PATIENT COUNSELING

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3. Only two-thirds of the capacity of the bottle should be filled with the viscera and preservative to avoid bursting of the bottle due to decomposition gas formation.
4. The bottle should be covered with a piece of cloth, and tied by a string and the ends should be sealed.
5. The bottles should be properly labeled.
6. Sample of preservative used should be preserved in a separate bottle.
7. The sealed bottles are put into a box which is locked and the lock is sealed.
8. A viscera forwarding letter to be sent to The Regional Forensic Science Laboratory.
9. The Key of the box and viscera forwarding letter (form) with a sample of the seal, is kept in an envelope, which is sealed and sent with viscera box.
10. The viscera box is handed over to the police after taking his signature.

Viscera, tissue and body fluids: Preservation and Forwarding Procedures

Rajendra N kagne, Ananda Reddy

Preservation of viscera

Indications

Viscera of the victim have to be preserved in the following situations:

1. If death by poisoning is suspected by the police or by the doctor
2. Deceased was intoxicated or used to drugs
3. Cause of death was not found after autopsy
4. Death due to accident, suicide or homicide where suspicion of the use of intoxicants, sedatives or poisonous substance is raised
5. Advanced decomposition
6. Accidental death involving driver or machine operator
7. All brought dead cases to the casualty

Containers

- Clean, white and wide - mouthed glass bottles of one liter capacity should be used.
- Do not use rubber stopper, because it may extract poisons, such as chloroform and phenols.
- Blood should be collected in screw-capped bottle of about 150 m1 Capacity.

Preservation and dispatch of viscera

1. The stomach and small intestine with their contents are preserved in one bottle, and the liver and kidney in another bottle. The blood and urine are preserved separately.
2. The stomach and intestines are cut open before they are preserved. The liver and kidney are cut into multiple small pieces for uniform preservation.

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available to the patient and others involved in their care, so that everyone is clear about what has been agreed. This is particularly important if the patient has made an advance decision to refuse treatment. You should bear in mind that care plans need to be reviewed and updated as the situation or the patient's views change.

30. There is no standard format for taking consent for all the situations. The formats can be modified according to the need and preferably translated in the local language so that the patient can understand the nature of the consent clearly. This will also avoid complications in a suit filed by the patient with respect to consent.

    Trust, openness and good communication will ensure a good relationship between doctor and patient. Doctor must respect human life, so that the patient will trust them. To justify that trust Doctor must meet the standards expected from them in following domains.

    - Knowledge, skills and performance
    - Safety and quality
    - Communication, partnership and teamwork
    - Maintaining trust

A consent form is a legal document. It must contain the name and the signature of the patient, two witnesses, and the doctor along with his registration number. There is no standard format for taking consent for all the situations. The formats can be modified according to the need and preferably translated in the local language so that the patient can understand the nature of the consent clearly. This will also avoid complications in a suit filed by the patient with respect to consent.7

The level of disclosure has to be case-specific. There cannot be anything called a standard consent form. No doctor can sit in comfort with the belief that the "consent" can certainly avoid legal liability.

"One cannot know with certainty whether consent is valid until a lawsuit has been filed and resolved"- this has been highlighted by the note of The California Supreme Court.8

they have been given the information they want or need, and how well they understand the details and implications of what is proposed. This is more important than how their consent is expressed or recorded.

25. If it is not possible to get written consent, for example, in an emergency or if the patient needs the treatment to relieve serious pain or distress, you can rely on oral consent. But you must still give the patient the information they want or need to make a decision. You must record the fact that they have given consent, in their medical records.

26. Use the patient's medical records or a consent form to record the key elements of your discussion with the patient. This should include the information you discussed, any specific requests by the patient, any written, visual or audio information given to the patient, and details of any decisions that were made.

27. Before beginning treatment, you or a member of the health care team should check that the patient still wants to go ahead; and you must respond to any new or repeated concerns or questions they raise. This is particularly important if:

    - Significant time has passed since the initial decision was made
    - There have been material changes in the patient's condition,
    - In any aspect of the proposed investigation or treatment new information has become available, for example about the risks of treatment or about other treatment options.

28. Make sure that patients are kept informed about the progress of their treatment, and are able to make decisions at all stages, not just in the initial stage. If the treatment is ongoing, you should make sure that there are clear arrangements in place to review decisions and, if necessary, to make new ones.

29. You must record the discussion and any decisions the patient makes. You should make sure that a record of the plan is made

or visual or other aids. If you do, you must make sure the material is accurate and up to date.

19. It is your responsibility to discuss it with the patient. If this is not practical, you can delegate the responsibility to someone else, provided you make sure that the person you delegate to:

    - Is suitably trained and qualified
    - Has sufficient knowledge of the proposed investigation or treatment, and understands the risks involved
    - Understands, and agrees to act in accordance with, the guidance in this booklet.

