Private Practice by Government Doctors across the states : A Preliminary Study

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(A Preliminary study based on informal interviews with one or two key respondents to in each of 18 states. This report is to be seen as a draft. It is circulated for comments, corrections and further inputs and may take a further month to finalize. Not to be quoted now.)

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1. ANDHRA PRADESH : Private Practice Allowed:

In Andhra Pradesh, private practice by government doctors is legally permitted but only ban on to practice as consultants after hospital hours 9am – 4pm which makes sense but not run hospitals. Non clinical teaching faculty and doctors who have joined before 1987 are paid Non practicing Allowance hence they are prohibited from doing private practice.

The experience is that 80% of doctors under DPH (mainly in PHCs and CHCs) do not practice. These are usually basic MBBS doctors and many are young and preparing for PG entrance exams (Neet). Remaining is post graduates waiting for appointment in the public hospitals. Older generation basic graduates tend to practice. In contrast most doctors in CHCs and DHs (the VVP as it is known)(may be 90%) do practice as they are specialists. Most of them have their own nursing homes or private hospitals in the places of their working hospital itself and do practice even during 9am to 4pm working hours. Major violation takes in this area of ban on private practice and there is reason to believe that it also affects clinical decision making, like more elective CS sections in government hospitals, to not be disturbed after hospital regular hours. Referral of govt patients to their private nursing homes directly by themselves or through lower staff or outside brokers or medical shop personnel is frequent and justified to the patient, in the name of better patient care and facilities.

Most medical specialists who are teaching in medical colleges practice and almost all super specialists practice, and are attached one or other bigger or corporate. About ten percent have a roaring private practice, and for about 50 percent it is a limited 5 to 10 patients per day, but for others it could be less- a supplement to what they do in the public space. Pathologists, microbiologists and biochemists have their own labs o work in labs as consultants. Common practice to have a nursing home registered in the name of the spouse or a relative who is not in services.
As most doctors show themselves as consultants in their own hospitals, so they are registered with Clinical Establishment act too. Note that doctors working as consultants in OP clinics is legal in non-duty hours.

IMA keeps out of this discussion. The IMA stand on this is ambiguous, but more in support

The justification that most doctors express is that their salary and perks are less than that of comparable district and sub-district administrators. Further they are treated with poor respect by administrators and even held accountable for outbreaks or other medical and public health problems over which they do not have control. Thie general position is that most doctors would be willing to

forego private practice, if there is a fair remuneration, and due respect and a positive working environment.

2. ASSAM: Allowed with conditions

In Assam for medical college doctors, private practice beyond duty hours is allowed to all. For all other medical officers, there is an option to opt for NPA. Those who take NPA cannot do private practice at all. Those who do not take NPA can do private practice in non-duty hours. Most doctors (may) have opted for NPA. Despite NPA there had been a high level of private practice in government time. In July 2024, the government came down on this with a set of strong measures. It issued an order that any private nursing home allowing a government doctor to see patients during duty hours would face disciplinary action under the Clinical Establishments Act. It is reported that this practice came sown sharply as a result. The fact that the Joint director who supervises the CEA at the district level may themselves be in private practice dilutes enforcement. At the primary care level private practice also contributes to absenteeism, in a way it does not do at the higher levels. Uncertain whether non-opting for NPA seems to justify this behaviour. There is a lot of cross referral of public patients to private hospitals and even of admission of private patients in public hospitals based on patient needs. This is not viewed as unethical, rather as exercising the better option from both provider and patient view. The publicly funded health insurance is not tuned to address this issue.

There is a fear, that this enforcement of the non-practice clause is leading to exit of many senior specialists from public hospitals.

3. BIHAR- allowed, with no conditions.

All cadre of medical doctors, and other health workers are allowed to practice privately. Doctors are not given non-practicing allowances (NPA). Bihar health services rule, for both general and medical teaching cadre, do not mention anything about eligibility for private practice. However, as NPA is not paid, and the Job Description is silent on private practice, there is no regulation in place.

The only exceptions are doctors and staff at the Indira Gandhi Institute of Medical Sciences (IGIMS), Patna. IGIMS, Patna is envisaged to be the centre of excellence for Bihar, in line with AIIMS, PGIMER etc. The pay scale and other benefits (including NPA) are at par with AIIMS; therefore, staff here are not legally allowed to practice.

