within 48 hours i.e. by 22nd May, 2009.

64. Even if this Court was to accept the submission made by learned counsel for the respondents that the appellant was offering flimsy excuses to somehow prolong the proceedings and the health ground taken by him was not genuine, it does not explain the approach of the Committee which was well aware of the fact that at least six more depositions had been handed over to the appellant as late as on 20th May 2009. Even if he had been hale and hearty, he would still have required a reasonable time to respond to the additional depositions and simultaneously, prepare himself for cross-examining the complainants and completing his

deposition. This can only be termed as an unreasonable and unfair direction by the Committee.

65. The undue haste demonstrated by the Committee for bringing the inquiry to a closure, cannot justify curtailment of the right of the appellant to a fair hearing. The due process, an important facet of the principles of natural justice was seriously compromised due to the manner in which the Committee went about the task of conducting the inquiry proceedings. As noted above, when the proceedings, subject matter of the present appeal had taken place, the PoSH Act was nowhere on the horizon and the field was occupied by the Vishaka Guidelines. The said Guidelines also did not exclude application of the principles of natural justice and fair play in making procedural compliances. The silence in the Guidelines on this aspect could not have given a handle to the Committee to bypass the principles of natural justice and whittle down a reasonable opportunity of affording a fair hearing to the appellant. This Court has repeatedly observed that even when the rules are silent, principles of natural justice must be read into them. In its keen anxiety of being fair to the victims/complainants and wrap up the complaints expeditiously, the Committee has ended up being grossly unfair to the appellant. It has completely overlooked the cardinal principle that justice must not

only be done, but should manifestly be seen to be done. The principles of *audi alterem partem* could not have been thrown to the winds in this cavalier manner.

(e) HOW DID THE EXECUTIVE COUNCIL FALTER?

66. The error committed on the part of the EC, is no less grave. It is apparent that the EC continued to remain under an impression that the First Committee to which the complaints were forwarded, was only a 'fact-finding Committee' and that a full-fledged inquiry was still required to be conducted subsequently, in the manner prescribed under Rule 14 of the CCS (CCA) Rules. The result was that though the Report of the First Committee was accepted and the EC proceeded to place the appellant under suspension, for the very first time, it decided to issue him Memorandum detailing the Articles of Charge and the imputation of charges and further appointed a Former Judge of the High Court as an Inquiry Officer to conduct the inquiry in terms of the Rules. Respondent Nos. 2 and 3 got wiser only when the said proceedings commenced and the Inquiry Officer was appraised of the directions issued in Medha Kotwal's case where it had been clarified by this Court that the Complaints Committee contemplated in Vishaka's case (*supra*), will be deemed to be an Inquiry Authority for the purposes of the CCS (Conduct) Rules and its report shall be deemed to be a Report under the CCS (CCA) Rules.

67. When the employer itself was oblivious to the remit of the Committee and the Committee remained under the very same impression having described its proceedings as fact-finding in nature, it was all the more incumbent for the respondents to have paused on receiving the Report of the First Committee and verify the legal position before taking the next step. In all this back and forth, it was the procedure prescribed under Rule 14 for conducting an inquiry of sexual harassment at the workplace that came to be sacrificed at the alter of expeditious disposal, which can neither be justified nor countenanced.

68. The intent and purpose of the *proviso* inserted in Rule 14(2) of CCS (CCA) Rules and Rule 3C of CCS (Conduct) Rules is that the procedure required to be adopted for conducting an inquiry into the complaint of sexual harassment that can lead to imposition of a major penalty under the Rules, must be fair, impartial and in line with the Rules. Pertinently, the emphasis on adhering to the principles of natural justice during an inquiry conducted by a Complaints Committee finds specific mention in Rule 7(4) of the subsequently enacted Rules of 2013. But the spirit behind the due process could never be suppressed or ignored even in the absence of the Statute or the Rules inasmuch as the principles of natural justice is the very essence of the decision-making process and must be read into every judicial or even a quasi-judicial proceeding.

69. This is not to say that the Committee even if described as an Inquiring authority, by virtue of the ruling in Medha Kotwal's case (*supra*) and required to follow the procedure prescribed under Rule 14, was expected to conduct the inquiry as if it was a full-fledged trial. The expression used in the *proviso* to Rule 14(2), '*as far as practicable*' has to be read and understood in a pragmatic manner. In any such proceedings initiated by the Disciplinary Authority, a calibrated balance would have to be struck between the rights of a victim of sexual harassment and those of the delinquent employee. At the same time, fairness in the procedure would have to be necessarily adopted in the interest of both sides. After all, what is sauce for the goose, is sauce for the gander.

M. CONCLUSION

70. In the instant case, though the Committee appointed by the Disciplinary Authority did not hold an inquiry strictly in terms of the step-by-step procedure laid down in Rule 14 of the CCS (CCA) Rules, nonetheless, we have seen that it did furnish copies of all the complaints, the depositions of the complainants and the relevant material to the appellant, called upon him to give his reply in defence and directed him to furnish the list of witnesses that he proposed to rely on. Records also reveal that the appellant had furnished a detailed reply in defence. He had also submitted a list of witnesses and depositions. This goes to show that he was

well-acquainted with the nature of allegations levelled against him and knew what he had to state in his defence. Given the above position, non-framing of the articles of charge cannot be said to be detrimental to the interest of the appellant.

71. In fact, the glaring defects and the procedural lapses in the inquiry proceedings took place only thereafter, in the month of May, 2009, when 12 hearings, most of them back-to-back, were conducted by the Committee at a lightning speed. On the one hand, the Committee kept on forwarding to the appellant, depositions of some more complainants received later on and those of other witnesses and called upon him to furnish his reply and on the other hand, it directed him to come prepared to cross-examine the said complainants and witnesses as also record his further deposition, all in a span of one week. Even if the medical grounds taken by the appellant seemed suspect, the Committee ought to have given him reasonable time to prepare his defence, more so when his request for being represented through a lawyer had already been declined. It was all this undue anxiety that had led to short-circuiting the inquiry proceedings conducted by the Committee and damaging the very fairness of the process.

72. For the above reasons, the appellant cannot be faulted for questioning the process and its outcome. There is no doubt that matters of this nature are sensitive and have to be handled with care. The respondents had received as

many as seventeen complaints from students levelling serious allegations of sexual harassment against the appellant. But that would not be a ground to give a complete go by to the procedural fairness of the inquiry required to be conducted, more so when the inquiry could lead to imposition of major penalty proceedings. When the legitimacy of the decision taken is dependent on the fairness of the process and the process adopted itself became questionable, then the decision arrived at cannot withstand judicial scrutiny and is wide open to interference. It is not without reason that it is said that a fair procedure alone can guarantee a fair outcome. In this case, the anxiety of the Committee of being fair to the victims of sexual harassment, has ended up causing them greater harm.

73. This Court is, therefore, of the opinion that the proceedings conducted by the Committee with effect from the month of May, 2009, fell short of the "*as far as practicable*" norm prescribed in the relevant Rules. The discretion vested in the Committee for conducting the inquiry has been exercised improperly, defying the principles of natural justice. As a consequence thereof, the impugned judgment upholding the decision taken by the EC of terminating the services of the appellant, duly endorsed by the Appellate Authority cannot be sustained and is accordingly quashed and set aside with the following directions:

- (i) The matter is remanded back to the Complaints Committee to take up the inquiry proceeding as they stood on 5th May 2009.
- (ii) The Committee shall afford adequate opportunity to the appellant to defend himself.
- (iii) The appellant shall not seek any adjournment of the proceedings.
- (iv) A Report shall be submitted by the Committee to the Disciplinary Authority for appropriate orders.
- (v) Having regard to the long passage of time, the respondents are directed to complete the entire process within three months from the first date of hearing fixed by the Committee.
- (vi) The procedure to be followed by the Committee and the Disciplinary Authority shall be guided by the principles of natural justice.
- (vii) The Rules applied will be as were applicable at the relevant point of time.
- (viii) The decision taken by the Committee and the Disciplinary Authority shall be purely on merits and in accordance with law.
- (ix) The appellant will not be entitled to claim immediate reinstatement or back wages till the inquiry is completed and a decision is taken by the Disciplinary Authority.

N. EPILOGUE

74. Just as we celebrate a decade of the PoSH Act being legislated, it is time to look back and take stock of the manner in which the mandate of the Act has been given effect to. The working of the Act is centred on the constitution of the Internal Complaints Committees (ICCs) by every employer at the workplace and constitution of Local Committees (LCs) and the Internal Committees (ICs) by the appropriate Government, as contemplated in Chapters II and III, respectively of the PoSH Act. An improperly constituted ICC/LC/IC, would be an impediment in conducting an inquiry into a complaint of sexual harassment at the workplace, as envisaged under the Statute and the Rules. It will be equally counterproductive to have an ill prepared Committee conduct a half-baked inquiry that can lead to serious consequences, namely, imposition of major penalties on the delinquent employee, to the point of termination of service.

75. It is disquieting to note that there are serious lapses in the enforcement of the Act even after such a long passage of time. This glaring lacuna has been recently brought to the fore by a National daily newspaper that has conducted and published a survey of 30 national sports federations in the country and reported that 16 out of them have not constituted an ICC till date. Where the ICC have been found to be in place, they do not have the stipulated number of members or lack

the mandatory external member. This is indeed a sorry state of affairs and reflects poorly on all the State functionaries, public authorities, private undertakings, organizations and institutions that are duty bound to implement the PoSH Act in letter and spirit. Being a victim of such a deplorable act not only dents the self-esteem of a woman, it also takes a toll on her emotional, mental and physical health. It is often seen that when women face sexual harassment at the workplace, they are reluctant to report such misconduct. Many of them even drop out from their job. One of the reasons for this reluctance to report is that there is an uncertainty about who to approach under the Act for redressal of their grievance. Another is the lack of confidence in the process and its outcome. This social malady needs urgent amelioration through robust and efficient implementation of the Act. To achieve this, it is imperative to educate the complainant victim about the import and working of the Act. They must be made aware of how a complaint can be registered, the procedure that would be adopted to process the complaint, the objective manner in which the ICC/LC/IC is expected to function under the Statute, the nature of consequences that the delinquent employee can be visited with if the complaint is found to be true, the result of lodging a false or a malicious complaint and the remedies that may be available to a complainant if dissatisfied with the Report of the ICC/LC/IC etc.