    If you delegate, you are still responsible for making sure that the patient has been given enough time and information to make an informed decision, and has given their consent, before you start any investigation or treatment.

20. Keep up to date with developments in your area of practice, which may affect your knowledge and understanding of the risks associated with the investigations or treatments that you provide. Clear, accurate information about the risks of any proposed investigation or treatment, presented in a way patients can understand, can help them make informed decisions.

21. Discuss with patients the possibility of additional problems coming to light during an investigation or treatment when they might not be in a position to make a decision about how to proceed. If there is a significant risk of a particular problem arising, you should ask in advance what the patient would like you to do if it does arise. You should also ask if there are any procedures they object to, or which they would like more time to think about.

22. Ensuring that decisions are voluntary, particularly in vulnerable subjects.

23. Respect a patient's decision to refuse an investigation or treatment, even if you think their decision is wrong or irrational.

24. Before accepting a patient's consent, you must consider whether

information, you must explain the potential consequences of them not having it, particularly if it might mean that their consent is not valid. You must record the fact that the patient has declined this information. You must also make it clear that they can change their mind and have more information at any time.

15. Not to withhold information necessary for making decisions for any other reason, including when a relative, partner, friend or caretaker asks you to, unless you believe that giving it would cause the patient serious harm. In this context 'serious harm' means more than that the patient might become upset or decide to refuse treatment.

16. If you withhold information from the patient you must record your reason for doing so in the patient's medical records, and you must be prepared to explain and justify your decision. You should regularly review your decision, and consider whether you could give information to the patient later, without causing them serious harm.

17. Discuss a patient's diagnosis, prognosis and treatment options in the following way:

    - Share information in a way that the patient can understand and, whenever possible, in a place and at a time when they are best able to understand and retain it.
    - Give information that the patient may find distressing in a considerate way.
    - Involve other members of the health care team in discussions with the patient.
    - Give the patient time to reflect, before and after they make a decision, especially if the information is complex or what you are proposing involves significant risks
    - Make sure the patient knows if there is a time limit on making their decision, and who they can contact in the healthcare team if they have any questions or concerns.

18. Support your discussions with patients by using written material,

to result in an overall benefit for the patient.

7. Explain the options to the patient, setting out the potential benefits, risks, burdens and side effects of each option, including the option to have no treatment.
8. Not to put pressure on the patient to accept a particular option which they believe to be best for the patient. The patient has the right to accept or refuse an option for a reason that may seem irrational or for no reason at all.
9. If the patient asks for a treatment that the doctor considers would not be of overall benefit to them then, discuss the issues with the patient and explore the reasons for their request. If, after discussion, the doctor still considers that the treatment would not be of overall benefit to the patient, they do not have to provide the treatment. But they should explain their reasons to the patient, and explain any other options that are available, including the option to seek a second opinion.
10. If patients are not able to make decisions for them, the doctor must work with those close to the patient and with other members of the health care team.
11. Check whether patients have understood the information given, and whether or not they would like more information before making a decision.
12. Make it clear that they can change their mind about a decision at any time. You must answer patients' questions honestly and, as far as practical, answer as fully as they wish.
13. No one else can make a decision on behalf of an adult who has the capacity. If a patient asks you to make the decisions on their behalf or wants to leave decisions to a relative, partner, friend, caretaker or other person close to them, you should explain that it is still important that they understand the options open to them, and what the treatment will involve. If they do not want this information, you should try to find out why.
14. If a patient insists that they do not want even this basic

How to safeguard oneself from malpractice suits6

Registered Medical Practitioner must follow following points to avoid malpractice suits based on lack of consent or inadequate consent

1. Take consent from a patient, or other valid authority, before undertaking any examination or investigation, providing treatment, or involving patients in teaching and research.
2. Discuss with their patients about their condition and treatment options in a way they can understand, and respect their right to make decisions about their care.
3. Get their consent as an important part of the process of discussion and decision making, rather than as something that happens in isolation.
4. Share the information in proportion to the nature of their condition, the complexity of the proposed investigation or treatment, and the seriousness of any potential side effects, complications or other risks.
5. Work with their patients on following principles to ensure good practice in making decisions.
   - Listen to patients and respect their views about their health
   - Discuss with patients what their diagnosis, prognosis, treatment and care involve
   - Share with patients the information they want or need in order to make decisions
   - Maximize patients' opportunities, and their ability, to make decisions for themselves
   - Respect patients' decisions.
6. Make an assessment of the patient's condition taking into account the patient's medical history, views, experience, knowledge, clinical judgment and the patient's views and understanding of their condition, to identify which investigations or treatments are likely

abortion is invalid, whether or not the act causes injury to the consenting party (IPC 91).