Absenteeism is a major problem. Those living in the same city (like Patna, Muzaffarpur) generally come for duty for only a few hours a day. Those living away from their duty station (like doctors posted in Darbhanga, staying in Patna), attend duties only for a few days in a week. Recent enforcement of biometric attendance has improved attendance in cities like Patna, but the situation is more or less the same for other remote cities.

As most faculty members are busy in private practice and devote only a fraction of their time to their duty station, teaching both postgraduate and undergraduate are affected, especially clinical teaching. Quality of care is also compromised. Referral to private clinics of their own is reported. Engagement in private practice often leads to a poor sense of ownership, and responsibility and results in laissez-faire administration. All these problems are significantly less in IGIMS, Patna, though there is a small section who are doing so in relative secrecy. However, the services and quality are affected due to disproportionate load.

Problems are the same in CHCs and PHCs, but worst in the APHC where the absenteeism may be continuous leaving the facility non-functional. The small comfort is that there is no unfair charges made for care provided in public facilities.

There have been no significant efforts to address the issue of private practice among government doctors. Over a decade ago, a health secretary attempted to raise this concern and curtail private practice, but faced strong opposition from the Indian Medical Association and the Bihar Health Service Association. Medical teachers, primarily from the paraclinical and pre-clinical fields, have also raised the issue of non-practice allowances (NPA) and the regulation of private practice. However, they are largely outnumbered in this matter.

Bihar is one of the first few states to pass the Clinical Establishment Act, but its implementation is halted by a court order stating that 'no coercive action can be taken to implement CEA.' Moreover, the CEA does not mention control of private practice by public doctors. CEA largely focus on registration and regulation to ensure quality of care.

PMJAY rules are silent on this, but hospitals are careful not to show names as government doctors as owners of empanelled private hospitals or even list them. The top leadership in the state is concerned about disturbing the status quo. Doctors are perceived politically as a powerful lobby, therefore, not interfering to control private practice seems safe.

4. CHATTISGARH: optional, largely allowed, strict conditions:

The Chhattisgarh Basic Services Rules for government services, 1961, prohibit any commercial activity by public servants, including doctors. In general, medical officers, medical teachers, and other doctors working within the government system are not allowed to practice privately. However, there are some exceptions to these rules:

Eligible- but limited: Medical Officers and Specialists in General Health Services viz those posted at Primary Health Centres (PHC), Community Health Centres (CHC), District Hospitals (DH), or similar locations are not entitled to Non-Practicing Allowances (NPA) but are allowed to practice on a limited basis. They may treat patients at home but cannot establish a clinic or be affiliated with private establishments, clinics, nursing homes, or hospitals. They are required to maintain a register for all patients seen at their home, including the fees charged.

Not Eligible: Medical Doctors in Administrative Roles are entitled to NPA but are not permitted to engage in any form of private practice, including home-based consultations. This includes medical college faculty in administrative roles as HoDs, Deans or MS. *Non-clinical and para-clinical faculty members in medical colleges* are also not allowed to engage in private practice while being entitled to NPA.

Optional: Faculty members in clinical branches may choose between opting for NPA or practicing privately, only at the time of joining the services. Those who forgo NPA can practice privately, but only at home (similar to medical officers) and cannot open a clinic or work at other clinics or hospitals. Those opting to take NPA are prohibited from practice privately.

All home-based private practice can be done only outside of the duty hours.

However due non-enforcement of rules, many medical college faculties do practice privately even in private hospitals, and limit their hours on duty. This affects quality of care and affects teaching both undergraduate and post-graduate severely, and clinical teaching seems more affected. Referrals to their private clinics are present, though it may not be very frequent.

Multiple PILs have been filed in HC, at different points of time. On many occasions the Bilaspur High Court has taken cognisance of private practice by government doctors, terming it as a matter of grave concern, and ordering the state government to act. In one such order in November 2024, the Secretary of health were asked to furnish an affidavit to prevent private practice by govt doctors. This was contested by public doctors and IMA.

Districts hospitals and CHCs face all the problems described above. Their engagement in private practice often leads to a poor sense of ownership and responsibility. In CHCs and PHCs, there is trend of delegation of responsibilities to Rural Medical Assistants, working as Additional Medical Officers. Often patients themselves go to the private practice as they do not expect good quality of care at public facilities.