76. However salutary this enactment may be, it will never succeed in providing dignity and respect that women deserve at the workplace unless and until there is strict adherence to the enforcement regime and a proactive approach by all the State and non-State actors. If the working environment continues to remain hostile, insensitive and unresponsive to the needs of women employees, then the Act will remain an empty formality. If the authorities/managements/employers cannot assure them a safe and secure work place, they will fear stepping out of their homes to make a dignified living and exploit their talent and skills to the hilt. It is, therefore, time for the Union Government and the State Governments to take affirmative action and make sure that the altruistic object behind enacting the PoSH Act is achieved in real terms.

O. DIRECTIONS

77. To fulfil the promise that the PoSH Act holds out to working women all over the country, it is deemed appropriate to issue the following directions :

- (i) The Union of India, all State Governments and Union Territories are directed to undertake a timebound exercise to verify as to whether all the concerned Ministries, Departments, Government organizations, authorities, Public Sector Undertakings, institutions, bodies, etc. have constituted ICCs/LCs/ICs, as the case

may be and that the composition of the said Committees are strictly in terms of the provisions of the PoSH Act.

(ii) It shall be ensured that necessary information regarding the constitution and composition of the ICCs/LCs/ICs, details of the e-mail IDs and contact numbers of the designated person(s), the procedure prescribed for submitting an online complaint, as also the relevant rules, regulations and internal policies are made readily available on the website of the concerned Authority/Functionary/Organisation/Institution/Body, as the case may be. The information furnished shall also be updated from time to time.

(iii) A similar exercise shall be undertaken by all the Statutory bodies of professionals at the Apex level and the State level (including those regulating doctors, lawyers, architects, chartered accountants, cost accountants, engineers, bankers and other professionals), by Universities, colleges, Training Centres and educational institutions and by government and private hospitals/nursing homes.

(iv) Immediate and effective steps shall be taken by the authorities/managements/employers to familiarize members of the ICCs/LCs/ICs with their duties and the manner in which an inquiry ought to be conducted on receiving a complaint of sexual harassment at the workplace, from the point when the complaint is received, till the inquiry is finally concluded and the Report submitted.

- (v) The authorities/management/employers shall regularly conduct orientation programmes, workshops, seminars and awareness programmes to upskill members of the ICCs/LCs/ICs and to educate women employees and women's groups about the provisions of the Act, the Rules and relevant regulations.
- (vi) The National Legal Services Authority(NALSA) and the State Legal Services Authorities(SLSAs) shall develop modules to conduct workshops and organize awareness programmes to sensitize authorities/managements/employers, employees and adolescent groups with the provisions of the Act, which shall be included in their annual calendar.
- (vii) The National Judicial Academy and the State Judicial Academies shall include in their annual calendars, orientation programmes, seminars and workshops for capacity building of members of the ICCs/LCs/ICs established in the High Courts and District Courts and for drafting Standard Operating Procedures (SOPs) to conduct an inquiry under the Act and Rules.
- (viii) A copy of this judgment shall be transmitted to the Secretaries of all the Ministries, Government of India who shall ensure implementation of the directions by all the concerned Departments, Statutory Authorities, Institutions, Organisations etc. under the control of the respective Ministries. A copy of the judgment shall also be transmitted to the Chief Secretaries of all the States and Union Territories

who shall ensure strict compliance of these directions by all the concerned Departments. It shall be the responsibility of the Secretaries of the Ministries, Government of India and the Chief Secretaries of every State/Union Territory to ensure implementation of the directions issued.

(ix) The Registry of the Supreme Court of India shall transmit a copy of this judgment to the Director, National Judicial Academy, Member Secretary, NALSA, Chairperson, Bar Council of India and the Registrar Generals of all the High Courts. The Registry shall also transmit a copy of this judgment to the Medical Council of India, Council of Architecture, Institute of Chartered Accountants, Institute of Company Secretaries and the Engineering Council of India for implementing the directions issued.

(x) Member-Secretary, NALSA is requested to transmit a copy of this judgment to the Member Secretaries of all the State Legal Services Authorities. Similarly, the Registrar Generals of the State High Courts shall transmit a copy of this judgment to the Directors of the State Judicial Academies and the Principal District Judges/District Judges of their respective States.

(xi) The Chairperson, Bar Council of India and the Apex Bodies mentioned in sub-para (ix) above, shall in turn, transmit a copy of this judgment to all the State Bar Councils and the State Level Councils, as the case may be.

78. The Union of India and all States/UTs are directed to file their affidavits within eight weeks for reporting compliances. List after eight weeks.

79. The appeal is allowed on the above terms while leaving the parties to bear their own costs. Pending applications, if any, shall stand disposed of.

.....J.
[A.S. BOPANNA]

.....J.
[HIMA KOHLI]

NEW DELHI
MAY 12, 2023



**No. N-P050(20)/53/2023-PGMEB-
NMC (8226935)
Government of India
National Medical Commission
(O/o Secretary)**

Sector-8, Dwarka
New Delhi-110075
Dated the August, 2024

To,

Directors/ Principals/ Deans & HoDs
All Medical Colleges/ Institutions under NMC

Subject: Discontinuation of all the courses running under the umbrella of College of Physicians & Surgeons (CPS), Mumbai -reg.

I invite reference to the Post Graduate Medical Education Board's (PGMEB) Public Notice dated 16-08-2024 (copy enclosed) on the subject mentioned above, wherein the contents of the notice are self explanatory. All the concerned Institutions are requested to strictly adhere to the same.

Encl.: As above

Signed by B Srinivas
Date: 22-08-2024 17:32:17
[Prof. (Dr) B. Srinivas]
Secretary

Copy to:

- i. ACS/ PS/ Secretaries/ Department/s of Medical Education in all States/ Union Territories
- ii. PPS to Chairman, NMC
- iii. PPS to President(PGMEB)
- iv. DMMP-I System Integrator- for uploading of NMC Website
- v. Guard File

दूरभाष/Phone : 25367033,
25367035, 25367036

पॉकेट -14, सेक्टर-8, द्वारका, फेस1-, नई
दिल्ली-77-

ई-मेल/E-mail :
pgmeb.recognition@nmc.org.in

Pocket- 14,
Sector- 8, Dwarka,
Phase - 1, New Delhi-77

राष्ट्रीय आयुर्विज्ञान आयोग

National Medical Commission

स्नातकोत्तर आयुर्विज्ञान शिक्षा बोर्ड

Post Graduate Medical Education Board (PGMEB)

F.No. N-P050(20)/53/2023-PGMEB-NMC

Dated: 26.07.2024

PUBLIC NOTICE

Subject: Discontinuation of all the courses running under the umbrella of College of Physicians & Surgeons (CPS), Mumbai

The Post Graduate Medical Education Board (PGMEB) had served a Show Cause Notice (SCN) on the College of Physician and Surgeon (CPS), Mumbai for not following the regulatory provisions of the NMC/ erstwhile MCI. In its reply, CPS, Mumbai intimated that it considers itself as an examination like body National Board of Examination in Medical Sciences (NBEMS) with authority to give medical qualification. The Board found this as a misleading statement and observed that the NBEMS is a Government organization included in the Schedule of NMC Act 2019. Whereas the CPS is a non-government organization (examination body) and has no authority to permit or recognize any course of qualification run by any hospital or to conduct examination or award degree. As per **Section 22** of the UGC Act, 1956, the right of conferring or granting degrees can be done by a University established or incorporated by or under a Central Act, a Provincial Act or a State Act or an institution deemed to be a University under Section 3 or an institution specially empowered by an Act of Parliament to confer or grant degrees. Thus, degrees can only be issued by a University or any statutory body empowered by an Act of Parliament.

2. Hence, PGMEB, NMC has decided to **discontinue all the courses running under the umbrella of CPS, Mumbai with immediate effect.**

3. All the stakeholders including medical institutions/ hospital running the CPS courses and students who are in the process of taking admissions to the courses run by CPS may kindly take note of the decision of the PGMEB, NMC as their additional qualifications will not be recognized for registration if any admission take place after issuance of this public notice.

Signed by Aujender Singh
Date: 16-08-2024 16:04:24
(Aujender Singh)
Director, PGMEB



धर्मेन्द्र यादव
Dharmendra Yadav, ITS
CVO, NMC



राष्ट्रीय आयुर्विज्ञान आयोग
भारत सरकार
National Medical Commission
Government of India

Dated: 29/08/2024

CVO NMC, Message on Observance of CVC Vigilance Awareness Campaign and Vigilance Awareness Week, 2024.

Dear Colleagues,

As a part of our ongoing commitment to integrity and transparency, we are launching a Vigilance Awareness Campaign commencing from August 2024 to November 2024 as part of the nationwide campaign of Central Vigilance Commission. This initiative is designed to reinforce our dedication to ethical practices and to encourage vigilance in every aspect of our work.

This programme will provide valuable resources, training, and support to help us all recognize and address potential issues before they arise. Please stay informed about our policies, report any suspicious activities, and uphold the highest standards of honesty and trustworthy environment.

Thank you for your continued support and vigilance.

Warm Regards

Yours Sincerely,

**Sh. Dharmendra Yadav, ITS
Chief Vigilance Officer
National Medical Commission**



धर्मेन्द्र यादव
Dharmendra Yadav, ITS
CVO, NMC



राष्ट्रीय आयुर्विज्ञान आयोग
भारत सरकार
National Medical Commission
Government of India

Dated: 29/08/2024

**सीवीओ एनएमसी, सीवीसी सतर्कता जागरूकता अभियान और सतर्कता जागरूकता सप्ताह,
2024 के पालन पर संदेश।**

प्रिय साथियों,

सत्यनिष्ठा और पारदर्शिता के प्रति हमारी निरंतर प्रतिबद्धता के तहत, हम केंद्रीय सतर्कता आयोग के राष्ट्रव्यापी अभियान के हिस्से के रूप में अगस्त से नवंबर 2024 तक एक सतर्कता जागरूकता अभियान शुरू कर रहे हैं। यह पहल नैतिक प्रथाओं के प्रति हमारे समर्पण को और मजबूत करने और हमारे काम के हर पहलू में सतर्कता को प्रोत्साहित करने के लिए बनायी गई है।

यह कार्यक्रम हमें संभावित मुद्दों की पहचान करने और उनके उत्पन्न होने से पहले उनका समाधान करने के लिए मूल्यवान संसाधन, प्रशिक्षण और सहायता प्रदान करेगा। कृपया हमारी नीतियों के बारे में अद्यतित रहें, किन्हीं भी संदिग्ध गतिविधियों की रिपोर्ट करें और ईमानदारी और जवाबदेही के उच्चतम मानकों को बनाए रखें। पारदर्शी और भरोसेमंद वातावरण बनाए रखने में आपकी सक्रिय भागीदारी अत्यंत महत्वपूर्ण है।

आपके निरंतर समर्थन और सतर्कता के लिए धन्यवाद।

धर्मेन्द्र यादव
29/8/24

श्री धर्मेन्द्र यादव, आई.टी.एस
मुख्य सतर्कता अधिकारी
राष्ट्रीय चिकित्सा आयोग

**No. N-PO50(20)/53/2023-PGMEB-
NMC**



**Government of India
National Medical Commission
(O/o Secretary)**



Pocket- 14, Sector- 8,
Dwarka, Phase-1, New Delhi-77

Date: 30th August, 2024

To,

Directors / Principals / Deans & HoDs

All Medical Colleges / Institutions under NMC

Sub: Withdrawl of public notice dated 22.08.2024 reg. discontinuation of all the courses running under the umbrella of College of Physicians & Surgeons (CPS), Mumbai – Reg.

