

**CHAPTER 1**

**GENERAL**

**Introduction**

1. The instructions in this guide are intended to be a guide to medical officers and medical boards to enable them to approach the question of entitlement to disability and special family pensions in the proper perspective under the rules in force, and aim at facilitating the efficient discharge of their responsibilities.

2. The disability and special family pensions are sanctioned to Armed Forces personnel and their families respectively under the current rules if their disablement or death is accepted as attributable to or aggravated by service provided that for disability pension, barring invalidment cases the degree of disablement is twenty percent or more.

3. The Pension Sanctioning Authority is the Government of India or its delegate, the CDA(Pensions), Allahabad. Government of India has authorised the CDA(Pensions) to deal with the following types of cases :-

(a) JCOs, ORs and their equivalents in the Navy and Air Force :

- (i) Initial entitlement of disability pension.
- (ii) Reassessment of disability pension claims.
- (iii) Special family pension claims which arise from death during service or after discharge.
- (iv) The disability pension claims of personnel who are found in low medical category at the time of release/transfer to the pension establishment in terms of AI 95/62.

(b) Officers :

Reassessment of disability pension claims.

4. The Service HQ (The Government i.e., the Ministry of Defence) with the concurrence of the Ministry of Defence (finance) decides the entitlement aspect of following types of cases :-

(a) The disability and special family pension claims of officers.

(b) Reassessment of disability claims of officers which have not been settled by the CDA (Pensions).

(c) The disability and special family pension claims of JCOs, ORs and equivalents in the Navy and Air Force which have not been settled by the CDA (Pensions).

#### **Appeal Against the Decision Regarding Entitlement**

5. Servicemen and their families have a right to appeal against the adverse decision of the Pension Sanctioning Authority regarding entitlement within six months of the date of communication of such decision.

#### **Entitlement Rules**

6. When disablement or death is regarded solely due to service rendered subsequent to the 31st March, 1948, entitlement will be decided under Post-March 1948 Rules. But where disablement or death can be regarded as related wholly or partially due to service rendered from 3rd September, 1939 to 31st March 1948- or during any period after 31st March 1948, when emergency entitlement rules are in vogue, the decision on entitlement will be taken under the War-time Entitlement Rules or under Emergency Criteria as the case may be. Chapter VII in this Guide on assessment of disablement applies to all cases irrespective of entitlement rules. With effect from 01 Jan 82 ER 1982 amended vide MOD letter No.1(1)/81/Pen-C dated 22/11/83 have come into force.

#### **Definitions**

7. (a) **Disability** : Denotes solely the actual wound, injury or disease, the disablement caused by which gives rise to a claim for compensation. It is to be carefully distinguished from disablement which means physical or mental injury or damage, or loss of physical or mental capacity suffered by reason of a disability or disabilities.

(b) **Entitlement:** Is the recognition by the Pension Sanctioning Authority after consideration of both the medical and non-medical evidence that a disability has been influenced in its onset or course by the conditions of service. Such a disability is called an "Accepted Disability".

(c) **Member:** Means a person who was or is in the Forces.

(d) **Reasonable Doubt:** Implies that there must be reasons-i.e.facts from which the doubt arises. It is one which influences the decisions arrived at by a reasonable and prudent person when conducting important affairs of his own life. Accordingly, for the purpose of these instructions it will be construed as an alternative favouring a member, which can be supported by rational arguments based on adequate premises and is not merely a strained or fanciful acceptance of vague or remote possibilities.

(e) **Consensus of medical opinion:** Means the views of medical authorities recognised as speaking with authority on the disability(ies) in question in regard to the effect of service conditions on its development.

#### **Functions of Medical Boards**

8. The function of a medical board is to inform and advise the Pension Sanctioning Authority on the basis of all available records and their own clinical examination concerning :-

(a) The clinical history and condition of a member on account of a disability or disabilities alleged to be related to service.

(b) The particular evidence on which the Boards base their opinion on the relation or otherwise, of a disability to service.

(c) The degree of permanent or temporary impairment of function produced by a disability with particular reference to the amount of that impairment resulting from service. In cases of reassessment by resurvey medical boards the amount of impairment due to extraneous factors will have to be separated from those due to service.

(d) (i) The refusal of a member to undergo medical treatment (including operation) which would have cured or

improved the disability or resulted in arresting further deterioration of the condition.

(ii) Retardation of the cure or aggravation of the disability by the member.

### **Causal Connection**

9. Before an award can be made for a disability or death claimed to be related to service, a causal connection between disability or death and military service has to be established by evidence.

Death or disability may be due to wounds, injury or disease. Evidence of causal connection or otherwise, in cases of disease, can be obtained in various ways. For instance, the man may have admitted when he was enrolled, that he suffered from the disease previously; or in statements made before or on admission to hospital, he may have explained when he began feeling unwell or out of sorts, adding how his time shortly prior to that was spent, thereby giving an indication or clue to the proximate time and circumstances of possible source of exposure. It may be that the consensus of medical opinion is against the acceptance of the particular disability as due to service. That will constitute evidence that it is not attributable to service, but then the disease may have been worsened by service and therefore aggravated by it. If the condition deteriorates naturally, and military service does not accelerate the worsening, there will be no case for conceding acceptance on the basis of aggravation. Thus, there is a distinction between a disability contracted or worsened by service and one merely contracted or worsened in service.

10. Service conditions provide safe environment for a healthy population with a good nutritional and physical background. Acquisition of infection in such circumstances may be the result of a temporary breakdown in the health environment. However, all infections acquired during service are not necessarily attributable to it. Causal connection between sources of infections and conditions of service has to be established before attributability can be conceded. Every case would be examined on merits and totality of circumstances would be considered. Award of attributability would be conceded only where there is greater probability of infection being due to circumstances of military service or conditions thereof.

The standard of acceptable evidence required would naturally be stricter for servicemen under normal peace time conditions than for those serving under field service conditions.

Causal connection between the infection acquired by an individual and the military service can be established in cases of infections and diseases which have a definite incubation period and/or when such cases occur in a cluster. Diseases like chicken-pox, cholera, mumps, plague, etc., fall in this category.

In diseases occurring sporadically, it is not always possible to detect the source of infection, time, date and place specifically. The presence of healthy carriers in the community at large and in the service community, complicates the problem of determination of source of infection. Further, development of an infection into a manifest disease is related to the dose, virulence of the organism, environment and climatic conditions, natural and acquired resistance of the individual; and temporary lowering of the individual's resistance as a result of physical/mental stress and strain of military service. Resistance is also impaired with frequent changes in environmental and climatic conditions and exposure to adverse weather conditions. Occurrence of a disease in endemic or epidemic form in a service area or induction of troops from such area to another area, promote spread of infection. The close community life in the barracks and community cooking and living favour transmission of infecting organism. Adverse living conditions like living under canvas, in bunkers or in dug-outs favour transmission from person to person.

The essential thing to do in such cases would be to establish with a reasonable degree of certainty the time and circumstances of exposure and its relationship with service conditions. Where the available evidence is not conclusive, the pros and cons should be carefully weighed with a view to decide whether, on the whole, the preponderance of probability as opposite to balance of probabilities against the claimant is such as to exclude all reasonable doubt.

## CHAPTER II

### ENTITLEMENT : GENERAL PRINCIPLES

1. Although the certificate of a properly constituted medical authority vis-à-vis the invaliding disability, or death, forms the basis of compensation payable by the government, the decision to admit or refuse entitlement is not solely a matter which can be determined finally by the medical authorities alone. It may require also the consideration of other circumstances e.g. service conditions, pre-and post-service history, verification of wound or injury, corroboration of statements, collecting and weighing the value of evidence, and in some instances, matters of military law and discipline. Accordingly, Medical Boards should examine cases in the light of the aetiology of the particular disease and after considering all the relevant particulars of a case, record their conclusions with reasons in support, in clear terms and in a language which the Pension Sanctioning Authority, a lay body, would be able to appreciate fully in determining the question of entitlement according to the rules. In expressing their opinion medical officers should comment on the evidence both for and against the concession of entitlement. In this connection, it is as well to remember that a bare medical opinion without reasons in support will be of no value to the Pension Sanctioning Authority.

2. While the question of entitlement on purely medical grounds present little or no difficulty in the case of a wound or injury, cases falling in the category of diseases may present varying degrees of difficulty.

3. If it is established on evidence that the disease was brought about by service conditions, then attributability is clearly indicated. If on the other hand, a disease not attributable to service---having been of pre-enrolment origin or having its origin in other than service conditions, has been influenced in its subsequent course by conditions of service, the claim would stand for acceptance on the basis of aggravation.

#### Evidence for Entitlement Purposes

4. Opinion on entitlement must be impartially given in accordance with the evidence, the benefit of any reasonable doubt being given to the claimant.

5. Evidence to be accepted for the purpose of these instructions should be of a degree of cogency which though not reaching certainty, nevertheless carries a high degree of probability. In this connection, it is as well to remember that proof beyond reasonable doubt does not mean proof beyond a shadow of doubt. If the evidence is so strong against a member as to leave only a remote possibility in his favour which can be dismissed with the sentence "of course it is possible but not in the least probable" the case is proved beyond reasonable doubt. If on the other hand the evidence be so evenly balanced as to render impracticable a determinate conclusion one way or the other then the case would be one in which the benefit of doubt could be given to the claimant.

6. If there is no note, or adequate note, in the service documents of material facts on which the claim is based, it would be for the service authorities to make all practicable investigations to establish the fact, calling upon the claimant, if necessary to assist. For instance, it may be possible to obtain reliable corroborative evidence of the fact.

7. Evidentiary value is attached to the record of a member's condition at the commencement of service, and such record has, therefore, to be accepted unless any different conclusion has been reached due to the inaccuracy of the record in a particular case or otherwise. Accordingly, if the disease leading to member's invalidation out of service or death while in service, was not noted in a medical report at the commencement of service, the inference would be that the disease arose during the period of member's military service. It may be that the inaccuracy or incompleteness of service record on entry in service was due to a non-disclosure of the essential facts by the member, e.g., pre-enrolment history of an injury, or disease like epilepsy, mental disorder etc. It may also be that owing to latency or obscurity of the symptoms, a disability escaped detection on enrolment. Such lack of recognition may affect the medical categorisation of the member on enrolment and/or cause him to perform duties harmful to his condition. Again, there may occasionally be direct evidence of the contraction of a disability, otherwise than by service. In all such cases, though the disease cannot be considered to have been caused by service, the question of aggravation by subsequent service conditions will need examination.

The following are some of the diseases which ordinarily escape detection on enrollment :-

(a) Certain congenital abnormalities which are latent and only discoverable on full investigations, e.g. CONGENITAL DEFECT OF SPINE, SPINA BIFIDA, SACRALIZATION.

(b) Certain familial and hereditary diseases, e.g., HAEMOPHILIA, CONGENITAL SYPHILIS, HAEMOGLOBINOPATHY

(c) Certain diseases of the heart and blood vessels, e.g., CORONARY ATHEROSCLEROSIS, RHEUMATIC FEVER.

(d) Diseases which may be undetectable by physical examination on enrolment, unless adequate history is given at the time by the member, e.g., GASTRIC and DUODENAL ULCERS, EPILEPSY, MENTAL DISORDERS, HIV INFECTIONS.

(e) Relapsing forms of mental disorders which have intervals of normality.

(f) Diseases which have periodic attacks, e.g., BRONCHIAL ASTHMA, EPILEPSY, CSOM etc.

8. The question whether the invalidation or death of a member has resulted from service conditions, has to be judged in the light of the record of the member's condition on enrolment as noted in service documents and of all other available evidence both direct and indirect.

In addition to any documentary evidence relative to the member's condition on entering the service and during service, the member must be carefully and closely questioned on the circumstances which led to the advent of his disease, the duration, the family history, his pre-service history, etc. so that all evidence in support or against the claim is elucidated. Presidents of Medical Boards should make this their personal responsibility and ensure that opinions on attributability, aggravation or otherwise are supported by cogent reasons; the approving authority should also be satisfied that this question has been dealt with in such a way as to leave no reasonable doubt.

9 On the question whether any persisting deterioration has occurred, it is to be remembered that invalidation from service does not necessarily imply that the member's health has deteriorated during service. The disability may have been discovered soon after joining and the member discharged in his own interest in order to prevent deterioration. In such cases, there may even have been a temporary worsening during service, but if the treatment given before discharge was on grounds of expediency to prevent a recurrence, no lasting damage was inflicted by service and there would be no ground for admitting entitlement. Again a member may have been invalided from service because he is found so weak mentally that it is impossible to make him an efficient soldier. This would not mean that his condition has worsened during service, but only that it is worse than was realised on enrolment in the army. To sum up, in each case the question whether any persisting deterioration is or is not due to service will have to be determined on the available evidence which will vary according to the type of the disability, the consensus of medical opinion relating to the particular condition and the clinical history.

**CHAPTER III****CLINICAL ASPECTS OF ENTITLEMENT****General**

1. Reports of medical boards are the basis of executive action, and will be read by both medical and lay officials, whose duty is to maintain a just and uniform application of the rules. It is, therefore, of the utmost importance that the Board's report should be legibly written (specially medical terms or abbreviations) and in unambiguous language so that the reader may be able to accurately visualise the condition for which compensation is claimed, the circumstances of its origin and development, and the general constitutional make-up of the person examined. No indication whatsoever should be given to, or in the hearing of, a person being examined, of the views of the Board as to his title to person or the assessment of the disablement.

**Wound and Injuries**

2. Resulting from enemy action.---Entitlement is dependent on :-

(a) an authentic official record of the casualty, or other reliable corroborative evidence.

(b) the condition being consistent with the effects of the wound or injury which would be expected to occur.

It is possible that in a few cases, there may be no record of the casualty other than the admission of the member to hospital. In this connection, it is important to note that an entry showing that the man has been admitted to hospital for "OLD GUN SHOT WOUND" merely indicates that he has been admitted for treatment of an old injury or unspecified wound; it does not establish how the wound was received or even that the original injury was, in fact, a gun shot wound. If, therefore, the only casualty record is in these or similar words, the Board should not comment on the question of entitlement, but leave it open for decision by the Pension Sanctioning Authority after seeking further clarification from the service authority.

3. Not resulting from enemy action.- Injury sustained as a result of an accident, and gun shot and other wounds notified as accidental, will, as a rule, have been the subject of enquiry at the time by the appropriate service authority; and if the documents show that they have decided that the injury or wound was received on duty and that the member was not to be blamed, no opinion need be given, as the question of entitlement will be decided by the Pension Sanctioning Authority; but opinion on medical aspects as in clauses (a), (c) and (d) of para 7 of CHAPTER I, will be given.

In other cases, i.e., in the case of an injury of which there is no record in official documents or other verification, the member's statement as to date, place, circumstances etc., should be carefully recorded and the Board should say whether the disability claimed, resulted from the injury but should otherwise leave the question of entitlement open for decision by the Pension Sanctioning Authority, as in para 2 above as the question would depend largely on non-medical issues.

4. Self-inflicted - The circumstances in which a wound or injury is self-inflicted are, as a rule, known from an injury report and/or Court of inquiry proceedings which is usually available. Cases of self-inflicted wound or injury require special investigation and consideration and the Board should say whether the disability claimed resulted from the wound or injury but should otherwise leave the question of entitlement open for the Pension Sanction Authority to decide.

#### **Diseases**

5. Service personnel are constantly under medical review through out their service and are further medically examined before proceeding on field service. Therefore, the appearance of a disability, other than that of a constitutional or developmental origin during military service, in general, presents a strong probability that the risks of military duty during service were responsible for it. During the period of intensive training and active service a man may undergo stress, exposure and hardships. Such stress and exposure may have an influence on the onset of, or course of disability. In a person weakened by strain or hardship, serious infection may occur, or latent infection may become manifest from exertion or strain.

6. In considering whether a particular disease is due to service, it is necessary to relate the established facts in the aetiology of the disease and of its normal development to the effect that any specific conditions of service, e.g., exposure, stress, climate etc., may have had on its manifestation. Regard must be paid to the time factor. The effects of strain, exposure or other compulsions of service would usually be expected to manifest themselves not long afterwards; and if the disability did not come under notice for a considerable time after the member was removed from such conditions as would affect his disability, there would naturally be doubt whether the disease had arisen due to service conditions.

7. In order to come to the decision the Board must be satisfied as to the diagnosis of the disability. It is therefore, of the utmost importance that the evidence, documentary or otherwise, on which the diagnosis is based should be critically considered and any reasons for doubt clearly indicated, so that further investigations by special tests or observations may be carried out if practicable.

8. The reported or alleged conditions of service which may have influenced the origin and development of the disease must be critically examined, and information from the member sought on matters of doubt. The medical officers who prepare the statement of case on page 2 of AFMSF-16, should obtain and record the member's own version of the origin and course of the disability. The Medical Board should study the statement of case and also other relevant information recorded in the documents available to them before coming to their conclusions.

9. Certain fairly clear-cut ideas regarding diseases and their relation to service have emerged as a result of experience and these are set out in Chapter VI with a view to assisting the boards in arriving at proper decisions in individual cases.

#### **Physical Examination**

10. The effect on function should be described so as to make apparent from what normal activities the examinee is debarred. The terms slight, moderate or severe, without qualifications, are insufficient. Physical examination, whilst primarily directed to the condition for which compensation is sought, must also be sufficiently comprehensive to reveal the existence of other injuries, diseases or defects.

11. Wounds and injuries should be described with anatomical precision and appropriate measurements. It is important to insert right or left; front or back; upper or lower and such terms as fracture of leg should not be used. The use of diagrammatic sketches to show the position of scars etc. will simplify description and facilitate subsequent consideration of the case. All scars, even those not connected with wounds or injuries received during service, should be recorded. For cases of gross facial disfigurement, photographs should be made to show the nature and extent thereof. In describing conditions in which either the upper or lower limbs are involved, the effect on function is of paramount importance.

12. Particular care should be taken to avoid the use of vague or ambiguous terms of diagnosis such as "debility", "second degree constitution", "anaemia" etc., which have a varied aetiology, without specification of the cause of the symptoms. Where the cause is obscure, special advice should be sought and, if necessary, hospital observation requested for.

#### **Clinical Summing Up**

13. The case should invariably be summed up and the diagnosis recorded at the conclusion of the report on physical examination. When the diagnosis remains in doubt, a reasonable statement of probabilities should be given with any recommendation which the Board may desire to make on further examination or observation. The summary should also include the opinion about the effect on function and a particular note of the occurrence of pain, if any, with the Board's opinion as to its nature, frequency and severity.

14. To have a correct appreciation of the case and to bring out the above mentioned facts, the following suggestions are made:-

(a) It is advisable for OsC hospitals, Officers-in-Charge, divisions/departments to keep specimen copies of the medical board proceedings which show the correct method of writing a statement of case, i.e., the various headings under which the case report has to be prepared so that important details are not missed. It is the responsibility of the senior officers to ensure that the document is prepared correctly before submission to the medical board office and the Boards in their turn should also insist on correct documentation before considering a case.

(b) In the case of diseases affected by stress and strain, dietetic compulsions etc; and in endemic states, the relevant information should be entered in medical documents.

(c) It is imperative that every specialist writing an opinion on a disability which is permanent or of a progressive organic nature, should record it under two heads :-

(i) A brief account of the circumstances as related to service factors which have a causal connection with the disability, e.g., name of the place, field or peace station where the first onset of symptoms occurred. How service conditions at that time were considered specific as against a similar occurrence which may equally be common in civil life, special stress factors specific, e.g., physical, mental and climatic.

(ii) Brief clinical notes bringing out the aetiology pathogenesis, specific disabilities and their effects on function. If these diseases are degenerative and progressive in nature, this fact should be brought out; and also whether these are capable/not capable of improvement.

(d) Percentage of disablement may be suggested.

(e) Information in AFMSF-81/AFMSF-10 should be complete. These forms usually contain little or no information regarding stress and strain, exposure to adverse climatic conditions, high altitude area, service afloat on high seas and dietetic compulsions in respect of disease where these factors are known to play some part. In cases of cardiovascular catastrophe, the details of duties performed by the individual day by day and hour by hour during the previous 14 days should be mentioned in the appropriate column by the OC Unit. Expressions like normal stress and strain of service should not find a place in these documents. Perhaps, these defects can be removed to some extent with better liaison between OC Unit/OC hospital

(f) Every attempt should be made to initiate the injury report soon after the patient's admission to hospital, and if possible, get it finalised before holding the categorisation/invalidating medical boards. The fact that injury report has been initiated, should be clearly mentioned in the medical case sheet with the date of its initiation.

**CHAPTER IV**  
**ENTITLEMENT RULES**

**ENTITLEMENT RULES FOR CASUALTY PENSIONARY AWARDS, 1982**

1. The Entitlement Rules set out below apply to service personnel who become non-effective on or after 1st January 1982. The cases arising on or after 1st January 1982 may be considered under these rules provided that such a case is still outstanding on the date of issue of these rules. For the purpose of defining whether a case will be treated as outstanding or not, it may be clarified that where such a case has already been decided even at the initial stage, the same will be treated as having been decided. Such cases will not be reopened. These rules shall be read in conjunction with this guide.

2. These Rules do not apply to the cases where disablement or death, on which the claim to casualty pensionary award is based, took place (a) during the period from 3<sup>rd</sup> Sep 1939 to 31<sup>st</sup> March 1948, which will be dealt with in accordance with the entitlement criteria laid down as per Wartime Rules vide GHQ/ AG Br letter No 106123/4/PP 3(a) dated 25 Nov 1946 and (b) during post 1948 periods of emergencies which will be dealt with in accordance with Annexure II to this chapter.

3. Pending decision on a general case to give pay and allowances to probationary nurses and cadets undergoing training at NDA/IMA and other pre-commission and probationary commission training institutions/academies of the Defence Services, they will continue to be governed under the existing instructions for casualty pensionary awards.

4. Invalidating from service is a necessary condition for grant of a disability pension. An individual who, at the time of his release under the Release Regulations, is in a lower medical category than that in which he was recruited will be treated as invalidated from service. JCOs/ORs & equivalents in other services who are placed permanently in a medical category other than 'A' and are discharged because no alternative employment suitable to their low medical category can be provided, as well as those who having been retained in alternative employment but are discharged before the completion of their engagement will be deemed to have been invalidated out of service.

5. The approach to the question of entitlement to casualty pensionary awards and evaluation of disabilities shall be based on the following presumptions :-

Prior to and during service

(a) A member is presumed to have been in sound physical and mental condition upon entering service except as to physical disabilities noted or recorded at the time of entrance.

(b) In the event of his subsequently being discharged from service on medical grounds any deterioration in his health which has taken place is due to service.

6. Disablement or death shall be accepted as due to military service provided it is certified by appropriate medical authority that :-

(a) the disablement is due to a wound, injury or disease which -

(i) is attributable to military service, or

(ii) existed before or arose during military service and has been and remains aggravated thereby. This will also include the precipitating/hastening of the onset of a disability.

(b) The death was due to or hastened by -

(i) a wound, injury or disease which was attributable to military service; or

(ii) the aggravation by military service of a wound injury or disease which existed before or arose during military service.

7. Where there is no note in contemporary official records of a material fact on which the claim is based, other reliable corroborative evidence of that fact may be accepted.

8. Attributability/aggravation shall be conceded if causal connection between death/disablement and military service is certified by appropriate medical authority.

**Onus of Proof**

9. The claimant shall not be called upon to prove the conditions of entitlement. He/She will receive the benefit of any reasonable doubt. This benefit will be given more liberally to the claimants in field/afloat service cases.

**Post Discharge Claims**

10. Cases in which a disease did not actually lead to the member's discharge from service but arose within 10 years thereafter, may be recognised as attributable to service if it can be established medically that the disability is a delayed manifestation of a pathological process set in motion by service conditions obtained prior to discharge and that if the disability had been manifest at the time of discharge the individual would have been invalided out of service on this account.

11. In cases where an individual in receipt of a disability pension dies at home and it cannot from a strictly medical point of view, be definitely established that the death was due to the disablement in respect of which the disability pension was granted:-

(a) the benefit of doubt in determining attributability should go to the family of the deceased, if death occurs within 10 years from the date of his invalidment from service unless there are other factors adversely affecting the claim; and

(b) if death takes place more than 10 years after the date of man's invalidment from service, the benefit of doubt will go to the State.

**Duty**

12. A person subject to the disciplinary code of the Armed Forces is on duty:-

(a) when performing an official task or a task, failure to do which would constitute an offence triable under the disciplinary code applicable to him.

(b) When moving from one place of duty to another place of duty irrespective of the mode of movement.

(c) During the period of participation in recreation and other unit activities organized or permitted by service authorities and during the period of travelling in a body or singly by a prescribed or organized route.

Note 1

(a) personnel of the Armed Forces participating in

(i) local/national/international sports tournaments as member of service teams, or

(ii) mountaineering expeditions/gliding organized by service authorities, with the approval of Service HQrs; will be deemed to be 'on duty' for purpose of these rules.

(b) personnel of the Armed Forces participating in the above named sports tournaments or in privately organized mountaineering expeditions or indulging in gliding as a hobby in their individual capacity, will not be deemed to be 'on duty' for purpose of these rules, even though prior permission of the competent service authorities may have been obtained by them.

(c) Injuries sustained by personnel of the Armed Forces in impromptu games and sports outside parade hours, which are organized by, or with the approval of, the local service authority, and death or disability arising from such injuries, will continue to be regarded as having occurred while 'on duty' for purpose of these rules.

Note 2

The personnel of the Armed Forces deputed for training at courses conducted by the Himalayan Mountaineering Institute, Darjeeling shall be treated on par with personnel attending other authorised professional courses or exercises for the Defence Services for the purpose of the grant of disability/family pensions on account of disability/death sustained during the courses.

(d) Personnel while travelling between place of duty to leave station and vice versa to be treated on duty irrespective of whether they are in physical possession of railway warrant/concession vouchers/cash TA etc or not. An individual on authorised leave would be deemed to be entitled to travel at public expense.

(e) The time of occurrence of injury should fall within the time an individual would normally take in reaching the leave station from duty station or vice versa using the commonly authorised mode(s) of transport. However, injury beyond this time period during the leave would not be covered.

(f) The provision of this rule are applicable only when journey is undertaken by the shortest possible routes. Any deviation from the shortest routes will require sanction of the competent authority.

(g) Where an individual is recalled from leave for reasons beyond his own control or returns to duty station earlier voluntarily, benefit would be given if sanction of the competent authority exists for the same.

(h) Where more than one mode of transport exists for going to/coming from leave station, the benefit should be given irrespective of the mode of transport chosen. For instance, journey by road is at times more convenient than by train. In case an individual opts for the most convenient mode of transport, the benefit should be given to the individual. This benefit should also be given to the individual where dislocation of normal traffic is due to strike, flood or other natural calamities and one is compelled to travel by unconventional mode of transport due to reasons beyond one's control (MOD letter No.1(1)/81/D(Pen-C)-Vol-II dated 27 Oct 1998).

(j) When journeying by a reasonable route from one's official residence to and back from the appointed place of duty, irrespective of the mode of conveyance whether private or provided by the government.

(k) An accident which occurs when a person is not strictly 'on duty' as defined may also be attributable to service, provided that it involved risk which was definitely enhanced in kind or degree by the nature, conditions, obligations or incidents of his service and that the same was not a risk common to human existence in modern conditions in India.

Thus, for instance, where a person is killed or injured by another party by reason of belonging to the Armed Forces, he shall be deemed 'on duty' at the relevant time. This benefit will be given more liberally to the claimant in cases occurring on active service as defined in the Army/Navy/Air Force Act.

(1) Attributability will be conceded if death or disability occurred as result of attack by or during action against extremist, anti social elements either on duty or leave, travelling between duty station and leave station. However, death and disability due to personal enmity is rejectable vide GOI No. 1(5)/89/D/PENC Min of Def letter dated 02 Nov 1995).

13. In respect of accidents or injuries the following rules shall be observed :-

(a) Injuries sustained when the man is "On duty" as defined, shall be deemed to have resulted from military service, but in cases of injuries due to serious negligence/misconduct the question of reducing the disability pension will be considered.

(b) In cases of self inflicted injuries whilst on duty, attributability shall not be conceded unless it is established that service factors were responsible for such action; in cases where attributability is conceded, the question of grant of disability pension at full or at reduced rate will be considered.

#### **Diseases**

14. In respect of diseases, the following rules will be observed :

(a) For acceptance of a disease as attributable to military service, the following two conditions must be satisfied simultaneously:

(i) That the disease has arisen during the period of military service; and

(ii) That the disease has been caused by the conditions of employment in military service.

(b) If medical authority holds, for reasons to be stated, that the disease although present at the time of enrolment

could not have been detected on medical examination prior to acceptance for service, the disease, will not be deemed to have arisen during service. In case where it is established that the conditions of military service did not contribute to the onset or adversely affect the course of disease, entitlement for casualty pensionary award will not be conceded, even if the disease has arisen during service.

(c) Cases in which it is established that conditions of military service did not determine or contribute to the onset of the disease but, influenced the subsequent course of the disease, will fall for acceptance on the basis of aggravation.

(d) In case of congenital, hereditary, degenerative and constitutional diseases which are detected after the individual has joined service, entitlement to disability pension shall not be conceded unless it is clearly established that the course of such disease was adversely affected due to factors related to conditions of military service.

15. The onset and progress of some diseases are affected by environmental factors related to service conditions, dietic compulsions, exposure to noise, physical and mental stress and strain. Disease due to infection arising in service, will merit an entitlement of attributability. Nevertheless, attention must be given to the possibility of pre-service history of such conditions which, if proved, could rule out entitlement of attributability but would require consideration regarding aggravation. For clinical description of common diseases reference shall be made to this guide. The classification of diseases affected by environmental factors in service is given in Annexure-I to these rules.