Delivery: Consent of the party concerned, is required before examination for evidence in delivery.

Unconscious victim or assailant: Examination findings can be divulged to the police only after the patient regains consciousness and consents for this disclosure.

Prisoner: Prisoner can be treated forcibly without consent, in the interest of the society.

Inmates of hostel: For treating an inmate of the hostel, consent is necessary if he is above 12 years. Within the age of twelve the Principal or Warden can give consent. If an inmate above 12 years refuses treatment and he is likely to spread the disease, he can be asked to leave. However, if he stayed on, he will be treated without consent.

Autopsy: It is improper and illegal to perform an autopsy without proper consent or authorization. Medico-legal autopsies do not require consent. Here autopsy is done on authorization. The statutory enactment enables the state to order an autopsy in all suspicious and unnatural deaths.

Clinical autopsy requires the consent of the surviving spouse or next of kin. Failure to get consent is grounds for a charge of mutilation of the deceased and the 'hurt' sustained by the legal heir of the deceased body (emotional trauma, mental anguish, mental hurt). If it is necessary to remove and retain part of the body for future study and examination specific consent must be obtained.

Tissue transplantation: A living donor above 18 years, provided he is not mentally defective can give consent for removal of tissues from his body during life. Consent should be obtained in writing after having been given independent medical advice as to the risk.

To remove tissues from the body after death, consent of the deceased should be obtained in writing at any time, or orally in the presence of two or more witnesses, during his last illness. Even if consent was given by the deceased during life, permission must be obtained from the person in possession of the body, before removal of tissues. (THOA-1994)

Police officer not below the rank of an S.I. If the person is not willing, reasonable force can be used. (Cr. P.C. 53, 1973)

Alcohol abuse: Here the person should not be examined and blood, urine or breath should not be collected without his consent. If the person becomes unconscious and is incapable of giving consent to examination and treatment carried out. The consent of the guardian or relatives, if available, should be taken. The findings should not be divulged to the police until after the subject regains consciousness and gives consent. When a person is deeply intoxicated and cannot comprehend the informed consent it is advisable to wait till he becomes sober and gives consent for divulging the findings to the authorities.

Child offenders: Consent for examination is obtained from the parent or guardian. When the requisition is from the Magistrate, consent for physical examination is not required.

Marriage and conjugal obligations: Marriage contract provides bilateral conjugal obligations for a sexual relationship. Therefore, in procedures like sterilization, artificial insemination etc. involving the genital organs of a married partner it is advisable to obtain informed consent from both the husband and wife. Failure in this situation may result in doctor being sued for damages for negligence.

Rape: The victim's consent is must and the examination shall be made only by, or under the supervision of, a female registered medical practitioner. (CrPC 53 & 54)

Pregnancy: :Sometimes the diagnosis of pregnancy is difficult, especially in the early months and the patient tries to conceal it. Here before examination the physician must obtain, preferably in writing the consent of the woman in the presence of witnesses. Without the consent, physician can be sued by civil action for damages and criminal for assault.

Medical termination of pregnancy act (1971): Consent of the pregnant woman alone is sufficient provided she has attained the age of 18 years and is not a lunatic.

Consent for committing a crime or illegal act such as criminal

A person undergoing trial has the right to prevent the doctor from disclosing his condition to a third party. Convicted persons have no such right and the doctor can disclose the matter to the authorities.

Operation and treatment: The consent of a spouse is not necessary for an operation or treatment of the other. Even for gynecological operations required to safeguard her health, consent of the wife alone is sufficient.

It is advisable to take the consent of the spouse if it involves danger to life, impairment of sexual function or destruction of an unborn child. When an operation is made compulsory by law, for example, vaccination, no consent is necessary.

Discharge against medical advice: It is unlawful to detain an adult patient in the hospital against his will. If a patient demands discharge against medical advice, this should be recorded and his signature obtained.

Professional negligence: Consent is not a defense in professional negligence.

Medicolegal context: In medico-legal cases where an examination is requested by the law, consent must be obtained, whether it is the victim or the assailant that has to be examined. Examination without consent amounts to assault.

Examination may reveal findings, which when used in the process of investigation can damage the party examined. If later on the party is proved to be innocent, the damage sustained cannot be undone. This is why the right to deny consent for examination is generally given to the party.

Here consent is of the informed type. It is also said that the examination findings may go against him and can be used as evidence in court.

Insane person: Consent is obtained from the parent/ guardian/ state/ relative (IPC 89).

Criminal cases: Medical officer can examine an accused under arrest in a crime, without his consent when the request is made by a

acid peel. Additional consent will have to be obtained before proceeding with the latter.