In compliance of Hon'ble High Court of Judicature at Bombay Order dated 22.08.2024, the letter of even number dated 22-08-2024 and the public notice of even number dtd. 16.08.2024 (copies enclosed) w.r.t. "Discontinuation of all the courses running under the umbrella of College of Physicians & Surgeons (CPS), Mumbai –reg" stands withdrawn.

**Signed by B Srinivas
Date: 31-08-2024 07:17:04
(Dr. (Prof.) B. Srinivas)**

Secretary

**No. N-P050(20)/53/2023-PGMEB-
NMC (8226935)
Government of India
National Medical Commission
(O/o Secretary)**

Sector-8, Dwarka
New Delhi-110075
Dated the August, 2024

To,

Directors/ Principals/ Deans & HoDs
All Medical Colleges/ Institutions under NMC

Subject: Discontinuation of all the courses running under the umbrella of College of Physicians & Surgeons (CPS), Mumbai -reg.

I invite reference to the Post Graduate Medical Education Board's (PGMEB) Public Notice dated 16-08-2024 (copy enclosed) on the subject mentioned above, wherein the contents of the notice are self explanatory. All the concerned Institutions are requested to strictly adhere to the same.

Encl.: As above

Signed by B Srinivas
Date: 22-08-2024 17:32:17
[Prof. (Dr) B. Srinivas]
Secretary

Copy to:

- i. ACS/ PS/ Secretaries/ Department/s of Medical Education in all States/ Union Territories
- ii. PPS to Chairman, NMC
- iii. PPS to President(PGMEB)
- iv. DMMP-I System Integrator- for uploading of NMC Website
- v. Guard File

दूरभाष/Phone : 25367033,
25367035, 25367036

पॉकेट -14, सेक्टर-8, द्वारका, फेस1-, नई
दिल्ली-77-

ई-मेल/E-mail :
pgmeb.recognition@nmc.org.in

Pocket- 14,
Sector- 8, Dwarka,
Phase - 1, New Delhi-77

राष्ट्रीय आयुर्विज्ञान आयोग

National Medical Commission

स्नातकोत्तर आयुर्विज्ञान शिक्षा बोर्ड

Post Graduate Medical Education Board (PGMEB)

F.No. N-P050(20)/53/2023-PGMEB-NMC

Dated: 26.07.2024

PUBLIC NOTICE

Subject: Discontinuation of all the courses running under the umbrella of College of Physicians & Surgeons (CPS), Mumbai

The Post Graduate Medical Education Board (PGMEB) had served a Show Cause Notice (SCN) on the College of Physician and Surgeon (CPS), Mumbai for not following the regulatory provisions of the NMC/ erstwhile MCI. In its reply, CPS, Mumbai intimated that it considers itself as an examination like body National Board of Examination in Medical Sciences (NBEMS) with authority to give medical qualification. The Board found this as a misleading statement and observed that the NBEMS is a Government organization included in the Schedule of NMC Act 2019. Whereas the CPS is a non-government organization (examination body) and has no authority to permit or recognize any course of qualification run by any hospital or to conduct examination or award degree. As per **Section 22** of the UGC Act, 1956, the right of conferring or granting degrees can be done by a University established or incorporated by or under a Central Act, a Provincial Act or a State Act or an institution deemed to be a University under Section 3 or an institution specially empowered by an Act of Parliament to confer or grant degrees. Thus, degrees can only be issued by a University or any statutory body empowered by an Act of Parliament.

2. Hence, PGMEB, NMC has decided to **discontinue all the courses running under the umbrella of CPS, Mumbai with immediate effect.**

3. All the stakeholders including medical institutions/ hospital running the CPS courses and students who are in the process of taking admissions to the courses run by CPS may kindly take note of the decision of the PGMEB, NMC as their additional qualifications will not be recognized for registration if any admission take place after issuance of this public notice.

Signed by Aujender Singh
Date: 16-08-2024 16:04:24
(Aujender Singh)
Director, PGMEB

No. 1069(11)/22023-PGMEB-NMC
Government of India
National Medical Commission
(O/o Secretary)

Sector-8, Dwarka
New Delhi-110075
07-09-2024

**Subject: Clarification on the mandatory requirement of dissertation/
thesis submission -regarding.**

Reference is invited to letter no. 1069(11)/22023-PGMEB-NMC dated 28-08-2024 of the Post Graduate Medical Education Board (PGMEB) addressed to all the Vice-Chancellors of Health Science Universities and Dean/ Principals of Medical Colleges/ Institutions has given clarification on the mandatory requirement of dissertation/ thesis submission, the contents of which are self explanatory. All concerned stakeholders are requested to kindly take note of the same.

Encl.: As above

Yours sincerely,

Signed by B Srinivas

Date: 07-09-2024 08:44:36

DR B SRINIVAS
SECRETARY

Copy to:

- i. ACS/ PS/ Secretaries/ Department/s of Medical Education in all States/
Union Territories
- ii. PPS to Chairman, NMC
- iii. PPS to President (PGMEB)
- iv. DMMP-I System Integrator- for uploading of NMC Website
- v. Guard File

दूरभाष/Phone : 25367033, 25367035, 25367036
 फैक्स/Fax : 0091-11-25367024
 ई-मेल/E-mail : pgmeb@nmc.org.in
 पॉकेट- 14, सेक्टर-8, द्वारका, फेज-1, नई दिल्ली -110 077
 Pocket-14, Sector-8, Dwarka, Phase-1, New Delhi-110 077

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

No.F.N-1069(11)/22023-PGMEB-NMC

Dated 28-08-2024

To

The Vice-Chancellors of Health Science Universities in India
 The Deans/Principals of Medical Colleges/Institutions in India

Subject: Clarification on the Mandatory Requirement of Dissertation/Thesis Submission

Dear Sir/Madam,

The Post Graduate Medical Education Board (PGMEB) of the National Medical Commission (NMC), through its public notice dated 13th June 2024, had previously informed all concerned medical colleges/institutions about the requirement to complete the final examination by 31st December 2024.

2. In an online meeting held on 31st July 2024 with representatives from various health universities, concerns were raised regarding the mandatory submission of the dissertation/thesis as a prerequisite for appearing in the final examination for the PG Broad Specialty batch of 2021. It was clarified during this meeting that as the agenda of the meeting was on the scheduling of examinations, therefore, issue of the thesis may be decided according to the provisions of PGMER-2023. Subsequently, the Maharashtra University of Health Sciences, Nashik, in a letter dated 01-08-2024 and other stakeholders have sought clarification on this matter.

3. In this regard, it is informed that the National Medical Commission has notified the Post Graduate Medical Education Regulations, 2023 (PGMER-23), published in the Official Gazette on 1st January 2024. Additionally, a public notice provided point-wise clarification in the form of Frequently Asked Questions (FAQs) via No. N-106911/2/2023-PGMEB-NMC dated 10th April 2024, specifically addressing the examination of dissertations and the process for the viva voce examination, as detailed in Item No. 6 (copy enclosed).

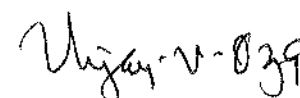
4. Regulation 5.2 (iii) of the Post Graduate Medical Education Regulations 2023 provides that all broad speciality and super speciality students will do thesis related research and will write thesis.

5. Similarly, relevant provision regarding dissertation/thesis as contained in Regulation 8.4 of the Post Graduate Medical Education Regulations 2023, reproduces as under:

Five per cent of mark of total marks of Clinical/Practical and Viva Voce marks (20 marks) will be of dissertation/thesis and it will be part of clinical/practical examination marks. External examiner outside the state will evaluate dissertation/ thesis and take viva voce on it and marks will be given on quality of dissertation/thesis and performance on its viva voce.

6. Therefore, student will submit the dissertation to the University through HoD and Dean of the Medical College. The student cannot be prevented from appearing in the examination if he has not obtained the approval of dissertation/thesis from the HoD. The dissertation now accounts for 5% of the total marks in the clinical/practical and viva voce components, meaning 20 marks out of the total marks allocated for these components are reserved for the dissertation. This change in the guidelines will help in the quality of thesis related research work.

7. This clarification is being disseminated to all concerned, including postgraduate students, to avoid any confusion.



(Dr. Vijay Oza)
President, PGMEB

डॉ. (प्रो.) बी. श्रीनिवास (एमडी)
सचिव
Dr. (Prof.) B. Srinivas (MD)
Secretary



राष्ट्रीय आयुर्विज्ञान आयोग
स्वास्थ्य एवं परिवार कल्याण मंत्रालय
भारत सरकार

National Medical Commission
Ministry of Health & Family Welfare
Government of India

**MESSAGE OF THE SECRETARY (NMC) ON THE OBSERVANCE OF
VIGILANCE AWARENESS CAMPAIGN, 2024 AND VIGILANCE AWARENESS
WEEK, 2024**

I am happy to learn that Central Vigilance Commission is observing Vigilance Awareness Week (28th October, 2024 to 3rd November, 2024) as a prelude to Vigilance Awareness Campaign from 16th August, 2024-15th November, 2024 with a very apt theme "*Culture of Integrity for Nation's Prosperity*".