(i) Common diseases known to be affected by exposure to weather :- Diseases such as bronchitis, rheumatism and nephritis - indeed most diseases of the respiratory system, joints and kidneys - are affected by climatic conditions. The period and the conditions of service at any particular place should be taken into account in determining causal connection with service.

(ii) Common diseases known to be affected by stress and strain:-This should be decided with due reference to the nature of the duties an individual has had to perform in military service. It may be that in some cases the

individual had been engaged on sedentary duties when they will normally not qualify.

(iii) Diseases endemic to certain areas :- Diseases such as malaria, kalazar, filariasis, dysentery, cholera, etc are endemic to certain areas. These diseases may also be introduced by movements of infected persons. In determining causal connection with service, it will have to be established that the conditions of military service exposed the individual to the infection as a result of which he contracted the disease. Where there is medical evidence of the contraction of the disease either prior to entry into service, or while off duty or on leave, or desertion or unauthorised absence, etc attributability should not be accepted unless the disease occurs within the incubation period.

(iv) Diseases due to infections in service :- Entitlement to pension will be admitted if the exposure to infection arose from the circumstances of member's service.

(v) Diseases known to be affected by dietary compulsions :- The compulsions of service would also cover such cases as gastric disorders, e.g. gastritis, gastric and duodenal ulcers, where it is established that the member was unable to follow a dietary regime required for his condition. The effect of service in such cases will be limited essentially to the question of aggravation of pre-existing constitutional condition.

(vi) Diseases known to be affected by service in the submarine arm of the Navy :- Service in sub-marines imposes crowded living in closed confined environments for long periods. Operating conditions involve exposure to excessive heat and cold; and exposure to abnormal concentration of carbon di-oxide and other fumes and gases; continued vibrations; lack of exercises and compulsions of diet. Closed confinement and deprivation of wider human contact result in severe mental stresses for prolonged period which precipitate psychosomatic or neurotic disorders. In emergency escape drill from submarines, and in normal diving the human body is exposed to marked pressure variations resulting in barotrauma of various organs, which may vary from transient incapacity to permanent damage to vital organs of the body and central nervous system. Decompression sickness is a well established phenomenon both in Navy and in underwater construction trades. Apart from these

considerations, the close contact and lack of fresh air and ablution facilities result in promoting droplet infection and skin disease. The vitiated atmosphere because of accumulation of carbon di-oxide and other fumes and gases has a deleterious effect on human physiology, work capacity and especially pulmonary function.

(vii) Diseases which run their course independently of external circumstances :- There are certain diseases which would have run the same course whether the individual had been in the Forces or not, e.g. malignant diseases like Cancer etc. Such cases will be accepted as aggravated by service only if it is clear that owing to exigencies of service, the man did not receive treatment of a satisfactory character and standard or such treatment was so delayed as to be less effective than it should have been.

(viii) Sexually Transmitted Diseases :- Sexually transmitted diseases being normally the result of individual's own conduct, are not accepted as attributable to/aggravated by service. A sequela of the disease may, however, be accepted on the basis of aggravation if its onset is proved to have been hastened or precipitated by exceptional stress and strain of the service.

If the disease has been of a pre-enrolment origin, any sequela resulting in natural course of the disease, will not be accepted as related to service. If however, the late manifestation/sequela is proved to have been hastened or precipitated due to exceptional stress and strain of service, entitlement may be accepted on basis of aggravation. The cases of medical workers handling patients of sexually transmitted diseases and infected material will be accepted as related to service.

(ix) Invalidation on account of indulgence in drugs or drinks :- Entitlement shall not be conceded if the disability or death on which the claim is based, resulted from indulgence in drugs or drinks which was within one's own control.

#### **Communicable Diseases and Diseases Due to Infection**

16. Death or disablement resulting from such disease other than sexually transmitted diseases contracted during service shall be regarded as attributable to military service. Where the disease may have been contracted prior to enrolment or during leave, the

question of determining the incubation period in a particular case will arise and an opinion on this point should be expressed.

### Miscellaneous Rules

#### 17. Medical opinion and Competent Medical Authorities

(a) For the purpose of these rules, the following authorities shall be the Appropriate/Competent Medical Authorities for giving medical opinion on the aspects of assessment of disability and acceptance of death/disablement due to causes attributable to/aggravated by military service :-

- |                                                                   |                                                                                                                            |
|-------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|
| (i) In respect of initial claims of commissioned officers.        | Medical Advisor (Pension)/Jt Dir AFMS (Pension) in the Office of the Dir. General, Armed Forces Medical Services (DGAFMS). |
| (ii) In respect of initial claims of personnel below Officer rank | Medical Advisor (Pension)/Jt. Dir AFMS (Pension) attached to the Office of Chief CDA (Pensions).                           |
| (iii) At the First Appeal stage.                                  | Dy. DGAFMS (Pension) in the Office of the DGAFMS.                                                                          |
| (iv) At the Second Appeal stage.                                  | Dir. General Armed Forces Medical Services (DGAFMS).                                                                       |

#### 18. Disease Cases

(a) At the time of invalidment/release of a service personnel medical views on attributability/aggravation and degree of disability shall be given by the Invaliding Medical Board (IMB)/Release Medical Board (RMB). The findings of the IMB/RMB which are recommendatory in nature, shall be reviewed by the Competent Medical Authority at the time of consideration of initial claim/appeal for grant of disability pension. The Competent Medical Authority may for reasons to be accorded in

writing, alter or modify the recommendations of IMB/RMB/RSMB/Lower Medical Authorities.

(b) The Competent Medical Authorities after review of the IMB/RMB proceedings/findings of the lower medical authorities, study of related medical/service documents, the clinical profile recorded and keeping in mind the aetiology and nature of disease, shall evaluate the role played by service factors in the onset/progress of the disability. The recommendations of the Competent Medical Authority as accepted by the Pension Sanctioning Authorities i.e., Chief CDA (Pension)/Service HQ shall be final with regard to the entitlement and assessment of disability for the purpose of grant of disability.

19. Injury Cases

The findings of the IMB/RMB in injury cases shall be treated as final and for life. These cases will not be adjudicated by the Competent Medical Authority at the initial stage.

20. Predisposition : "Predisposition" or "inherent constitutional tendency" in itself is not a disease. And if there is a precipitating or causative factor in service which produces the disease, then it is attributable to service, notwithstanding the inherent disposition.

21. Aggravation : If it is established that the disability was not caused by service, attributability shall not be conceded. However aggravation by service is to be accepted unless any worsening in his condition was not due to his service or worsening did not persist on the date of discharge/claim.

22. Conditions of Unknown Aetiology : There are a number of medical conditions which are of unknown aetiology. In dealing with such conditions, the following guiding principles are laid down :-

(a) If nothing at all is known about the cause of the disease, and the presumption of the entitlement in favour of the claimant is not rebutted, attributability should be conceded.

(b) If the disease is one which arises and progresses independently of service environmental factors then the claim may be rejected.

**Unforeseen Effects of Service Medical Treatment**23. Delay in diagnosis/adverse effects of treatment

The question as to whether, through the exigencies of service, the diagnosis and/or treatment of wound, injury or disease was delayed, faulty or otherwise unsatisfactory, including the adverse/unforeseen effects of treatment, shall also be considered. The entitlement for any ill-effects arising as a complication from such factors shall be conceded as attributable.

**Assessment**

24. Assessment of degree of disability is entirely a matter of medical judgement and is the responsibility of the medical authorities.

The degree of disablement due to service/duty of a member of the military forces shall be assessed by making a comparison between the condition of the member as so disabled and the condition of a normal healthy person of same age and sex, without taking into account the earning capacity of the member in his disabled condition in his own or any other specific trade or occupation, and without taking into account the effects of any individual factor or extraneous circumstances.

Where disablement is due to more than one disability a composite assessment of the degree of disablement shall also be made by reference to the combined effect of all such disabilities in addition to separate assessment for each disability.

In other than paired organs, conditions may co-exist which through interaction may give also rise to the need for consideration under the greater disablement principle. One of the simplest example is, the pensioner with entitlement for bronchitis who also suffers from coronary atherosclerosis and as a consequence of acute bouts of coughing claims increasing frequency of attacks of angina. In such cases it is a matter of clinical judgement as to the extent to which the assessment for bronchitis should be increased to cover the greater disablement arising from the interaction between that condition and the coronary atherosclerosis. The pensioner is not entitled to the total assessment of disablement for the coronary atherosclerosis which might well be in the regions of 30 to 40%, but only to that portion of that assessment which it is reasonable to add to cover greater disablement. Depending on the increased frequency in the

attacks of angina due to severe bouts of coughing a greater disablement addition in the less than 20% range might well be appropriate.

(a) The assessment of a disability is the estimate of the degree of disablement it causes, which can properly be ascribed to service as defined below.

(b) The disablement properly referable to service will be assessed as under :-

(i) **At the time of discharge from the forces:** Normally, the whole of the disablement then caused by the disability. This will apply irrespective of whether the disability is actually attributable to service, or is merely aggravated thereby.

(ii) **On resurvey of disability after discharge from service :** The whole of the disablement then caused by the disability, less the following :-

(aa) The part due to non-service factors, such as individual's habits, occupation in civil life, accident after discharge, climatic environment after discharge;

(ab) Any worsening due to the natural progress of the disability since discharge, apart from the effect of service.

**Note:** Deduction (1) will be made in all cases; while deduction (2) will apply only in cases where the disability is accepted as aggravated by, but not attributable to, service.

### **Appeals**

25. **Right of appeal :** Where entitlement is denied by the Pension Sanctioning Authority on initial consideration of the claim, the claimant has a right of appeal against decision on entitlement and assessment. Whereas for decisions on entitlement all concerned authorities have to give opinions, assessment of degree of disablement is entirely a matter of medical judgement and is the responsibility of appropriate medical authority.

26. Detailed procedure to be followed for appeals shall be issued by Ministry of Defence from time to time, However, to avoid

inordinate delay in taking final decisions on the disability/family pensionary claims, suitable time limits at each stage of the claim shall be laid down.

### **Appellate Bodies**

#### 27. (a) **Defence Minister's Appellate Committee on Pensions**

DMACP shall deal with second or the final appeal on claim for casualty pensionary awards. This committee consists of :

Chairman	RM/RRM
Members	Chiefs of Staff (Army, Navy & Air Force)
	Defence Secretary
	Financial Adviser (DS)
	DGAFMS
	JAG (Three Services)

#### (b) **Appellate Committee for First Appeals**

ACFA shall deal with claims for casualty pensionary awards on first appeals. This Committee consists of :-

Chairman	AG/COP/AOP respective Service HQ.
Members	Deputy Director General (Pensions) of Office of the DGAFMS
	Deputy Financial Adviser (Pensions)

### **Decision of Appellate Committee for First Appeals**

28. After consideration of all relevant issues involved in a case, the appellate body shall give decision of upholding or rejecting the appeal by consensus.

**Functions and Responsibilities**

29. (a) **Service HQ**: Appropriate Service Authority shall be responsible for giving their views on matters relating to relevant service factors.

(b) **Judge Advocate General (JAG)** : He shall be responsible for giving opinion on legal matters.

(c) **Medical Authority**: Assessment of disablement and acceptance of attributability/aggravation in cases of disabilities other than injuries are medical issues. Views on such medical issues shall be given by the Competent Medical Authorities defined under Rule 17.

**Annexure I to Chapter IV**

**CLASSIFICATION OF DISEASES**

**1. Diseases Affected by Climatic Conditions**

- a. Bronchitis, Pneumonia
- b. Pleurisy, lung abscess, and bronchiectasis
- c. Arthritis
- d. Rheumatism
- e. Lumbago
- f. Local effects of severe cold climate i.e. frost bite, trench foot, chilblains
- g. Effects of hot climate i.e. heat stroke and heat exhaustion

**2. Diseases Affected by Stress and Strain**

- a. Psychosis and psychoneurosis
- b. Bronchial Asthma
- c. Myocardial infarction, and other forms of IHD
- d. Peptic ulcer

**3. Diseases Affected by Dietary Compulsions**

- a. Worm infestation particularly round worm infections
- b. Gastritis
- c. Food poisoning, especially due to tinned food
- d. Gastric ulcer
- e. Duodenal ulcer
- f. Nutritional disorders
- g. Diabetes mellitus
- h. Hypertension, IHD
- j. Congestive cardiac failure

**4. Diseases Affected by Training, Marching, Prolonged Standing etc.**

- a. Tetanus, erysipelas, septicaemia and pyaemia etc. resulting from injuries.
- b. Ankylosis and acquired deformities resulting from injuries
- c. Post traumatic epilepsy and other mental changes resulting from head injuries.
- d. Internal derangements of knee joints
- e. Deformities of feet
- f. Osteoarthritis of spine and lower limb joints
- g. Burns sustained through petrol, fire, kerosene oil etc. leading to scars and various deformities and disabilities.
- h. Hernia
- j. Varicose veins
- k. Corn, calcaneal spur
- l. Stress fractures

**5. Environmental Diseases**

- a. Diseases contracted in the course of official duty of attending to a sexually transmitted or infectious patient, or while conducting a postmortem examination.
- b. Diseases contracted on account of handling infectious material, poisonous chemical and radioactive substances.

**6. Disease Affected by Altitude**

- a. High altitude pulmonary oedema and pulmonary hypertension
- b. Acute mountain sickness
- c. Psychosis, psychoneurosis, suicide
- d. Thrombosis/Internal hypertension
- e. Snow blindness/solar dermatitis

**7. Diseases Affected by Service in Submarines and Diving**

- a. Acoustic trauma resulting from continuous noise and vibrations
- b. Effects of exposure to high levels of toxic gases
- c. Droplet infections

- d. Neurosis and psychosomatic disorders
- e. Effects of barotrauma
- f. Decompression sickness
- g. Dysbaric osteo-necrosis

**8. Diseases Affected by Service in Flying Duties**

- a. Otitic barotrauma
- b. Altitude decompression sickness
- c. Hypoxia
- d. Explosive decompression
- e. Ejection injuries

**9. Diseases Not Normally Affected By Service**

- a. Malignant diseases (Cancer and carcinoma)
- b. Pernicious anaemia, Addison's disease
- c. Osteitis deformans (Paget's disease)
- d. Gout
- e. Acromegaly
- f. Cirrhosis of the liver-if alcoholic
- g. Error of refraction
- h. Hypermetropia
- j. Myopia
- k. Astigmatism
- l. Presbyopia
- 12. Glaucoma--acute or chronic-unless there is a history of injury due to service or of disease of the eye due to service.

ANNEXURE I TO CHAPTER IVENTITLEMENT RULES FOR THE DISABILITY AND SPECIAL  
FAMILY PENSIONARY AWARDS IN RESPECT OF ALL RANKS  
OF THE ARMED FORCES DURING EMERGENCY

Period of Emergency	Government of India Letter
8 Sep 62 to 9 Jan 68	A/01927/AG/PS-4(a)/9948/Pen-C dated 26 Dec 1962
<b>03 Dec 71 to 31 Mar 72</b>	<b>A/01927/AG/PS-4(d)/11130/Pen-C</b>
<b>25 Mar 71 to 31 Mar 72</b> <b>(Op Cactus Lily)</b>	<b>dated 16 Dec 71. (reproduced below)</b>
15 Aug 71 to 31 Mar 72 (Naval personnel)	PN/3948/1191/Pen-c dated 01 Feb 72

No A/01927/AG/PS-4(d)/11139/Pen-C  
Bharat Sarkar  
Raksha Mantralaya  
New Delhi, the 16<sup>th</sup> Dec 1971.

**Sub : Entitlement rules for disability & family pensionary awards in respect of all ranks of Armed Forces during the present emergency.**

Sir,

1. I am directed to say that in partial modification of the existing rule 2 of the Entitlement rules, the President has been pleased to decide that with effect from 3<sup>rd</sup> December 1971 till the termination of the present emergency or upto 31<sup>st</sup> March 1972 which ever is earlier, entitlement to disability or family pensionary awards in respect of all ranks of the Armed forces, eligible for pension under the military rules, disablement or death shall be accepted as due to service, if :

(a) the disablement is due to a wound, injury or disease which:

- (i) is attributable to service, or
- (ii) existed before or arose during service and has been or remains aggravated thereby.

(b) the death was due to or hastened by :

- (i) a wound or injury or disease which was attributable to service, or
- (ii) the aggravation by service of a wound, injury or disease which existed before or arose during service.

2. In dealing with these cases, the benefit of reasonable doubt, will be given to the claimant. The entitlement shall be denied only if it can be established beyond reasonable doubt that the conditions mentioned above are not fulfilled.
3. Where an injury or disease, which led to discharge or death during service, was not noted in a medical report or other appropriate enrolment papers prepared at the time of commencement of the individual's service, fulfilment of the conditions mentioned may be accepted unless there is positive evidence to the contrary.
4. Where there is no note in contemporary official records of material fact on which the claim is based, other reliable corroborative evidence of that fact may be accepted.
5. "Service" means service in the armed forces from 3<sup>rd</sup> December 1971 except for casualties in OP CACTUS LILY in which case it will mean service from 25<sup>th</sup> March 1971.
6. These orders will apply retrospectively from 25<sup>th</sup> March 1971 in respect of casualties due to Op CACTUS LILY.
7. This letter issues with the concurrence of the Ministry of Finance (Defence) vide their U>O No. 5535-Pen of 1971.

Sd/-xxxx

Note : A form, which should be attached to the invaliding medical board proceedings in respect of all ranks to provide additional information, is given below:-

(Auth : DGAFMS letter No. 16033/DGAFMS/MA(Pens) dated 28 Jan 1972 addressed to DsMS)

In the opinion of the Medical Board and with reference to the Emergency Rules (Govt of India, Min of Def letter NO. A/01927/AG/PS-4(d)/11130/Pen-C dated 16 Dec 71) is the disability due to :

- (a) disease attributable to service during Emergency wef 25.3.71/3.12.71 or
- (b) disease which has been and remains aggravated by such service during the Emergency.

Note 1. If the answer to (b) is affirmative, was the disease, one which:

- (i) Existed before service during the Emergency.
- (ii) Arose during service during the Emergency

Note 2. If the answer to either (a) or (b) is in the affirmative, was the service during the Emergency in question in a field service area or not?

2. If the answer to (a) or (b) of question (2) is in affirmative, what are the reasons on which their opinion is based?

3. If the answer to (a) and (b) of the question (2) are in the negative, do the board consider:

(a) (i) that the disease existed during service before the Emergency and/or

(ii) that the individual at the time of commencement of Emergency was not fit for service demanded of him in the medical category.

(iii) what are the reasons and evidence on which the answers to (i) and (ii) above are based ?

(b) that there has been a deterioration in the man's condition during service during the Emergency? If so, on what evidence do the board base their opinion that it is not due to service during the Emergency.

(c) that, to their satisfaction, no deterioration has resulted from neglect, delay, faulty technique or lack of reasonable skill in service medical treatment or the exigencies of service before, during or after the treatment?

**Government of India letters on the following subjects are reproduced :**

(a) Scheme for grant of Ex-gratia Awards in case of Death/Disablement of cadets (direct) to causes attributable to or aggravated by Military Training - Letter No. 1(5)/93/D(Pen-C) dated 16.04.96.

(b) Liberalised pensionary awards in the case of death/disability as a result of attack by or during action against extremists, anti-social elements- Letter No. 1(5)/89/D(Pen - C) dated 02.11.1995.

(c) Implementation of the Government Decisions on the recommendations of the Fifth Central Pay Commission regarding disability pension/war injury pension/special family pension/liberalised family pension/dependent pension/liberalised dependent pension for the Armed Forces Officers and Personnel Below Officer Rank retiring, invaliding or dying in harness on or after 1.1.1996. Letter No.1(2)/97/D(Pen - C) dated 31 Jan 2001.

(d) Modalities for implementation of the recommendations of the Fifth Central Pay Commission contained in paras 164.10 and 164.22 of the report regarding the findings of the Medical Boards. Letter No. 1(2)/97/D(Pen-C) dated 07.02.2001.

(e) Delegation of power in service HQrs. Letter No. 4684/Dir (Pen)2001 dated 14 Aug 2001.

**(a) Letter No 1(5)/93/D/(PEN-C) dt 16.04.96**

**Sub: Scheme for grant of ex-gratia Awards in case of Death/Disablement of Cadets(direct) due to causes attributable to or aggravated by Military Training**

Sir,

I am directed to state that the President is pleased to sanction a scheme for grant of ex-gratia awards in respect of Cadets in the event of death/disablement due to causes attributable to or aggravated by the conditions of military training. The rates and other conditions for grant of these

ex-gratia benefits shall be as laid down in the succeeding paragraphs.

2. **Ex-Gratia Awards in Cases of Disablement:** In cases of invalidment on medical grounds due to disabilities attributable to or aggravated by the conditions of military training, an ex-gratia award at the rate of Rs. 1275/- per month for life shall be admissible to the ex-cadets (except service entry). In addition, a Disability Award on ex-gratia basis shall also be admissible to the ex-cadet at the rate of 600/- per month for 100% disability, during the period of disablement. The amount of disability award shall be proportionately reduced when the degree of disablement is less than 100%. No disability award shall be payable in cases where the degree of disablement is less than 20% or the disablement has not been accepted as attributable to or aggravated by the conditions of military training.
3. **Ex-gratia Awards in Cases of Death :** As per terms and conditions of recruitment, majority of the Cadets such as entries through IMA, Ex-NDA and direct entries etc, are required to be bachelors and they cannot marry during the pre-commission training. However, in case of entries such as Technical graduate entry/post graduate entry/Short Service Commission (tech and non tech), entry through the Army Cadets College (ACC) etc, marriage prior to pre-commission training is not a bar. In the event of death of a cadet due to causes attributable to military training, the following ex-gratia awards shall be payable to the Next of kin of the deceased Cadet depending on his marital status :
  - (i) On the death of married or unmarried cadet during training, Ex-gratia Award at the rate of Rs.1275/- per month and Ex-gratia amount of Rs.2.5 Lakhs (Authority : MOD Letter No. 1(6)/99/D(Pen-C) dated 05 Jul 2001 shall be admissible to the widow/children of the deceased cadet. This award shall be payable to the widow until her death or re-marriage (with a person other than the real brother of the deceased Cadet), whichever is earlier. After death or disqualification of the widow on account of re-marriage, the ex-gratia award shall be payable to the sons/unmarried daughters (in the order of seniority in age) till they attain the age of 25 years. In case of unmarried daughter (s), the payment of ex-gratia award shall be stopped on her/their getting married.

In the absence of eligible widow/children, ex-gratia award shall be paid to the dependent parents as per rates given in the para 3 (ii) below

- (ii) In case of unmarried/widower cadet with no children, ex-gratia award at the rate of Rs.1275/- per month shall be payable to the dependent parent(s) of the deceased cadet for life. In the absence of parents, the ex-gratia award shall be payable to the dependent brother(s)/unmarried sister(s) in the order of seniority of age, till they attain the age of 25 years. In case of unmarried sister(s), the payment of ex-gratia award shall be stopped on her/their getting married.
- (iii) The ex-gratia award shall be payable to only member of the family at a time.
- (iv) In the event of death of an ex-cadet in receipt of disability award under para 2 above, Ex-gratia Award at the above shall be admissible to the family of the deceased Cadet provided that the death is caused by the disability sustained during military training, which was accepted as attributable to or aggravated by the conditions of military training.

4. **Constant Attendance Allowance (CAA)** : When the degree of disability is assessed at 100% and is accepted as attributable to or aggravated by the conditions of military service, Constant Attendance Allowance at the rate of Rs.600/- per month shall be admissible to the ex-Cadet on the recommendation of the Invaliding Medical Board.

5. No ex-gratia award under these instructions shall be payable if the death/disablement is neither attributable to nor aggravated by the conditions of military service/training.

6. Other rules and procedures regarding assessment/re-assessment of disablement and acceptance of disability/death as attributable to or aggravated by conditions of military service/training in cases of cadet shall be the same as for regular commissioned officers of the Armed Forces. The procedure for sanction and conditions for grant of ex-gratia awards to the Next of Kin in case of deceased Cadets shall be same as in cases of casualties of regular commissioned officers due to attributable causes.

7. Awards under these instructions are being sanctioned purely on ex-gratia basis and the same shall not be treated as pension

for any purpose. However, Dearness Relief shall be admissible on the Ex-gratia Awards sanctioned under para 2 & 3 of the instructions.

8. The provisions of this letter shall be applicable in cases of casualties occurring on or after 01.8.97. However, the benefit of revised monthly Ex-gratia amount shall be admissible to pre 01.8.97 cases as well with financial effect wef 01.8.97. ( MOD letter No 1(6)/99/D( Pen C) dated 05 July 2001 and 11 Feb 2002 refers)

9. This issues with the concurrence of the Finance Division of this Ministry vide their U.O. No. 607/Pen/96 dated 9.4.96.

Sd/xxxx

**(b) Letter No 1(5)/89/D(Pen-C) dt 02 Nov 1995**

**Sub : Liberalised pensionary awards in the case of death/disability as a result of attack by or during action against extremists, anti-social elements etc.**

Sir,

I am directed to state that the President is pleased to decide that Liberalised Pensionary Awards as defined in Ministry of Defence letter No. 1(5)/87/D(Pensions/Services) dated 30 Oct 1987 and letter No. 1(6)/91/D(Pen-C) dated 07 Mar 1991, will be admissible in the cases of Armed Forces personnel who are killed or disabled as a result of attack by extremists, anti social elements etc. or during action against dacoits, smugglers, hostiles etc. as applicable to civilian Government servants vide Govt of India, Department of P & PW O.M. No. 33/5/89-P&PW (K) dated the 9 April 1990. The claims for Liberalised Pensionary Awards in case of Armed Forces personnel will be regulated as under:

**(a) Applicability** : These orders shall apply to all the categories of Armed Forces personnel.

**(b) Scope** : These orders will apply to Defence personnel killed or disabled as a result of attack by extremists, anti-

social elements etc. or during action against dacoits, smugglers, hostiles etc.

2. The benefits of these orders shall be restricted only to those cases where the death/disability is directly caused by actual operations. The following guidelines are laid down to enable Pension Sanctioning Authorities to determine whether benefits of these orders are attracted or not and decide the case accordingly:

(a) Cases when a person is killed/ injured by anti social elements/extremists : (i) When a Defence personnel is killed by anti-social elements/extremists while on duty (as defined in Entitlement to Casualty Pensionary Awards Rules 1982 or in an encounter, the family will be entitled to benefits of these orders.

(ii) In case death occurs during deployment to contain demonstration/agitation etc. by anti-social elements and extremist, the benefits of these orders will be extended to the family.

(iii) If the service personnel is killed by persons other than anti-social elements/extremists due to personal enmity, the benefits of these orders shall not be applicable.

(iv) If any member of Armed Forces gets killed by such elements while travelling from Duty Station to Leave Station and vice-versa, his family shall be allowed the benefits of these orders.

(v) If any Defence personnel gets killed/injured as a result of an attack by anti-social elements when travelling on duty by any mode of transport, the family, he/she shall be entitled to the benefits of these orders.

(vi) If an individual while on leave, is killed for ransom of being a member of the Armed Forces, his/her NOK would be covered under sub para 12 (f) of the Entitlement Rules to Casualty Pensionary Awards to the Armed Forces Personnel-1982, promulgated vide Govt of India, Ministry of Defence letter No. 1(1)/81/D(Pen-C) dated 221.11.1983. Accordingly, the deceased personnel would be treated on duty and the NOK would be entitled to Liberalised Family Pension.

(b) Cases where a person is killed/injured deliberately with a view to spread terror : When anti-social elements/extremists etc.

deliberately kill/injure any service personnel with a view to spread terror, the NOK/individual will be eligible to the benefits under these orders.

3. Armed Forces personnel who are invalided out due to disability sustained in above mentioned circumstances, shall be entitled to War Injury Pension and other benefits in terms of para 18 of Min of Defence letter No. 1(5)/87/D(Pension/Services) dated 30 Oct 87.

4. Armed Forces personnel who are retained in service inspite of disability for life which occurred in the circumstances narrated above, and retire subsequently will also be entitled for Lumpsum compensation in lieu of War Injury elements in terms of Govt of India, Ministry of Defence letter No. 1(6)/91/D(Pen-C) dated 07 Mar 1991.

5. If a service personnel having sustained an injury in such cases is invalided out of service with a War Injury Pension under these orders but dies subsequently as a result of the same injury, he/she will be deemed to have been killed in action and the awards under these order will be admissible to the family from the date following the date of his/her death.

6. Claims of service personnel for grant of liberalised pensionary awards in the event of casualties occurring as a result of attack by extremists, anti-social elements etc, or action against dacoits, smugglers, hostiles etc. shall be adjudicated by the Pension Sanctioning Authorities as under :-

(a) In cases of casualties while on duty or otherwise in the operational area, the claims shall be adjudicated by the Chief CDA(P) under the delegated powers as in the case of war like operations. The claim of a service personnel disabled or killed while on duty outside operation area shall also be adjudicated by CDA(P).

(b) Claims of service personnel killed/disabled outside notified area of operation, while not on duty shall be adjudicated by the Ministry of Defence.