There is reluctance from political parties to confront the doctors associations. Administrators do not want to take the initiative. There is fear of doctors exit. IMA is constantly demanding change in the rule, that requires private practice to be restricted to the home, arguingthat it's not best use of doctors' skills if they are not allowed to practice from established clinics of hospitals. Doctors are also demanding that the option to choose NPA or no NPA should be given on an yearly basis, rather than at the time of joining. CEA provision is silent about the private practice of govt doctors. However, as govt. doctors are prohibited from practising privately in public facilities, they cannot register a clinical establishment under their name. There is clear and strong provision in the clinical establishments act. Any hospital employing govt. doctors not only loses it empanelment, but pending insurance payments are also forfeited. This was very much in the news in recent months.

5. **DELHI: Not allowed:**

Private practice is not allowed to all categories and an NPA is paid to all.

There is some level of private practice but this is still limited and not all pervasive. There is no absenteeism due to this- or even much referral from the government provider to his own practice, or refusal to see properly at the public hospital.

IMA is silent on the issue- largely no objections to the restrictions. There is no mention of this in clinical establishments act nor in state funded insurance programmes? – no.

6. **HIMACHAL : Not allowed.**

Private practice is not allowed to all categories and an NPA is paid to all. This is part of the service rules. There is a 20 percent NPA that is included as part of the basic for DA.

Private practice in contravention of the rules is almost completely non-existent. Nor has been this an issue in the past and nor have there been any demands for the same. The IMA is silent on this issue. CEA and PFHI is also silent- but then there has been no reason for them to intervene.

Unfortunately there are some recent perverse developments. Himachal government has withdrawn NPA for new entrants and this is leading to huge protests. The recruitment is now being done through HR holding agencies on contractual basis with freeze on regular appointments. Entry level salaries have been slashed to 50 percent of the earlier sums. Taken together all of this is likely to encourage private practice. These measures are also encouraging exit of doctors from public services.

Government position is that now there are four medical colleges and a surplus of doctors, and hence vacancies can be filled even without NPA. They believe that enforcement of the law is possible and desirable and the "stick" without any "carrot" is the way to go. There are issues of whether the specialists is able to perform the range of services he or she is qualified to perform- due to postings.

7. HARYANA: Not allowed

Private practice is not allowed to all categories and an NPA is paid to all.

There is some level of private practice but this is still limited and not all pervasive. At PHC and CHC level many doctors are contractual, and since this is a clause in the contract, it has been easier to ensure this. There is no absenteeism due to this- or even much referral from the government provider to his own practice, or refusal to see properly at the public hospital.

IMA is silent on the issue- largely no objections to the restrictions. There is no mention of this in clinical establishments act nor in state funded insurance programmes? – no.

8. JHARKHAND: Allowed, with no conditions, Not allowed with NPA for medical colleges

Private practice is allowed for government doctors except for those working in medical colleges. Medical college faculty are paid NPA and not allowed private practice. However, even though it is illegal, many doctors do private practice.

Private practice by government doctors have many ill effects. It affects the availability of doctors during duty timings. In district hospitals and CHCs doctors arrive late and leaving early from duty. Doctors lobby with non-medical staff in secondary care centres who channel patients to 'concerned doctors private clinic' siting poor facilities in DHs/CHCs especially for deliveries/surgeries etc even when the hospitals are reasonably equipped. These non-medical staff get 'monetary cuts' for this. ASHAs can also be part of such referrals. There are many instances of doctors remaining in their private clinics who do not report to duty at all, with the support of senior administration. In addition in medical colleges there is adverse impact on teaching.

No additional fee is collected at the govt hospitals; but the overall behaviour of providers is such that the patients would consider seeing them in their private clinic if they can afford it, to secure better care.

In PHCs doctors sit in the private practice chambers which is generally adjacent to the PHCs, during working hours. In case of any supervisory/monitoring visit, they will immediately come to the PHC campus.

Patients occasionally complain against doctors/hospitals siting they were not available in the hospital. But no action is taken against any doctors except for nominal enquiries. Doctors who are in senior administrative positions generally own hospitals/nursing homes/labs etc. The same is true with teaching college specialists. So, they generally take no steps to curb private practice. The IMA does not challenge this, and one reason is govt. doctors hold senior positions in IMA and private doctors get administrative advantages through their doctor friends who are in senior positions in the government.

There is no effort in the clinical establishments act or in the PM-JAY to address this issue.

9. **KARNATAKA: Allowed:**

Private practice is allowed and there is no NPA paid. There is however something called a special allowance paid to all specialists which begins at about Rs 40000 per month and goes to about Rs 85,000.