National Medical Commission has been following zero tolerance approach towards corruption and has taken stringent actions against corruption. The Commission will be conducting various activities like Essay Competition, Poster Competition & Slogan Writing Competition and the participation will not be limited to only officials but also their families. A Training session will also be held on Administrative and Preventive Vigilance for creating awareness on vigilance for the officials of NMC.

All of us must remember that being vigilant and practicing honesty and integrity in all our everyday actions are the key to achieve prosperity. Let us re-affirm our commitment towards transparency and preventing corruption. Finally, I extend my greetings to all concerned and wish a very successful Vigilance Awareness Week, 2024.


(Dr. B. Srinivas)
Secretary

डॉ. (प्रो.) बी. श्रीनिवास (एमडी)
सचिव
Dr. (Prof.) B. Srinivas (MD)
Secretary



राष्ट्रीय आयुर्विज्ञान आयोग
स्वास्थ्य एवं परिवार कल्याण मंत्रालय
भारत सरकार
National Medical Commission
Ministry of Health & Family Welfare
Government of India

सतर्कता जागरूकता अभियान, 2024 और सतर्कता जागरूकता सप्ताह, 2024 के पालन पर
सचिव (एनएमसी) का संदेश

मुझे यह जानकर खुशी हुई कि केंद्रीय सतर्कता आयोग, 16 अगस्त, 2024 - 15 नवंबर, 2024 तक सतर्कता जागरूकता अभियान की प्रस्तावना के रूप में एक उपयुक्त विषय "सत्यनिष्ठा की संस्कृति से राष्ट्र की समृद्धि" के साथ सतर्कता जागरूकता सप्ताह (28 अक्टूबर, 2024 से 3 नवंबर, 2024) इस वर्ष राष्ट्रीय आयुर्विज्ञान आयोग में मनाया जा रहा है।

राष्ट्रीय आयुर्विज्ञान आयोग भ्रष्टाचार के प्रति शून्य सहिष्णुता दृष्टिकोण का पालन कर रहा है और भ्रष्टाचार के खिलाफ सख्त कार्यवाई के लिए प्रतिबद्ध है। इस उपलक्ष्य पर आयोग में निबंध प्रतियोगिता, पोस्टर प्रतियोगिता और नारा लेखन प्रतियोगिता जैसी गतिविधियाँ आयोजित की जा रही हैं और इसमें भागीदारी केवल आयोग के कर्मचारियों तक ही सीमित नहीं होगी, अपितु उनके परिवार के सदस्य भी शामिल हो सकते हैं। आयोग के समस्त कर्मचारियों/अधिकारियों में सतर्कता का जज्बा कायम रहें इसके लिए सतर्कता विभाग, राष्ट्रीय आयुर्विज्ञान आयोग प्रशासनिक और निवारक सतर्कता पर एक प्रशिक्षण सत्र का आयोजन कर रहा है।

हम सभी को यह याद रखना चाहिए कि सतर्क रहना और अपने सभी दैनिक कार्यों में ईमानदारी और निष्ठा का अभ्यास करना समृद्धि प्राप्त करने की कुंजी है। आइए हम पारदर्शिता से भ्रष्टाचार को रोकने के प्रति अपनी प्रतिबद्धता की फिर से पुष्टि करें। अंत में, मैं आयोग के सभी अधिकारियों और कर्मचारियों का आभार प्रकट करता हूँ और सतर्कता जागरूकता सप्ताह - 2024 के अत्यंत सफल होने की कामना करता हूँ।

(डॉ. बी. श्रीनिवास)
सचिव

डॉ. बी. एन. गंगाधर
अध्यक्ष

Dr. B. N. Gangadhar
Chairman



राष्ट्रीय आयुर्विज्ञान आयोग
स्वास्थ्य एवं परिवार कल्याण मंत्रालय
भारत सरकार

National Medical Commission
Ministry of Health & Family Welfare
Government of India

संदेश

मुझे यह जानकर खुशी हुई कि केंद्रीय सतर्कता आयोग चाहता है कि सभी संगठन अगस्त, 2024 से तीन महीने के अभियान के दौरान निवारक सतर्कता से संबंधित गतिविधियां करें।

इस वर्ष का सतर्कता जागरूकता सप्ताह का विषय "राष्ट्र की समृद्धि के लिए सत्यनिष्ठा की संस्कृति" है।

इस वर्ष का विषय राष्ट्रीय चिकित्सा आयोग के लिए उपयुक्त है जो सत्यनिष्ठा की संस्कृति को, भ्रष्टाचार से लड़ने के लिए बढ़ावा देती है। राष्ट्रीय चिकित्सा आयोग के लिए यह और भी महत्वपूर्ण है कि वह शासन और सार्वजनिक प्रशासन में नैतिकता और पारदर्शिता की आवश्यकता के बारे में अधिक संवेदनशीलता पैदा करने के लिए उदाहरण पेश करे।

सभी कर्मचारियों और हितधारकों को भ्रष्टाचार के खिलाफ लड़ाई में भाग लेना चाहिए और राष्ट्र की समृद्धि के लिए सत्यनिष्ठा की संस्कृति को दोहराने के लिए एक साथ आना चाहिए। सभी कर्मचारियों को अपने पेशेवर और व्यक्तिगत जीवन में सत्यनिष्ठा की संस्कृति को बढ़ावा देना चाहिए।

आइये हम सब इस भ्रष्टाचार विरोधी अभियान में पूरे जोश के साथ भाग लें।

(Handwritten signature)

(डॉ. बी.एन. गंगाधर)
अध्यक्ष, राष्ट्रीय चिकित्सा आयोग

डॉ. बी. एन. गंगाधर
अध्यक्ष

Dr. B. N. Gangadhar
Chairman



राष्ट्रीय आयुर्विज्ञान आयोग
स्वास्थ्य एवं परिवार कल्याण मंत्रालय
भारत सरकार
National Medical Commission
Ministry of Health & Family Welfare
Government of India

MESSAGE

I am happy to learn that the Central Vigilance Commission desires all organizations to undertake activities related to preventive vigilance during the three month campaign from August, 2024.

The theme of this year's Vigilance Awareness Week is "Culture of Integrity for Nation's Prosperity".

This year's theme is appropriate for National Medical Commission which promotes the culture of Integrity in order to fight corruption. It is all the more important for NMC to lead by example to create greater sensitivity about the need for ethics and transparency in governance and public administration.

All the employees and stakeholders should participate in the fight against corruption and come together to reiterate the culture of integrity for Nation's Prosperity. All Employees should nurture the culture of integrity in our professional and personal life.

Let us all participate in this anti-corruption campaign with full zeal.


(Dr. B.N.GANGADHAR)



CDN.20011/260/2024/Coordination-NMC
Government of India
National Medical Commission
Policy & Coordination Division



Pocket- 14, Sector- 8,
 Dwarka, Phase-1, New Delhi-77
 18-09-2024

Public Notice

Subject : Inauguration of Tobacco Cessation Centers in Medical Institutions-reg

In continuation of NMC's public notice dt. 16.08.2024 (copy attached), all medical colleges are hereby informed that the Tobacco Free Youth Campaign 2.0 is scheduled to be launched by the Hon'ble Union Minister of Health and Family Welfare on **24th September 2024 from 11.00am to 12.30pm**. During this event, it is proposed that the **Hon'ble Union Minister of Health and Family Welfare will also inaugurate the Tobacco Cessation Centers (TCCs) in all medical Institutions across India through a virtual platform. A copy of the letter dt. 9.9.2024 from MoHFW in this regard alongwith the approved design for the inauguration plaque is enclosed.**

2. In line with this initiative, operational guidelines for establishing TCCs in medical institutions were released on World No Tobacco Day 2024 (Available at : [https://ntcp.mohfw.gov.in/assets/document/Guideline manuals/OperationalGuidelinesforEstablishingTobaccoCessationCentresinMedicalInstitutions.pdf](https://ntcp.mohfw.gov.in/assets/document/Guideline%20manuals/OperationalGuidelinesforEstablishingTobaccoCessationCentresinMedicalInstitutions.pdf)), followed by a National Webinar conducted by MoHFW on 20th August 2024.

3. In view of the above, all medical institutions are hereby directed to make arrangements for the establishment of TCCs in accordance with the Operational Guidelines, display the inauguration plaque outside the TCC and facilitate the virtual inauguration, The web-link for joining the launch event will be shared in due course of time.

4. This issues with the approval of Competent Authority.

Signed by B Srinivas

Date: 18-09-2024 11:40:04

DR B SRINIVAS

SECRETARY

srinivas.b@nic.in

To

Principals / Deans of all Medical Colleges/Institutions.
(Under the Purview of National Medical Commission)



CDN-20011/218/2024-Coord-NMC
Government of India
National Medical Commission
Policy and Coordination Division



Pocket- 14, Sector- 8,
 Dwarka, Phase-1, New Delhi-77
 Dated the 16-08-2024

PUBLIC NOTICE

Sub: Establishment of Tobacco Cessation Centers in All Medical Colleges.

In accordance with the Operational Guidelines launched on May 31, 2024, on World No Tobacco Day, the Ministry of Health and Family Welfare, in collaboration with the National Medical Commission, is initiating the establishment of Tobacco Cessation Centres (TCCs) in all medical colleges across India. These centres will be critical in advancing public health by assisting individuals in quitting tobacco use and thus reducing tobacco-related diseases.

2. As part of the Tobacco Free Youth Campaign 2.0, the National Medical Commission mandates that all medical colleges under its jurisdiction must establish a Tobacco Cessation Center. The centres should be operationalized as soon as possible, with comprehensive guidance provided via a scheduled webinar.

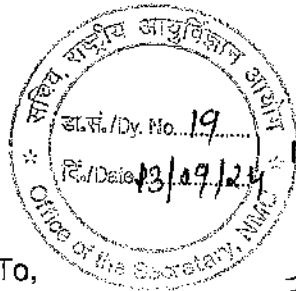
Key Points:

- i. A webinar will be held on **August 20, 2024**, from **02:00 PM to 03:30 PM** to orient all medical institutes regarding the setup and management of these centres.
 - ii. Participation in the webinar is **mandatory** for all medical institutes to ensure effective implementation of the TCCs.
 - iii. The Tobacco Cessation Centres are to be officially launched virtually by the Hon'ble Health Minister during the Tobacco Free Youth Campaign 2.0.
 - iv. All medical colleges must comply with the guidelines and ensure that their Tobacco Cessation Centres are fully operational in a timely manner.
3. Detailed programme of the webinar is enclosed. Link for the aforementioned webinar will be shared in due course.
4. This issues with the approval of competent authority.