7. The claims falling under the category mentioned in para 6 (a) above shall be submitted by the concerned service HQ/Record Office to the CCDA (P) alongwith detailed statement of the case, duly approved by the competent authority, with a certificate to the effect that the casualty occurred as a result of attack by or during an action against extremist/anti-social elements etc. A

copy of the F.I.R lodged with the civil police and/or proceedings/recommendations of the Court of Inquiry will also be invariably submitted alongwith such claims. On the basis of documents received from the service HQrs/ROs and after satisfying itself that the claim is admissible under these orders, the Pen Sanctioning Authority will notify the pensionary benefits after adjudication in consultation with its Medical Adviser (Pension). In cases of claims falling under the category mentioned in para 6 (b) above, Service HQrs/ROs will submit claims alongwith the necessary documents and certificates to the Ministry of Defence through the CDA(P) Allahabad who will submit the claim to the Ministry of Defence alongwith an Audit Report, for adjudication/final decision.

8. These orders shall be applicable to all cases arising on or after 01 Jan 1986.

9. This issues with the concurrence of Defence (Finance) vide their U.O. NO. 1780/Pen/95 of 1995.

Sd/-xxxx

**(c) Letter No 1(2)97/D(Pen-C) dt 31.01.2001**

**SUBJECT: IMPLEMENTATION OF THE GOVERNMENT DECISIONS ON THE RECOMMENDATIONS OF THE FIFTH CENTRAL PAY COMMISSION REGARDING DISABILITY PENSION/WAR INJURY PENSION/SPECIAL FAMILY PENSION/LIBERALISED FAMILY PENSION/ DEPENDENT PENSION/LIBERALISED DEPENDENT PENSION FOR THE ARMED FORCES OFFICERS AND PERSONNEL BELOW OFFICER RANK RETIRING , INVALIDING OR DYING IN HARNESS ON OR AFTER 01.01.1996.**

Sir,

The undersigned is directed to state that in pursuance of Government decisions on the recommendations of the Fifth Central Pay Commission, sanction of the President is hereby accorded to the modification, to the extent specified in this letter, in the rules/regulations concerning above mentioned pensionary benefits of the Commissioned Officers (including MNS) and Personnel Below Officer Rank (PBOR) including NCs(E) of the three services, Defence Security Corps and the Territorial Army (here-in-after collectively referred to as Armed Forces personnel).

1.2 The provisions of the Pension regulations of the three Services and various Service instructions/Government orders which are not affected by the provisions of this letter, will remain unchanged.

### **Part I - Date of effect and definitions**

2.1 The provisions of this letter shall apply to the Armed Forces personnel who were in service on 1.1.1996 or joined/join service thereafter specified in this letter.

2.2 Where pension has already been sanctioned provisionally or otherwise in cases occurring on or after 1.1.1996 the same would be revised in terms of these orders. In cases where pension has been finally sanctioned under the pre-revised orders and if it happens to be more beneficial than the pension becoming due under these orders, the pension already sanctioned shall not be revised to the disadvantage of the pensioners.

### **Definitions**

#### **3. Reckonable Emoluments :**

3.1. Unless otherwise specified in this letter, the term 'Reckonable Emoluments shall mean :

(a) **For Officers.** Pay including Rank Pay, Non-practising Allowance, Stagnation Increment, if any, last drawn by the officer (Ref SAI 2/S/98, SNI 2/S/98 and SAFI 2/S/98)

(b) **For Personnel Below Officer Rank (PBOR).** Pay including classification allowance, Stagnation increment, if any, last drawn by the individual. (Ref SAI 1/S/98, SNI 1/S/98, SNI 1/S/98 and SAFI 1/S/98).

3.2 In the case of individuals who opt/opted to continue to draw pay in the pre-revised scales beyond 31.12.95 and remain/remained in that scale till retirement/discharge/invalidment/death in harness, pension/family pension and retirement/death gratuity shall be regulated in terms of Para 3.3 and 3.4 of Ministry of Defence letter No. 1(6)/98/D(Pen/Ser) dated 03 Feb 98.

**PART II - PENSIONARY BENEFITS ON DEATH/DISABILITY IN ATTRIBUTABLE/AGGRAVATED CASES**

4.1 For determining the pensionary benefits for death or disability under different circumstances due to attributable/aggravated causes, the cases will be broadly categorised as follows :

**Category A**

Death or disability due to natural causes neither attributable to nor aggravated by military service as determined by the competent medical authorities. Examples would be ailments of nature of constitutional diseases as assessed by medical authorities, chronic ailments like heart and renal diseases, prolonged illness, accidents while not on duty.

**Category B**

Death or disability due to causes which are accepted as attributable to or aggravated by military service as determined by the competent medical authorities. Disease contracted because of continued exposure to a hostile work environment, subject to extreme weather conditions or occupational hazards resulting in death or disability would be examples.

**Category C**

Death or disability due to accidents in the performance of duties such as :

- (i) Accidents while travelling on duty in Government Vehicles or public/private transport
- (ii) Accidents during Air Journeys
- (iii) Mishaps at sea while on duty
- (iv) Electrocution while on duty, etc.
- (v) Accidents during participation in organised sports events/adventure activities/expeditions/training.

**Category D**

Death or disability due to acts of violence/attack by terrorists, anti-social elements, etc whether on duty other than operational duty or even when not on duty. Bomb blasts in public places or transport, indiscriminate shooting incidents in public, etc. would be covered under this category, besides death/disability occurring while employed in the aid of civil power in dealing with natural calamities.

**Category E**

Death or disability arising as a result of :

- (a) Enemy action in international war.
- (b) Action during deployment with a peace keeping mission abroad
- (c) Border skirmishes.
- (d) During laying or clearance of mines including enemy/mines as also minesweeping operations.
- (e) On account of accidental explosions of mines while laying operationally oriented mine-field or lifting or negotiating minefield laid by the enemy or own forces in operational areas near international borders or the line of control.
- (f) War like situations, including cases which are attributable to/aggravated by :-
  - (i) Extremist acts, exploding mines etc, while on way to an operational area.
  - (ii) Battle inoculation training exercises or demonstration with live ammunition.
  - (iii) Kidnapping by extremists while on operational duty.
- (g) An act of violence/attack by extremists, anti-social elements etc while on operational duty.

(h) Action against extremists, anti-social elements, etc. Death/disability while employed in the aid of civil power in quelling agitation, riots or revolt by demonstrators will be covered under this category.

(i) Operations specially notified by the Govt from time to time.

**4.2. Cases covered under category 'A' would be dealt with in accordance with the provisions contained in the Ministry of Defence letter No. 1(6)98/D(Pens/services) dated 3.2.98 and cases under category 'B' to 'E' will be dealt with under the provisions of this letter.**

**Notes.**

(i) The illustrations given in each category are not exhaustive. Cases not covered under these categories will be dealt with as per Entitlement Rules to casualty pensionary awards in vogue.

(ii) The question whether a death/disability is attributable to or aggravated by military service will be determined as per provisions of the Pension Regulations for the Armed Forces and the Entitlement Rules in vogue as amended from time to time.

(iii) In case of death while in service which is not accepted as attributable to or aggravated by Military Service or death after retirement/discharge/invalidment, Ordinary Family Pension shall be admissible as specified in Min of Def letter No. 1(6)/98/D(Pen/Ser) dated 03 Feb 98 as modified vide Ministry of Defence letter No. 1(1)/99/D(Pen/Ser) dated 07.06.99.

(iv) Where an Armed Forces personnel is invalided out of service due to non-attributable/non-aggravated causes, Invalid pension/gratuity shall be paid in terms of para 9 of Ministry of Defence letter No. 1(6)/98/D(Pen/Ser) dated 03 Feb 98 as amended/modified vide Ministry of Defence letter No. 1(1)/99/D(Pen/Ser) dated 07.06.99.

**PART III - FAMILY PENSIONARY BENEFITS IN ATTRIBUTABLE/AGGRAVATED  
CASES**

**5. Special Family Pension (SFP)**

5.1 In case of death of an Armed Forces Personnel under the circumstances mentioned in category "B" or "C" of Para 4 above. Special Family Pension shall continue to be admissible to the families of such personnel under the same conditions as in force hithertofore. There shall be no condition of minimum service on the date of death for grant of Special Family Pension.

5.2. The Special Family Pension shall be calculated at the uniform rate of 60% of Reckonable Emoluments as defined in para 3 above, subject to a minimum of Rs. 2550/-, irrespective of whether widow has child(ren) or not. There shall be no maximum ceiling on Special Family Pension. Ministry of Defence order No. F.PC 1(2)/97/D(Pen-C) dated 22.9.99 stands amended accordingly.

5.3 In case the children become the beneficiary, the Special Family Pension at same rate (ie., 60% of Reckonable Emoluments) shall be admissible to the senior most eligible child till he/she attains the age of 25 years or upto the date of his/her marriage whichever is earlier. Thereafter Special Family Pension shall pass on to next eligible child.

**Notes.**

(i) Widowed/divorced daughters upto the age of 25 years or marriage whichever is earlier shall also be included in the definition of family for the purpose of Special Family Pension.

(ii) In case the eligible child is physically or mentally handicapped and unable to earn a livelihood, the Special Family Pension would be admissible for life to such a child subject to same conditions as in force hithertofore.

5.4 In case of personnel below officer rank, the existing provisions of nominating anyone from the eligible members of the family (except dependant brothers/sisters) for the first life award of Special Family Pension and of transferring the same in full to the widow regardless of her financial position in the event of death of parents, where they were nominated as the original awardees, shall continue.

5.5 Families of SSCOs and ECOs who die under circumstances mentioned in category 'B' and 'C' of para 4.1 above shall also be entitled to Special Family Pension as per para 5.1. above.

5.6. Dependant Pension in respect of Officers(including MNS Officers, TA Officers & ECOs/SSCOs): Dependent pension shall be admissible to the parent(s)/eligible brothers and sisters(in the absence of parents) of the deceased Officers, who die under circumstances as mentioned in para 5.1 above as a bachelor or widower without children, at a rate equal to 50% of notional Special Family Pension that would have been admissible as per para 5.2 above.

Notes : (1) Condition as laid down in para 5.3 above regarding age limit and marriage shall equally apply to dependant brothers/sisters for grant of dependent pension which shall be paid to the senior most eligible brother/sister at a time.

(2) The condition regarding means limit was dispensed with vide MOD letter No. 1(5)/87/D(Pen/Ser) dt 31.10.87. Status-quo ante will continue.

**5.7 Second life award in respect of PBOR including NCs(E) :** Second Life Awards (Special Family Pension) shall be admissible to the parent(s) of the deceased irrespective of single or both and in the absence of the parents, to the eligible brothers and sisters of the deceased, at the rates specified in para 5.6 above and the condition specified in the note thereunder.

**5.8 Special Family Pension or Remarriage of widow :** Special Family Pension on remarriage of widow, shall be regulated as follows:

**(a) Commissioned Officers**

(i) If she has child(ren) :

(aa) If she continues to support children after remarriage      Full Special Family pension continue to widow

(ab) If she does not support children after marriage      Ordinary Family Pension (OFP) equal to 30% of emoluments last drawn to the re-married widow

50% of the Special Family Pension to the eligible children

(ii) If widow has no children Full Special Family Pension to continue to widow.

**(b) PBOR**

**(i) If Special Family Pension is sanctioned to the widow:**

Same provisions as applicable to officers.

**(ii) Where first life award is sanctioned to parents:**

- |                                                                                                            |                                                                                             |
|------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------|
| (aa) If widow continues to support children after re-marriage or has no issues                             | 50% of SFP to parents<br>50% of SFP to widow                                                |
| (ab) If widow does not support child (ren) after re-marriage but the children are supported by the parents | Full SFP to parents<br>Ordinary Family Pension to widow.                                    |
| (ac) If children are not supported either by the re-married widow or the parents                           | 50% of SFP to parents,<br>50% SFP to eligible child (ren), Ordinary Family Pension to widow |
| (ad) On death or disqualification of parents and the widow supports the children or has no issues          | Full SFP to widow                                                                           |
| (ae) Or death or disqualification of parents and the widow does not support the children                   | Full SFP to eligible children, Ordinary Family Pension to widow.                            |

**6. Liberalised Family Pension (LFP)**

6.1 In case of death of an Armed Forces Personnel under the circumstances mentioned in category "D" & "E" of para 4.1 above, the eligible member of the family shall be entitled to Liberalised Family Pension equal to reckonable emoluments last drawn as defined in para 3.1 above, both for officers and PBOR. Liberal Family Pension at this rate shall be admissible to the widow in

the case of officers and to the nominated heir in the case of PBOR until death or disqualification.

6.2 If the Armed Forces Personnel is not survived by widow but is survived by child/children only, all children together shall be eligible for Liberalised Family Pension at rate equal to 60% reckonable emoluments as defined in Para 5.2. Liberalised Family Pension shall be payable to the child/children for the period during which they would have been eligible as in the case of Special Family Pension. The Liberalised Family Pension shall be paid to the senior most eligible child at a time. On his/her death/disqualification it will pass on to next eligible child. The provision of para 5.3 (except rates) will be applicable here also.

**Note :** In view of the rationalisation of Liberalised Family Pension and provisions on re-marriage of widow, Children Allowance will not be payable to Liberalised Family Pension.

6.3 Families of SSCO's and ECO's who die under circumstances mentioned in category 'D' and 'E' of para 4.1 above shall also be entitled to Liberalised Family Pension as per para 6.1 above.

**6.4 Dependent pension (liberalised) in respect of Commissioned Officers. (including MNS, TA officers and ECOs/SSCOs):** Where an officer dies as a bachelor or as a widower without children under the circumstances mentioned in para 4.1 'D' & 'E' above, Dependent Pension (liberalised) shall be admissible to parents without reference to their pecuniary circumstances at the rate of 75% of Liberalised Family Pension for both parents and at the rate of 60% of Liberalised Family single parent. On the death of one parent, dependent pension at the latter rate shall be admissible to the surviving parent. In the absence of parents, dependent pension shall be admissible to dependent brother(s)/sister(s) if otherwise eligible, at the rate of 60% of LFP.

**Note :** Condition as laid down in Para 5.3 above regarding age limit and marriage shall equally apply to dependent brother/sister for grant of dependent pension which shall be paid to the senior most eligible brother/sister at a time.

**6.5 Second life award (liberalised Family Pension) in respect of PBOR including NCs(E) :** Second life award in respect of personnel below officer rank who die under the circumstances mentioned in para 4.1 'D' & 'E' above shall be regulated as under :

(a) If the first receiptent (other than the parents) of the family pensionary award dies/is disqualified earlier than 7 years (counting from the date of casualty), the award will be continued at the same rate to the parents as second life award, if still alive, for the balance of 7 years without any reduction. After the initial period of 7 years, the second life award will be continued at the rate of 60% of the Liberalised Family Pension.

(b) Where the first life award was given to a parent and the widow remarries, the Liberalised Family Pension shall be regulated depending upon the period of widow's remarriage as follows:-

**(i) If widow continues to support the children or has no children :** Widow will get family pension equal to Special Family Pension (ie, 60% of liberalised family pension or reckonable emoluments) from the date of remarriage and the parents will also get family pension at the rate of 60% of liberalised family pension for the balance of 7 years if the remarriage of widow takes place during 7 years of casualty. After the period of seven years or where remarriage of widow took place after seven years, widow will get family pension @ 60% liberalised family pension and parents will get family pension at the rate of 30% of liberalised family pension. On death or disqualification of parents, widow will get family pension equal to the liberalised family pension for life.

**(ii) If widow does not support the children :** Widow will get Ordinary Family Pension (ie 30% of Reckonable emoluments) for life from the date of remarriage and the parents will continue to get first life award at the same rate (ie, full liberalised family pension) for balance of seven years where remarriage takes place within 7 years of casualty, provided they support the children. Otherwise, the entitlement of parents will be equally divided between the parents and children. After the period of 7 years or where remarriage of widow takes place after seven years of casualty, parents will get family pension at the rate of 60% of liberalised family pension provided they support the children, otherwise it will be divided equally between the parents and the children. On the death/disqualification of parents of deceased service personnel, the senior most eligible

child will get family pension at the rate of 60% of liberalised family pension.

Note: Wherever children become beneficiary the award will be continued for a period and subject to conditions as applicable for grant of Special Family Pension. Provisions of Para 5.3 above shall also apply.

**6.6 Liberalised Family Pension on Re-marriage of Widow:**

Liberalised Family Pension on remarriage of widow, shall be regulated as follows :

**(a) Commissioned Officers**

(i) If she has children :-

(aa) If she continues to support - Full Liberalised Family Pension  
children after remarriage continue to widow

(ab) If she does not support - Ordinary Family pension 30% to  
children after re-marriage widow.

Special family Pension at 60%  
to eligible children

(ii) If widow has no children - Full Liberalised Family Pension  
to continue to widow.

**(b) PBOR**

**(i) If Liberalised Family Pension is sanctioned as first life award to the widow :** Same provisions as at (a) above shall be applicable.

**(ii) Where first life award is sanctioned to parents :** The admissibility of Liberalised Family Pension in such cases would be regulated as mentioned in Para 6.5 (b) above.

**PART IV - DISABILITY/WAR INJURY PENSIONARY AWARDS**

**7. Disability Pension on Invalidment**

7.1 Where an Armed Forces Personnel is invalided out of service under circumstances mentioned in category 'B' & 'C' of para 4.1 above which is accepted as attributable to or aggravated by

Military Service, he/she shall be entitled to disability pension consisting of service element and disability element as follows :

**(I) Service Element :-**

**(i) Commissioned Officers** : The amount of service element shall be equal to the retiring pension determined as per para 6.1 of this Ministry's letter No 1(6)/98/D(Pen/Ser) dated 03 Feb 98. For this purpose the reckonable qualifying service shall mean the actual service rendered by the officer plus the full weightage appropriate to the rank held at the time of invalidment (except in the case of TA officers) as given in para 5(b) of the ministry's above said letter dated 03 Feb 98. There shall be no condition of minimum qualifying service having been actually rendered for earning this element, if otherwise due.

**(ii) PBOR** : Service element will be determined as follows :-

<u>Length of actual Qualifying service Rendered (without Weightage)</u>	<u>Entitlement of Service Element</u>
15 years or more (20 years or more in the case of NCs(E))	Equal to normal service relevant to the length of qualifying service actually rendered plus weightage of service as given in para 5 & 6 of Ministry's letter dated 03 Feb 98 Ibid.
Less than 15 years (20 Years in case of NCs(E))	Equal to service pension as determined as per para 6.2(b) of Ministry Letter dated 03 Feb 98 but it shall in no case be less than 2/3 <sup>rd</sup> of the minimum service pension admissible to the rank/pay group.

Note : The existing provisions in the case of PBOR regarding grant of service element equal to minimum service pension appropriate to the rank and pay group in case where service is less than 15 years (20 years in case of NCs(E)) and the disability is sustained in

flying/parachute jumping duty or while being carried on duty in an aircraft under proper authority shall continue.

(ii) (a) **Disability Element** : The rates of Disability for 100% disability for various ranks shall be as follows :

<b><u>Rank</u></b>	<b><u>Amount p.m.</u></b>
i) Commissioned Officers and Honorary Commissioned Officers of the three Services, MNS, TA and DSC	Rs. 2600/-
ii) Junior Commissioned officers and equivalent ranks of the three services, TA and DSC	Rs. 1900/-
iii) Other ranks of the three services, TA and DSC	Rs. 1550/-

(b) Disability lower than 100% shall be reduced with reference to percentage as laid down in para 7.2 below. Provided that where permanent disability is not less than 60%, the disability pension (ie, total of service element plus disability element) shall not be less than 60% of the reckonable emoluments last drawn.

7.2 Where an Armed Forces personnel is invalided out under circumstances mentioned in Para 4.1 above, the extent of disability or functional incapacity shall be determined in the following manner for the purpose of computing the disability element:-

<b><u>Percentage of disability As assessed by invaliding Medical board</u></b>	<b><u>Percentage to be reck- oned for computing of disability element</u></b>
less than 50	50
between 50 and 75	75
between 76 and 100	100

## **8. Disability Element on Retirement/Discharge**

8.1 Where an Armed Forces Personnel is retained in service despite disability arising/sustained under the circumstances mentioned under category 'B' & 'C' in para 4.1 above and is subsequently retired/discharged on attaining age of retirement or on completion of tenure, he/she shall be entitled to disability element at the rates prescribed at para 7.1.II(a) above for 100% disablement.

8.2 For disabilities less than 100% but not less than 20%, the rate shall be proportionately reduced. No disability element shall be payable for disabilities less than 20%. Provisions contained in para 7.2 above shall not be applicable for computing disability element. Disability actually assessed by the duly approved Release Medical Board/Invaliding Medical Board as accepted by the Pension Sanctioning Authority, shall reckon for computing disability element.

8.3 Retiring/Service Pension or Retiring/Service Gratuity as admissible as per Ministry of Defence letter No 1(6)/98/D(Pen/Services) dated 03 Feb 98 shall be payable in addition to disability element from the date of retirement/discharge.

**Note** : An Armed Forces Personnel who retires voluntarily/or seek discharge on request shall not be eligible for any award on account of disability. Provided that Armed Forces Personnel who is due for retirement/discharge on completion of tenure, or on completion of service limits or on completion of the terms of engagement or on attaining the prescribed age of retirement, and who seeks pre-mature retirement/discharge on request for the purpose for disability element.

## **9. Lumpsum Compensation in Lieu of Disability Element**

9.1 In case a person belonging to the Armed Forces is found to have a disability which is sustained under the circumstances mentioned under category "B" & "C" in para 4.1 above which is assessed at 20% or more for life but the individual is retained in service despite such disability, he/she shall be paid a compensation in lumpsum (in lieu of disability element) equal to the capitalised value of disability element on the basis of disability actually assessed (i.e. provisions of para 7.2 above shall no apply). The rates of disability element for calculating capitalised value shall be as laid down in para 7.1 (II) (a). The above rates shall be proportionately reduced for lesser

percentage of disability. The age next birthday will be reckoned with reference to the date of onset of disability with loading of age, if any, recommended by the Disability Compensation Medical Board. Once a compensation has been paid in lieu of the disability element, there shall be no further entitlement to the disability element for the same disability under the provisions of para 8 above. Such disability shall also not qualify for grant of any pensionary benefits or relief subsequently.

9.2 The provision contained para 9.1 above shall be applicable to casualties on or after 01 Jan 96.

#### **10. War Injury Pension on Invalidment**

10.1 Where an armed Forces Personnel is invalided out of service on account of disabilities sustained under circumstances mentioned in category 'E' of para 4.1 above, he/she shall be entitled to War Injury Pension consisting of Service element and War Injury element as follows :-

(a) **Service Element** : Equal to Retiring/Service Pension to which he/she would have been entitled on the basis of his/her pay on the date of invalidment but counting service upto the date on which he/she would have retired in that rank in normal course including weightage as admissible. Provisions of para 6 of Ministry of Defence letter No.1(6)/98/D(Pen/Ser) dated 03 Feb 98 shall apply for calculating Retiring/Service Pension. There shall be no condition of minimum qualifying service for earning this element

(b) **War Injury Element** : Equal to reckonable emoluments last drawn for 100% disablement. However, in no case the aggregate of Service element and War Injury element should exceed last pay drawn. For lower percentage of disablement. War Injury element shall be proportionately reduced.

10.2 Provisions contained in para 7.2 shall equally apply to individuals invalided out under the circumstances mentioned in category 'D' and 'E' of para 4.1 above for calculating War Injury element of War Injury Pension.

10.3 Retirement gratuity admissible on invalidment due to war injury shall be calculated on the basis of reckonable

emoluments on the date of invalidment but counting service upto the date on which he/she would have normally retired in that rank plus weightage as applicable (total not exceeding 33 years). Other provisions of Retirement Gratuity contained in para 12.1 of Min of Def letter No. 1(6)/98/D(Pen/Ser) dated 03 Feb 98 shall equally apply.

#### **11. War Injury Pension on Retention in Service.**

**11.1** Armed forces personnel who are retained in service despite the disability due to war injury sustained under circumstances mentioned in Category 'E' of para 4.1 above, and retire subsequently will have an option as follows to be exercised with in a period as prescribed by the Government from time to time:-

- (a) To draw lump sum compensation in lieu of War Injury element, foregoing war injury element at the time of subsequent retirement/discharge or
- (b) To draw war injury element at the time of retirement in addition to retiring/service pension admissible on retirement/discharge foregoing lump sum compensation.

#### **11.2 Lumpsum Compensation in Lieu of War Injury Pension**

In case an Armed Forces Personnel is found to have a disability which sustained under the circumstance mentioned in category 'E' in para 4.1 above which is assessed at 20% or more for life but the individual is retained in service despite such disability and opts for lump sum compensation, he shall be paid the lump sum compensation in lieu of war injury element. The rates for calculation of lump sum compensation in lieu of war injury element for 100% disability for life will be as under :-

- (a) Commissioned Officer and Hony Commissioned Officer of - Rs.5200/-
- (b) JCOs and equivalent ranks of the Air Force, Navy, TA and DSC - Rs.3800/-
- (c) Other ranks/NCs(E) and equivalent rank of Air Force, Navy, TA and DSC - Rs.3100/-

For disability due to war injury of less than 100% the rates shall be proportionately reduced. The one time compensation in

lump sum in lieu of War Injury element will be equal to the capitalised value of War Injury element which shall be calculated in accordance with Regulation 344 of the Pension Regulations for the Army (and similar corresponding provisions in the Pension Regulations for the Air Force and the Navy) and will be equal to the capitalised value of war injury element for the actual percentage of the disability at the appropriate rate mentioned in para 11.2 above. For this purpose, the rank shall be the rank held at the time of injury sustained by the individual due to war. Age next birthday will be reckoned with reference to the date of onset of disability with loading to age, if any, recommended by the competent Medical Board.

Compensation in lieu of war injury element will be payable provided the degree of disablement is equal to or more than 20%. Once the compensation in lieu of war injury element due to disability for life has been paid, there shall be no further entitlement on account of such a disability at the time of retirement/discharge from the Armed Forces. Since this is one time payment on account of compensation, no restoration will be permitted.

**11.3** The provision contained in para 11.2 above shall be applicable to casualties occurring on or after 01 Jan 96.

**11.4 War Injury Element on Subsequent Retirement** : Where an Armed Forces personnel is retained in service despite injury/disability sustained under the circumstances mentioned in category 'E' of para 4.1 above and does not opt for lump sum compensation in lieu of war injury, he/she shall be entitled to the payment of war injury element on a monthly basis at the rates prescribed under Para 11.2 above on subsequent retirement/discharge or on completion of the term of engagement.

**11.5** For disabilities less than 100% but not less than 20%, the above rates shall be proportionately reduced. No war injury element shall be payable for disabilities less than 20%. Provisions contained in para 7.2 above shall not be applicable for computing war injury element. Disability actually assessed by the duly approved Release Medical Board/invalidating Medical Board shall reckon for computing war injury element.

**Note** : An Armed Forces Personnel who retires voluntarily/or seek discharge on request shall not be eligible for any award on account of disability. Provided that Armed Forces Personnel who is due for retirement/discharge on completion of tenure, or on completion of service limits or on completion of the terms of

engagement or on attaining the prescribed age of retirement, and who seeks pre-mature retirement/discharge on request for the purpose of getting higher commutation value of pension, shall remain eligible for disability element.

**12. Liberalised Disability Pension in respect of Armed Forces Personnel sustaining disability under the circumstances mentioned in Category 'D' of Para 4.1 above.**

Armed Forces personnel sustaining disability under the circumstances mentioned in category 'D' of para 4.1 above shall be entitled to same pensionary benefits as admissible to war injury cases on invalidment/retirement/discharge including lump sum compensation in lieu of disability, as mentioned in paras 10 and 11 above. However, on invalidment they shall be entitled to disability element instead of war injury element in addition to service element. The service element will be equal to retiring/service pension to which he/she would have been entitled on the basis of his/her pay on the date of invalidment but counting service upto the date on which he would have retired in the rank in the normal course including weightage as admissible. Provisions of para 6 of Ministry of Defence letter No. 1(6)/98/D(Pen/Services) dated 3.2.98 shall apply for calculating retiring/service pension. There shall be no condition of minimum qualifying service for earning this element. The disability element would be admissible as laid down in para 7.1(II)(a) above. For lower percentage of disablement, this amount shall be proportionately reduced. However, in no case aggregate of service element and disability element shall be less than 80% of reckonable emoluments last drawn.

**Note.** Armed Forces personnel sustaining disability under the circumstance mentioned in Category 'D' of para 4.1 above shall not be treated as War Disabled. Hence they will not be entitled to any special concession/dispensation otherwise available to war disabled.

**Constant Attendance Allowance**

**13.** Constant Attendance Allowance shall continue to be admissible under the conditions as hithertofore. However, it shall be admissible at a uniform rate of Rs.600/-pm, irrespective of rank.

**GENERAL - PART V****Rounding off of Pensionary Awards**

14. The amount of various pensionary awards admissible as per this letter shall be rounded off to the next higher rupee by the Pension Sanctioning Authorities.

**Minimum/Maximum Pension**

15. If the amount of any monthly pension(excluding Constant Attendance Allowance) admissible under the provisions of this letter works out to less than Rs.1275/-pm, it shall be stepped up to Rs.1275/-pm and authorised for payment at this rate. Disability element shall not be taken into account for the purpose of stepping up of service element to the minimum level of Rs.1275/-pm. In cases where disability element is paid in isolation, it shall not be stepped up to the minimum level of Rs 1275/-pm. There will be no maximum ceiling on the amount of pension.

**Dearness Relief**

16. Dearness Relief shall be admissible only beyond average CPI 1510 on the revised pattern introduced vide Ministry of Personnel, Public Grievances and Pension, Department of Pension and Pensioners' Welfare Office Memorandum No 42/2/97-P&PW(G) dated 27 Oct 97 on various types of pension/family pension admissible under the provisions of this letter.