At the PHC, CHC level private practice is always there- but absenteeism due to this, or referrals to their own clinics, or charges in public hospitals are a limited problem. For most the practice is not very high. In medical colleges private practice may be more common, and even absenteeism happens, though reduced public time is the main form it takes. Biometric attendance is introduced to reduce this, and there has even been plans of two-hourly biometrics to confirm presence- but that was perhaps not followed up. Just to indicate that the problem is significant.

Since potentially the PFHI provides monetary incentives for procedures in public hospital this should reduce referrals to private clinics- but the amount that comes as incentive is not big enough for that play. There is also a danger that since the public hospital is the gate-keeper to private care, the gate-keeping could face serious conflicts of interests. Management is aware of it, and feels that this can be uncovered by the digital cross-checks. When such malpractice is detected threats of either withdrawal of the special allowance or transfers seems to work. The clinical establishments act and the IMA are not engaged with this issue.

10. **KERALA: Mixed: Allowed to health service doctors with strict conditions. Not allowed in medical colleges and administrators.**

From 1/10/2009, Government of Kerala banned private practice by doctors in government medical and dental colleges in the state (under DME**)** (GO (P) No. 318/2009/H&FWD dated September 10, 2009). Amendment of Kerala Government Servants Conduct Rules, 1960 with respect to Private Practice of doctors had been issued in this regard. Non-Practicing Allowance for Medical College doctors is paid at @ 25% of the Basic Pay (Band Pay + Academic Grade Pay), with DA payable on the Non-Practicing Allowance also.

Under the directorate of health services, the doctors in administrative cadres (Director, Addl Director, DD etc.) are banned from doing private practise. But other PHC/ CHC/DH doctors are allowed to do so with clear restrictions. The guidelines were modified very recently in Sep 2024

Key restrictions in the New Guidelines issued in 2024 are:

Kilometre Restriction on Private Practice: prohibited from conducting private practice within a 1-kilometer radius of the hospital where they work, BUT can do so in their own homes or in government-provided quarters within this restricted zone. This move is meant to prevent overlaps between their roles in public healthcare and private consultations.

Limitations on Commercial Properties Doctors cannot run their private practices in buildings that were constructed for commercial purposes or are attached to labs, scanning centres, medical institutions, or pharmacies. This is meant to limit commercial influence on the private healthcare they provide and that the practice remains independent from other healthcare services.

Minimal Equipment Usage Doctors are required to use only the bare minimum equipment necessary for diagnosing an illness, ensuring that advanced technologies and medicines available in government hospitals are not exploited for personal gain. For dental doctors, however, the use of essential

equipment like dental chairs and minimal instruments is permitted, reflecting the nature of their practice.

No Referrals to Government Hospitals To prevent conflicts of interest, the new guidelines state that doctors should not refer patients from their private practice to government institutions for follow-up services such as injections, administration of medicine, or diagnostic tests. Moreover, doctors are prohibited from utilizing government hospital resources, such as medicines and equipment, for their private practice.

Proof of Residence: Doctors conducting private practice from their homes must provide proof of residence. Acceptable documents include Aadhaar cards, utility bills (electricity, water, or telephone), or building tax receipts. If none of these documents are available, a residence certificate issued by local government authorities must be provided.

There is a pushback on these restrictions and many hold these to be restrictive. There is also the fear raised that there is a significant exit of doctors from public practice, and this will increase. But the greater likelihood of exit is when specialists are posted in facilities where there is no space to practice their speciality- and they have to serve as generalists. Poor working environment, a lack of autonomy are also cited as reasons for increasing exit.

The ban on private practice by medical college specialists is not fully observed, and nor are the restrictions for others. But many specialists are also not into significant private practice. Where they are practicing, there is an adverse impact on teaching and research, but no absenteeism, no illegal charging in public hospitals and no push to refer to private clinics. There is however a study that shows a significant out of pocket expenditure for surgeries in public hospitals, but the source of this needs to be understood further. Government doctors do gain a competitive advantage in private practice, and therefore the IMA is not much opposed to restrictions, but it will not come against the practice either. There are no restrictions in either the clinical establishments act nor in the publicly funded health insurance programmes.