Signed by B Srinivas

Date: 16-08-2024 17:14:12

DR B SRINIVAS
 SECRETARY
 srinivas.b@nic.in



T-20018/07/2024-SAS

Government of India
Ministry of Health & Family Welfare
National Tobacco Control Programme

DIARY SECTION

13 SEP 2024

National Medical Commission

Dated 09th September 2024

To,

The Secretary,
National Medical Commission,
Delhi

Subject: Inauguration of Tobacco Cessation Centers in Medical Institutions - reg.

Sir,

In continuation with the letter dated 24th May 2024 from the Additional Secretary, MoHFW, the letter dated 14th June from the undersigned and the circular issued by the Secretary, NMC on 12th July 2024, this is to inform you that the Tobacco Free Youth Campaign 2.0 is scheduled to be launched by the Hon'ble Union Minister of Health and Family Welfare on **24th September 2024 from 11:00am to 12:30pm**. During this event, it is proposed that the Hon'ble Union Minister of Health and Family Welfare will also inaugurate the Tobacco Cessation Centers (TCCs) in all medical institutions across India through a virtual platform.

2. In line with this initiative, operational guidelines for establishing TCCs in medical institutions were released on World No Tobacco Day 2024 (Available at: <https://ntcp.mohfw.gov.in/assets/document/Guidelinemanuals/OperationalGuidelineforEstablishingTobaccoCessationCentresinMedicalInstitutions.pdf>), followed by a National Webinar conducted by MoHFW on 20th August 2024. The approved design for the inauguration plaque is enclosed.

3. In this regard, NMC is requested to issue directives to all medical institutions to make arrangements for the establishment of TCCs in accordance with the Operational Guidelines, display the inauguration plaque outside the TCC and facilitate the virtual inauguration. The web-link for joining the launch event will be shared in due course of time.

4. This issue with the approval of the competent authority.

Thanking you,

Yours faithfully

Signed by Dr. Poonam
Dr. Poonam Meena
Deputy Secretary to Government of India
Date: 09-09-2024 19:49:09

Encl:

1. *Letter dated 24th May 2024 and 14th June 2024*
2. *Circular dated 12th July*
3. *Approved Plaque design for inauguration*



No. 47/15/2024-Coord-NMC
Government of India
National Medical Commission
(Policy & Coordination Division)

75
Azadi Ka
Amrit Mahotsav

Pocket- 14, Sector- 8,
Dwarka, Phase-1, New Delhi-77
Dated: 12-07-2024

CIRCULAR

Subject: Establishment of Tobacco Cessation Centres in Medical Colleges across the country- regarding.

In line with its commitment to promote public health and combating the adverse effects of tobacco use, the Government has decided to establish Tobacco Cessation Centres in medical colleges across the country. This initiative aims to strengthen the healthcare infrastructure by integrating specialized services for tobacco cessation into the educational and healthcare framework.

2. All the hospitals attached to each of the medical colleges are directed to make provisions for "Tobacco Cessation Centre". This can be a special clinic run by the Department of Psychiatry and/or other departments. These Centres should also be established in rural and urban health centres that the college has adopted for training. These Centres along with tobacco cessation, will also work as "Drug De-addiction Centres".
3. This issues with the approval of Chairman, NMC.

Signed by B Srinivas
Date: 12-07-2024 14:01:19

Dr. (Prof.) B Srinivas
Secretary, NMC

To,

All Medical Colleges/ Institutions.
(under the purview of National Medical Commission)



वी. हेकाली झिमोमी, भा.प्र.से.
अपर सचिव

V. Hekali Zhimomi, IAS
Additional Secretary



भारत सरकार
स्वास्थ्य एवं परिवार कल्याण मंत्रालय
निर्माण भवन, नई दिल्ली - 110011

05 JUL 2024

भारत सरकार

स्वास्थ्य एवं परिवार कल्याण मंत्रालय
निर्माण भवन, नई दिल्ली - 110011
Government of India
Ministry of Health & Family Welfare
Nirman Bhawan, New Delhi - 110011



D.O. No. P.H/012/04/2021-TC
Dated 24th May, 2024

Dear Sir,

India has made laudable progress and is recognized as one of the regional and global leaders in tobacco control. Tobacco consumption continues to be the leading preventable cause of death in the world. The second round of the Global Adult Tobacco Survey in India (GATS-2), 2016-17 reported that 28.6% (26.7 crore) adults use tobacco in various forms. According to GATS-2 tobacco cessation data, 38.4% of smokers and 35.4% of smokeless tobacco users attempted to quit in the past 12 months. Additionally, 46.6% of current smokers and 45.2% of smokeless tobacco users either planned to or were thinking about quitting.

2. Provision of Tobacco Cessation Services for all the tobacco users is one of the main objectives of the National Tobacco Control Programme and offering help to quit also constitutes one of the key interventions of the WHO FCTC to reduce demand for tobacco. I would like to mention that health professionals have a prominent role to play in tobacco control. A medical practitioner or doctor within a medical institute/college not only has the expertise to diagnose and treat diseases but can also educate the patient how tobacco use contributes to the specific ailment.

3. Given the connection between medical institutions and hospitals, healthcare professionals in these institutions can provide primary, secondary, and tertiary prevention services to the tobacco users, the establishment of Tobacco Cessation Centres (TCC) in medical institutes becomes imperative. Taking forward this opportunity, I would like to request the National Medical Commission to coordinate with all Medical Institutions for setting up the Tobacco Cessation Centre. In this regard, the Tobacco Control Section is coming up with the Operational Guidelines for setting up TCC in Medical Colleges and would be released on this year's World No Tobacco Day on 31st May, 2024. This model of establishing a TCC in a Medical Institution is formulated with the aim of promoting and fostering inter-disciplinary clinics in medical institutions across the country. This proactive approach is intended to make a valuable contribution to tobacco cessation as well as control efforts while protecting patients from the significant public health impact of tobacco use.

4. I strongly believe that empowering medical professionals with the tools and knowledge to facilitate tobacco cessation reinforces our commitment to public health and ensures a comprehensive approach to tackling the pervasive challenges posed by tobacco use. Looking forward to your support for the cause of working towards tobacco control.

With regards,

(V. Hekali Zhimomi)

To

Dr B.N. Gangadhar
Chairman
National Medical Commission
Pocket-14, Sector-8, Dwarka-1, New Delhi-110077

THP

3678970 / JIS / 117466 / 2024

Room No. 244, 'A' Wing, Nirman Bhawan, New Delhi-110011

File No. P.16012/04/2021-TC (Computer No. 3132510) Tel: 011-23054708 23054709 E-mail: zhimomiv@ias.nic.in

File No P.16012/04/2021-TC
Government of India
Ministry of Health and Family Welfare
(Tobacco Control Section)

Nirman Bhawan, New Delhi 110011
Dated 14th June, 2024

To

Dr (Prof.) B. Srinivas
Secretary
National Medical Commission
Pocket-14, Sector-8, Dwarka Phase-1
New Delhi - 110077.

Subject:- Request letter regarding facilitating the setting up of Tobacco Cessation Centre (TCC) in all Medical Institutions- reg

Sir,

I would like to express my gratitude for your kind support in developing the important guidelines on "Operational Guidelines for setting up Tobacco Cessation Centre (TCC) in Medical Colleges". The Guidelines have been released on the occasion of "World No Tobacco Day" held on 31st May, 2024 and the same is available on the links given below.

2. Further, in continuation of this Ministry's D.O. Letter No.P.16012/04/2021-TC dated 24th May, 2024 (copy enclosed), I would like to reiterate that the model of establishing TCC in Medical Institution is formulated with the aim of promoting and fostering inter-disciplinary clinics in medical institutions across the Country. This proactive approach is intended to make a valuable contribution to tobacco cessation as well as efforts to protect the public from use of tobacco.

3. Taking forward this opportunity, I want to share that the specific activity has also been included as one of the 100 days agenda under Viksit Bharat Goals and the same was discussed in the meeting with Secretary(HFW) held on 10.06.2024.

4. In view of the above, I would request your intervention to facilitate in setting up the Tobacco Cessation Centre in all Medical Institutions of the Country. Looking forward of your cooperation for this cause within medical communities.

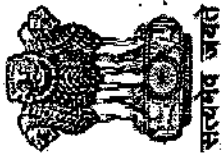
Yours sincerely,

(Dr. Poonam Meena)

Deputy Secretary to Government of India
Telephone-23062205

Encl:-2

NB: (<https://ntcp.mohfw.gov.in/assets/document/Guideline-manuals/Operational%20Guidelines%20for%20Establishing%20Tobacco%20Cessation%20Centres%20in%20Medical%20Institutions.pdf>)



Ministry of Health and Family Welfare
Government of India

College Name

Tobacco Cessation Centre

NATIONAL TOBACCO CONTROL PROGRAMME
INAUGURATED VIRTUALLY BY

SHRI. JAGAT PRAKASH NADDA
HON'BLE UNION MINISTER OF HEALTH & FAMILY WELFARE

On the occasion of
Tobacco Free Youth Campaign 2.0
September 24, 2024

National Medical Commission (NMC)
Medical Assessment & Rating Board (MARB)

Pocket- 14, Sector- 8, Dwarka, Phase - 1,
New Delhi-77

PUBLIC NOTICE

Subject: SB Civil Writ Petition No. 16822/2024 titled as JIET Medical College & Hospital Vs. Union of India and SBCWP 12053/2024-Tirupati Balaji Educational Trust v Union of India & ors

It is hereby informed that recently the Hon'ble High court of Jodhpur, in the above mentioned cases, have directed the Commission to issue Letter of Permission to the following medical colleges situated in the state of Rajasthan;

- a) JIET Medical college and Hospital, Jodhpur from 50 to 100 MBBS seats.
- b) Pacific Medical Science College and Hospital, Bhilo ka Bedla, Udaipur from 150 to 250 seats.

2. Whereas, this Commission along with Union of India has preferred Second appeal before the Division Bench of the Hon'ble High Court against the orders in the above mentioned Writs, which are currently sub-judice.

3. All stake-holders are hereby informed about the pendency of the cases.

(Dr. B Srinivas)
Secretary, National Medical Commission

To

All Medical Institutions/Colleges/stake-holders concerned.

Copy to:

Director (IT) -for uploading this Public Notice on the website of NMC today itself.