**Procedure for Sanction of Revised Pension in Respect of Those who Already Retired**

17. The procedure for revision of pensionary awards as per provisions of this letter , in respect of those who have already retired on or after 1.1.96 and in whose cases pensionary benefits at pre-revised rate have already been notified will be prescribed by the Pension Sanctioning Authority and intimated to service Headquarters and Record Offices.

18. Pension Regulations of the three Services will be amended in due course.

19. This issue with the concurrence of the Finance Division of this Ministry vide their U.O. No. 299/Pen/2001 dated 31.1.2001.

Sd/xxxx

(d) Letter No 1(2)/97/D(Pen-C)dt 07.02.2001

Sub : Modalities for implementation of the recommendation of the fifth Central Pay Commission contained in paras 164.10 and 164.22 of the report regarding the findings of the Medical Boards

Sir,

The undersigned is directed to state that in pursuance of the Government's decisions on the recommendations of the Fifth Central Pay Commission, as contained in paras 164.10 and 164.22 of the report, sanction of the President is hereby accorded to the modifications, to the extent specified in this letter, in the rules and regulations concerning the findings of the Medical Boards, attributability/aggravation and adjudication of cases for disability pension.

#### Injury Cases

2. Attributability. Decision regarding attributability would be taken by the authority next to the Commanding Officer which is no case shall be lower than a brigade/sub area commander or equivalent.

3. Assessment. The assessment with regard to the percentage of disability as recommended by the Invaliding Medical Board/Release Medical Board as approved by the next higher medical authority, would be treated as final and for life both in respect of percentage as well as duration(MOD 1(2)/97/D(Pen C) dated 13 Jun 02) unless the individual himself requests for a review.

4. Approving Authority for Medical Boards. Medical Board proceedings in respect of the personnel of the three services will be approved by the next higher medical authority than the one which constituted the board as heretofore. In case where

disability is abnormally high or low, approving authority will refer the proceeding back to the medical boards for reconsideration. If required he may physically examine/get the individual re-examined to ascertain the correct position. However in case the competent adjudicating authority while taking its decision in the matter feels that there is need to seek further clarifications or opinion from DGAFMS, the orders do not preclude him from doing so. In the light of this clarification pending cases of injuries in service HQs can be settled in consultation with DGAFMS. MOD letter No 1(2)/97/D( Pen C) dated 13 Jun 02 refers

#### **Disease Case**

**5. Attributability/Aggravation.** Attributability/aggravation in respect of cases pertaining to invalidment owing to various disease/retirement with various diseases shall continue to be adjudicated by MA(P) in respect of personnel below officer rank (PBOR) and MOD in case of Commissioned Officer as hithertofores.

**6. Assessment.** The assessment with regard to percentage of disability as recommended by the Invaliding Medical Board/Release Medical Board and as adjudicated by MA(P) in respect of PBOR and MOD in case of Commissioned Officers would be treated as final and for life unless the individual himself requests for review, except in cases of disabilities which are not of a permanent nature. In the event of substantial difference of opinion between the initial award given by the Medical Boards and MA(P), the case will be referred to a Review Medical Board. The opinion of the Review Medical Board, which will be constituted by DGAFMS as and when required shall be final.

**7. Re-assessment of Disability.** There will be no periodical reviews by the Re-survey Medical Board for re-assessment of disabilities. In cases of disabilities adjudicated as being of a permanent nature, the decision once arrived at will be final and for life unless the individual himself requests for a review. In cases of disabilities which are not of a permanent nature, there will be only one review of the percentage by the Re-assessment Medical Board, to be carried out later, within a specified time frame. The percentage of disability assessed/recommended by the Re-assessment Medical Board will be final and for life unless the individual himself asks for a review. The review will be carried out by Review Medical Board constituted by DGAFMS. The percentage of disability assessed by the Review Medical Board will be final.

8. There will be no changes in the procedure for handling special cases and post discharge claims.

9. The attributability/aggravation aspect for adjudication of special family pension claim will be dealt with as follows :-

(a) Injury Cases : As per provisions contained in Para 2 above

(b) Disease Cases : As per provisions contained in Para 5 above

10. The provisions contained in this letter will be applicable to service personnel who were in service on or after 01 Jan 96. The cases which have been finalised prior to issue of this letter will not be re-opened. As regards pre 01 Jan 96 disability pensioners, the assessment made by the Reassessment Medical Board held on or after the date of issue of this letter will be considered as final and for life unless the individual himself asks for a review. This review will be carried out by Review Medical Board constituted by DGAFMS. The percentage of disability assessed by the Review Medical Board will be final. These rules will be read in conjunction with Pension Regulations of the three Services, Entitlement Rules to Casualty Pensionary Awards to the Armed Forces Personnel, 1982 and Guide to Medical Officers (Military Pension ) 1980 as amended time to time.

11. Paras 8.2 and 11.5 of this Ministry's letter of even number dated 31 Jan 2001 so far as these relate to reckoning disability actually assessed by the duly approved Release Medical Board/Invaliding Medical Board for computing war injury pension stand modified as per the provisions contained in this letter.

12. This issue with the concurrence of the Finance Division of this Ministry vide their U.O. No. 137/DFA/(Pen-O) dated 01 Feb 2001.

Sd/xxxx

(e) Govt of India, MOD letter :

No.4684/DIR(PEN)/2001  
Government of India  
Ministry of Defence,  
Deptt, of Defence

New Delhi, the 14<sup>th</sup> August, 2001

**O R D E R**

Sanctioned is hereby accorded in pursuance of MOD ID No. 34(3)/2001/D(O&M)n dated 3.8.2001 for delegation of administrative powers with the approval of Raksha Mantri to the Service HQrs in respect of the subjects indicated below;-

- (a) (i) Division of family pension between eligible family members
- (ii) Initial cases for award of Special Family Pension and ex-gratia for officers
- (iii) Recovery from pensionary benefits first charge being Public Fund dues thereafter Non-Public Fund dues from the residual benefits.
- (iv) Payment of dues to NOK of Deserters.
- (v) Condonation of shortfall in Qualifying Service for grant of pension in respect of PBOR beyond six months and upto 12 months.
- (vi) Time bar sanction for filing appeals for Ordinary Family Pension, Special Family Pension, disability Pension etc. in respect of officers and PBOR beyond 12 months.
- (vii) Grant of ex-gratia award to Cadets on death/disability within the Govt. approved terms and conditions.
- (viii) Pensionary award to officers dismissed from Service otherwise than with disgrace/cashiered.
- (ix) Pensionary award to officers who are discharged, called upon to resign or are retired.
- (x) Grant of pension to PBOR dismissed from Service

(xi) Grant of Disability Pension to officers.

(xii) First appeal against rejection of Ordinary Family Pension, Special Family Pension, Disability Pension/ex-gratia award etc. to officers and PBOR.

(xiii) First claim for pension and gratuity submitted after 12 months from due date where Pension Sanctioning Authority is not satisfied with reasons for delay.

(xiv) Implementation of judgements delivered by various courts/CATs including those with financial implications where further appeal is not contemplated.

(xv) Condoning of delays in conducting release medical boards (GOI, MOD Order No. 4684/Dir(Pens)/2001 dated 20 Sep 2001).

(b) Approving Authority in the Service HQrs in respect of the above subjects will be AG/COP/AOP/AOA as the case may be. Any further re-delegation of these powers will require prior approval of Ministry of Defence.

(c) Authenticative Authorities for authenticating of orders/documents will be the authorities as specified in Ministry of Home Affairs SO No. 2297 dated 3.11.1958. Further, the complaints/written statement in suits in any court of civil jurisdiction or in writ proceedings by/or against the Central Government shall be signed by the authorities, indicated in the Ministry of Law's Notification dated 14.2.1990. Any further devolution of powers in this regard will require approval of MHA and Ministry of Law respectively. Proposal for this purpose, if need be, may be initiated by the Service HQrs, and be referred to these Ministries for issue of necessary corrigendum through D(O&M) Section of this Ministry.

(d) Concurrence of Integrated Finance shall continue to be obtained wherever required as hitherto for without involving this Ministry.

2. The relevant Regulation(s) of Pension Regulation for the Army/Navy/Air Force shall stand amended accordingly. Formal amendments to Pension Regulations will, however, be issued in due course of time.

3. In case Pension Regulations and any other Govt, orders/instructions are required to be amended, necessary proposals in this regard will be initiated by the Service HQrs.

4. Cases for R.M's approval will be submitted, wherever required by the Service HQrs, after approval of AG/COP/AOP/AOA. Whenever required such cases should be routed through the Pension branch of this Ministry.

5. As regards to composition of First Appellate Committee(FAC), the chairperson of the Committee shall be the AG/COP/AOP in the respective Service HQrs, in place of Director/Dy.Secretary incharge of Pension Division in the Ministry of Defence. The composition of the Second Appellate Committee headed by RM/RRM will remain unchanged. However, the cases shall be submitted for recommendations of the Members of the Committee and approval of RM/RRM direct by the Service HQrs.

6. These orders will take effect from the date of issue.

7. This issues with the concurrence of Defence(Finance) vide their u.o. No.1539/Addl.FA(B) dated 13<sup>th</sup> August 2001.

Sd/xxxx

**CHAPTER V****MISCELLANEOUS PROVISIONS****Individuals who Aggravate or Retard the Cure of a Disability**

1. In giving their opinion on the above subject, the medical officers and the medical boards should inter alia state in detail how exactly the individual brought about the retardation or aggravated the disability. It must be realised that bare opinions with no reasons in support can hardly be of any assistance to the authorities concerned in deciding the issue.

**Refusal to Undergo Medical Treatment or Operation**

2. In giving their opinion on the subject, the medial officers and the medical boards should state in detail the particulars of the treatment or operation advised which an individual refused. The record should also show whether it was explained to the individual that there was reasonable probability or cure or reduction in the degree of disablement or prevention of further deterioration by the prescribed treatment of operation. This is necessary to enable pension sanctioning authority to take appropriate decision on the issue.

3. All the possible consequences of refusal of operation/medical treatment will be explained to the patient in his own language or a language which he fully understands, by the medical officer in charge of the case, in the presence of an officer of the individual's unit, or the unit to which he is attached. Further, a certificate stating that he refuses to undergo medical treatment or operation as advised and that all the consequences of refusal of treatment have been explained to him and understood by him, should be obtained from the individual. However, these cases shall be governed by Regulation 177 of the Pension Regulations for the Army Part I, 1961, which gives details regarding the grant of disability pensions in cases where an individual suffering from a disability accepted as attributable to, or aggravated by military service refused to undergo an operation or other medical treatment, which, in opinion of the service medical authority would cure the disability or reduce the degree of disablement. Such cases shall not be treated as those of "aggravation" or

"retardation" of cure under Regulation 118, but shall be dealt with as follows :

(a) If the refusal to undergo treatment or an operation is reasonable, full disability pension normally admissible under the Regulations, may be granted.

(b) If the refusal to undergo treatment or an operation is unreasonable :

(i) If the medical board certifies that an operation will cure the disability. Disability pension will withheld, but the normal service pension or gratuity if any, admissible under the Regulations or the gratuity admissible under Regulation 186, where applicable, may be granted.

(ii) If the medical board certifies that an operation or medical treatment will reduce the disability to a lower percentage. Disability element of pension will be restricted to that appropriate to the lower percentage of disablement. If that percentage is less than 20 percent, the normal service pension or gratuity if any, admissible under the Regulation, or the pension or gratuity admissible under Regulation 186, where applicable, may be granted.

4. The question whether an individual's refusal to undergo medical treatment or an operation for his disability is reasonable or unreasonable, shall be decided in accordance with the criteria published in Appendix V to Pension Regulations for the Army, Part I (1961), which reads as under :

(a) Refusal to undergo medical treatment or an operation may be held to be reasonable :

(i) When, in the opinion of the medical authorities, it is improbable that such treatment or operation would cure the disability or reduce its percentage, or where such treatment or operation may be severe and dangerous to life .

(ii) When, in the opinion of the OC unit, to undergo the operation or the treatment prescribed, is opposed to religious or caste prejudices of a valid nature and the refusal is the bonafide outcome of such prejudices.

(b) Refusal to undergo medical treatment or an operation will be treated as unreasonable :

(i) When, in the opinion of the medical authorities, it is due to malingering

or

(ii) When, in the opinion of the OC, it is due to a desire to avoid further service or to obtain or retain a pension, or to receive an enhanced pension.

(c) If in the opinion of the OC Unit the individual has grounds not covered by the above paragraphs for refusing medical or operative treatment, the case will be referred to the Area/independent Sub-Area Commander for a decision as to whether the objection is reasonable or not, and his decision will be final.

#### **Unforeseen Effects of Treatment**

5. In giving their opinion with regard to unforeseen effects of treatment medical officers and the medical boards should keep in mind that :

(a) Complications do arise in certain cases in spite of the utmost skill in treatment etc. and this should particularly be borne in mind in cases where the treatment is given in the interest of the member to save his life or reduce a disability.

(b) On the question of negligence, delay or faulty technique or lack of skill.- It must be remembered that once a man is in hospital under qualified medical care, there can normally be no delay. Cases in which there was any delay in getting a member admitted to hospital will involve consideration of non-medical issue. For instance, in a case of sexually transmitted disease, the natural tendency is to conceal the disease as much as possible. Though rare, there can be cases in which there has been delay due to the exigencies of service in making proper diagnosis or providing proper

treatment. Such cases will need special examination, the benefit of any reasonable doubt being resolved in favour of the member. In this connection, it must however be remembered that inevitable delay occurs in arriving at a diagnosis in many cases of malignant diseases- especially malignant diseases of the internal organs. This is usually due to the necessity of carrying out observations on the patient, the indefiniteness of signs and symptoms, the elaborate clinical and pathological investigations and tests required to exclude other diagnosis. These investigations may take some weeks. In such cases, the time usually taken in arriving at a correct diagnosis does not constitute delay, and the question of giving the individual the benefit of reasonable doubt does not arise. In some cases, however, the time usually taken in arriving at a correct diagnosis may be unduly exceeded or diagnosis missed because of either faulty techniques, inadequate clinical judgement or lack of diagnostic facilities. Such abnormal delays would materially affect the treatment and the degree of disability and even fatal outcome. In such cases where abnormal delay has occurred in establishing the correct diagnosis, the question of giving the individual the benefit may be considered favourably.

As regards faulty technique or lack of skill in surgical cases, it would always be possible to decide the issue from the relevant medical records. "Faulty" technique in treatment implies the use of drugs obviously wrong or contra-indicated, an unreasonably low or high dosage, procedures not generally recognised as correct or the lack of proper precautions.

(c) On the question whether a treatment other than the one administered was also appropriate, or it was more appropriate, it is stressed that the medical officer on the spot is in the best position to judge what particular form of treatment is indicated at any particular moment. Accordingly, in the absence of any strong "Positive", evidence to the contrary, it is reasonable to presume that the treatment given is appropriate to the condition.

#### **Chronic Poisoning, Intoxication and Sexually Transmitted Diseases**

6. Compensation cannot be awarded for any disablement or death arising from intemperance in the use of alcohol, tobacco or drugs, or from sexually transmitted diseases, as these are matters within the member's own control. It follows that where alcohol, tobacco

or drugs or sexually transmitted diseases have aggravated an accepted disability, it is necessary to exclude the effects thereof in assessing the disablement ascribable to service conditions.

7. Where alcoholism is reported to be the factor in, or the result of, a mental disability leading to discharge, the facts and the conclusions reached should be recorded, and the claim will then be for examination on non-medical issues.

8. It should be borne in mind that alcoholism may have a selective action on the central nervous system, that it may produce symptoms, identical in many respects with those of neurosis or psychosis, and that the only evidence of alcoholism may be nervous or mental disorder itself.

9. Though alcoholism may rightly often be regarded as a symptom of mental instability, it is seldom the case that such instability itself can be correctly attributed to the effects of service conditions except in certain cases of head injury. Alcoholism cannot be regarded as an effect of an "attributable" disability unless it is clear that there is no previous history of alcoholism and the "attributable" disability must have been of such severity as to have made the first addiction to alcohol outside the member's own control.

Comment [DAP1]:

#### **Classical Sequelae**

Comment [DAP2]:

10. A classical sequelae of a disease or injury may be defined as a pathological condition generally recognised as liable to follow that disease or injury and having a definite connection with it, as :

(a) A further manifestation, in another organ or different part of the body, of the same morbid condition as caused the original disease; or

(b) A later or terminal phase of the disease, which but for the previous existence of that disease would not have developed; or

(c) A disease following a wound or injury, which but for that wound or injury would not reasonably have been expected to occur and is not due in any way to extraneous factors or happenings or to the member's own act.

Shortly, then, a classical sequelae acceptable as such is a fresh development, a further stage or a terminal phase of the accepted disability brought about directly and solely by that disability without other causative factor, e.g. Valvular Heart Disease (VHD) supervening on rheumatic fever and liver abscess following amoebic dysentery.

11. As regards developments which are prima facie classical sequelae it will be necessary to consider carefully each case, in consultation with Medical Adviser (Pensions), whether the new condition is in fact a direct outcome of the original disability and, further, whether its development (having regard to the lapse of time, the attendant circumstances and the nature of the entitlement) is solely referable to the condition resulting from service.

**Note :** Sometimes, the individual may be unwilling for operation/treatment for the present but may do so at a later date. In such cases the individual will be placed in appropriate medical category, however, any deterioration in health/complications due to the disability during the period of conditional refusal will not be considered as attributable/aggravated even if the original disability was attributable to or aggravated by service.

Appendix 'A' to Chapter - V

UNWILLINGNESS CERTIFICATE FOR TREATMENT (SURGICAL/MEDICAL)

1

PART-I

No.....Rank.....Name.....  
Unit.....  
Diagnosis.....  
Treatment refused.....  
.....(specify surgical/medical/investigations).

PART - II

I, No.....Rank.....Name.....hereby express my unwillingness for undergoing treatment.....(specify type of treatment/operation/investigative procedure) which is considered essential by the treating medical officer. The reason for this refusal is..... The consequences of this refusal to undergo treatment has been explained to me in detail in the language I understand and I accept the same. I also understand that this may have adverse effect on my disability pension, which may be admissible to me as per Pension Regulations-1961 (Part-I) at the time of release/invalidment from service.

(Signature of the individual)  
No.....Rank.....  
Name.....

Witness No.1

Witness No.2

Signature.....

Signature.....

No.....Rank.....Name.....

No.....Rank.....Name.....

Unit.....

Unit.....

COUNTER SIGNATURE OF MEDICAL OFFICER I/C CASE

Appendix 'B' to Chapter -V

UNWILLINGNESS CERTIFICATE OF NOK FOR TREATMENT  
(SURGICAL/MEDICAL)

PART-I

No.....Rank.....Name.....  
Unit.....  
Diagnosis.....  
Treatment refused.....  
.....(specify surgical/medical/investigations)

PART-II

I, .....(Name of NOK).....(specify relationship) of  
No.....Rank.....Name.....  
Hereby express my unwillingness for the treatment.....(specify type of  
treatment /operation/investigative procedure) of my .....(specify  
relationship)which is considered essential by treating medical officer. The  
reason for this refusal is ..... The consequences of this refusal to  
undergo treatment has been explained o me in detail in the language I understand  
and I accept the same. I also understand that this may have adverse effect on  
the disability pension of my.....(specify relationship, which may be admissible  
to him/her as per Pension Regulations-1961 (Part-I) at the time of  
release/invalidment from service.

(Signature of the NOK)  
Name.....  
Address.....

Witness No.1

Signature.....  
No.....Rank.....Name.....  
Unit.....

Witness No.2

Signature.....  
No.....Rank.....Name.....  
Unit.....

COUNTER SIGNATURE OF MEDICAL OFFICER I/C CASE

**CHAPTER VI****CLINICAL ASPECTS OF CERTAIN DISEASES****AIDS**

1. A viral infection caused by HIV Type I and II retroviruses, acquired through homo and heteroexual means, sharing of IV needles among drug abusers or unscrined blood transfusion and also by sharing of tooth brush and of razors.

**Attributability:** HIV does not kill by itself but weakens the immune system over a period of time leading to opportunistic infections/malignancy. Medical Boards will examine all evidence to establish a causal relationship between service related factors and exposure to HIV or otherwise. Where a causal relationship with service can be established, attributability may be conceded in the following cases:

- a Accidental infection by documented blood transfusions/ invasive procedures/ instrumentation in a service / referred civil/ private hospital.
- b Health Care workers engaged in treatment and nursing where a possible causal relationship can be established. Reference guidelines issued vide para 9 b Annexure 4 of DGAFMS letter No 5496/DGAFMS DG-3A dated 18 Jun 2001.
- c Evidence of any other event relating to service with a strong likelihood of a causal relationship.

The following conditions will not be considered as attributable in relation to HIV infection:

- a Sexual contact with heterosexual exposures.
- b Intravenous drug abusers.
- c Homosexuals.

**HIV Infection with Pulmonary Tuberculosis:** Keeping in view the high prevalence of Tuberculosis in India, attributability may be conceded in the following circumstances:

a If Pulmonary Tuberculosis was the presenting feature and the individual was found to be HIV positive subsequently, attributability in such cases should be given to the individual with regard to Tuberculosis.

b If the individual had received treatment for Pulmonary Tuberculosis in the past. In such cases there is a strong likelihood that Pulmonary Tuberculosis is due to reactivation or relapse.

c Pulmonary tuberculosis developing in an established known case of HIV positivity at a later date should be considered as part of the AIDS complex. Attributability should not be considered for such cases.

d In cases where attributability of Tuberculosis is conceded, two diagnosis will be given viz:

- |                  |         |
|------------------|---------|
| (i) Tuberculosis | ICD 011 |
| (ii) AIDS        | ICD 042 |

Note: In cases where attributability is not conceded only one diagnosis of AIDS ( ICD 042 ) will be given.

**Assessment of Longevity:**

a Asymptomatic HIV Infection: Since transition to AIDS may not occur even upto 10 - 15 years, such cases on release can be recommended for full commutation of pension.

b AIDS: With the advances in highly active retroviral therapy and treatment of opportunistic infections, these cases are known to survive for long periods. The assessment should be based on the clinical profile of the case and consensus of medical opinion. Loading of age for 01 - 02 years at RMB is considered appropriate in such cases.

**Assessment of Degree of Disablement On Invalidment and Release:**

- a Asymptomatic HIV infection - As per Medical Boards recommendation

- b Manifest AIDS defining illness - 100%
- c On release ( RMB ) - Actual percentage

### Adrenocortical Insufficiency

2. Primarily an idiopathic disease with a few cases accounted by systemic tubercular and fungal infection and also as a result of bacteremic infection e.g. pneumococcus, meningococcus, staphylococcus and sometimes as a complication of falciparum malaria. It will be appropriate to concede attributability in all such cases.

### Anaemia (Aplastic)

3. This condition may be either primary (idiopathic) or secondary.

The primary condition is rare, usually occurring in young adults and has been held as due to a congenital defect in the bone marrow. The disease is progressive and fatal.

The secondary variety may be the result of many factors. The most common are the toxic effects of certain chemicals (e.g.) benzol, T.N.T., arsenical drugs. Sulphonamides are occasionally a cause, as may be gold injections, x-ray and radium may give rise to this anaemia. Occasionally overwhelming septic infections may end with this type of anaemia.

Where full investigations have failed to reveal any of the known causes, then it would be reasonable to regard the disease as of idiopathic nature and unrelated to service as far as causation is concerned. However aplastic anaemia due to service related causative factors like septic infections and exposure to obnoxious agents in professions such as x-ray irradiation and chemicals in the case of factory workers and painters are acceptable as attributable to service.

### Appendicitis

4. Appendicitis is the commonest major surgical disease, is widespread and no age is exempt and no social group immune. The essential factor in the causation of appendicitis is obstruction of the lumen. When obstruction occurs the contents of the lumen cannot escape, the germs multiply and increase in virulence,

finally invade and infect the surrounding tissues. It occurs from the age of 6 months to 80 years in both sexes equally. Physical/mental stress and service diet or undernutrition or infection in service or debility thereafter can play no part in the causation of appendicitis. As the germs causing the infection are endogenous, tropical infections except amoebic dysentery can play no part. An injury can only be a factor if it displaces or kinks a long appendix resulting in the cutting off of the local blood supply.

Under the circumstances, only cases where there has been a delay in diagnosis or treatment would receive consideration on the basis of aggravation if such delay in diagnosis or treatment should result in unforeseen complications. Complications to surgery such as hernia, intestinal obstruction should be treated as aggravated by service.

### **Bronchial Asthma**

5. The term bronchial asthma would be reserved for those cases of chronic lung disease in which attacks of respiratory embarrassment develop. Bronchial asthma is essentially an allergic condition. The disease is predisposed by a variety of causes such as heredity, food, emanations from animals, bronchitis, nasal sinus infection, respiratory tract infection such as bronchitis, nasal polyp, gastrointestinal irritation, climate (cold air), locality, emotion and nervous shock. The other exciting factors are tobacco, smoke, dust, strenuous exercise, certain drugs and exposure to organic materials, fumes and chemical substances in working environment.

Mere physical stress and strain occasioned with psychological factors are not appreciable cause of asthma. Asthmatics are very sensitive to both climate and locality but the effects are so variable in patients that no general rule can be laid down. Some patients are better in dry and others in damp and foggy climate. The dictum that one man's meat is another man's poison is eminently true of asthma. Sudden exposure to cold or occupations involving inhalation of vapours e.g., drivers, cooks, bakers, rubber workers may bring on an attack.

While increased susceptibility to allergens and exciting factors may result from exacerbations of asthma occasioned by service factors, such manifestations in service would not automatically be regarded as necessarily amounting to permanent or persistent aggravation. Each case must be considered on its own

merits and the question of persistence of aggravation can only be determined by previous history, nature and length of exposure to service factors, the effect of treatment, subsequent employment and progress of disease. Assessment is difficult in asthma during intermission. However, presence of residual lung signs such as (rhonchi, prolonged expiration) hyperinflated emphysematous lungs, pigeon chest deformity and impaired lung function tests are useful guide to chronicity of the disease.

All asthma cases should be accepted on the basis of aggravation.

### **Bronchogenic Carcinoma**

6. There is no statistical evidence to suggest that cancer is more frequent in service personnel than in the general population of the same age group. Bronchial carcinoma usually arises independent of pre-existing chronic bronchitis, bronchiectasis or fibrosis of the lung. Chronic bronchitis is common in cases of bronchial carcinoma as also bronchiectasis and pulmonary fibrosis but there is no statistical evidence that bronchial carcinoma has a higher incidence in patients suffering from these diseases than in the population generally.

Attributability can be conceded in rare cases arising out of granulomatous infection, such as tuberculosis lungs and foreign body in the lungs e.g. bullets. Lung cancer arising in close time relationship to hazards of occupations dealing with coal, iron and irradiation will be adjudged attributable to service.

### **Bronchiectasis**

7. Bronchiectasis is an acquired disease and less commonly due to congenital disorder such as congenital cystic disease of lungs. Bronchiectasis is generally secondary to suppurative pneumonias, pul TB, diffuse airway obstructive disease like asperigillar bronchopulmonary disease, asthma and chronic bronchitis.

Attributability is conceded if it follows any infective disease of lung which had already been accepted on the basis of attributability.

Aggravation will be appropriate if the disease sets in as a sequelae to airway obstructive diseases and in individuals suffering from congenital cystic disease or have served in adverse terrain and climatic zones for a considerable period.

Congenital cystic disease of lungs can be aggravated by exposure to climatic conditions in so much as that this condition may predispose to respiratory infections such as bronchitis. Should the individual suffering from congenital cystic disease has bronchitis, it is likely that cyst will become infected and he will present symptoms of bronchiectasis and lung abscess.

### **Cardiomyopathy**

8. Cardiomyopathies are diseases of heart muscle of unknown origin.

It is a distinct entity by itself and excludes the diseases of heart such as IHD, hypertensive heart disease, congenital heart disease and all forms of specific heart muscle diseases.

In hypertrophic cardiomyopathy the role of heredity is convincing.

Many forms of specific heart muscle disease produce clinical picture indistinguishable from dilated cardiomyopathy e.g. connective tissue disorder, sarcoidosis and alcoholic heart disease. In contrast amyloidosis and eosinophilic heart disease produce restrictive cardiomyopathy.

Myopathies are generally constitutional diseases. However, aggravation may be examined if the individual did not get the benefit of immediate attention and sheltered appointment. Alcohol induced cardiomyopathy is rejectable.

### **Cancer**

9. Cancer is one of the diseases regarded as usually unaffected by ordinary conditions of service. While its precise cause is still unknown and entitlement is not normally conceded, there is adequate material both of scientific and statistical nature which brings into light the causative factors and the connection between service related factors and carcinogenesis. Post World War II research highlighted the interaction of nuclear explosion and occurrence of cancers. American Armed Forces committed to enemy action in Vietnam also studied the occurrence of cancers in troops in action.

The recognized causative agents for carcinogenesis are :-

- (a) Viral infection
- (b) Radiation from nuclear sources
- (c) Ultra violets rays
- (d) Chemicals
- (e) Acquired chromosomal abnormalities
- (f) Congenital chromosomal abnormalities

(g) Diet, exercise, life styles

The service related conditions in relation to carcinogenesis are as under:-

(a) **Terrain:** Exposure to UV rays in high altitude areas, high back ground irradiation and pollution are etiological factors now recognised in initiating carcinogenesis. Service personnel are forced to stay long in certain terrains, can get exposed to noxious factors.