11. MAHARASHTRA: Not Allowed:

The prohibition of private practice by government doctors is a service rule under the Maharashtra Civil Services (Conduct) Rules, 1979 (Point 16, page 11). Also, government resolution (GR) dated 7 August 2012 bans private practice by government doctor and to accept non-practicing allowance (NPA). The GR also prevented government doctors from changing their assigned location, opening their own hospitals or dispensaries, or practicing in other hospitals. The Bombay High Court put a stay on parts of the 2012 GR. In 2021, the Directorate of Health Services issued instructions for doctors under National Health Mission to not indulge in private practice. In July 2023 Bombay high court allowed private practice to doctors employed on a contractual basis under National Health Mission after working hours and stated that authorities (employer) can take strict action against the doctors including termination of contractual doctors if doctors found to be absent during duty hours.

In practice, many specialists and primary doctors are engaged in private practice informally due to poor monitoring or consensus with district civil surgeon or district health officers. More details of how this plays out in field conditions require to be obtained.

IMA opinions that it is essential to revisit the norms surrounding private practice. State-funded insurance programs like the Mahatma Jyotiba Phule Jan Arogya Yojana (MJPJAY) in Maharashtra do not explicitly address the issue of private practice by government doctors.

12. **MADHYA PRADESH: Allowed with conditions.**

Private practice after government duty hours is legal in Madhya Pradesh. The condition is that it must be conducted at the doctor's residence. Government doctors are not permitted to join private nursing homes or hospitals. This rule applies to all doctors, whether MBBS or specialists.

There is a provision for Non-Practice Allowance (NPA), but not sure about it's implementation.

The provision about not referring to own clinics, or nursing home and practicing in them is widely breached. The problems are most at DH levels where time spent in public hospital is limited. But there are also many doctors for whom public practice is the major practice, and private practice a minor supplement.

There are moves by government to ban private practice, but these are sporadic and not sustained.

The justification for private practice is that that government doctors are often the best clinicians, and their services should be available to a broader population- not only the poorest. Many middle class patients avoid government hospitals due to inadequate laboratory and diagnostic facilities, or overcrowding, and thus opt to visit doctors in private settings.

IMA recognizes the reality of private practice and also supports this.

Clinical establishment act may have provision of private practice by government doctors at their home using minimal equipment, such as a stethoscope and BP machine, but prohibits setting up diagnostic or laboratory services at home. (perhaps this is in service rule and not in CEA- to be confirmed). PFHI is silent on the issue of private practice by government doctors.

13. **MEGHALAYA- Allowed, with no conditions:**

Private practice is allowed to government doctors under the service rules. This applies to all cadre. There are rules preventing them from being part of any nursing home or hospital. There is no NPA paid to any cadre.

Private practice leads to less time spent in the public hospital, and a reluctance to expand the services provided there beyond the minimal expected. There are also concerns about the quality of care provided in public hospital- The sentiment among doctors is that this should be permitted as part of public choice. Private Clinic locations could be more convenient. There are public private partnerships meant to close gaps in access and few of them hire the public doctor to provide care, since they can get no other. This is not seen as a problem. But in most PPPs this does not happen and they bring in dedicated doctors from outside.

There are no clauses on this in the clinical establishments act or in government health insurance programme.

14. **ODISHA : Allowed, with no conditions:**

Private practice is legal. NPA was tried but did not work and is now not eligible for any cadre.

In medical colleges there is no problem of absenteeism, but quality of care, quality of teaching, research are all compromised. There is reduction in effective duty hours and some level of referral to private clinics.

The government view is that though desirable it is impossible to enforce. IMA remains silent. Part of the reason is that the leadership of IMA have many senior retired government specialists and given their own lifetime experience, they do not see any reason to retrain it. It is not mentioned in clinical establishments act. The state funded insurance programmes act, to some level at least as a perverse incentive, since they get more earnings if the patient is referred to the private hospital and the surgery or procedure undertaken there.

At the PHC and CHC level, it does lead to absenteeism as well and there is an extensive problem with this.

15. PUNJAB: Not allowed:

Private practice is not allowed to all categories and the NPA is paid to all. NPA is 25 % of basic

Despite this, about half the medical college specialists may be at some level of private practice, and this is more at DH, CHC and PH level.

There is no absenteeism due to this- or even much referral from the government provider to their own private practice, or refusal to see properly at the public hospital. These were such problems till 2012 but has been attended to by strengthening government oversight. However public doctors do leave early or on time and then attend to private practice- and more complex, challenging, paying work is in private sector, whereas mostly in public hospital it is a work-to-rule.