CDN-20011/98/2024/Coordination-NMC

**Government of India
National Medical Commission
Policy & Coordination Division**



Pocket- 14, Sector- 8,
Dwarka, Phase-1, New Delhi-77
28-11-2024

Show Cause Notice

Subject: Non-submission of the details of stipend paid to UG interns, PG residents and Senior Residents or PGs in Super Specialty by various Medical Colleges/Medical Institutions.

Hon'ble Supreme Court of India in the WP(C) No.730/2022 & other cases, vide their orders dt. 16-09-2023 and 01-04-2024, has directed NMC to submit the details of stipends paid to the Medical Interns and residents. Accordingly, all the Health Institutions/Medical Colleges were directed, vide Public Notice dated 16-04-2024, to submit to NMC, the details of stipend paid to their UG interns, PG residents and Senior residents or PGs in Super Specialty for the financial year 2023-24 as per Annexure-1 on E-mail ID: stipend23-24@nmc.org.in

2. It was further, directed to upload the details for financial year 2024-25 onwards on the website of the Medical College/ Medical Institutions concerned and also required to be updated on monthly basis (by 5th of every month) as per the Annexure-2 and at the end of the financial year, the complete statement be submitted to NMC on E-mail ID: stipend24-25@nmc.org.in

3. It is observed that the requisite data is still to be furnished by many colleges on the E-mail IDs provided as above. The failure of these medical colleges in submitting the information reg. payment of stipend to the interns / residents is considered seriously, and **the medical colleges as per the attached list who have not submitted the requisite information, are hereby directed to show cause as to why penal action should not be taken against them for their failure to submit the information / details of stipend paid**

4. The defaulting medical colleges are also directed to furnish the data relating payment of stipend during 2023-24 on the dedicated e-mail ID stipend23-

24@nmc.org.in **IMMEDIATELY**. and within next 3 days from the issue of this show cause notice.

Signed by B Srinivas

Date: 28-11-2024 14:32:28

DR B SRINIVAS

SECRETARY

srinivas.b@nic.in

28-11-2024

To,

Dean / Principal of Medical College

(As per list attached: 115 Govt. Medical Colleges & 83 Pvt. Medical Colleges)

List of Government college

Report not received

S.No.	Name of the College	State	Name of the Affiliating University
1	Government Medical College, Machilipatnam	Andhra Pradesh	Dr. YSR University of Health Sciences
2	Government Medical College, Nandyal	Andhra Pradesh	Dr. YSR University of Health Sciences
3	SVIMS - Sri Padmavathi Medical College for Women, Alipiri Road, Tirupati	Andhra Pradesh	Sri Venkateswara Institute of Medical Sciences (SVIMS), Tirupati
4	Tomo Riba Institute of Health & Medical Sciences, Naharlagun	Arunachal Pradesh	Rajiv Gandhi University
5	Gauhati Medical College, Guwahati	Assam	Srimanta Shankardeva University of Health Sciences
6	Nagaon Medical College	Assam	Srimanta Shankardeva University of Health Sciences
7	Dhubri Medical College, Dhubri	Assam	Srimanta Shankardeva University of Health Sciences
8	Patna Medical College, Patna	Bihar	Aryabhatta Knowledge University, Patna
9	Nalanda Medical College, Patna	Bihar	Aryabhatta Knowledge University, Patna
10	Government Medical College, Purnea	Bihar	Aryabhatta Knowledge University, Patna
11	Employees State Insurance Corporation Medical College, Patna	Bihar	Aryabhatta Knowledge University, Patna
12	Pt. J N M Medical College, Raipur	Chattisgarh	Pt. Deendayal Upadhyay Memorial Health Sciences and Ayush University, Raipur
13	Government Medical College, Korba	Chattisgarh	Pt. Deendayal Upadhyay Memorial Health Sciences and Ayush University, Raipur
14	Chandulal Chandrakar Memorial Government Medical College, Durg	Chattisgarh	Pt. Deendayal Upadhyay Memorial Health Sciences and Ayush University, Raipur
15	Maulana Azad Medical College, New Delhi	Delhi	Delhi University
16	Atal Bihari Vajpayee Institute of Medical Sciences and Dr. RML Hospital, New Delhi	Delhi	Guru Gobind Singh Indraprastha University
17	Dr. Baba Saheb Ambedkar Medical College, Rohini, Delhi	Delhi	Guru Gobind Singh Indraprastha University
18	North Delhi Municipal Corporation Medical College, Delhi	Delhi	Guru Gobind Singh Indraprastha University
19	Surat Municipal Institute of Medical Education & Research, Surat	Gujarat	Veer Narmad South Gujarat University
20	Government Medical College, Porbandar	Gujarat	Bhakta Kavi Narsing Mehta University, Bikha Roa, Khadia
21	Government Medical College, Panchmahal Godhra	Gujarat	Shri Govind Guru University, Godhara

22	Pt. B D Sharma Postgraduate Institute of Medical Sciences, Rohtak (Haryana)	Haryana	PT. B.D. Sharma University of Health Sciences, Rohtak
23	Shri Atal Bihari Vajpayee Government Medical College, Faridabad	Haryana	PT. B.D. Sharma University of Health Sciences, Rohtak
24	Kalpana Chawala Government Medical College, Karnal, Haryana	Haryana	PT. B.D. Sharma University of Health Sciences, Rohtak
25	Shaheed Hasan Khan Mewati Government Medical College, Nalhar	Haryana	PT. B.D. Sharma University of Health Sciences, Rohtak
26	Government Medical College, Nahan, Sirmour H.P.	Himachal Pradesh	Himachal Pradesh University
27	Dr. Rajendar Prasad Government Medical College, Tanda, H.P	Himachal Pradesh	Himachal Pradesh University
28	Government Medical College, Handwara	Jammu & Kashmir	University of Kashmir
29	Government Medical College, Udhampur	Jammu & Kashmir	University of Jammu
30	Government Medical College, Doda, Kashmir	Jammu & Kashmir	Kashmir University
31	Government Medical College, Rajouri, J&K	Jammu & Kashmir	Jammu University
32	Government Medical College, Anantnag	Jammu & Kashmir	Kashmir University
33	M G M Medical College, Jamshedpur	Jharkhand	Kolhan University, Chaibasa
34	Dumka Medical College, Dighi Dumka	Jharkhand	Sidho Kanhu Murmu University
35	Palamu Medical College, Palamu	Jharkhand	Nilamber-Pitamber University
36	Hazaribagh Medical College, Hazaribagh	Jharkhand	Binod Bihari Mahto Koyalanchal University, Dhanbad
37	Raichur Institute of Medical Sciences, Raichur	Karnataka	Rajiv Gandhi University of Health Sciences, Karnataka
38	Chitradurga Medical College and Research Institute	Karnataka	Rajiv Gandhi University of Health Sciences, Karnataka
39	Chikkamagaluru Institute of Medical Sciences, Chikkamagaluru	Karnataka	Rajiv Gandhi University of Health Sciences, Karnataka
40	Yadgiri Institute of Medical Sciences, Yadgiri	Karnataka	Rajiv Gandhi University of Health Sciences, Karnataka
41	Shri Atal Bihari Vajpayee Medical College & Research Institute	Karnataka	Rajiv Gandhi University of Health Sciences, Karnataka
42	Chamrajanagar Institute of Medical Sciences, Karnataka	Karnataka	Rajiv Gandhi University of Health Sciences, Karnataka
43	Karwar Institute of Medical Sciences, Karwar	Karnataka	Rajiv Gandhi University of Health Sciences, Karnataka
44	Gadag Institute of Medical Sciences, Mallasamudra, Mulgund Road, Gadag	Karnataka	Rajiv Gandhi University of Health Sciences, Karnataka
45	Employees State Insurance Corporation Medical College, Gulbarga	Karnataka	Rajiv Gandhi University of Health Sciences, Karnataka

46	Employees State Insurance Corporation Medical College, Bangalore	Karnataka	Rajiv Gandhi University of Health Sciences, Karnataka
47	Government Medical College, Pariyaram, Kannur (Prev. Known as Academy of Medical Sciences)	Kerala	Kerala University of Health Sciences, Thrissur, Kerala
48	Government Medical College, Kottayam	Kerala	Kerala University of Health Sciences, Thrissur, Kerala
49	T D Medical College, Alleppey (Allappuzha)	Kerala	Kerala University of Health Sciences, Thrissur, Kerala
50	Government Medical College, Konni	Kerala	Kerala University of Health Sciences, Thrissur, Kerala
51	Government Medical College, Idukki.	Kerala	Kerala University of Health Sciences, Thrissur, Kerala
52	Government Medical College, Parippally, Kollam	Kerala	Kerala University of Health Sciences, Thrissur, Kerala
53	Shyam Shah Medical College, Rewa	Madhya Pradesh	Madhya Pradesh Medical Science University, Jabalpur
54	Government Medical College, Chhindwara, MP	Madhya Pradesh	Madhya Pradesh Medical Science University, Jabalpur
55	Government Medical College, Khandwa, MP	Madhya Pradesh	Madhya Pradesh Medical Science University, Jabalpur
56	Government Medical College, Vidisha, MP	Madhya Pradesh	Madhya Pradesh Medical Science University, Jabalpur
57	Government Medical College, Datia, MP	Madhya Pradesh	Madhya Pradesh Medical Science University, Jabalpur
58	Sri Bhausaheb Hire Government Medical College, Dhule	Maharashtra	Maharashtra University of Health Sciences, Nashik
59	Government Medical College, Latur	Maharashtra	Maharashtra University of Health Sciences, Nashik
60	Government Medical College, Akola	Maharashtra	Maharashtra University of Health Sciences, Nashik
61	Rajiv Gandhi Medical College and Chhatrapati Shivaji Maharaj Hospital, Thane	Maharashtra	Maharashtra University of Health Sciences, Nashik
62	Dr. Shankarrao Chavan Government Medical College, Nanded	Maharashtra	Maharashtra University of Health Sciences, Nashik
63	SRTR Medical College, Ambajogai	Maharashtra	Maharashtra University of Health Sciences, Nashik
64	Government Medical College, Parbhani	Maharashtra	Maharashtra University of Health Sciences, Nashik
65	Government Medical college and District Hospital, Ratnagiri	Maharashtra	Maharashtra University of Health Sciences, Nashik
66	Government Medical College, Sindhudurg	Maharashtra	Maharashtra University of Health Sciences, Nashik
67	Government Medical College, Alibag	Maharashtra	Maharashtra University of Health Sciences, Nashik
68	Government Medical College, Nandurbar	Maharashtra	Maharashtra University of Health Sciences, Nashik
69	Government Medical College, Churachandpur	Manipur	Manipur University
70	Jawaharlal Nehru Institute of Medical Sciences, Porompat, Imphal	Manipur	Manipur University
71	Guru Govind Singh Medical College, Faridkot	Punjab	Baba Farid University of Health Sciences, Faridkot
72	Government Medical College, Amritsar	Punjab	Baba Farid University of Health Sciences, Faridkot