(b) **Occupational hazards:** All ranks working in nuclear powered submarines, doctors and paramedics working with electro-magnetic equipment, personnel working with radars, communication equipment, microwave and also those handling mineral oils such as petrol and diesel are exposed despite stringent safety measures.

(c) **Infection:** as a cause of cancer has been documented in certain malignancies. Though identification of an organism may not be possible due to lack of facility but there is gross evidence clinically to suspect infection.

(d) **Diet :** The ration issued in services may not contain adequate amount of fibre, fresh vegetables and fruits which are cancer preventing agents. The personnel may not be able to procure and supplement the diet due to remote location, non availability of the material.

(e) **Exercise :** Physical exercise is known to protect against cancer like that of colon. Postings at high altitude, uncongenial weather conditions, insurgency affected areas, interfere with exercise programmes.

(f) **Stress and strain :** Stress and strain of services is something unique and has now been documented in initiating certain cancers in human beings.

The question of relationship between a malignant condition and an accepted injury is difficult to establish. The vast majority of traumatic lesions however severe, show no tendency to be followed by cancer either immediately or remotely.

10. **Malignancies Considered Attributable to Service**

(a) **Due to occupational hazards:**

(i) Any cancer in those personnel working or exposed to radiation source in any forms:

- (aa) Acute leukaemia
- (ab) Chronic lymphatic leukaemia
- (ac) Astrocytoma
- (ad) Skin cancers

(ii) Any cancer in those exposed to chemical especially petroleum products or other chemicals :-

- (aa) Carcinoma bladder
- (ab) Renal cell carcinoma

(b) **Due to Viral Infection:**

- (i) Hepato-cellular carcinoma (HV B&C)
- (ii) Ca nasopharynx (EB virus)
- (iii) Hodgkin's disease (EB virus)
- (iv) Non-Hodgkin's Lymphoma (Viruses)
- (v) Acute Leukaemia (HTLV1)
- (vi) Ca anal canal (human papilloma virus)
- (vii) Any cancer due to HIV infection (contracted out of blood transfusion in service)

(c) Any cancer which is detected from 30 days to five years after combat induced stress.

11. **Malignancies Aggravated by Service:**

- (a) Passive smoking (Ca lung)
- (b) Diet (Ca pancreas, colo rectal Ca)
- (c) Stress - Any cancer detected in an individual who has taken part in an operation of any nature.

12. **Malignancies Not Attributable and Not Aggravated**

Tobacco related cancers in smokers and tobacco users e.g. carcinoma lung, carcinoma oral cavity, carcinoma bladder. Cancers due to congenital chromosomal abnormalities e.g. CML where Ph chromosome identified.

**Lead Time**

For consideration of aggravation/attributability a lead time of at least 5 years of service must be reckoned except where there has been exposures to combat/active operation.

**13. Cataract**

Cataract is primarily due to degenerative changes in the lens causing defective vision.

The causes of cataract are many :-

- (a) Senile cataract
- (b) Metabolic disease - Diabetes mellitus  
Hypocalcaemia  
Galactosemia
- (c) Trauma - Direct penetrating injury eye  
Concussion  
Ionizing radiation  
(Radiographer)  
Electric shock and lightning  
Prolonged exposure to UV  
Light (for decades)
- (d) Complicated cataract - Secondary to uveitis  
Chroiditis  
High myopia  
Glaucoma
- (e) Drugs - Steroids, chlorpromazine,  
amiodarone
- (f) IOL Implant
- (g) Complications of atopic dermatitis and psoriasis

It is unaffected by conditions of military service in both its onset and course unless the onset or course is brought about or hastened by an ocular injury or infection during service. The disability could also be aggravated by long service under adverse conditions, as for example in prolonged active operations or as a prisoner of war.

Senile cataract is not usually affected by service unless the disease shows abnormal rapid rate of progress associated with a debilitating disease or illness or long service under bad conditions when aggravation is appropriate.

Attributability is conceded when the cataract is secondary to trauma related to service, infection, post drug therapy and unforeseen complication to surgery.

In diabetic cataract, entitlement depends whether diabetes itself is brought about by service.

#### 14. Cerebrovascular Accident (Stroke)

Stroke or cerebrovascular accident is a disease of acute onset leading to neurological deficit such as hemiplegia caused by intravascular events. Cerebral infarction following thrombosis and embolism accounts for a large number of cases whereas cerebral hemorrhage is the cause only in a few cases. Atherosclerotic thrombosis is of gradual onset and any permanent neurologic deficit is preceded by TIAs (Transient ischaemic attacks).

TIAs result mostly from embolism of thrombus or platelet material from an extra cerebral artery (Internal carotid) and some times due to stenosis of a major artery, altering hemodynamics in the event of change of posture and exertion.

Mural thrombus from the heart in IHD and SBE and ulcerated plaques of atherosclerotic arteries are the principal source of embolism.

Among other causes, physical trauma (heat) and mechanical trauma and arteritis associated with infection like TB, connective tissue disorder (PAN, SLE) can give rise to stroke. Service in HAA can precipitate stroke by virtue of hypercoagulable state.

About half of the strokes caused by cerebral hemorrhage are due to subarachnoid hemorrhage from rupture of a berry aneurysm (Circle of Willis) and less commonly due to arteriovenous malformation. Remaining cases of hemorrhage in cerebral substance are due to rupture of small perforating arteries/arterioles weakened by hypertension or atheromatous degenerations.

The majority cases exhibit greater degree of hemiparesis, dysphasia, (if dominant hemisphere is involved), hemianaesthesia and hemianopia. In some cases ataxia, cranial nerve palsy, nystagmus may be the presentation depending on the territory of brain involved.

It will be appropriate to award attributability if there is sufficient evidence of infection underlying the disease and physical and mechanical trauma related to service.

Aggravation can be conceded when atherosclerosis is the underlying cause and exceptional stress and strain of service is in evidence irrespective of his service in peace or field.

It nearly takes 6 months for complete recovery. However, cases showing no sign of improvement upto two years are unlikely to improve further and should be labelled as permanent.

#### 15. **Chronic Bronchitis**

Chronic bronchitis and emphysema are a group of diseases with pure chronic bronchitis at one end and emphysema at the other end of the spectrum. Chronic bronchitis develops in response to long continued action of various types of irritants on bronchial mucosa. The most important of these is cigarette smoke but others include exposure to dust, smoke and fumes in occupational hazards or as a result of environmental pollution. Exposure to dampness, sudden changes in temperature and fog may precipitate an attack. Infection plays a secondary role. In the light of adverse service conditions in difficult terrain and climate, certain occupational hazards (such as drivers, cooks) and environmental pollutions, it will be appropriate to concede aggravation. A major proportion of air flow obstruction in chronic bronchitis is irreversible unlike the air flow obstruction in chronic asthma leading to trapping of air and permanent disability like emphysema.

#### 16. **Corns**

Corns occur usually on the toes, soles or sides of the feet. It is usually a result of wearing ill fitting boots especially if these be tight and is also due to viral infection when multiple corns detected. These cases where definite correlation with service is established, attributability is appropriate.

A corn may result from neglect or improper treatment of a callosity (which is thickened and indurated skin with overgrowth

of the epidermis resulting from continued friction or pressure over any area.)

17. **Cholecystitis**

Primarily a disease of females. However, males are no exception to it. Calculus cholecystitis is most commonly come across. This is a constitutional disease. However, fatty foods taken out of dietetic compulsion of service can precipitate an attack. Aggravation can be appropriate in such cases.

18. **Cirrhosis of Liver**

Cirrhosis is a chronic paranchymal liver disease as a sequelae to alcohol abuse and virus infection (HBV and HCV). Individuals suffering from hepatitis B infection in association with hepatitis D are more prone to develop progressive liver disease. Attributability is appropriate where antecedent history of infection during service is in evidence.

19. **Conjunctivitis**

Conjunctivitis can be caused by multiple agents, infection, allergy and trauma. Bacteria and virus are by far the commonest causes. Conjunctivitis is generally a self limiting disease except a few like trachoma leading to complications such as deformity of eyelids and corneal opacity. Corneal involvement is frequent in epidemic keratoconjunctivitis due to adenovirus.

Conjunctivitis due to non STD infection and service related trauma such as foreign body, contact lens, artificial eye, if acquired during service should be treated as attributable. However, allergic conjunctivitis triggered by grass, pollen and spores can be regarded as aggravated by service. Assessment of this disability is based on visual acuity which has been affected by the disease.

Trachoma is a disease of remission and exacerbation. The disease in remission may go unnoticed during screening for enrolment.

Exacerbation of the disease may occur due to glare, dust and smoke as chances of reinfection is remote during service. In personnel engaged in trades like cooking, driving, service in active operational area and paint spraying, the disease if detected, should be accepted as aggravated by service.

## 20. Chronic Degenerative Disease of CNS

Diseases like motor neuron disease, chorea, athetosis, Alzheimer's disease are grouped under this category. A variety of possible causes including viral infection, trauma, exposure to toxins and electric shock have been postulated for motor neuron disease but no factual evidence exists to support any of these in typical cases. In case of chorea the majority falls in Huntington's disease but other causes include post-drug therapy (L Dopa, phenothiazines), viral encephalitis, rheumatic chorea and hyper thyroidism. The exact cause of parkinsonism is not known, however repeated trauma e.g. punch drunk syndrome in boxers, encephalitis (Japanese B, Encephalitis lethargica), certain drugs like reserpine, phenothiazin and carbon dioxide poisoning, exposure to certain toxic agents, can lead to parkinsonism. Alzheimer's disease of presenile onset is insidious and often in middle life. Genetic factors play a predominant role in genesis of presenile Alzheimer's disease.

Attributability will be appropriate if there is antecedent history of infection, trauma and exposure to drug therapy.

The diseases are not normally affected by external circumstances unless it can be established that the individual had the disease for sometime and continued serving. In other words, the course of the disease may be held to be hastened by stress and strain of service in an individual with an established disease by conceding the benefit of reasonable doubt.

## 21. Colonic Polyps and Diverticulosis

Colonic polyps are premalignant conditions in adults and they are of uncertain aetiology. Dietetic compulsion such as consumption of tinned food, imbalanced diet and employment in uncongenial climate and terrain (e.g. HAA, War) may lead to irregular bowel habits and constipation which may precipitate the symptoms of disease. Aggravation will be appropriate in such cases.

Diverticular disease of colon is an idiopathic disorder and may result from raised intra colonic pressure coupled with weakness in the wall of the colon. Diet atleast is partly responsible as diverticulosis is rare in the areas of the world where the diet is one of high residue.

Dietetic compulsion of service such as imbalanced diet can predispose to complications such as pain and GI bleed. Aggravation due to service factoFr can be examined in such cases.

## 22. Congenital Heart Disease

It has been routinely observed that cases of congenital heart diseases like atrial septal defect having escaped detection at the time of recruitment become symptomatic and detected very late in service. Some of these diseases manifest quite late i.e. during 3rd to 4th decade of life and manifest only when subjected to exceptional stress and strain of service e.g. HAA/FSCA/uncongenial areas. Aggravation can be conceded in such cases.

## 23. Deafness

In the great majority cases of ear disease it is necessary to investigate the condition of hearing and to ascertain whether the deafness if present is due to involvement of sensory neural apparatus or conduction apparatus. The common causes of conductive deafness are wax, Otitis media and Otosclerosis.

Sensory neural deafness is due either to disease of cochlea or auditory fibres in the 8th nerve and its connection in the brain stem. Here both air and bone conduction are affected and is frequently associated with tinnitus.

The common causes are :

### (a) Infection

Viral infection e.g. mumps, influenza  
Cerebrospinal fever  
TB meningitis  
Labrynthitis complicating otitis  
media (commonest cause of SN deafness)  
Ramsay Hunt Syndrome (Herpes-Zoster Oticus)

### (b) **Toxic drugs and chemicals**

Tobacco, alcohol (rarely)  
Quinine, streptomycin, kanamycin, neomycin, vancomycin,  
Lead, arsenic

### (c) **Degenerative diseases eg** Multiple sclerosis

### (d) **Injury**

### (e) **Tumours** eg Acoustic neuroma

(f) **Meniere's disease** (affecting cochlear apparatus)

(g) **Senile deafness** due to involvement of cochlear apparatus

Caisson workers, divers, airmen and mountaineers are liable to develop deafness due to labyrinthine trauma (hemorrhage air embolism) resulting from sudden compression and decompression.

Medical opinion would hold that nerve deafness could be due to service only when it is as a result of an attributable service injury or outcome of infection contracted during service.

However, those working in close proximity of gun fire (small arms, grenade, arty guns, bomb blast, tanks) and in constant exposure to blast of loud noises such as working with aeroengines, rivetters, factory workers run the risk of labyrinthine deafness. In these cases intensity of continuity, duration and distance of sound nuisance should be considered before conceding aggravation.

#### 24. Diseases of Retina

All retinal diseases are associated with reduction of acuity of vision, contraction of field of vision, colour blindness and sometimes progress to blindness.

Retinal diseases are divided into broad categories as under :

##### (a) Retinal Perivasculitis

Primary retinal perivasculitis is known as Eale's disease. It is primary autoimmune disease. In small percentage of cases it is associated with tuberculosis, choroiditis and septic focus in the body when it can be called attributable to service. Exposure to cold or systemic infection can adversely affect the course of disease where aggravation can be considered.

(b) Optic Neuropathy: Optic neuritis encompasses morphological variants such as retrobulbar neuritis, papillitis, neuro retinitis and optic atrophy. It is a degenerative disease with multiple sclerosis accounting for majority of cases. However, choroiditis, sinus infection, head injury, penetrating injury eye, certain drugs (ethambutal, chloramphenicol), tobacco, alcohol, atherosclerotic embolism of artery concerned, Cerebral malaria can cause this . Optic neuropathy may be a

complication to SLE and temporal arteritis. When optic neuropathy develops due to trauma related to service, infection and drug therapy, attributability is conceded.

The disability could be aggravated by hardship privations and exposure to exceptional stress and strain of service. Smoke, stress of reading or writing cannot affect the onset or course of the disease.

(c) **Retinal Detachment**: Retinal detachment is a degenerative disease. Degeneration is either due to lattice degeneration or myopic degeneration. Trivial trauma can produce retinal detachment in both these conditions. Physical stress of service e.g. organised games, sports activity, training, PT parade, boxing can precipitate an attack.

(d) **Degeneration and Dystrophy of Fundus**

(i) **Serous Central Retinopathy**: It is common condition characterized by unilateral localized detachment of sensory retina at macula. If florescent angiography shows multiple leak, the particular condition may be due to tubercular disease. Hence attributability can be conceded. About 80% of Central Serous retinopathy undergo spontaneous recovery and visual acuity is restored within six months.

(ii) **Retinal Vascular Diseases**: Generally associated with Diabetes and Hypertension. Retinal artery occlusion may be due to vegetation from heat as in subacute bacterial endocarditis and thrombus in myocardial infarction. Central retinal vein occlusion is associated with hypertension and hyperviscosity syndrome in leukaemia and polycythaemia vera.

(iii) **Retinitis Pigmentosa**: It is a generic name for a group of hereditary disorders characterized by progressive loss of photo receptor retinal pigment i.e. rods and cones. Night blindness is the main complaint with loss of acuity of vision. Disability is rejectable.

(iv) **Maculopathies**: These are seen in myopics and certain toxic maculopathies due to drugs (chloroquin, quinine, chlorpromazine).

25. **Demyelinating Diseases of CNS**

Demyelinating diseases of CNS encompasses a host of conditions like multiple sclerosis, Guillain-Barre syndrome,

Acute demyelinating encephalomyelitis and progressive multifocal encephalopathy and slow virus infection.

Acute demyelinating encephalo myelitis follows weeks after exanthem such as measles, chickenpox or after vaccination. Guillain-Barre syndrome may develop during or after virus infection of upper respiratory tract.

Multiple sclerosis is a disease in which a host of factors such as environment, genetics and immunology have a role to play. However rise in incidence in countries with temperate climate suggest greater role of environment. Hence individuals serving in terrains and climate akin to temperate zones may develop the disease which can be accepted on the basis of aggravation.

All demyelinating disorders with preceding history of infection, vaccine therapy during service are to be adjudicated as attributable to service.

#### 26. **Diabetes Mellitus**

This is a metabolic disease of unknown origin. Environmental factors interact with genetic susceptibility to determine the onset of different variants of diabetes.

In case of IDDM, inheritance is HLA linked and viruses like coxackie and EMC may induce diabetes by setting an autoimmune destruction of pancreas. On the other hand, NIDDM is not HLA linked and there is no evidence that autoimmunity or virus have anything to do with it.

Secondary diabetes can be due to drugs or due to trauma to pancreas or brain surgery or otherwise. Rarely, it can be due to diseases of pituitary, thyroid and adrenal gland.

Diabetes arising in close time relationship to service out of infection (IDDM), trauma, post surgery and post-drug therapy be considered "attributable".

It would be appropriate to concede aggravation by service where the conditions of service are shown to have been such as to produce delay in proper treatment resulting in persisting worsening.

27. **DNS**

It is a hereditary disease. If acquired during service due to trauma during a boxing event or an organised game activity, should be treated as "attributable".

28. **Disorders of Cardiac Rhythm and Conduction**

These are aberrations in heart rate due to varied pathological and physiological states. These conditions may arise from some organic heart disease like rheumatic heart disease, ischaemic heart disease, hypertension, subacute bacterial endocarditis, myocarditis, vascular disease and drugs. It also occurs as a result of focal sepsis, thyrotoxicosis, excessive use of tea, coffee, tobacco, alcohol and as a result of flatulent distension of the stomach or intestine. Physical exertion or emotional excitement may predispose to an attack.

Attributability is conceded if arrhythmia and heart blocks develop as a sequelae to infections in the heart. Aggravation is awarded based on the primary disease affecting heart in relevance to service profile.

29. **Diseases of Female Reproductive System**

With the induction of females into Armed Forces, a new scenario has emerged as certain diseases specific to reproductive system can be adversely affected by service conditions. At the time of enrolment it is mandatory to ascertain certain information pertaining to reproductive system such as LMP, regularity of periods, clinical examinations and ultrasonography to exclude any pelvic pathology. Certain common diseases of female reproductive system are being discussed here with relevance to service in Armed Forces.

(i) **Disorders of Menstruation**

(a) **Amenorrhoea:** Amenorrhoea ( Absence of menstruation) may be primary or secondary:

- i) Primary amenorrhoea is either due to non development of genital tract or lesion in hypothalamic-pituitary-ovarian axis. Recommended to be unfit for commissioning in military service.

ii) Secondary amenorrhoea is commonly caused by pregnancy or lactation. Pathological causes can be lesion in the hypothalamic - pituitary - ovarian - uterin axis. This condition is neither attributable nor aggravated by military service.

b) **Dysfunctional Uterine Bleeding:** It is an endogenous disorder and is neither attributable nor aggravated by service.

ii) **Pelvic Inflammatory Disease:** Pelvic inflammatory disease can be due to endogenous or exogenous infection. If exogenous infection other than STD is proved, attributability is appropriate. Pelvic tuberculosis is attributable to service.

iii) **Prolapse Uterus:** Proplapse uterus is due to weakness of the uterine supports. Chronic increase in intra-abdominal pressure due to chronic cough, constipation may adversely affect the disease. This condition is neither attributable nor aggravated by service.

(iv) **Abortion:** Majority of abortions take place due to chromosomal abnormalities and are not related to service conditions. The condition is a temporary disability and is neither attributable nor aggravated by service.

(v) **Stress Incontinence of Urine:** Stress incontinence of urine is involuntary loss of urine on increasing intra abdominal pressure. It is caused by loosening of blader neck supports. It is neither attributable nor aggravated by service conditions.

(vi) **Pelvic Endometriosis:** This is an endogenous disorder and neither attributable nor aggravated by service.

(vii) **Fibroid Uterus:** This is an endogenous disorder and is neither attributable nor aggravated by service.

(viii) **Pelvic Malignancies:** Carcinoma of cervix, endometrium, ovary, vagina, vulva and fallpian tubes may adversely affect the functioning. These are endogenous

disorders and are neither attributable nor aggravated by service.

(ix) **Menopause:** Menopausal symptom may be severe and adversely affect the functioning of the individual. This condition is neither attributable nor aggravated by service.

(x) **Pregnancy Complications:** Any pregnancy complication including ectopic pregnancy, abortions, antepartum haemorrhage, attributable may be considered if there is delay in institution of treatment due to service conditions.

### 30. Disorders of Immune Dysregulation

These can be classified as :-

- (a) Arthritides
- (b) Vasculitides
- (c) Systemic lupus erythromatosis
- (d) Inflammatory myositis
- (e) Systemic sclerosis

Disease of various other etiologies like infections, metabolic disorders, degenerative diseases can have presentation in the above classes and need to be excluded. The etiology of these various diseases of immune dysregulation is not definitely known but involve an interplay of genetic (HLA associated) and environmental (foreign antigens) agents which cause an immunological attack against the self (autoimmunity).

(a) **Arthritides** : This includes Spondylo-arthropathy (seronegative) and Rheumatoid arthritis (Sero-positive). Spondylo-arthropathy have a constellation of diseases like unclassified spondylo-arthropathy, ankylosing spondylitis, reactive arthritis, psoriatic arthritis, Reiter's syndrome and enteropathic arthritis. All these are aggravated by physical stress of service like training, marching and prolonged standing.

(b) **Vasculitides:** includes a number of diseases involving large, medium and small arteries and veins. Etiology is due to abnormalities in both humoral and cell mediated immunity except hepatitis B and hepatitis C virus associated vasculitis. Other than these exceptions, aggravation due to service is appropriate as exposure to cold, climatic region

and hypoxia of HAA can adversely affect the course of the disease.

(c) **Systemic Lupus Erythromatosus** : SLE is a disease characterized by multitude of antibodies and multi-system involvement. Aggravated by exposure to ultraviolet light as in HAA and exposure to sun.

(d) **Inflammatory Myositis**: Inflammatory myositis includes dermatomyositis and polymyositis. It is of unknown etiology but abnormalities of cell mediated immunity and humoral immunity is seen, can be precipitated by exertion. Hence aggravation by service is appropriate.

(e) **Systemic Sclerosis**: Systemic sclerosis has no known etiological agents. It is characterized by increased collagen in skin and viscera. It is aggravated by exposure to severe cold.

### 31 **Diseases Peculiar to Naval Service**

(i) **Pulmonary Barotrauma**: Pulmonary Barotrauma occurs in divers and sub-mariners due to rapid ascent from depth, increase of pressure in lung and counter lung system and also due to lack of sufficient air for breathing as a result of loss of mouth piece and breathing from mask space, mouth piece block due to vomitus and diving with relief-valve open. Signs and symptoms appear few minutes after coming to surface. Chest pain, breathlessness and haemoptysis and CNS symptoms are the common presentation due to air embolism. Attributability is appropriate in such cases.

(ii) **Decompression Sickness**: Decompression sickness is a condition peculiar to flyers, divers and submariners. It is caused by inert gas such as nitrogen, which is a component of air mixture that we intake, goes into solution in large quantities at great pressure and the same separates out from physical solution in tissues in form of bubbles giving rise to symptom of bodyache, breathing difficulty and those due to involvement of other systems.

Attributability may be conceded if the same is acquired while on duty.

(iii) **Dysbaric Osteonecrosis**: Exposure to pressure substantially greater than normal atmospheric pressure is known to be associated with death of portion of long bones.

The disability is detected inadvertently while investigating a case of diving related pathology or even during routine x-ray examination of long bones. The lesions are mainly confined to head, neck and shaft of long bones.

### 32. Eczema/Dermatitis

Eczema is an inflammatory response of the skin primarily not infectious or contagious. Reaction is due to many agents such as exogenous factors (irritants/contact) or endogenous factors (constitutional). A sensitive person may develop eczema due to stimuli encountered as a result of military service. These include mechanical stimulus of the skin from friction of clothing and chemical and biological irritants in those handling equipment and in also in those engaged in professional work. The friction may occur during marching, PT, military exercise, thermal irritation, from sweating or over reaction of the secretions of the skin. Exposure to cold appears also to be a precipitating factor in some cases. An ulceration or infection of skin or septic wound may cause sensitisation.

Any case of eczema beginning subsequent to enrolment, the onset of which is accepted as precipitated by service conditions, must be considered as attributable to service and not merely aggravated.

### 33. Epilepsy

This is a disease which may develop at any age without obvious discoverable cause. The persons who develop epilepsy while serving in forces are commonly adolescents with or without ascertainable family history of disease. The onset of epilepsy does not exclude constitutional idiopathic type of epilepsy but possibility of organic lesion of the brain associated with cerebral trauma, infections (meningitis, cysticercus, encephalitis, TB) cerebral anoxia in relation to service in HAA, cerebral infarction and hemorrhage, and certain metabolic (diabetes) and demyelinating disease should be kept in mind.

The factors which may trigger the seizures are sleep deprivation, emotional stress, physical and mental exhaustion, infection and pyrexia and loud noise.

Acceptance is on the basis of attributability if the cause is infection, service related trauma.

Epilepsy can develop after time lag/latent period of 7 years from the exposure to offending agent (Trauma, Infection, TB). This factor should be borne in mind before rejecting epilepsy cases.

Where evidence exists that a person while on active service such as participation in battles, warlike front line operation, bombing, siege, jungle war-fare training or intensive military training with troops, service in HAA, strenuous operational duties in aid of civil power, LRP on mountains, high altitude flying, prolonged afloat service and deep sea diving, service in submarine, entitlement of attributability will be appropriate if the attack takes place within 6 months. Where the genetic factor is predominant and attack occurs after 6 months, possibility of aggravation may be considered.

34. **Errors of Refraction:**

(a) **Astigmatism** : May be very rarely due to injury or ulceration of the cornea. In the absence of evidence of injury or inflammatory disease of the eye, the condition may be accepted as unaffected by military service.

(b) **Hypermetropia** : May be very rarely, due to injury or disease of the focusing muscles of the eye. In the absence of evidence of injury or disease, the condition may be accepted as unaffected by military service.

(c) **Myopia** : Myopia, particularly in cases in which rapid changes have occurred, can be aggravated by service in the following conditions :

(i) Young myopes upto 25 years of age working at prolonged clerical duties under poor lighting conditions.

(ii) High myopes (myopia over 6 D) of all ages, provided the myopia is of progressive nature.

(iii) Myopes who have suffered from long debilitating illness due to service, particularly between the age 18 to 25.

(iv) Myopes who show choroidal degeneration, which is a frequent accompaniment of high myopia. In such individuals service for a considerable period, or prolonged duty under severe physical strain might have an aggravating effect.

(v) Myopia has a natural tendency to progress, but the worsening of the myope's vision brought about by a detachment of, or haemorrhage into, the retina may be precipitated by service conditions, which must be carefully considered in relation to each individual case.

35. **Glaucoma**

(a) **Primary and Idiopathic:** which may be either acute or chronic. Its onset is generally speaking unaffected by service conditions; but exceptionally, an acute attack may be brought on by worry, fatigue, or illness and, if any of these were considered to be the result of service, aggravation might have to be conceded.

The onset may be insidious and it may reveal its presence for the first time as an acutely painful eye, but in the absence of evidence of undue mental or physical stress occasioned by war service, it can not be considered that this disease is attributable to or has been aggravated by service factors.

(b) **Secondary Glaucoma:** This may be due to a service trauma and would be attributable. It may be caused by iritis and intra-ocular haemorrhage, and entitlement would, therefore, have to be considered in relation to the underlying cause. It may also be the result of an intra-ocular tumour.

In general terms it may be said that, in the great majority of cases there is a disturbance of the intra-ocular circulation to which is frequently added an obstruction to the circulation of the intra-ocular fluids. The factor common to all cases is the increase of intra-ocular pressure. In such cases, therefore, the primary condition which is responsible, for these changes or sequelae must be considered in relation to entitlement and not the glaucoma per se.

36. **Fibrosis of Lungs**

Fibrosis of the lung is a condition in which the amount of lung fibrous tissue is increased to varying extent in accordance with the severity of the disease.

It is caused by :

- (a) Tuberculosis - This is the commonest cause. pneumoconiosis, as in miners etc.
- (b) Silicosis in builders and in professionals engaged in quarries.
- (c) Irritant gases (chlorine, bromine etc.) Lung irritants in chemical warfare.
- (d) Pneumonia - If the pneumonia is accompanied by complications, or in bronchopneumonia which may arise in children as a complication of acute infective disease (such as measles, whooping cough etc).
- (e) Local inflammatory or destructive lesions (abscess, parasitic cysts etc).
- (f) Sometimes follows collapse of the lung.
- (g) There may be some fibrosis of the lung in congestive heart failure.
- (h) Extrinsic allergic alveolitis due to exposure to organic dust.

The condition could be aggravated by inflammatory diseases of the lung; by certain occupations such as coal miners, silica workers etc. The disease is a chronic condition developing over a period of time.

If the disease was of tuberculous origin acquired before enrolment, it will be only reasonable to expect aggravation by stress and strain of service where manifested by reactivation of the underlying tuberculous lesion.

Irrespective of the underlying cause, physical exertion by PT, parade, route marches, hill climbing and equivalent activity can aggravate the disease.

37. **Fistula in Ano**

Fistula in ano is an unnatural channel leading from the anal canal to the external surface, and usually follows an inflammation in the peri-anal region.

It may follow dysentery, diarrhoea or constipation, ischiorectal abscess, tubercular ulceration, syphilis, cancer and trauma to the area. The unnatural channel discharges foul smelling pus and is a source of great discomfort to an individual suffering from the disease.