IMA is silent on the issue- largely no objections to the restrictions. There is no mention of this in clinical establishments act nor in state funded insurance programmes.

16. RAJASTHAN: Allowed

The Rajasthan Civil Services (Medical Attendance) Rules, 1970, outline the regulations governing government doctors' private practices. These rules prohibit medical officers who receive the Non-Practicing Allowance (NPA) of prevalent among doctors at the CHC and DH levels, i.e more than 80%. With very less proportion of PHC level medical officers performing private practices due to their priorities towards PG admission. Private practices is all types. By the rule even when private practice is allowed, government doctors cannot do surgeries in the private hospital.

There is no charging in the public hospital and absenteeism as such is not a major problem, but every other problem is there. There is a reduction in public time- comes late to the hospital and leaves early Private practice is associated with serious compromise to quality of care in public hospitals. Thee is referral of public patients to private clinics, on a number of grounds. For example they refer saying: “get this test done and show me the reports (at the clinic)”, “the procedures will take time, see me (at clinic at specific time) there we’ll talk in detail”, “we have better equipment (at clinic) you can consult me there” etc. . This creates long queues of patients, increases their wait time, reduces the consultation time, impacts the quality of care. Patients coming from remote areas have to bear additional cost due to this. There are also reports of government medicines being dispensed in private clinics for a fee along with more courteous services there. They may admit private patients in the public hospital, but then unlikely to charge them there.

Administrators’ perception is that permission for practice is essential for doctors in government facilities, in a situation of high vacancies. Doctors perception is that if done after duty hours, there should be no problem raised. Additionally, in January 2024, Rajasthan's Health Minister Gajendra Singh addressed the issue of absenteeism among government doctors and warned that those engaging in private practice during official duty hours would face suspension.

17. **TAMILNADU: Allowed, except for administrators**

Private practice is allowed for all doctors and specialists except for those who are part of the public health service cadre under the directorate of public health whose tasks are administrative in nature. Private practice is also disallowed for those who are holding administrative offices under the directorates of medical services (JDHS) and medical education (Deans) or who are in non-clinical specialities. The administrative cadre who are banned private practice are eligible for this NPA. But the NPA amount is less than Rs 3000 per month. PHC Medical Officers have the option to choose—those who do not engage in private practice are eligible for NPA.

Interviews indicate that public health cadre officers, both in rural and urban areas, do not engage in private practice, and they have a heavy full day work load. However, in the administrative cadre of other directorates (medical services and medical education), private practice is common, as most officers in these roles hold specialist degrees and receive only a nominal NPA.

There is not much problems of absenteeism or charging of fees in public sector, or even of referral to private clinics or of private practice in duty hours. However in medical colleges it does compromise teaching and research and create poor role models. And excessive practice with conflict of interests though infrequent are still a problem. The CMCHIS (PFHI in Tamil Nadu) monetary incentive is no safeguard against this, but perhaps help reduce unnecessary referrals. But since referral to own nursing homes occur, we do not quite know the extent it helps. The CMCHIS has no instructions that address this problem and the clinical establishment act is silent on this problem. IMA is also silent on this issue.

18. **TELENGANA: Allowed: but for new recruits- prohibited.**

In Telangana private practice is legally allowed. However, in recently recruited doctors the appointment letter restricts private practice and there is no NPA and the legal basis for this is the service rules.. Where it is legally allowed the adverse impact on public services is most in medical college hospitals and tertiary care, very limited adverse effect in district hospitals and PHCs and almost none in the PHC doctor. This private practice of the government medical colleges is mostly restricted to after duty hours, and is not contributing to absenteeism, or charging of fees in public duty hours or cross referrals. On paper they cannot be attached to a nursing home, but this is not enforced in the publicly funded insurance programme. The introduction of biometric attendance is expected to help curb any absenteeism.

For the new recruits where private practice is prohibited, there is still some private practice ongoing, but after duty hours, and more in medical colleges as per the pattern. It is not clear whether therefore the ban is making a difference.

1. **GOA:**
2. **GUJARAT:**
3. **JAMMU & KASHMIR**
4. **UTTAR PRADESH: Allowed- no conditions- similar to Bihar- report awaited.**
5. **UTTARAKHAND: Allowed- no conditions- report awaited.**
6. **WEST BENGAL: allowed- conditions?**
7. **ARUNACHAL**
8. **MANIPUR**
9. **MIZORAM**

10. **SIKKIM**
11. **TRIPURA**

+ 6 union territories.