73	Dr B R Ambedkar State Institute of Medical Sciences, SAS Nagar , Mohali	Punjab	Baba Farid University of Health Sciences, Faridkot
74	Jawaharlal Nehru Medical College, Ajmer	Rajasthan	Rajasthan University
75	R N T Medical College, Udaipur	Rajasthan	Rajasthan University of Health Sciences
76	Government Medical College, Dausa	Rajasthan	Rajasthan University of Health Sciences
77	Government Medical College, Alwar	Rajasthan	Rajasthan University of Health Sciences
78	Government Medical College, Hanumangarh	Rajasthan	Rajasthan University of Health Sciences
79	Government Medical College, Chittorgarh	Rajasthan	Rajasthan University of Health Sciences
80	Government Medical College, Dholpur	Rajasthan	Rajasthan University of Health Sciences
81	Government Medical College, Sri Ganganagar	Rajasthan	Rajasthan University of Health Sciences
82	Government Medical College, Barmer	Rajasthan	Rajasthan University of Health Sciences
83	Government Medical College, Churu	Rajasthan	Rajasthan University of Health Sciences
84	Government Medical College, Dungarpur	Rajasthan	Rajasthan University of Health Sciences
85	Government Medical College, Bharatpur, Rajasthan	Rajasthan	Rajasthan University of Health Sciences
86	Madurai Medical College, Madurai	Tamil Nadu	The Tamilnadu Dr. MGR Medical University, Chennai
87	Rajah Muthiah Medical College, Annamalai Nagar	Tamil Nadu	Annamalai University
88	Government Medical College, Thiruvallur	Tamil Nadu	The Tamilnadu Dr. MGR Medical University, Chennai
89	Government Medical College, Ariyalur	Tamil Nadu	The Tamilnadu Dr. MGR Medical University, Chennai
90	Government Medical College, Pudukottai, Tamil Nadu	Tamil Nadu	The Tamilnadu Dr. MGR Medical University, Chennai
91	Government Medical College, Omandurar	Tamil Nadu	The Tamilnadu Dr. MGR Medical University, Chennai
92	Government Medical College, Karimnagar	Telangana	Kaloji Narayana Rao University of Health Sciences, Warangal
93	Government Medical College, Nirmal	Telangana	Kaloji Narayana Rao University of Health Sciences, Warangal
94	Government Medical College, Khammam	Telangana	Kaloji Narayana Rao University of Health Sciences, Warangal
95	Government Medical College, Vikarabad	Telangana	Kaloji Narayana Rao University of Health Sciences, Warangal
96	Government Medical College, Kamareddy	Telangana	Kaloji Narayana Rao University of Health Sciences, Warangal
97	Government Medical College, Kumuram Bheem Asifabad	Telangana	Kaloji Narayana Rao University of Health Sciences, Warangal
98	Government Medical College, Mancherial	Telangana	Kaloji Narayana Rao University of Health Sciences, Warangal
99	Government Medical College, Ramagundam	Telangana	Kaloji Narayana Rao University of Health Sciences, Warangal
100	Government Medical College, Mahabubabad	Telangana	Kaloji Narayana Rao University of Health Sciences, Warangal
101	Government Medical College, Nalgonda	Telangana	Kaloji Narayana Rao University of Health Sciences, Warangal

List of Private colleges Report not received

S.No.	Name of the College	State	Name of the Affiliating University
1	Dr. P.S.I. Medical College , Chinoutpalli	Andhra Pradesh	Dr. YSR University of Health Sciences
2	P E S Institute Of Medical Sciences and Research, Kuppam	Andhra Pradesh	Dr. YSR University of Health Sciences
3	Sri Balaji Medical College, Hospital and Research Institute, Chittoor	Andhra Pradesh	Dr. YSR University of Health Sciences
4	Gayathri Vidya Parishad Institute of Health Care & Medical Technology, Visakhapatnam	Andhra Pradesh	Dr. YSR University of Health Sciences
5	Nimra Institute of Medical Sciences, Krishna Dist., A.P.	Andhra Pradesh	Dr. YSR University of Health Sciences
6	NRI Institute of Medical Sciences, Visakhapatnam	Andhra Pradesh	Dr. YSR University of Health Sciences
7	Radha Devi Jageshwari Memorial Medical College and Hospital	Bihar	Aryabhata Knowledge University, Patna
8	Shree Narayan Medical Institute and Hospital	Bihar	Bhupendra Narayan Mandal University, Madhepura
9	Netaji Subhas Medical College & Hospital, Amhara, Bihta, Patna	Bihar	Aryabhata Knowledge University, Patna
10	Lord Buddha Koshi Medical College and Hospital, Saharsa	Bihar	B.N. Mandal University
11	Raipur Institute of Medical Sciences (RIMS), Raipur	Chattisgarh	Pt. Deendayal Upadhyay Memorial Health Sciences and Ayush University, Raipur
12	Kiran Medical College, Surat	Gujarat	Veer Narmad South Gujarat University
13	SAL Institute of Medical Sciences, Ahmedabad	Gujarat	Gujarat University
14	Swaminayan Institute of Medical Sciences & Research	Gujarat	Swaminayan University
15	Dr.Kiran C.Patel Medical College and Research Institute	Gujarat	Veer Narmad South Gujarat University
16	Dr. M.K. Shah Medical College & Research Centre, Ahmedabad	Gujarat	Gujarat University
17	GMERS Medical College, Hadiyol, Himmatnagar	Gujarat	Hemchandracharya North Gujarat University, Patan
18	GMERS Medical College, Dharpur Patan	Gujarat	Hemchandracharya North Gujarat University, Patan
19	Maharishi Markandeshwar College of Medical Sciences & Research, Sadopur	Haryana	Maharishi Marakandeshwar University (Deemed), Ambala

20	Maharishi Markandeshwar Medical College & Hospital, Solan	Himachal Pradesh	Maharishi Marakandeshwar University, Kumarhatti, Solan
21	Jawaharlal Nehru Medical College, Belgaum	Karnataka	KLE Academy of Higher Education & Research (Deemed), Belgaum
22	S S Institute of Medical Sciences & Research Centre, Davangere	Karnataka	Rajiv Gandhi University of Health Sciences, Karnataka
23	JJM Medical College, Davangere	Karnataka	Rajiv Gandhi University of Health Sciences, Karnataka
24	Sri Chamundeshwari Medical College Hospital & Research Institute	Karnataka	Rajiv Gandhi University of Health Sciences, Karnataka
25	Dr. Chandramma Dayananda Sagar Instt. of Medical Education & Research, Harohalli, Hubli	Karnataka	Dayananda Sagar University, Bangalore
26	Sri siddhartha Institute of Medical Sciences & Research Centre, Bangalore	Karnataka	Sri Siddhartha Academy of Higher Education, Tumkur
27	Akash Institute of Medical Sciences & Research Centre, Devanhalli, Bangalore, Karnataka	Karnataka	Rajiv Gandhi University of Health Sciences, Karnataka
28	Shridevi Institute of Medical Sciences & Research Hospital, Tumkur	Karnataka	Rajiv Gandhi University of Health Sciences, Karnataka
29	Subbaiah Institute of Medical Sciences, Shimoga, Karnataka	Karnataka	Rajiv Gandhi University of Health Sciences, Karnataka
30	SDM College of Medical Sciences & Hospital, Sattur, Dharwad	Karnataka	Shri Dharmasthala Manjunatheshwara University, Karnataka
31	Jubilee Mission Medical College & Research Institute, Thrissur	Kerala	Kerala University of Health Sciences, Thrissur, Kerala
32	Al-Azhar Medical College and Super Speciality Hospital, Thodupuzha	Kerala	Kerala University of Health Sciences, Thrissur, Kerala
33	P K Das Institute of Medical Sciences, Palakkad, Kerala	Kerala	Kerala University of Health Sciences, Thrissur, Kerala
34	Dr. Moopen s Medical College, Wayanad, Kerala	Kerala	Kerala University of Health Sciences, Thrissur, Kerala
35	L.N. Medical College and Research Centre, Bhopal	Madhya Pradesh	LNCT University, Bhopal
36	Ram Krishna College Hospital & Research Centre, Bhopal	Madhya Pradesh	Madhya Pradesh Medical Science University, Jabalpur
37	LNCT Medical College & Sewakunj Hospital, Indore	Madhya Pradesh	Madhya Pradesh Medical Science University, Jabalpur
38	Chirayu Medical College and Hospital, Bairagarh, Bhopal	Madhya Pradesh	Barkatullah University
39	Mahatma Gandhi Missions Medical College, Aurangabad	Maharashtra	MGM Institute of Health Sciences (Deemed University), Navi Mumbai