The disability would be aggravated by further attacks of bowel disease and duties entailing pressure on the anal region, e.g. riding on a motor cycle and long hours of driving by MT drivers and AT drivers.

38. **Goitre**

Goitres are swellings of thyroid which can be broadly divided into simple goitre and toxic goitre.

Simple goitre can be a diffuse or multinodular enlargement of the thyroid. It is likely that sub optimal dietary iodine intake associated with dietary compulsions and employment in localities peculiar to Armed Forces may lead to development of goitre which may present either in euthyroid and hypothyroid state. Sometimes hypothyroid state may develop as an after math to ablation of gland to over generous surgery or irradiation and also drug therapy like PAS, lithium carbonate and phenylbutazone. Attributability can be conceded in simple and multi nodular goitre due to iodine deficiency in endemic areas and in hypothyroidism following therapeutic trials.

Toxic goitres are commonly seen in Grave's disease and less commonly in multinodular goitre, sub-acute Dequervan's thyroiditis and adenoma thyroid showing features of toxicity. At times hyperthyroid state may follow therapeutic and diagnostic trial with iodine compounds like anti-arrhythmic drugs e.g. amiodarone, radiographic contrast media and during the course of iodine prophylaxis programme. Grave's disease is an immunologically mediated disease and its onset or course can be aggravated by service conditions such as worry, stress and strain, shock which

can precipitate the toxic symptoms. It will be appropriate to concede attributability in hyperthyroidism associated with multinodular goitre and sub-acute thyroiditis and also in post therapeutic and diagnostic trials of iodine and its compounds.

#### 39. Gout

Gout is generally a genetic disorder but may be secondary to conditions like leukaemia, polycythemia vera and psoriasis. The disease can be aggravated by exercise, alcohol, starvation, diets rich in nucleic acid like animal protein, milk and dal. In the presence of these exciting factors common to armed forces, aggravation due to service can be examined.

#### 40. Hepatitis

Hepatitis is caused by hepatitis viruses, non-viral agents like amoeba, *Toxoplasma gondi*, Leptospiral and rarely by drugs. Virus infection constitutes the single largest group accounting for nearly 99% of all hepatitis. The viruses responsible are Hepatitis A, Hepatitis B, Hepatitis C, Hepatitis D and Hepatitis E. The common drugs and chemicals injurious to liver are ethanol, phenacetin, acetaminophen, isoniazid, rifampicin, cimetidine and halothane.

The spread of disease in hepatitis associated with A and E virus is feco-oral, whereas the spread of hepatitis due to B,C,D are mostly parenteral though close personal contact is necessary for transmission as these viruses tend to be secreted in body fluids like saliva, urine, semen and vaginal secretions.

Chronic hepatitis is a chronic parenchymal liver disease caused by alcohol, hepatitis B and C virus infection, drugs e.g. methotrexate and auto-immune hepatitis. Diagnosis of chronic hepatitis is made when the liver disease has been present on clinical grounds at least for six months.

Three principal histologically variants some times reflected clinically are persistent hepatitis, aggressive hepatitis and lobular hepatitis. Cirrhosis often develops in cases of aggressive hepatitis.

Hepatic amoebiasis is common in the tropics and subjects of Armed Forces are no exception to this. The infection most commonly affects the right lobe of liver. The disease runs a short protracted course and is cured with therapy.

Attributability is conceded in infections and in all cases of viral hepatitis acquired in service but those acquired due to AIDS contracted out of affection and drug abuse are rejectable. Attributability is also conceded in cases where hepatitis is a sequelae to drug therapy for treatment of diseases.

High transaminase level (6 times) and presence of HBs Ag are diagnostic of HBV hepatitis. When the test is negative for HBs Ag, HBV infection is unlikely but not ruled out as antigenemia is transient and the timing of diagnostic test is not perfect. However, antigenemia can last upto 05 months. The failure to detect HBs Ag should not exclude the possibilities of infection with HBC, HBD, HBE, HBA viruses as there is no diagnostic back up available to detect these in peripheral service hospitals. In such cases attributability will be appropriate.

#### 41. Hernia

Hernia arising during active service can be due to effects of certain respiratory diseases, innate weakness in muscles and also due to complication of surgery. In males, inguinal hernia is a common disability which may manifest due to prolonged hours of physical activity peculiar to service. Aggravation is appropriate in such cases. On the same analogy femoral hernia in females can be accepted on the basis of aggravation.

#### 42. Hemorrhoids

It is a constitutional disease. However, in certain occupations involving prolonged sitting (e.g. clerks, DRs, drivers) and raised intra abdominal pressures in weight lifters, can aggravate and complicate the disability when aggravation due to service can be examined.

#### 43. Hypertension

The first consideration should be to determine whether the hypertension is primary (essential) or secondary. If secondary, entitlement considerations should be directed to the underlying disease process (e.g. Nephritis), and it is unnecessary to notify hypertension separately. It is better to clearly indicate whether it is a case of essential hypertension, giving the evidence in support.

As in the case of artherosclerosis, entitlement of attributability is never appropriate, but where disablement for

essential hypertension appears to have arisen or become worse in service, the question whether service compulsions have caused aggravation must be considered. Each case should be judged on its merits taking into account particularly the physical condition on entry into service, the age, the amount and duration of any stress and whether any other service compulsion has operated.

Hypertension generally arising in close time relationship to service in field area, active operational area, war like situation both in peace and field area, counter-insurgency areas and high altitude areas are acceptable as aggravated when exceptional stress and strain of service is in evidence. However, in certain cases the disease has been reported after long and frequent spells of service in field/HAA/active operational area. Such cases can be explained by variable response exhibited by different individuals to stressful situations. Aggravation can be considered taking into account the duration of service in active operational areas and sector profile.

#### 44. Inflammatory Bowel Disease

Opinion has been divided over the origin of inflammatory bowel disease. Infective agents such as RNA virus, Mycobacterium kansasii, Pseudomonas, Anaerobes, Y enterocolitica and some immunological aberrations and an assortment of concept of psychosomatic, dietary, vascular, traumatic, hormonal and other mechanisms have been implicated in genesis of these diseases.

The diseases falling in the group is ulcerative colitis and Crohn's disease and these are characterized by unpredictable exacerbations and remissions. Relapse is often associated with emotional stress, inter-current infection or use of antibiotics. Stress and strain of service will materially influence the course of disease and aggravation can be conceded.

The complications of these diseases are fissure in ano, stricture rectum, fistula. The extra intestinal complications are ankylosing spondylitis, uveitis, cirrhosis and amyloidosis. While assessing the disease, the assessment for the complication should be kept in mind.

**45. Irritable Bowel Syndrome**

It is a disease of disturbed mobility of colon with uncertain aetiology. Patients with psychological disturbances in form of domestic worries and anxiety may precipitate the attack. Stress and strain of service may aggravate the disease.

**46. Injuries to Oral Cavity**

Injuries to oral cavity and its contents tongue, nerves can be caused by way of trauma during service and more commonly due to cancer involving floor of mouth and less commonly due to benign pathology of dentures and floor of the mouth.

Attributability can be examined by judging the etiological factors in relevance to service.

**47. Ischaemic Heart Disease (IHD)**

IHD is a constitutional disease. It is almost always due to occlusive thrombus at the site of rupture of an atheromatous plaque in the coronary artery. Prolonged stress and strain hastens atherosclerosis by triggering of neurohormonal mechanism and autonomic storms. It is now well established that autonomic nervous system disturbances precipitated by emotions, stress and strain, through the agency of catecholamines affect the lipid response, blood pressure, increased platelet aggregation, heartrate and produce ECG abnormality and arrhythmias. Therefore where exceptional and prolonged stress and strain of service can reasonably be established, aggravation can be conceded. On the other hand acute and severe mental and physical stress of very short duration may precipitate acute cardiovascular catastrophe by suddenly creating marked reduction of blood supply relative to its demand and favours coronary spasm, resulting in ischaemia. Therefore intimate causal relationship must be accepted and attributability can be conceded.

The service in field and high altitude areas apart from physical hardship imposes considerable mental stress of solitude and separation from family leaving the individual tense and anxious as quite often separation entails running of separate establishment, financial crisis, disturbance of child education and lack of security for family. Apart from this, compulsory group living restricts his freedom of activity. These factors jointly and severally can become a chronic source of mental stress and strain precipitating an attack of IHD.

Severe regimentation in the day to day service life, working to deadlines, prolonged hours of uncongenial duties are inherent in the working of services. In addition, severe mental trauma associated with operations of high pressure planning and similar other duties in three services, severe physical stress and strain of field service and active operational areas, stresses of multitude of duties and responsibility must be given consideration while establishing causal relation between acute cardiovascular catastrophe and service.

The magnitude of physical activity and emotional stress is no less in peace area. Tough work schedules and mounting pressure of work during peace time compounded by pressure of duties, maintenance of law and order, fighting counter insurgency and low intensity war in deceptively peaceful areas and aid to civilians in the event of natural calamities have increased the stress and strain of service manifold. Hence no clear cut distinction can be drawn between service in peace areas and field areas taking into account quantum of work, mental stress and responsibility involved. In such cases, aggravation due to service should be examined in favour of the individual.

It is concluded that a myocardial infarction may be attributable to or aggravated by service or unrelated to service factors as follows :-

(a) **Attributability will be conceded where** : A myocardial infarction arises during service in close time relationship to a service compulsion involving severe trauma or exceptional mental, emotional or physical strain, provided that the interval between the incident and the development of symptoms is approximately 24 to 48 hours. Attributability will be conceded in cases related to activities like high pressure planning for/in operation or extreme physical strain, but not in cases of stress and strain in office or extra/work duties which are matters of normal official life. Attributability can also be conceded when the underlying disease is either embolus or thrombus arising out of trauma in case of boxers and surgery, infectious diseases. e.g. SBE, vaccinia, exposure to HAA, extreme heat. However, IHD occurring in a setting of hypertension, diabetes and vasculitis, entitlement can be judged on its own merits.

(b) Aggravation will be conceded in cases in which there is evidence of :-

(i) Severe mental and/or emotional stress due to participation in operation or high pressure planning for operation or other similar activities involving equivalent stress and strain.

(ii) Severe physical stress in the field or other similar activities involving stress in peace or training during the preceding two weeks.

(iii) Atheroma manifesting itself clinically as angina, myocardial infarction, sudden death and abnormalities of the electrocardiogram.

In such cases aggravation will be conceded if an individual known to be suffering from ischaemic heart disease, or one in whom it can be otherwise established that there has been a failure to make a diagnosis of ischaemic heart disease, as a result of which he was not given suitable duties in a lower medical category and kept under observation, but allowed to continue to perform duties in a higher medical category with its connected stress and strain, resulting in illness of critical or catastrophic proportions leading to death.

There would be cases where neither immediate nor prolonged exceptional stress and strain of service is evident. In such cases the disease may be assumed to be the result of constitutional factors, heredity and way of life such as indulging in risk factors e.g. smoking. Neither attributability nor aggravation can be conceded in such cases.

#### 48. **Keratitis**

Keratitis is an inflammation of cornea with or without ulceration and on healing an opacity or opacities may be left which may interfere with vision.

It is essentially an infection by various micro organism excited by a number of causes e.g. injury, foreign body exposure (facial nerve palsy), conjunctivitis.

The viruses causing keratitis are herpes and Varicella virus. Certain morphological variants of viral keratitis are disciform keratitis, nummular keratitis and punctate keratitis.

Bacteria such as staphylococcus and pseudomonas can cause keratitis. Few morphological variants such as interstitial keratitis, phlyctenular keratitis, marginal keratitis are due to hypersensitivity reaction to bacterial toxins (TB, Staphylococcus).

Keratitis may be associated with fungal infection and collagen disorders.

Keratitis is a self limiting disease if treated adequately. If left with a residual opacity centrally it may obstruct vision.

Attributability is appropriate when there is evidence of infection and trauma in relevance to service.

#### 49. **Knee Injury**

This constitutes by far the largest group of bony joint injury and consists of following elements singly or in combination:

- (a) Traumatic synovitis
- (b) Medial and lateral collateral ligament injury
- (c) Anterior and posterior cruciate ligament tear
- (d) Meniscus tear
- (e) Fatpad impingement
- (f) Cartilage tear

Internal derangement of knee (IDK) or haemarthrosis should be considered as a provisional diagnosis and effort should be made to reach a final diagnosis by corroborating clinical evidence with investigations such as x-Ray and CT scan arthroscopy.

Acceptance is generally on the basis of aggravation unless preceding history of trauma on duty makes it attributable.

#### 50. **Laryngo-Tracheal Injury**

Laryngo-tracheal injury is a common injury seen in Armed Forces. This can be due to MT accident, injury due to boxing and wrestling, bullet injury, basket ball game and also due to diving into a swimming pool.

Vocal cord paralysis is a common outcome of such injury. Vocal cord palsy can also be due to viral laryngitis, complication of thyroid surgery, neck surgery in malignancy. Irradiation of neck may also give rise to vocal cord palsy.

Sometimes tracheal stenosis occurs in tracheal injury, burns, post tracheostomy and bullet injury.

Attributability and aggravation can be conceded depending on merit of each case.

#### 51. Lumbago Sciatica

Lumbago Sciatica is a clinical entity which is caused by arthritis or strain of joints of the spine or pelvis or by diseases of bones of the spine.

In the absence of skeletal abnormality the causes of low backache are as under :-

- (a) Musculo-fascial strain
- (b) Lumbar spondylosis
- (c) Facet joint arthropathy
- (d) Prolapsed inter-vertebral disc (due to trauma, unguarded movement of spine e.g. sudden flexion and rotational strain, lumbar spondylosis).
- (e) Sacroillitis, ankylosing spondylitis
- (f) Spondylolisthesis

Sciatica in addition to lumbago can be a presentation in lumbar spondylosis, PIVD and facet joint arthropathy due to nerve cord compression.

Lumbago and sciatica can be aggravated by cold climate and strenuous physical activities. Aggravation due to service can be conceded.

#### 52. Leprosy

Leprosy is caused by Mycobacterium leprae and occurs in two main forms, tuberculoid and lepromatous. It is characterized by extreme chronicity. It is not yet definitely established as to how leprosy is transmitted. Although skin to skin contact with infectious cases may play a role in transmission, there are other modes of transmission also, viz recovery of large number of lepra bacilli from nasal mucosa of reservoir of infection namely lepromatous leprosy, has led to possibility of droplet infection

through nose blows, sneezing, coughing etc by lepromatous cases. Also the lepromatous ulcers in the skin discharge a large number of bacilli. Mechanical transmission by biting insects and part played by ingestion of leprabacilli has not been clearly established.

The incubation period is not definitely known and various periods have been given by different authorities. There is a long interval between the exposure to infection and the appearance of definite recognisable symptoms of the disease. However, the accumulated evidence indicates that the incubation period is usually not less than 2 years in an adult but this would debar an individual showing manifestation of disability between 1-2 years of service being considered for entitlement provided clear evidence of contact is established and as further explained in clause(a) below; "Entitlement".

Cases in which the bacilli can be demonstrated can only be considered as infectious. The bacteriologically positive cases are generally but not always cases of lepromatous type. Lately, some laboratory evidence has been produced that even neural cases are infectious but this view has not as yet been universally accepted.

#### **Entitlement**

(a) **Attributability**: Attributability should be accepted in respect of any individual contracting leprosy after being in service for two years. Cases diagnosed within the year of enrolment cannot be considered as attributable to service. Cases where manifestation of the disease occurs between 1-2 years of service will be decided on their own merits, provided clear evidence of attributability for service reasons is produced. If there is evidence to show that the individual had a prolonged and intimate contact arising out of service with an infectious case, attributability shall have to be conceded.

(b) **Aggravation**: Leprosy is not aggravated by conditions normally met within military service. Aggravation can only be conceded when the individual due to circumstances of service, e.g. as prisoner of war due to prolonged active operations, has not been able to receive proper modern treatment.

53. **Lymphadenitis Neck**

The disease is an inflammation of the lymphatic tissue and lymph glands. There are three possible causes:

(a) **Tuberculosis** : (Commonest cause) usually occurs in children and young adults in unhygienic surrounding. It is a slow process. The tuberculous infection is usually superimposed on already unhealthy tissues. The onset of this form of the disease could be precipitated and its course hastened by stress and strain and by poor hygienic conditions.

(b) **Due to Septic Absorption** : From bad teeth, adenoids, septic conditions of the scalp etc. Not affected by service except in cases where it resulted from such conditions as an infection of the scalp due to a service injury etc.

(c) **Syphilitic** : Very rare in the neck. Not affected by service.

54. **Mental (Psychiatric) Disorders**

Psychiatric illness results from a complex interplay of endogenous (genetic/biological) and exogenous (environmental, psychosocial as well as physical) factors. This is true for the entire spectrum of psychiatric disorders and the earlier dichotomy between "neurosis" and "psychosis" is no longer valid. The relative contribution of each, of course, varies from one diagnostic category to another and from case to case.

The concept of aggravation due to the stress and strain of military service can be, therefore, evaluated independent of the diagnosis and will be determined by the specific circumstances of each case. Grant of compensatory benefits related to aggravation by service factors may be considered in the following circumstances :

(a) Psychiatric disorder arising within 6 months (extendable upto 12 months in some cases) of serious/multiple injuries (e.g. amputation of upper/lower limb, paraplegia, quadriplegia, severe head injury resulting in hemiplegia of gross neurocognitive deficit) which are themselves considered

attributable to military service. This includes Post Traumatic Stress Disorder (PTSD).

(b) Psychiatric disorders arising within 6 months (extendable upto 12 months in exceptional cases) of:

- (i) CI ops tenure exceeding 2 years
- (ii) HA tenure exceeding 18 months
- (iii) Siachen tenure exceeding 6 months
- (iv) Deployment of extreme isolated posts for over 6 months
- (v) Incarceration as PW for more than 60 days
- (vi) Being held hostage under threat of death/torture for over 30 days
- (vii) Separation from the immediate family for 12 months or more at a stretch owing to exigencies of service, except when such separation is due to the individual being under arrest/involved in disciplinary proceedings.

(c) Psychiatric disorders arising within 3 months of denial of leave due to exigencies of service in the face of :

- (i) Death of parent when the individual is the only child/son.
- (ii) Death of spouse or children
- (iii) Heinous crimes (e.g. murder, rape or dacoity) against members of the immediate family
- (iv) Reprisals or the threat of reprisals against members of the immediate family by militants/terrorists owing to the fact of the individual being a member of the Armed Forces
- (v) Natural disasters such as cyclones/earthquakes involving the safety of the immediate family
- (vi) Marriage of children or sister when the individual is the only brother thereof and specially if their father is deceased

3. Attributability may be granted under special/extraordinary circumstances associated with any of the factors enumerated in para 2 above, but the medical board must set out in writing the reasons for the same. This provision should be used sparingly/with transparent objectivity and the medical board should not allow its decision to be swayed by sympathy or other extraneous considerations.

#### 55. Oesophageal Stricture

The common causes are drugs, post- endoscopy sclerotherapy and accidental ingestion of scleroagents.

Reflex oesophagitis mostly results from hiatus hernia which is a congenital disease missed commonly during enrolment. There is a general tendency for oesophagitis when the individual is subjected to military training and stress and strain of service.

Aggravation due to service is considered in all cases except those having an intent to commit suicide with corroding agent.

#### 56. Osteo-arthritis

Osteo-arthritis is a constitutional disease principally affecting the weight bearing joints such as spine, hips, knees. Osteo-arthritis can be primary or secondary. Secondary osteo-arthritis can be due to continued minor traumas, intra-articular factor, mal-alignment of fractures, septic arthritis, Rheumatoid arthritis, Aseptic necrosis (due to Cortico steroid therapy, collagen disease, Caisson's disease), neuropathic (diabetes, leprosy, peripheral nerve disease).

The spectrum of diseases included in this category are :

- (a) Lumbar spondylosis
- (b) Cervical spondylosis
- (c) Osteoarthritis hip, knee, ankle

Rigours of training and regimental duties and physical activities (marching, sentry duty, patrolling, active operational activity), driving, prolonged hours of working, standing, sitting as in professionals paramedics and clerks can overtly/covertly cause continuous trauma to major weight bearing joints. Apart from this, uncongenial climate (cold, damp) and terrain can adversely affect the course of the disease. Even when there is no evidence of definite injury, stress or strain associated with duty cannot be excluded. The disease is generally accepted on the basis of aggravation. However the fact that many young soldiers develop the disorder prematurely makes a strong case for attributability in the light of repeated minor trauma associated with occupational stress and strain.

## 57. Otitis Media

Otitis media can be classified into acute and chronic, based on extent of inflammatory reaction and the presence or absence of suppuration. It should be noted that an initial non-suppurative condition may proceed to suppurative one and chronicity if neglected or inadequately treated. The common predisposing factors are upper respiratory tract infection, infection from postnasal packs in the treatment of epistaxis and rarely as a manifestation of allergy.

Chronic otitis media may be :

- (a) **Active**: When there is pus discharge
- (b) **Quiescent**: With intermittent pus discharge for a period less than 6 months.
- (c) **Inactive**: Cessation of discharge for six months without resumption. It may reactivate by reinfection through perforation of tympanic membrane.
- (d) **Healed**: Total extinction of disease and healing of perforated tympanic membrane.

Chronic suppuration in attic and antrum associated with perforation (attic) and posterior marginal perforation and complications like cholesteatoma and polyp are ominous signs and carries a risk of bone destruction, recurrence after surgery.

If chronic suppurative otitis media originates during service it should be accepted as attributable to service. When diagnosed comparatively early in service there may be evidence of cholesteatoma, polypi and granulation, which would show beyond reasonable doubt that the condition existed before service. This, however, would not necessarily be the case when the disease is discovered for the first time after long service and in the absence of any pre-service ear trouble. The importance of a detailed study history and findings in the member's original service documents cannot be over-emphasised. However, a history of a single isolated attack of acute otitis media in childhood cannot, in the absence of any intervening history of aural disease, be held to be the commencement of an injurious process which only gave rise to symptoms in service many years later.

The pre-existing disease can be aggravated by such conditions as exposure to adverse climatic conditions such as damp or cold, debilitating disease, exposure to gun fire or bomb bursts and swimming in infected waters.

58. **Otosclerosis**

Otosclerosis is hereditary progressive form of conductive or middle ear deafness but it may be associated with an added perceptive or nerve deafness due to involvement of the nervous elements of the cochlea, particularly in the later stages of the disease. It is now widely held that, although other aural conditions may co-exist with otosclerosis, the only conditions which have an adverse effect on the disease itself are prolonged serious or debilitating conditions, serious injury involving fractures of major bones, or pregnancy, when deterioration occurs in close time relationship to such events.

From the entitlement point of view, it is important to establish a firm diagnosis, i.e. that the condition present is otosclerosis, and not another form of conductive deafness e.g. otitis media; and that any disablement present is due entirely to otosclerosis, and not partly to an additional aural condition which may or may not be related to service.

59. **Pancreatitis**

Inflammation of Pancreas results due to chronic alcoholism, cholelithiasis, viral infections e.g. mumps, post surgery sequelae, post endoscopy (ERCP) and also due to certain drugs like azothioprim .

Attributability can be considered in those cases with preceding history of surgery, drug therapy, endoscopy (ERCP) and concurrent history of mumps, orchitis and parotitis.

60. **Paraplegia**

Paraplegia due to spinal cord compression is one of the commonest neurological emergencies in the Armed Forces. The principal cause of spinal cord injury is trauma to the spine, a hazard so common in perilous service conditions of Armed Forces. Apart from this, prolapsed inter-vertebral disc associated with lumbar spondylosis, tuberculosis, transverse myelitis, Gullian Barre syndrome can give rise to the disability. Prolonged and intensive physical activity of service during training and active operation hastens degenerative change in inter-vertebral disc

which may progress to cord compression. In such cases aggravation due to service will be appropriate.

Attributability should be conceded if the cause is infection or injury during duty.

61. **Peptic Ulcer**

Peptic ulcer can occur at lower oesophagus, stomach, duodenum and an anastomotic stromal ulcer in post gastrojejunostomy. Although some constitutional pre-disposition to ulcer exists, infection with *Helicobacter pylori* accounts for 90% of duodenal ulcer and 75% of gastric ulcer. Service in HAA/active operational areas and dietetic compulsions pre-dispose to peptic ulcer increasing the risk of complication and reducing the response to therapy. NSAIDS are held responsible for small proportion (30%) of cases of gastric ulcer and duodenal ulcer.

Generally speaking when an ulcer develops under service conditions and there is no evidence that injurious process commenced prior to entry in service the disability is accepted as attributable to service either on the grounds of infection or over generous drug therapy with NSAIDS

Where there is evidence of symptoms of the basic injurious process pre-service and service conditions have occasioned a worsening which persists at the date of discharge or claim, entitlement of aggravation would be appropriate. However, where it can be shown that the member's condition on discharge or claim was no worse than on entry, then rejection would be appropriate.

62. **Peripheral Neuropathy**

The cause of peripheral neuropathy may be due to infection (e.g. Gullian Barre syndrome, leprosy, typhoid), connective tissue diseases (PAN, SLE, rheumatoid arthritis), exposure to drugs. (amiodarone, vincristine, INH, phenytoin), metabolic (diabetes, hypothyroidism) and hepatic failure. Attributability and aggravation can be offered judging the merit of each case.

63. **Peripheral Vascular Diseases**

Although very little is known about their cause, majority have an immunological basis as underlying cause. However, certain variants of vasculitis such as polyarteritis nodosa, Hypersensitivity vasculitis and Kawasaki disease have been linked up with infection as exciting cause. For example PANs associated

with certain viral infection such as Hepatitis B, A and cytomegalo virus infection. Similarly Hyper sensitive vasculitis which have been reported in connection with certain drugs and infection, such cases can be decided on the line of attributability. In atherosclerosis of blood vessels arising in association with diabetes and Berger's disease, aggravation can be examined if the disease has deteriorated on account of adverse/uncongenial service conditions in field/HAA. Raynaud's disease and vascular disorders associated with physical injuries like cold, radiation can be conceded attributability if there is evidence of exposure to such agents in close time relationship with onset of disease.

#### 64. Pneumonia

Pneumonia is an acute infection of lung usually caused by bacteria and less commonly virus and fungus in predisposed and immuno-compromised individual.

Precipitating or pre-disposing causes are exposure, over fatigue, over exertion, chill, debilitating conditions and diseases, alcoholic excess etc. It may be a terminal disease in the aged. The incubation period is from one to seven days. If a man develops pneumonia while in military service, it is to be presumed that predisposing factors like exposure, chill, over fatigue etc were encountered by reason of military service unless there is evidence that the man was on other than military duty prior to contraction of the infection or that he suffered from pre-disposing causes by reason of his own fault.

For example, immuno-compromised individuals suffering from AIDS and diabetes, the pneumonia arising out of this may not be acceptable unless the primary diseases have similar basis of acceptance. Nosocomial pneumonias due to steroid therapy, post operative nasogastric intubation, endotracheal intubation, tracheostomy, infected ventilators, nebulizers, intracath, attributability is conceded.

#### 65. Pulmonary Eosinophilia

This is a clinicopathological entity commonly due to parasitic infection (helminth, filaria), bacterial infection, fungal infection (aspergillar bronchopulmonary disease) and at times due to drugs (NFT, aspirin, busalfan, chloropropamide).

In tropical countries our troops are being perenially exposed to uncongenial environment. Attributability to service can be considered in the light of supportive x-ray and lab findings.

**66. Prolapse Rectum**

A partial prolapse of the rectal mucosa normally occurs during defaecation, the mucous membrane retracting above the sphincter on completion of the act. When there is undue weakness of the pelvic muscles or haemorrhoids are present, pathological prolapse is observed.

This disability is rarely caused by military service but aggravation of the disability may be brought about by stress and strain of war service. Every case has to be weighed on its own merits.

**67. Psoriasis**

Psoriasis is a genetically determined disease. A family history is obtained in about 30 per cent of cases. Endocrines may also play a part in causation. Onset may be spontaneous or it may be precipitated by infections, especially streptococcal infections. Local trauma may determine the site and occasionally it appears for the first time at the site of a healing wound. Mental and emotional stress are generally regarded as not causative but may give rise to exacerbations. The disease is frequently associated with a type of arthritis very similar to rheumatoid arthritis except that the distal interphalangeal joints are frequently involved and the agglutination test for rheumatoid arthritis is almost invariably negative. Rarely ultraviolet radiation may worsen psoriasis.

**68. Renal Disorders**

It has long been appreciated that specific lesions of urinary tract frequently give rise to a constitutional array of clinical signs and symptoms and laboratory findings which when taken together constitute syndromes that effectively narrow the range of causal entities into broad subgroups outlining the exact diagnosis. These syndromes serve as an useful framework upon which the orderly system of nephrology is evolved.

**69. Acute Renal Failure**

It is a rapid deterioration in renal function sufficient to result in accumulation of nitrogenous wastes in the body. The common causes are :

(a) **Acute Glomerulonephritis :**

- Due to post streptococcal infection.
- Occult visceral sepsis
- Infective endocarditis
- SLE, vasculitis

(b) **Acute Tubulo-interstitial Nephritis :**

- Acute pyelonephritis, chronic pyelonephritis
- Chronic UTI
- Acute tubular necrosis
- Arteriolar nephrosclerosis
- Analgesic nephropathies
- Nephrotoxins e.g. antibiotics and radiography contrast media
- Transplant rejection
- Multiple myeloma, leukaemia

(c) **Acute Tubular Necrosis:**

- Hypovolemia due to burns, hemorrhage
- Vascular pooling in anaphylaxis, Sepsis and drugs
- Decreased cardiac output in CVS failure.
- Haemolysis in malaria
- Rhabdo-myolysis in trauma and heat stroke
- Infection e.g. Diarrhoea, Septic abortion, peritonitis, pancreatitis
- Drugs - contrast media, anaesthetic agent

(d) **Calculus:** Sixty to eighty percent of adults suffering from Acute glomerulonephritis recover over a period of 2 to 4 years. Twenty to forty percent of the cases have residual hypertension and asymptomatic urinary abnormalities.

Majority of Acute renal failure cases recover. Only ten percent of cases progress to chronic renal failure.

If Acute renal failure follows trauma on duty, infection hypovolemia, drug therapy, attributability can be conceded. When associated with multi-system disease, aggravation due to service can be examined based on his service profile.

#### 70. Chronic Renal Failure

Chronic renal failure is a syndrome resulting from progressive and irreversible destruction of nephrons. This syndrome is considered when azotaemia lasts for more than 3 months.

The causes are :

- (a) Chronic glomerulonephritis i.e. endstage of glomerular diseases with infection central to pathogenesis e.g. post streptococcal GN, MPGN, Focal sclerosing glomerulo nephritis.
- (b) Chronic pyelonephritis
- (c) Calculus
- (d) Hypertension
- (e) Diabetes mellitus.

Recovery is poor as the disease is progressive irrespective of the cause and the course is unpredictable.

Attributability/Aggravation can be awarded taking into account the cause and also service profile which would have adversely affected the course of disease.

#### 71. Rapidly Progressive Renal Failure

A separate entity which invariably progresses to chronic renal failure within a period of one to two years if course is not halted by therapy.

The causes are :

- (a) Acute and sub acute infections e.g. post streptococcal glomerulo nephritis
- (b) Multi system disease eg SLE, Vasculitis, PAN, HS purpura, malignant hypertension
- (c) Idiopathic primary glomerular disease e.g Idiopathic crescentic GN, Mebrano proliferative GN, Berger's Disease
- (d) Acute tubulo-interstitial disease due to infection and multi system disease.

Diseases due to infection acquired during service are acceptable as attributable. Aggravation due to service can be examined, in case due to multi system disease and

vasculitis taking into account the service factor modifying the course of disease.

72. **Asymptomatic Urinary Abnormalities**

It is characterized by mild degree of hematuria, pyurea casts and protenuria below nephrotic range. The causes are due to glomerulonephritis and tubulo interstitial disease.

The combination of nephronal hematuria and protenuria suggests worse prognosis than one alone.

Course is usually unpredictable and may lead to chronic renal failure.

This category of cases are usually detected during routine medical check up.

In the absence of azotaemia - Assessment - 20-30% may be appropriate.

73. **Nephrotic Syndrome**

The syndrome is generally held to be present when a patient demonstrates massive protunuria, reduced serum albumin, edema and hyperlipidemia.

The causes of nephrotic syndrome are :

- (a) Primary glomerular diseases
  - Minimal change glomerular disease
  - Membranous glomerulopathy
  - Focal Segmental glomerular sclerosis
  - Mesangio proliferative glomerular nephritis
  - Membrano proliferative glomerular nephritis
- (b) Infection - post streptococcal GN, leprosy, hepatitis B, malaria
- (c) Multi system Disease
  - SLE
  - Vasculitis
  - Diabetic glomerular sclerosis

If the syndrome is due to infection during service, attributability can be conceded.

Primary glomerulonephritis which may arise out of immune complex disease in the absence of infection and septic foci as a precursor to immune phenomenon, aggravation due to service can be examined. Similarly aggravation can be thought of in kidney disorder due to multi system disease taking into account his service profile.

- (a) Minimal lesion GN recover completely
- (b) In membranous glomerulo nephritis, 50% develop chronic renal failure in 25 years.
- (c) 50% of Focal segmental glomerulo nephritis develop chronic renal failure.
- (d) 50% of membrane proliferative glomerulo nephritis develop chronic renal failure in few years.
- (e) Course is variable in mesangio proliferative glomerulo nephritis.

#### 74. **Congenital Diseases of Kidney**

Certain congenital diseases such as polycystic disease of kidney, horse-shoe kidney, duplication of collecting system escape detection at the time of enrolment and many manifest later in service as asymptomatic urinary abnormality, hypertension and frequent urinary tract infection. These cases are generally rejectable. However, aggravation due to service can be examined taking into account the stress and strain and adversity of service.

#### 75. **Urolithiasis**

Urinary stones usually arise because of break down of delicate balance between excretion of low soluble material and attempt to conserve water by kidney. The balance is upset by failure of adaptation to combination of factors such as diets, climate, activity and also infection.

The increased frequency of urolithiasis in service population discloses the fact that people from Armed Forces constitute special risk group by virtue of service in difficult terrain, climate, compulsive dietary practice and excessive physical activity. The role of infection as a cause to urolithiasis is debated as it may be a complication that may entail following treatment of urolithiasis e.g. instrumentation. However, certain bacterial infection can precipitate urolithiasis.

Aggravation is examined taking into account his service profile.

76. **Rhinitis**

Rhinitis is commonly associated with infection, allergy and certain psychosomatic factors. Alteration in temperature, humidity of inspired air and anxiety can precipitate vasomotor rhinitis. Allergic and vasomotor rhinitis should be adjudicated as aggravated, whereas that due to infection may be considered as attributable.

Atrophic rhinitis is a disease of uncertain origin. It has been ascribed to an unsuspected chronic infection or to severe nasal infection in patients having inadequate diet or vitamin deficiency. It can be a complication to surgery of the nose. Acceptance on the basis of aggravation may be appropriate as service in cold climate/HAA may adversely affect the course of disease.

77. **Sinusitis**

Paranasal Sinuses can either be affected singly or in a group. The common pre-disposing factors are nasopharyngeal infections, tonsillitis, DNS, bathing in unhygienic pools, poor general environment (bunkers, ill ventilated house, over crowding) exposure to cold. Viruses are offending agents with bacteria as secondary invaders. Chronic sinusitis follows acute sinusitis in which infection has failed to resolve due to inadequate treatment.

78. **Spondarthritides**

This is a group of diseases in which an inflammatory arthritis is characterized by negative test for Rheumatoid factor, sacroilitis, spondylitis, asymmetric oligoarthritis, anterior uveitis, familial association and high prevalence of HLA B 27.

The spondarthritides encompasses a spectrum of diseases such as ankylosing spondylitis, Reiter's disease, juvenile chronic arthritis and enteropathic arthritis following ulcerative and crohn's disease.

The current concept of aetiology of these disorders are that they may arise as an abnormal response to infection in genetically predisposed person carrying B 27 antigen.

Ankylosing spondylitis is a chronic inflammatory arthritis involving spine and sacroiliac joint with progressive stiffening and fusion of axial skeleton in cold climate, difficult terrain and hazardous occupation like drivers (MT, AT, tank), can adversely affect the course of disease. Bony ankylosis of vertebral joints is the predominant lesion and may be accompanied by restricted chest movement, iritis, myelopathy and cauda equina syndrome. Once the disease is acquired, the disability is irreversible and permanent. Aggravation due to service is appropriate in all these cases.

79. **Squint**

Squint is a manifest deviation of the visual line of the eye due to mal-development of the inherent instinct to blend the images of the two eyes. Untreated in childhood the defect continues in adult life. External factors cannot usually adversely affect the conditions either in its onset or course. Very rarely squint may be associated with specific fevers or violent mental disturbances which provide the exciting cause.

Squint can be considered as attributable to service if it is due to injury, infection during military service.

80. **Gonadal Dysfunction (Hypogonadism)**

Hypogonadism may result from infections (tuberculosis, mumps, leprosy), varicocele, diabetes, hypoxia (HAA), service related psychogenic factors. It is also reported in professionals engaged in cardiac cath lab, nuclear medicine, x-ray departments and endocrine lab (RIA). Those working in nuclear powered submarines are not immune to this disorder.

Attributability will be appropriate when there is evidence of service related trauma and infection acquired during service. In other cases, aggravation can be examined.

81. **Tuberculosis**

1. **Pulmonary Tuberculosis:** Where the disease existed before enrolment, either :

(a) In a latent state, the focus of infection having been localised or

(b) In active state, the infection having escaped notice, the possibility of aggravation in service cannot be denied as, in either case, the disease would very rapidly manifest with overt picture and other abnormalities on relevant investigations following strenuous activities of service life.

2. **Short service cases will, accordingly be examined in the following manner :**

(a) Generally speaking, entitlement in any case in which parenchymatous changes of a tubercular nature are found in the lungs within six months of enrolment, would be limited to one of aggravation, as it would be reasonable to conclude in such cases that the disease had its inception prior to service.

(b) Cases of pulmonary tuberculosis, pleurisy with effusion without evidence of old tubercular disease elsewhere in the body provided this developed in a man who had undergone training or who had experienced severe and adverse climatic factors, attributability would be conceded.

(c) Any case of pulmonary tuberculosis developing after six months' service : In those cases where the history, clinical and radiological findings point to a recently acquired infection attributability would be conceded.

(d) Where the case is a reactivation of an old focus, the case will be dealt with under the following formula:

(i) In a case of pulmonary tuberculosis in which the disease was latent at the commencement of war service and in ordinary circumstances of civil life would reasonably be expected to have remained so, but was reactivated and made manifest by service factors (see para 1 above), acceptance as attributable would be appropriate.

(ii) If the pulmonary tuberculosis was latent at the commencement of field/operational service but inevitably has become manifest in course of time, the effect of service factors would be limited to an acceleration of natural progress, and, acceptance, if justified, would be on the basis of aggravation.

(iii) Tuberculosis other than pulmonary. The same consideration, as in the case of pulmonary tuberculosis, apply and with equal force.

3. **Tuberculosis manifesting after discharge from the service:** When tuberculosis develops after discharge from the service the time that has elapsed between the member's discharge and the first symptoms pointing to the onset of the disease is of special importance in estimating the probable relation between the disease and the member's service.

If tuberculosis develops within six months of discharge from the service it may normally be taken that the onset or reactivation of the disease was during service. Where it develops between 6 and 12 months after discharge, there is reasonable probability that the onset was during service. When, the development does not occur until more than 12 months after discharge, the probability is, in the absence of evidence to the contrary, that the onset was after discharge.

The following terms are used to describe stages in treatment:

(a) **Active:** All cases discharging tubercle bacilli within the preceding 3 months and individuals on antitubercular therapy will be considered as active.

(b) **Quiescent:** Cases in which :

(i) The general condition and exercise tolerance are good, having regard to extent of the lesion,

(ii) There is no evidence of toxæmia,

(iii) No tubercle bacilli have been found on three consecutive monthly examinations by stained film and

(iv) Changes revealed by other clinical investigations and by serial skiagrams point to regression of the tuberculosis lesion.

(c) **Arrested:** Cases in which the disease has been quiescent for a continuous period of at least two years.

(d) **Cured/Recovered:** Cases in which the state of radiological quiescence has continued uninterrupted for a period of five years and there has been no deterioration of his general health, effort tolerance and pulmonary function during preceding two years.

4. Assessment of extent of disablement should be done on the basis of subjective and objective parameters like clinical examination, and evaluation of functional capacity with

- a) Range of chest expansion
- b) Exercise tolerance like 12 minutes walking test
- c) Presence of any evidence to suggest pulmonary hypertension, right ventricular hypertrophy and/or evidence of cor pulmonale.
- d) Spirometry when available should be carried out to estimate functional capacity. Vital capacity above 70% of normal can be taken as normal lung function amounting to disability of less than 20%.

82 **Uveitis**

Uveitis is essentially inflammation of uveal tract which can be anatomically divided into :

- (a) Anterior uveitis affecting Iris and anterior part of Ciliary body.
- (b) Intermediate uveitis affecting Ciliary body and periphery of retina.
- (c) Posterior uveitis affecting predominantly choroids called retino-choroiditis.

The underlying causes are :

- (a) **Infection:** TB, leprosy, herpes, candida, toxins from septic tooth or septic focus in the body, toxoplasma
- (b) **Trauma:**
  - Boxing
  - Organized games
  - Penetrating ocular injury
  - Ocular surgery leading to sympathetic uveitis
- (c) **Systemic disease:** Sequelae to ankylosing spondylitis, diabetes, psoriasis
- (d) **Idiopathic:** Idiopathic uveitis can be triggered off by infection elsewhere in the body such as Klebsiella and Yersinia. Since elaborate investigation with invasive techniques are not without danger, it is appropriate to award attributability to idiopathic uveitis in addition to those arising out of infection and trauma connected with service. Aggravation can be examined in other causes taking into account worsening of the disability during the service.

83. **Valvular Heart Disease**

The principal causes of valvular heart disease are Rheumatic carditis, IHD, infective endocarditis and less commonly to certain myocardiopathy. It takes nearly 15-20 years for valvular disease to develop from the onset of rheumatic fever. Attributability or

aggravation can be conceded by judging the merit of each case and also considering the primary disease.

Mitral valve prolapse (floppy mitral valve) is commonly detected in Armed Forces. It is primarily a congenital abnormality and also may be a complication to the diseases enumerated above. Aggravation can be examined if the individual continued serving with the disability for a consider able period before it could be detected.

#### 84. Vertigo

It is due to disorder of vestibular system. The causes of vertigo are as under :

- (i) Central: Trauma to 8th nerve at the base of brain  
Tumours at cerebellopontine  
angle(acoustic neuroma)  
Disseminated sclerosis  
Posterior inferior cerebellar artery  
thrombosis.
- (ii) Peripheral: Meniere's disease  
Vestibular neuronitis  
Vertebrobasillar insufficiency in  
cervical spondylosis  
Labrynthitis  
Diabetes mellitus, hypertension  
Drugs (salicylates, quinine,  
dihydrostreptomycin, kanamycin,)  
Otitis media

Vertigo arising out of infection during therapy and trauma connected with service should be treated as attributable. Aggravation can be conceded if stress and strain of service had played a role in onset of ID e.g. cervical spondylosis, hypertension.

APPENDIX TO CHAPTER VIINCUBATION PERIODS IN RESPECT OF CERTAIN INFECTIOUS DISEASES

Diseases	Usual incubation Period	Minimum & maximum incubation period for deciding Attributability
Amoebic Dysentery	21 days	14 days to 03 months
Ankylostomiasis	4-6 weeks	
Anthrax	02-05 days	
Bacillary Dysentery	1-5 days	Upto 7 days
Cerebro-spinal fever	03-04 days	02 - 10 days
Chicken pox	14-21 days	07-21 days
Cholera	01 to 2 days	hours-5 days
Common Cold	12 to 48 hours	
Dengue	5-6 days	03-10 days
Diphtheria	2-5 days	01-07 days
Epidemic Encephalitis	Uncertain	
German Measles	18 days	14-21 days
Gonorrhoea	2-6 days	Upto 21 days
HIV	4 weeks to 6 months	01 year
Influenza	1-4 days	
Infantile Paralysis (AC ANT POLIO)	7-14 days	3-35 days
Kala Azar	02 months to 04 months	02 weeks to 02 years
Leprosy	2-5 years	6months-several years
Malaria	8-14 days	08 days to months
Malaria Quartan	18 days to 06 weeks	
Measles	10 days	07-14 days
Mumps	18 days	12-21 days
Oriental Sore	14 days to 6 months	Upto 1 year
Plague	1-8 days	Upto 15 days
Pneumonia	1-2 days	Upto 7 days
Rabies	02-08 weeks	Variable. May be 4 Days to many years
Relapsing Fever	2-14 days	
Rheumatic Fever	Uncertain	
Sandfly Fever	2-7 days	
Scarlet Fever	1-8 days	
Small Pox	8-17 days	
Syphilis	3-4 weeks	10-90 days
Tetanus	2-14 days	upto 56 days
Trench Fever	5-12 days	

Typhoid and Para typhoid Fever	10-14 days	03 days to 03 weeks
Tuberculosis	Uncertain	
Undulant Fever	6-21 days	
Viral Hepatitis-A	04 weeks	15days-45 days
Viral Hepatitis-B	12 weeks	45 days-180 days
Whooping Cough	07-10 days	
Yellow Fever	2-6 days	10-13 days, hospital acquired

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Occasionally cases do occur in shorter and longer incubation periods.

**CHAPTER VII****ASSESSMENT****Definition**

1. The evaluation of a disablement for pension purposes is called assessment.
2. Medical Officers are called upon to evaluate a disablement at the time of Invaliding Medical Board, Release Medical Board for those released in low med cat, or on subsequent occasions.

**Basis of assessment**

3. The purpose of the disablement evaluation is to ensure compensation on equal terms for all members of the Armed Forces of similar status suffering from a like disablement which may be due to injury or disease. It is estimated by reference to the physical or mental capacity for the exercise of the necessary functions of a normally occupied life, which would be expected in a healthy person of the same age and sex. It should represent the extent to which the disablement has reduced that capacity. It is determined solely on general functional capacity. Consideration should not be given to the member's capacity or incapacity to follow his own or any specific trade or occupation. Assessment should be based on measurement of plain facts. Sympathy, sentiments and personal feelings should not come in the way of assessment.

For arriving at a proper assessment of a disability, it is necessary to elicit a conclusive history, carry out a thorough clinical examination and all relevant laboratory and radiological investigations. It has to be determined whether the disability is temporary or permanent and also the degree of disablement as it pertains to working capacity. The physical examination and laboratory tests must be relied upon more than ever to substantiate or disprove symptoms and complaints. In many cases, the physical findings may be negative, but the patient may complain only of pain, e.g. a headache, pain in the chest etc. The evaluation of a disablement based on measurement of function is a sound procedure by means of which a reliable medical opinion may be reached by reason or logic rather than by intuition, conjecture or assumption.

### Definition of Function

4. The term "function" is one that is commonly used to denote the usefulness of a part of the body. In stating the extent of loss of function of a part, one has got to find out what the patient cannot do. For this, one should know what constitutes activity with perfection. When anatomical or physiological changes have taken place leading to the stiffness, atrophy or pain and the usefulness and the efficiency of the organ are impaired, the extent of the clinical disturbance is revealed through physical examinations.

However, the extent of deficiency of functional ability does not correspond to the extent of physical limitation. Limitation of motion by 50 per cent does not mean 50 percent loss of function. The clinical findings must be designated as factors contributing to the loss of function and not measuring it.

5. In analysing the problem of assessment a thorough examination together with a deterioration of the anatomical or physiological alterations from normal as compared to abnormal physical state of the same age and sex and the effect of such alterations are taken into consideration. In the case of injuries or diseases, the important points to note are :-

- (a) Quickness of action
- (b) Coordination of movements
- (c) Strength
- (d) Security
- (e) Endurance

Expressed negatively, loss of function may be estimated in terms of (1) delayed action; (2) awkwardness; (3) weakness; (4) insecurity; (5) diminished endurance; (6) lowered swift factor and (7) the adverse influence of the conspicuous impairment.

6. The functional factors e.g. in the hand may be stated as (1) quickness and nimbleness of digital action; (2) coordination of fingers and thumb in opposing finger tips to thumb and thumb to fingers and palm; (3) Strength of gripping and fist making ability, striking, slapping, holding and pushing power; (4) security or reliability of delicate finger sense; and (5) endurance of holding, gripping or pinching.

In respect of leg, foot and toes, the factors would be : (a) quickness, nimbleness, springiness of step and gait (b)

coordination of feet and toes in smoothness and steadiness of steps and gait (c) strength or weight-bearing and power of action in standing, walking, running or jumping and (d) security or reliability or toe, heel or foot action.

In an examination of the back, the gait, deformity, dressing or undressing, sitting down or getting up attitude will have to be taken into consideration, as also muscle spasm. Stiffness of the spine causes movement of the hips prior to that of the spine.

In the hip, the stance or gait or sitting down as in dressing, muscle spasm or rigidity, swelling or atrophy, degree of movement at the hip, have to be taken into consideration.

In the knee, the gait, swelling, atrophy, movements painful or free, limitation of such movements have to be considered.

In the foot, the gait, deformity swelling, movements active and passive, muscle power, weight-bearing on toes and heels, and ankylosis if any, have to be taken into consideration.

In the shoulder, the general appearance, deformity, swelling, atrophy, extent of motion painful or free, will have to be considered, as also any neurological signs. The same applies to elbow, wrist and the hands.

In head injury cases, the peculiar characteristic manner of special coordination of movements, gait, general appearance and behaviour with an examination of the scalp, the eyes, the facial expression along with an examination of the reflexes will have to be considered amongst other symptoms attributed to trauma, such as headache, dizziness insomnia, nausea, vomiting etc.

In all the above, there must be distinct recognition between organic disturbances and functional neurosis. Once this distinction is made in the clinical entity of the disability, the examiner is in a position to evaluate the disability on the merits of pathological significance.

### **Principles of Assessment**

7. The assessment of a disability for pension purposes is the estimate of the degree of disablement it causes, which can properly be ascribed to service. The disablement properly referable to service is assessed slightly differently at the time of discharge from the forces.

8. There are various stages of a disability. These are : treatment period, healing period, temporary disablement or permanent disablement - partial or total. Thus, a disability causes disablement which may be temporary or permanent.

9. In the light of the above, differentiation should be made between "NIL DISABLEMENT" and "NO DISABILITY".

"Nil Disablement" means that although a definite disability is, or has been in evidence, any disablement resulting therefrom has either ceased or has become so small as not to be appreciable.

"No Disability" means a case where an individual is said to be suffering from a disability but medical science can find no evidence of the existence of that disability either present or past.

10. Disabilities which necessitate invalidation from service are capable of improvement in due course or are of permanent nature. "Permanent" means persisting for all times, i.e. the disablement is supposed to be in a permanent state when the condition of the disability is unchangeable.

### **Computation of Assessment**

11. In the forces, the evaluation of disablement or assessment, is made to ensure compensation on equal terms for all members suffering from like disablement. When the assessment is below twenty per cent, it may be assessed as 1-5 per cent; 6-10 per cent; 11-14 per cent and 15-19 per cent. Subsequent assessments are made in multiples of 10, rising from 20 per cent; to maximum of 100 per cent. If the disability is assessed at 100 per cent, a recommendation will invariably be made as to the necessity or otherwise for a constant attendant, bearing in mind that the necessity arises solely from the condition of disability. If an attendant is recommended, the period for which such attendant is necessary, should be mentioned.

A member of the Armed Forces who is in receipt of a disability pension in respect of disablement, the degree of which is not less than 100 per cent, may be awarded constant attendant allowance if it is certified by the Medical Board why a constant attendant on him is necessary on account of the disablement.

**At the Time of Discharge From the Forces**

12. Normally, the whole of the disablement when caused by the disability will be accepted. This rule will apply irrespective of whether the disability is attributable to service, or is merely aggravated thereby. In the latter event, part of the disablement on discharge may have been present before service and/or may have been brought about by the natural progress of the disability during the service period. But as it is impossible, for so long as the stress and strain of service continues, to apportion quantitatively the effect of service and non-service factors, the entire disablement at the time of discharge will be taken into account. For example :-

(i) Where a person who had a partially disabled hand sustains an injury to the same hand which renders it less useful than before or a person with an impaired foot injuries the other as a result of service thus increasing his defect in locomotion; or

(ii) Where a person gives history of cough and cold prior to enrolment and is invalided out of service for chronic bronchitis held to be aggravated by service, pension will be admissible for the total disablement. Special consideration should be given to cases in which the disablement has been or may have been worsened by the improper or excessive use of alcohol, tobacco or drugs, or by sexually transmitted diseases. In such cases, the effects of such activity will be excluded in assessing disablement ascribable to service.

13. It is realised that it is not always possible to decide what portion of the disability is due to natural progress and what portion is due to persisting effects of service aggravation or due to extraneous factors. The Medical Board will have to decide the issue based on all facts placed before them, their knowledge of the natural history of the particular disease, the circumstances after discharge, as the clinical condition etc.

13 A. In attributable cases, if death occurs after invaliding, the family is entitled to pension if the fatal disability is related to the invaliding disability, irrespective of the degree of disablement.

14. **Assessment with Regard to Percentage of Disability**

The assessment with regard to percentage of disability as recommended by the invaliding Medical Board, Release Medical Board and as adjudicated by MA(Pens) in respect of PBOR and MOD in case of commissioned officers would be treated as final unless the individual himself requests for review except in case of disabilities which are not of permanent nature. In the event of substantial difference of opinion between the initial award given by the Medical Boards and MA (Pens), the case will be referred to a Re-assessment Medical Board. The opinion of the Reassessment Medical Board, which will be constituted by DGAFMS as & when required will be final.

15. **Reassessment of Disability** - There will be no periodical reviews by the Resurvey Medical Boards for re-assessment of disabilities. In case of disabilities adjudicated as being of a permanent nature, the decision once arrived at will be final unless the individual himself requests for a review. In cases of disabilities which are not of a permanent nature, there will be only one review of the percentage by a Medical Board to be carried out later within a specified time frame. The percentage of disability assessed/recommended by the Board will be final unless the individual himself asks for a review. The review will be carried out by Re-assessment Medical Board constituted by DGAFMS.

16. **Assessment Less Than 20 per cent**

In cases where an individual's disability at the time of invaliding is permanently below pensionable degree - i.e. less than twenty per cent, he may claim to be brought before a Medical Board within a period of seven years from the date of his discharge. If the disability is still assessed at permanently below the pensionable degree, no claim for reassessment will be considered.

## 17. Paired Organs

(1) Where a disability due to service exists in one or both of the paired organs such as "eyes, ears, limbs" the condition and degree of disablement if any, should be noted separately for each organ, but the Board's recommendation of an assessment of disablement for pension purposes, will be based on an estimate of the functional capacity at the time of invaliding, of the paired organs working together.

(2) It may happen that the functional capacity of the combined paired organs is partly due to an accepted disability or disabilities and partly due to a disability or disabilities unconnected with service. In these cases, the following principles should be observed for the assessment of the disablement :-

(a) The first assessment for pension purposes is made on the total functional incapacity of the paired organs working together at the time of invalidation and without any deduction on account of "unaccepted components".

(b) Subject to the exceptions specified below any subsequent increase in the non service disablement existing after discharge, whether due to injury or disease, will be excluded from the assessment.

(c) Cases arise in which at the time of discharge, there is damage by service to only one of the paired organs and the other is either normal, or impaired in a minor degree. Where the disablement acceptable under clause (b) above and the disablement of the other limb or organ are together assessable at any subsequent date at 100 per cent, the assessment for pension purposes will be increased by one half of the difference between the current assessment and 100 per cent. For instance, a pensioner receiving an award at 40 per cent for the loss of one eye, who later loses the sight of his other eye through a non service cause, will have his award increased to 70 per cent; and a pensioner with an award at 80 per cent for a gun shot wound of an arm, who later develops severe arthritis of his other arm, thereby being 100 per cent disabled, will qualify for a revised award at 90 per cent. Where the combined disablement of the pair of organs is less than 100 per cent, but is more than twice the disablement acceptable under clause (b) above, the assessment will be increased to one half

of the combined. If for example, a pensioner with an award at 30 per cent for the loss of vision of one eye partially loses the sight of the other eye through a nonservice cause and the defective vision of both eyes together is assessable at 80 per cent, his award will be increased to 40 per cent.

(d) The provisions of the preceding sub-clause are applicable even where the second of a pair of organs has been disabled by some generalised disability e.g. (rheumatoid arthritis) which would also have disabled the first of the pair, if it has not previously been lost or damaged as the result of service.

(3) When a pensioner who has an award for the loss or disablement of one of the pair of organs (or limbs) has suffered loss or displacement of the other the Medical Board should give a full report on the condition of the second organ and the degree of disablement from this cause and also an opinion on the overall disablement from the two organs working together. If the pensioner has a generalised disability (e.g. disseminated sclerosis, rheumatoid arthritis, paralysis agitans) the Medical Board should assess its effect on the second organ or limb.

(4) Where the disability due to service has no connection with the pre-existing disability, as for example, a person who had lost a finger prior to enlistment, loses a great toe by service, compensation will be restricted to the loss of the great toe only.

(5) Specific injuries and individuals with artificial limbs/other surgical appliances - The assessment on account of disablement of individuals who have been provided with artificial limbs or other surgical appliances including surgical boots, leg instruments (walking calipers), spectacles, artificial eyes, aids to hearing, crutches, invalid chairs, tricycles, matatarsal bars, surgical belts etc will be made on the following basis :

(i) In cases of loss or amputation of limb or limbs, or a disability involving the loss of use of limb or limbs, the assessment will be made as given in this chapter without taking into account the fact of any artificial limb etc which may have been provided.

(ii) In other cases (excepting those of deafness) in which a surgical appliance has been provided in order to ameliorate the effect of an accepted disability, the assessment will be made on the basis of the residual functional incapacity after taking the surgical appliance into use, e.g. in defective vision, the assessment is based on the visual defect as measured after correction with glass or lenses. Again in a hernia which can be controlled by a truss, presents less disablement than one which could not be so controlled and is to be assessed accordingly. In case of deafness, in which aid to hearing is provided, the assessment will be made on the basis of functional incapacity without taking into account for the present, the use of the aid to hearing.

17 A

**Composite Assessment:**

(a) Where there are two or more disabilities due to service, compensation will be based on the composite assessment of the degree of disablement. Generally speaking, when separate disabilities have entirely different functional effects, the composite assessment will be the arithmetical sum of their separate assessments. But where the functional effects of the disabilities overlap, the composite assessment will be reduced in proportion to the degree of overlapping. There is a tendency for some Medical Boards to reduce the composite assessment in the former group of cases. This is not correct.