40	Maharashtra Institute of Medical Education & Research, Talegaon,Pune	Maharashtra	Maharashtra University of Health Sciences, Nashik
41	N. K. P. Salve Instt. of Medical Sciences and Research Centre and Lata Mangeshkar Hospital, Nagpur	Maharashtra	Maharashtra University of Health Sciences, Nashik
42	ACPM Medical College, Dhule	Maharashtra	Maharashtra University of Health Sciences, Nashik
43	Padmashree Dr. D.Y.Patil Medical College, Navi Mumbai	Maharashtra	Padmashree Dr. D Y Patil University (Deemed), Navi Mumbai
44	Mahatma Gandhi Mission Medical College, Vashi	Maharashtra	MGM Institute of Health Sciences (Deemed University), Navi Mumbai
45	Parbhani Medical College, Parbhani	Maharashtra	Maharashtra University of Health Sciences, Nashik
46	Dr. Rajendra Gode Medical College, Amravati	Maharashtra	Maharashtra University of Health Sciences, Nashik
47	Prakash Institute of Medical Sciences & Research, Sangli	Maharashtra	Maharashtra University of Health Sciences, Nashik
48	Sri Venkateswaraa Medical College, Hospital & Research Centre, Pondicherry	Pondicherry	Pondicherry University
49	Sri Guru Ram Das Institute of Medical Sciences and Research, Sri Amritsar	Punjab	Sri Guru Ram Das University of Health Sciences, Sri Amritsar
50	Dr S S Tantia Medical College Hospital & Research Centre	Rajasthan	Tantia University
51	Nandha Medical College & Hospital Erode	Tamil Nadu	The Tamilnadu Dr. MGR Medical University,Chennai
52	PSP Medical College Hospital and Research Institute	Tamil Nadu	The Tamilnadu Dr. MGR Medical University,Chennai
53	Sri Venkateswaraa Medical College Hospital and Research Institute, Chennai	Tamil Nadu	Sri Venkateswaraa University, Chennai
54	The Tamilnadu Dr. MGR Medical University,Chennai	Tamil Nadu	Dhanalakshmi Srinivasan University, a state private University of Tamil Nadu
55	Faculty of Medicine , Sri Lalithambigai Medical College and Hospital	Tamil Nadu	The Tamilnadu Dr. MGR Medical University,Chennai
56	Arunai Medical College And Hospital	Tamil Nadu	The Tamilnadu Dr. MGR Medical University,Chennai
57	Bhaarat Medical College & Hospital	Tamil Nadu	Bharath Institute of Higher Education & Research (Deemed Univ.), Chennai
58	Panimalar Medical College Hospital & Research Institute, Chennai,Tamil Nadu	Tamil Nadu	The Tamilnadu Dr. MGR Medical University,Chennai
59	Kamineni Institute of Medical Sciences, Narketpally	Telangana	Dr. YSR University of Health Sciences
60	Neelima Institute of Medical Sciences, Medchal	Telangana	Anurag University
61	CMR Institute of Medical Sciences	Telangana	Kaloji Narayana Rao University of Health Sciences, Warangal

62	Father Colombo Institute of Medical Sciences	Telangana	Kaloji Narayana Rao University of Health Sciences, Warangal
63	Arundathi Institute of Medical Sciences	Telangana	Kaloji Narayana Rao University of Health Sciences, Warangal
64	Prathima Relief Institute of Medical Sciences	Telangana	Kaloji Narayana Rao University of Health Sciences, Warangal
65	TRR Institute of Medical Sciences, Patancheru	Telangana	Kaloji Narayana Rao University of Health Sciences, Warangal
66	Mahavir Institute of Medical Sciences, Vikarabad, Telengana	Telangana	Dr. YSR University of Health Sciences
67	Maheshwara Medical College, Chitkul, Patancheru, Medak	Telangana	Dr. YSR University of Health Sciences
68	R.V.M. Institute of Medical Sciences and Research Centre, Siddipet	Telangana	Kaloji Narayana Rao University of Health Sciences, Warangal
69	Mallareddy Medical College for Women, Hyderabad	Telangana	Dr. YSR University of Health Sciences
70	Apollo Institute of Medical Sciences and Research, Hyderabad	Telangana	Dr. YSR University of Health Sciences
71	Malla Reddy Institute of Medical Sciences, Hyderabad	Telangana	Kaloji Narayana Rao University of Health Sciences, Warangal
72	Gautam Buddha Chikitsa Mahavidyalaya, Dehradun	Uttarakhand	Ras Bihari Bose Subharti University, Dehradun
73	SKS Hospital Medical College & Research Centre	Uttar Pradesh	Atal Bihari Vajpayee Medical University, Lucknow, Uttar Pradesh
74	Naraina Medical College & Research Centre	Uttar Pradesh	Atal Bihari Vajpayee Medical University, Lucknow, Uttar Pradesh
75	Venkateshwara Institute of Medical Sciences, Gajraula	Uttar Pradesh	Shri Venkateshwara University, Gajraula
76	Saraswati Medical College, Unnao, U.P.	Uttar Pradesh	CSJM University Kanpur
77	Krishna Mohan Medical College & Hospital, Mathura	Uttar Pradesh	Dr B R Ambedkar University, Agra, U.P.
78	Prasad Institute of Medical Sciences, Lucknow	Uttar Pradesh	Dr. Ram Manohar Lohia Avadh University, Faizabad
79	K.D. Medical College Hospital & Research Centre, Mathura	Uttar Pradesh	Dr B R Ambedkar University, Agra, U.P.
80	Mayo Institute of Medical Sciences, Barabanki	Uttar Pradesh	Dr. Ram Manohar Lohia Avadh University, Faizabad
81	JMN Medical College, Nadia	West Bengal	West Bengal University of Health Sciences, Kolkata
82	JIS School of Medical Science & Research, Howrah	West Bengal	JIS University, Kolkata
83	ICARE Institute of Medical Sciences & Research, Haldia, Purba Midanpore	West Bengal	West Bengal University of Health Sciences, Kolkata



**No. N-P016(20)/2/2024-PGMEB-
NMC(e-8269432) Government of
India
National Medical Commission**

Sector-8, Dwarka
New Delhi-110075
Date:09-12-2024

Circular

Subject: Directive Regarding the Premature Circulation of Official Communications.

It has come to the attention that certain communications, including notices, circulars, guidelines, instructions, and similar materials found in public domain on the name of NMC. This is to serve as a reminder that the official applicability of any such communication is effective only upon its formal publication on the **National Medical Commission (NMC) website and official twitter handle (NMC_BHARAT)**

2. NMC trusts that all concerned will cooperate fully in ensuring that official channels are used for communication and that NMC's standards are upheld.

3. NMC will not vouch for authenticity of Any Letter / Communication circulating in social media which is not on its website

Encl.: As above

[Prof. (Dr.) B. Srinivas]
Secretary

To: The Principal/Dean (All the Medical Colleges/Medical Institutions of India)

Copy to:

- i. DMMP-I System Integrator- for uploading of NMC Website
- ii. Guard File



.No. R.14020/1/2024-Regn.

Dated: .12.2024

PUBLIC NOTICE

As all are aware that National Medical Commission issues Additional Qualification (AQ) certificates to Registered Medical Practitioners after they acquire higher medical qualification(s) under section 26 of the IMC Act, 1956 read with Section 61(2) of the NMC Act, 2019. The said certificates are issued after due verification of the higher qualification(s) of the applicants from the concerned Institute/College/University including NBEMS.

2. In this connection, it is informed that National Board of Education in Medical Sciences (NBEMS) has recently issued a public notice dated 24.04.2024 vide which it has been communicated that the verification of credentials issued by NBEMS will now be through the "Credential Verification Online Portal (CVOP)" (available on NBEMS website <https://natboard.edu.in> under the tab "Digital Services") after the payment of prescribed fee for verification to NBEMS through its Miscellaneous Fee Payment Portal.

3. In view of above, all the applicants who have completed their additional qualification from NBEMS and desire to apply for Additional Qualification (AQ) certificates from NMC are advised to pay the prescribed fee to NBEMS through its Miscellaneous Fee Payment Portal, as mentioned above. After payment of fee to NBEMS, a legible copy of the payment receipt should be attached in the online AQ application under "Relevant PG document, if any" column. It may please be noted that only after successful payment of fee by the applicant, NMC will be able to submit request for verification of AQ to NBEMS.

Prof(Dr). B.Srinivas
Secretary
National Medical Commission

F.No. N-P016(20)/2/2024-PGMEB-NMC
National Medical Commission
Post Graduate Medical Education Board
(O/o Secretary)

Sector-8, Dwarka, Dated 16.12.2024

To,

The Directors/ Principals/ Deans
All Medical Colleges/ Institutions under NMC

Sub: Timing of remitting fees through payment gateway.

It is aware that all Medical Colleges/Institutes are required to pay/remit fee through link generated during filling form. It is noted that despite giving sufficient timeline including extension in filing application, there is high volume of rush on closing date. This may sometime fail the payment due to overload/glitches.

2. All the stakeholders are advised to file application timely before the closing date by shedding any lackadaisical approach and acting with high agility in filing application.

3. It may be noted that payment can be remitted in normal Banking timings on all days but on closing date payment shall be upto **14:00 hrs (i.e 2:00 p.m)** only. Further, for any technical failure/glitches of payment on closing time **i.e. 2 PM** of closing date onus would be on applicant only. So, to avoid that, they may remit payment sufficiently before the closing timing.

Signed by B Srinivas

Date: 19-12-2024 18:37:29

[Prof.(Dr.) B Srinivas]
Secretary

Copy to: i. ACS/ Pr.S /Secretaries/Departments of Medical Education in all States /Union Territories
ii. PPS to Chairman, NMC
iii. PPS to President (PGMEB)/President (UGMEB)/President (MARB)/President (EMRB)

- iv. DMMP-I System Integrator- for uploading of NMC Website.
- v. Guard File



दूरभाष/Phone : 25367033, 25367035, 25367036
ई-मेल/E-mail: secyoffice@nmc.org.in
वेबसाइट/Website : www.nmc.org

पॉकेट-14, सेक्टर-8, द्वारका, फेस-1, नई दिल्ली-110077
Pocket- 14, Sector- 8, Dwarka,
Phase – 1, New Delhi-110077

राष्ट्रीय आयुर्विज्ञान आयोग
National Medical Commission
Publication Division

F. No. PM-11013/01/2024/NMC/Publn.

Dated: 16.12.2024,

Public Notice

Subject: Intimation regarding opening of X (Twitter) Account of NMC and for authentic information-reg.

All the medical colleges/institutes & Medical Fraternities are intimated that NMC has opened account on X(Twitter). The address of the NMC account is **@NMC_BHARAT**. NMC will upload circulars, notices & other information on the aforesaid account on the social media platform in addition to the existing NMC website.

In order to have the faster & genuine information, updates, all the stakeholders are advised to follow NMC X account as early as possible.

All the stakeholders may note that for the authentic information/updates, they may refer to X (Twitter) & NMC Website (www.nmc.org.in) only.

(Dr. B. Srinivas)
Secretary
National Medical Commission

About National Medical Commission (NMC):

The National Medical Commission (NMC) is India's premier regulatory body overseeing medical education and practice. Committed to upholding the highest standards in healthcare education, NMC ensures the delivery of quality medical education and training across the nation.

For more information about NMC, please visit
www.nmc.org.in



राष्ट्रीय आयुर्विज्ञान आयोग
National Medical Commission

Publication Division, National Medical Commission
Pocket-14 , Sector-8, Dwarka Phase -1, New Delhi-110077, INDIA