(b) The assessments of amputation and other specific injuries as well as of other conditions, have been given in the succeeding paragraphs. In some particular conditions such as Diabetes, Nephritis, Hypertension and Mental Diseases, there may always be some differences of opinion among the Medical Officers. Therefore, it is suggested that the Medical Officer-in-charge case, as well as the Specialist while describing the disability, should bring out full details so that the functional incapacity caused may be reasonably assessed by one who reads through the record. It must be realised that the gait is an important factor in some diseases and injuries affecting the lower limbs. Gait should be described in such cases.

(c) The functional effects of two or more disabilities sometimes produce an overall disablement which is greater than that represented by the arithmetical sum of the separate assessments. The commonest examples will be found in cases of paired organs. There is also another type of case involving complementary organs, for which it is not possible to lay down hard and fast rules. A man with a material loss of vision coupled with a fair degree of deafness may be more seriously disabled than is suggested by the arithmetical sum of the separate assessments. The degree of blindness would be more incapacitating in a man so deaf than in a man with normal hearing, and conversely, the deafness would be more serious in a man partially blind than in a man with normal vision. Such cases require special consideration on their individual merits.

(d) **Assessment of amputation and other specified injuries** : Specific injuries involving the loss of limbs through defined sites and loss of certain other organs offer a basis on which uniform compensation can be given. These are given in Appendix I to this Chapter. It would be seen that the schedule relies almost entirely on injuries relating to an anatomical or structural loss, whether it be of a special sense organ or one or more limbs. Assessment for specified Minor Injuries is given in Appendix II to this Chapter.

A member who loses his left or right arm should be compensated according to whether he is left or right-handed. In cases involving amputation of hand/arm, the Medical Officer examining the member should indicate whether the individual is right or left-handed.

(e) **Injuries other than those of Amputation to Limbs:**

The scale of assessment for amputation will serve as a guide to the assessment of injuries to a limb. The loss of function of a limb or part of limb will be regarded as equivalent to a corresponding amputation provided that the condition cannot be remedied by treatment. For example, if a hand is useless and no remedial treatment is indicated, the disability should be assessed at the same rate as for amputation of hand. If, however the usefulness of the hand is due to a finger being bent into the palm—a condition which can be relieved by amputation of the finger, the assessment should not be higher than for the loss of a finger. It must be borne in mind, however, that the present disablement as compared with probable ultimate disablement, may be greater for a time because of a lack of adaptation and muscular weakness due not only to the injury itself, but also due to a period of disuse following the injury.

17 B **Ankylosis:** The assessment for complete fixation of a joint is determined appropriately with regard to its optimum position for greatest usefulness.

In most cases the optimum positions for the various joints are :

**Shoulder:** Arm abducted to about 50, the elbow slightly in front of the body, so that when the elbow is at right angle and the forearm supinated, the palm of the hand is towards the face. When the humerus is fixed to the scapula in this position, the arm be lifted to a considerable height by scapular action.

**Elbow:** The angle between humerus and forearm should be rather more than a right angle, about 110 degree. The forearm should be supinated so that the palm is slightly upwards.

**Wrist:** Between 15 degree and 45 degree of dorsiflexion with slight ulnar abduction the inferior radio-ulnar joint being unaffected.

**Hip:** Thigh flexed 10 degree with slight abduction and slight external rotation.

**Ankle:** Foot at right angle to leg.

When a joint is ankylosed in an unfavourable position, an increase in the scale of assessment corresponding to the additional degree of disablement entailed, would be justified. On the other hand, when a joint is not truly ankylosed but only limited in its movements, the assessment would normally be reduced.

**ASSESSMENT FOR VARIOUS ANKYLOSES**  
**IN OPITIMUM POSITION**

	Right	Left
Upper Extremity		
Shoulder	40%	30%
Elbow	40%	30%
Wrist	30%	20%
Lower extremity (Rt or Lt)		
Hip		60%
Knee		40%
Ankle		30%

This is the term used to indicate the position of greatest usefulness.

**Flail Joints**

18. Flail joints are more disabling than the ankylosed joints. Where there is abnormal mobility, the assessment of both upper and lower limb will be higher than that of ankylosis. Any improvement due to skilled orthopaedic treatment will call for corresponding reduction in assessment.

**Defective Vision**

19. Painful blind eye/loss of one eye	50%
Loss of vision one eye without complications or disfigurement, the other eye being normal	30%
Loss of lid and disfigurement	30%
Eventeration (loss of eye lid and surrounding tissue eye with vision unaffected both sides)	60%
Hemi anopia (Bilateral)	60%
Field defect one eye (cannot see particular quadrant, scotoma and wedge in field of vision)	20%
Field defect both eyes	40%

Ser No	When best obtain- able acuity is in one eye	When best obtain- able acuity is in the other	Asses- Sr No. sment Percent- age	When one eye removed best obtain- able acuity in remain- ing eye with Or without Glasses, is	Asse- ssme- nt perc- entage	
(1)	(2)	(3)	(4)	(5)	(6)	(7)
1	6/6 or 6/9 or 6/12	6/24	15-19	1 2 3	6/6} 6/9} 6/12}	40
2	6/6 or 6/9 or 6/12	6/36 6/60 3/60	20			

(1)	(2)	(3)	(4)	(5)	(6)	(7)
3	6/9 or 6/12	Nil	30	4	6/18	50
4	6/18	6/18	15-19	5	6/24	70
5	6/18	6/24	30	6	6/36	80
6	6/18	6/36)				
7	6/18	6/60)	40	7	6/60	90
8	6/18	3/60)		8	3/60	100 with CAA
9	6/18	Nil	50	9	Nil	100 with CAA
10	6/24	6/24	30			
11	6/24	6/36	40			
12	6/24	6/60)	50			
13	6/24	3/60)				
14	6/24	Nil	70			
15	6/36	6/36	50			
16	6/36	6/60)	60			
17	6/36	3/60)				
18.	6/36	Nil	80			
19	6/60	6/60)	80			
20	6/60	3/60				
21	6/60	Nil	90			
22	3/60	3/60	90			
23	3/60	Nil	100 with CAA			
24	Nil	Nil	100 with CAA			

(1) These assessments are based on the visual defects measured after correction with glasses, by the Snellen's test only.

(2) A person is held to be "blind" if he is so "blind" as to be unable to perform any work for which eyesight is essential.

(3) While assessing defective vision, field of vision must also be taken into consideration. If a man has a vision of 6/6 but his fields have contracted to 10 degrees, he is certifiably blind, and therefore, 100 per cent disabled.

(4) Individuals having vision less than 3/60 both eyes are treated as good as becoming completely blind and hence assessment of 100% is appropriate.

**NOTES :**

R.V.        6/6 means normal vision of the right eye, i.e. the right eye can read at six meters what it ought to be able to read at that distance.

L.V.        6/60 indicates a serious impairment in the vision of the left eye in that it can only read at six meters what it ought to be able to read at 60 meters.

L.V.        3/60 means that the visual acuity is only half that indicated by 6/60.

L.V.        NIL or 0/60 means that there is no useful vision in the left eye.

**Defective Hearing**

20. Where some useful hearing is present, the assessment of disablement should be related to the best use that can be made of both ears used together.

Unilateral total deafness gives rise to loss of direction of sound and also overall loss of discrimination of speech. Therefore, even if the other ear is normal, cases of unilateral total deafness should be assessed at twenty per cent (20%).

Broadly speaking, the disability due to deafness is directly related to the capacity for hearing the "conversational voice" or "shout".

Assessment should be based on the grade attained using both ears together, the percentage assessment appropriate to the grade thus attained is given below :

Grade	Degree of hearing attained	Assessment for both ears used together
1.	Total deafness	100%
2.	Shout not beyond 3 feet	80%
3.	Conversational voice not over 1 Foot	60%
4.	Conversational voice not over 3 Feet	40%
5.	Conversational voice not over 6 Feet	20%
6.	Conversational voice not over 9 Feet	-
	(a) Unilateral total deafness	20%
	(b) Otherwise	less than 20%

A case in which the right ear attained grade 4, the left ear grade 2 should be assessed as follows :

Disability for grade 4	40%
Disability for grade 2	80%
	-----
Total mean disability	40 + 80 = 60%
	-----
	2

The assessment given above take into account minor ailments such as headache, vertigo, tinnitus, sleeplessness etc. which generally accompany deafness.

**Assessment for Perforation** : This is made on the basis of presence or absence of discharge and the type of perforation as follows :

1. Central perforation one or both ears in latent stage	20%
2. Central perforation one ear, active stage	20%
3. Central perforation both ears, active stage	30%
4. Marginal or attic perforation, one ear	30%
5. Marginal or attic perforation, both ears	40%

These assessments take into account minor degrees of associated deafness. Greater degrees of deafness should be assessed as under the note on defective hearing. When, however, it is felt that there is overlapping of disabilities, the composite assessment will have to be appropriately less.

**Assessment for other ENT Conditions**

(a) **Laryngo-tracheal injuries:**

Loss of functional speech	60-70%
Gross hoarseness of voice leading to poor communication	20-30%
Tracheal stenosis with breathing difficulty	30-40%

(b) **Injuries to Oral Cavity:**

Lingual nerve injury leading to hemianaesthesia of tongue	20%
Unilateral hypoglossal nerve injury leading to motor palsy	30%
Hemi-glossectomy	30%
Hemi-mandibulectomy	30-40%

(c) **Sinusitis:** is progressively assessed as per number of sinuses involved :-

One sinus-less than 20%
Bilat sinus-20%
Pan sinusitis-30%

(d) **Rhinitis:**

Rhinitis (uncomplicated)	- 20%
Rhinitis (complicated e.g. polyp)	- 20-30%
DNS	- 20%

### Diseases of Circulatory System

21. In determining the degree of disablement in cardio vascular disease, there are two principal considerations :

(a) An estimate of the member's actual physical capacity to do work without distress.

(b) An estimate of the capacity of the member to engage in work of different grades - although the member may have the strength to accomplish a given task, it may be that such work can be undertaken at the risk of further damage to the heart.

Assessment should be broad based and should take into account exercise tolerance, ECG before and after exercise, rhythm, morphological and functional criteria of the heart and treatment modality offered.

#### Assessment for Cardio-Vascular Conditions

(a) Effort syndrome (with or without systolic murmurs)

Basal assessment - statement of distress in absence of actual signs of distress on exercise	Nil
with fair exercise tolerance	1-19%
with moderate exercise tolerance	20-30%
with poor exercise tolerance	30% or above

No assessment should be allowed for systolic murmurs per se, but hearts which display them should be very carefully scrutinised.

(b) Valvular heart disease with effort tolerance

(i) Mitral stenosis :

Basal assessment - Early stenosis uncomplicated and with good exercise tolerance	30%
Early stenosis with fair exercise tolerance	40%
Developed stenosis with fair exercise tolerance	50%
Developed stenosis with poor exercise tolerance	60%

With enlarged or fibrillating auricles	70%
With venous engorgement, without dropsy	80%
With venous engorgement, with dropsy	100%

(c) **Aortic disease :**

Basal assessment - Slight regurgitation with good exercise tolerance 40%

Slight, with poor tolerance	60%
Developed with much enlargement of heart	80%
Developed with enlargement and accompanied by much pallor and angina or renal disease	100%

(d) **Combined mitral stenosis and aortic regurgitation:**

Basal assessment	60%
With evidence of cardiac failure	100%

(e) **Enlargement of heart:**

Basal assessment-slight, with good exercise tolerance	20%
Moderate, with good exercise tolerance	40%
Moderate, with poor exercise tolerance	50%
Great enlargement of heart with poor exercise tolerance	70%
With fibrillation or venous engorgement	Add 30%
Aortic Aneurysm	70%-100%
Angina Pectoris	50-100%

(f) **Rhythm and conduction defect:**

(i) Auricular fibrillation without heart failure 40%

(ii) Paroxysmal tachycardia :

Infrequent attacks	20%
Severe infrequent attacks	30-40%
Severe frequent attacks	50-60%
Sick sinus syndrome	30%
Partial heart block	20-30%
Complete heart block	30-50%
Heart block with heart being run with a Pacemaker	40%

(g) **Myocardial ischemia** and status of Lt ventricular function based on Lt ventricular ejection force.

LV ejection force	percentage of award
35%-50%	30%
less than 35%	50%
congestive heart failure	80-100%

(h) **Assessment based on treatment modality offered for IHD**

The assessment is independent of NYHA assessment and not to be combined with NYHA assessment.

(i) PTCA done	40-50%
(ii) CABG in triple vessel disease	50-100%

1. **Essential hypertension:**

(i) Uncomplicated hypertension	30%
(ii) Hypertension with involvement of target organs (heart, brain, eye and kidney)	30-100%
(iii) Simple aneurysm aorta	30%
(iv) Dissecting aneurysm aorta	70%-100%

Heart size enlarges due to hypertrophy and dilatation. The enlarging size of the heart often leads to diminished efficiency. The enlarged size of the heart is not directly proportional to decreasing exercise tolerance. Therefore, it is necessary to separately examine the heart size and exercise tolerance in each individual case, to arrive at a correct assessment of disablement within the guidelines mentioned in the table given above.

Assessment in peripheral vascular diseases affecting mainly small and medium sized vessels should be based on the symptoms and functional capacity of affected part of body. In the presence of symptoms and signs, a minimum of 20% is awarded and it can be increased further based on functional capacity of the part and limb.

**Diseases of the Digestive System**

22. (a) **Peptic Ulcer**

Peptic Ulcer has a span of activity for seven to eight years before becoming inactive with treatment or end up in complications like stenosis or outlet obstructions. Sometimes invalid's own account and estimate of his symptoms are reflected by minimal clinical findings. Endoscopic healing is no absolute criterion for cure of the disease. If medical therapy is stopped after endoscopic healing, chances of recurrence is 60-80% in one year.

The assessment of peptic Ulcer is as under :-

(i) Uncomplicated peptic ulcer	20%
(ii) Complicated peptic ulcer	30-50%
<u>Haemorrhage</u>	
(Quantified by clinical hematological parameters and need for blood transfusion)	
Perforation (healed)	20%
Gastric outlet obstruction	30-40%
(iii) Complication of peptic ulcer treated with surgery	
Surgery uncomplicated	20%
Surgery complicated	30-50%
(anastomotic ulcer, Intestinal obstruction, Incisional Hernia)	

(b) **Inflammatory Bowel Disease**

Assessment is based on frequency of motion, blood stool, constitutional symptoms such as fever, degree of damage to bowel.

IBD only with intestinal lesions	30-40%
IBD associated with extra intestinal manifestation	30% plus assessment for extra intestinal lesion

(c) **Hernia**

As surgical repair is the only reliable treatment and the results are completely satisfactory and the operation is one which does not endanger life in the vast majority of cases, no permanent disablement results with proper treatment.

The chief factor in functional disability is that of endurance. Entitlement in cases where an operation is not instituted, would depend upon whether a truss is worn or not. Weakness even after wearing a truss would be 20 per cent.

(d) **Assessment of miscellaneous conditions of gut**

Colonic polyp, colonic diverticula	20%
Fistula in Ano, Haemorrhoids	20%
Prolapse rectum	20-30%
Pancreatitis uncomplicated	20%
Pancreatitis complicated with diabetes	30-40%

(e) **Assessment liver diseases**

Acute hepatitis	20-30%
Chronic hepatitis	30-40%
Cirrhosis with complication	50-100%

**Assessment of Lung Diseases**

23. Assessment of lungs is broad based, should take into account clinical, radiological, anatomical and functional states of lung. Apart from these, the degree of disablement due to lung disease can be evaluated by spirometric data, clinical bedside tests (6 minutes walk single breath counting, capacity to blow candle and ECG) spirometry indicates the presence of obstructive and restrictive lung diseases.

These disease can be objectively evaluated by demonstration of proportionate reduction in vital capacity (VC) forced expiratory volume in one second (FEV) and peak expiratory flow rate.

**(a) Obstructive Disease**

<u>Percentage FEV/VC</u>	<u>Assessment</u>
80% of predicted value	normal
60-80%	30%
50-60%	40%
40-50%	50%
less than 40%	80-100%

**(b) Restricted Diseases**

<u>Percentage VC and PEFR</u>	<u>Assessment</u>
80% of Normal	Nil
60---80% "	30%
50---60% "	40%
40---50% "	50%
<40% "	80---100%

**(c) Lung Volume**

There is a concomittant loss to lung volume in any parenchymal disease of the lungs and its complications such as fibrosis and collapse of lungs and also in the lung surgery. The indirect parameters are mediastinal shift, spacing of ribs as evident clinically and radiologically.

<u>Loss of lung volume and parietae</u>	<u>Assessment</u>
One lung	50%
Lobe	30%
Single Zone fibrosis	20%
Lower and middle zone fibrosis	20%
Fibrosis in all zones	40%
<u>Pleural thickening</u>	
Each zone	20%
Lower and middle zones	30%
All zones	40%
Resection of two or more ribs	20%

### **Assessment Pulmonary Tuberculosis**

24. The degree of disablement on invalidment from a service hospital will be regarded as 100 per cent for one year in cases which are "capable of improvement" and as 100 per cent for two years in cases which are regarded as "incapable of improvement". Thereafter, the assessment will be made as follows :

(a) **Capable of improvement:** In this condition, assessment depends upon whether disability is quiescent, arrested or cured/recovered, as defined in para 81 of chapter VI. A quiescent case, will be assessed at 50-100 per cent for two years; an arrested case at 20-50 per cent for three years; and a cured/recovered case at less than 20% final.

(b) **Incapable of improvement:** If the reassessment Medical Board confirm the initial findings that the disability is incapable of improvement a life award for 100 per cent disablement will be granted. If, on the other hand, the Reassessment Medical Board finds that there has been an improvement they will classify the disability as capable of improvement, and the degree of disablement will be assessed as in (a) above.

Disablement for cases after surgical treatment will depend upon functional incapacity suffered due to the disease and the effects of surgical treatment. An individual with a quiescent or arrested lesion may be employed, but the assessment will not be reduced because the individual is capable of earning his livelihood.

### **Assessment Chronic Bronchitis**

#### Assessment

- |     |     |                                            |         |
|-----|-----|--------------------------------------------|---------|
| 25. | (a) | Without emphysema                          | 20-40%  |
|     | (b) | With emphysema                             | 40-60%  |
|     | (c) | If the circulatory system is also affected | 50-80%  |
|     | (d) | With signs of heart failure                | 80-100% |

**Assessment Asthma**

26. Uncomplicated Asthma 20-40%

**Assessment of Bronchiectasis**

27. It is a common sequelae to pneumonias more so in tubercular pneumonia.

Assessed at 20-30%

**Assessment of Mental Diseases**

28. There seems to be a tendency to underassess psychoneurosis particularly hysteria on the part of some medical boards. As long as there is no element of malingering, the disablement on account of hysterical deafness, blindness, paralysis etc, should be the same as for those conditions resulting from organic causes.

Since the brain functions as a whole, in such cases the assessment should cover all the mental conditions present, irrespective of whether or not all the conditions present are "accepted" disabilities. The Boards should also give separate assessment for each condition, as compensation would be discontinued when the total disablement falls below pensionable degree viz 20 per cent or only the "non-accepted" condition persists, whichever is earlier.

Assessment is based on the criteria of individual's capability to look after himself and family.

(a) Person able to look after himself and interact with his family and gainfully employed :

Assessment 20-30% for a period of 5 years.

(b) Person is only able to look after himself but unable to interact with family :

Assessment 50-60% for a period of 5 to 10 years.

(c) Individual is not able to look after his basic needs:

Assessment 80-100% permanent

### **Assessment of Leprosy**

29. In this condition assessment depends upon whether the disability is active, quiescent, arrested or recovered. A quiescent lesion is one which shows no activity. An arrested lesion is one which has been quiescent for two years and a recovered lesion is one which has remained quiescent for five years. An active case, lepromatous or nodular, a case in lepra reaction, a case with facial disfiguration is assessed at 100 per cent for one year; a quiescent case between 50-100 per cent for two years; and an arrested case between 20-50% for three years. In cases which are "incapable of improvement", if the Reassessment Medical Board confirm the initial finding that the disability is still incapable of improvement, a life award for 100 per cent will be granted. If, on the other hand, there has been an improvement, the degree of disablement will be as above. Deformities have to be assessed depending on functional disablement.

The disablement should not be reduced simply because of re-employment.

### **Assessment of Bone and Specific Injuries**

#### **Assessment in Fracture (limb bones)**

30. Fracture may be intra articular or extra articular. Damage is maximum in intra articular fracture and fracture with faulty alignment as it may cause restriction of movement and associated osteo-arthritic changes.

<u>Category</u>	<u>Assessment</u>
(a) Intra articular with osteoarthritic changes	30-40% for life
(b) Long bone fracture, union with alignment	20%
(c) Long bone fracture with neurovascular bundle involvement	40-50%
(d) Shortening of the limbs	20-30%

- (e) Functional loss equivalent to loss of limbs at different levels due to non-union, delayed union, malunion and chronic infection scale as laid down in the text
- (f) Use of joint prosthesis, intramedullary nail plating 30-40%
- (g) Osteomyelitis as complication to comminuted fracture or systemic infection-
- |                                                     |     |
|-----------------------------------------------------|-----|
| Weight bearing bone                                 | 30% |
| Non-weight bearing bone                             | 20% |
| Osteomyelitis associated with pathological fracture | 40% |

**Assessment of Spinal Deformity**

31. It is a common sequelae to fracture vertebrae, caries spine and ankylosing spondylitis.

- |                                                                                   |        |
|-----------------------------------------------------------------------------------|--------|
| (a) Flexion, extension, lateral flexion deformity                                 | 20-40% |
| (b) Stiff spine                                                                   | 50%    |
| (c) Stiff spine with restriction of chest expansion (e.g. ankylosing spondylitis) | 60-80% |

**32. Assessment of low backache**

- |                                                |         |
|------------------------------------------------|---------|
| (a) Low backache                               | 20%     |
| (b) Low backache with neurological involvement | 30%-40% |

Duration of award in low backache due to musculo facial strain should be for a maximum period of 5 years and in the other causes of low backache, award can be extended for further period depending on clinical and radiological finding.

**Assessment for IDK**

33. Assessment is based on functional capacity of joint. Incapacitation is severe in cruciate ligament injury and cartilage injury giving rise to osteoarthritis.

(a) Traumatic synovitis and collateral ligament injury :

assessment 20% for a period of 5 years

(b) Cruciate ligament injury and chondroid injury :

assessment 20-30% for life

Appendix I to Chapter VIISCALE OF ASSESSMENT FOR SPECIFIC INJURIES

Disablement	Percentage
<b>Upper Limbs :</b>	
Loss of both hands or of all fingers and thumbs	100
Amputation left arm through shoulder	90
Amputation right arm through shoulder	90
Amputation below shoulder stump not exceeding 6 inches (right)	90
Amputation below shoulder stump exceeding 6 inches From the tip of acromion (right)	80
Amputation below shoulder stump not exceeding 6 inches (left)	80
Amputation below shoulder from tip of acromion stump not exceeding 6 inches (left)	70
Amputation elbow or below elbow with stump not exceeding 5 inches (left)	80
Amputation below elbow or through elbow with stump not exceeding 5 inches (left)	70
Amputation below elbow stump exceeding 5 inches (right)	70
Amputation below elbow stump exceeding 5 inches (left)	50
Loss of thumb (right)	50
Loss of four fingers (right)	50
Loss of thumb (left)	40
Loss of four fingers (left)	40
Loss of three fingers of one hand	30
Loss of two fingers on either hand	20

Note : Loss of an upper limb stated as right or left - it is understood that right one is the dominant limb; if the left limb is dominant, it should be taken as same as the loss of right limb.

**Lower Limbs :**

Loss of two limbs	100
Amputation of both feet	100
Amputation of one leg at hip or below hip with stump not exceeding 5 inches	90
Lisfrancs operation both feet	80
Amputation below hip with stump exceeding 5 inches	80
Amputation through both feet proximal to metatarso-phalangeal joint	80
Amputation through one foot proximal to metatarso-phalangeal joint	30
Amputation of leg below middle thigh through knee (knee disarticulation or short below knee stump)	70
Amputation of leg below knee	60
Loss of all toes of both feet through the metatarso-phalangeal joint	40
Loss of all toes of both feet distal to proximal inter-phalangeal joint	20
Loss of all toes of both feet proximal to the proximal inter-phalangeal joint	30
Loss of all toes of both feet proximal to proximal inter-phalangeal joint including amputation through metatarso-phalangeal joint	20
Lisfrancs Amputation of one foot	40

**Other specific injuries:**

Loss of hand and foot	100
-----------------------	-----

**Other disabilities :**

Loss of viscera- such as kidney Testis, Lungs should be individually assessed not less than	50
------------------------------------------------------------------------------------------------	----

Ventral hernia following missile injury abdomen beyond anatomical repair	50
-----------------------------------------------------------------------------	----

**Notes :**

(a) In assessing the disability for loss of toes, one should not be guided purely by the anatomical loss because the causative factors e.g. injury, effects of cold etc. invariably damage to the adjacent soft tissues and joints of the foot. Partial loss of a few toes may cause severe disability in such cases. Hence assessment must be done taking into consideration the functional impairment in its totality for the locomotor function for foot and limb.

(b) Along with a loss of limb or a part thereof, any dissociated deformity, scarring, loss of muscular power, stiffness etc should be taken into account and the disability percentage enhanced accordingly.

(c) When the wound, injury or illness causing the disability is not entered in the schedule, the disability should be assessed by the Medical Board at the percentage shown in the schedule most closely corresponding to the disability.

Appendix II to Chapter VIISPECIFIED MINOR INJURIES - PERCENTAGES OF ASSESSMENT FOR  
CALCULATING COMPOSITE ASSESSMENT

Injury	Assessment Percentage
Loss of :	
1. <b>Thumb, terminal phalanx</b>	20
2. <b>Fingers :</b>	
Index finger -	
Whole	14
2 phalanges	11
1 phalanx	9
Tip, nail, no bone	5
Middle finger -	
Whole	12
2 phalanges	9
1 phalanx	7
Tip, nail, no bone	4
Ring/little finger -	
Whole	7
2 phalanges	6
1 phalanx	5
Tip, nail, no bone	2

Injury	Assessment percentage
Fixed finger unable to be flexed or extended	scale as above for loss of fingers; or part of fingers affected

3. **Toes:**

Great toe-

Whole 14

1 joint 3

1 other toe-

whole 3

1 joint 1

2 toes excluding Great toe-

whole 5

1 joint 2

3 toes excluding Great toe-

whole 6

1 joint 3

4 toes excluding Great toe-

whole 9

1 joint 3

**Assessment of neurological disorders:**

Assessment is based on the following guidelines :

## (a) Muscle power, tone and contracture

Quadriplegia                    100% plus CAA  
Paraplegia                        100% plus CAA

Loss of Power (applicable to both upper and lower limb)

Rt limb (right handed person)      70%  
Lt limb                                      50%

Grades of muscle power can further be quantified by deriving percentage as under out of allotted percentage for absolute paralysis as above.

<u>Grades of motor power</u>	<u>Percentage to absolute palsy</u>
Gr 0-1	100%
Gr 2-3	60-90%
Gr 3-4	20-50%
Gr 5	less than 20%

(b) Balance

Disablement of balance is mainly due to lacunar infarct of cerebellum and vestibular system. This should be always corroborated with clinical profile to rule out malingering.

Frequent falls                    80-100%  
Walks with broad base        40-50%

(c) Sensation

Loss of sensation in distribution of major nerve	20-30%
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Hemi-anaesthesia	50-60%
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(d) Parietal lobe function

Apraxia, Agnosia	30-40%
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(e) Cognitive ability-Memory

Global	100%+CAA
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Moderate:

(i) Looks after himself independently	80%
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(ii) Looks after himself and family	60%
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(iii) Looks after himself, family and society	40%
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Mild	less than 20%
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(f) Speech - Loss of speech can be sensory, motor or combined.

Loss of speech (sensory or motor)	30% each
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Loss of speech (combined)	70%
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(g) Abnormal movement

It is a manifestation of extra-pyramidal disease.

(i) Single abnormal movement - e.g. twitching of eye or limb movement	less than 20%
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(ii) Multiple abnormal movement	20-40%
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(iii) Multiple abnormal movements 40-60%  
 amounting to disability in posturing  
 and functioning including speech  
 and inability to walk.

(h) Cranial nerves

Facial nerve palsy (one side)

Supra-nuclear palsy 20%

Infra-nuclear palsy 30-40%

While making assessment for cranial nerves the effect of palsy on the end organs should be observed and to be adjudicated depending on the damages.

(I) Peripheral nerve injuries - not recovered.

Ulnar nerve (rt hand) 60%

Ulnar nerve (lt hand) 50%

Radial nerve (rt hand) 50%

Radial nerve (lt hand) 40%

Median nerve (rt hand) 60%

Median nerve (lt hand) 40%

Sciatica nerve (rt or left) 60%

Common peroneal nerve 30%

(j) Head injury with residual lesions in brain - 100%

**Assessment of renal function**

Assessment of renal function is done by corroborating clinical profile with biochemical parameters.

(a) <u>Level of serum creatinine</u>	<u>Percentage</u>
1-3 mg	40%
3-5 mg	60%
5-7 mg	80%
>7 mg	100%
(b) <u>Dialysis</u>	
Dialysis dependent	100% + CAA
(c) Renal transplant cases with immuno-suppressant therapy	80-90%
(d) Loss of one kidney with other kidney normal	50%
(e) <u>Urolithiasis</u>	
Asymptomatic with normal renal function	20-30%
Symptomatic with normal renal function	30-40%
Symptomatic with abnormal renal Function	assesment will be based on Serum Creatinine level

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