If a consent form says that the patient has consented to undergo laser resurfacing by Dr. X, the procedure cannot be done by Dr. Y, even if Dr. Y is Dr. X's assistant, unless it is specifically mentioned in the consent that the procedure may be carried out by Dr. X or Dr. Y (or his authorized assistants).4 Blanket Consent is not legally valid.

Who can give consent?

A child above twelve years can give valid consent to suffer any harm which may result from an act done in good faith and for its benefit. Thus a child above 12 years can give valid consent for physical examination, diagnosis and treatment.

A child under twelve years or an insane cannot give valid consent to suffer any harm which may occur from an act done in good faith and for its benefit (IPC 89). The consent of the parent or guardian should be taken. If they refuse, the doctor cannot treat the patient.

A child's agreement to medical procedures in circumstances where he or she is not legally authorized or lacks sufficient understanding of giving consent competently is called 'assent'. Children are considered to give "assent" when they have sufficient competence to understand the nature, risks, and benefits of a procedure, but not enough competence to give fully informed consent

A person above 18 years can give valid consent to suffer any harm which may result from an act done in good faith and which is not intended or known to cause death or grievous hurt (IPC 87 and 88)

Thus, if a surgeon operates on a patient in good faith and for his benefit, the surgeon cannot be held responsible if the operation ends fatally.

Relevance of consent in medical practice5

Nature of illness: The nature of illness of a patient should not be disclosed to a third party without his consent. A doctor can disclose a secret without consent, if it is a privileged communication.

situations 'Therapeutic privilege" is an exception to the rule of "full disclosure". The doctor may in confidence, consult his colleagues to establish that the patient is emotionally disturbed. Apart from this, it is good for the doctor to reveal all risks involved in confidentiality to one of the close relatives and involve them in decision making.

Informed consent has now become a must in all operations, anaesthesia procedures and complicated therapeutic procedures. In the years to come, with the great advances in science and awareness of people regarding their rights with respect to consent, informed written witnessed consent can only acquire an added importance.

Emergency Doctrine

The emergency doctrine comes into play in situations where the patient will have to be treated without obtaining consent. An unconscious patient, non-availability of a relative or guardian, lack of time to contact them and the urgency of the situation are important factors which tolerate no delay in treatment.

In such situations the 'emergency doctrine' comes into operation and law presumes that consent is deemed to have been given. It protects the doctor interests, giving him immunity from proceedings against him for damages, for negligence or assault (IPC 92).

Loco Parents

In emergency situations involving children, when their parents or guardians are not available consent is taken from the people who are on the spot.

For example a school teacher can give consent for treating a child taken acutely ill during a picnic away from hometown. Even if the parents refuse consent no blame will be attached to the surgeon for an operation done to save the life of a child.

Blanket Consent

An all-encompassing consent to the effect "I authorize so and so to carry out any test/procedure/surgery in the course of my treatment" is not valid. It should be specific to a particular event. If, consent is taken for microderm-abrasion, it cannot be valid for any other procedure like

Types of Consent

Consent can be implied or expressed (Verbal or written).

Implied Consent: This is seen in routine medical practice and is quite adequate. Consent is implied in the mere fact that the patient comes to the physician with a problem or when a patient holds out his arm for an injection. The patient does not spell out his consent for treatment specifically. It is understood to have been given.

The reason for this is that, the procedure of diagnosis and treatment is simple and straight forward, the risks negligible and uncommon, and the conduct of the patient implies willingness of undergo treatment.

If there is slightest fear of complication, the doctor should seek expressed consent to safeguard his interests.

Expressed Consent This may be written or verbal. Any procedure beyond the routine physical examination, like operation, collection of blood, blood transfusion etc. needs expressed consent. Consent must be taken before the proposed act and not at that time of admission to the hospital.

For major operations and diagnostic procedures, written consent should be obtained in the presence of a disinterested third party, such as a nurse or receptionist. The nature and consequence of the procedure should be explained to the patient before getting the consent.

Informed Consent: In medical practice anything beyond the routine would require this type of consent. Here the doctor explains to the patient the 'relevant details' regarding the nature of his disease, the diagnostic procedures involved, the course and alternatives to the treatment proposed, risks involved and the prognosis.

The relative chances of success or failure is explained so that the patient can take an intelligent decision after attaining a comprehensive view of the situation. This safeguards the interests of the doctor.

The patient may be in dire need for treatment, but revealing the risks involved (the law of "full disclosure") may frighten him to a refusal. This situation calls for the common sense and discretion of the doctor.

What should not be revealed may at times be a problem. In such

CONSENT IN MEDICAL PRACTICE

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Introduction

Doctors practicing ethically and honestly should not have any reason for fear. Law whether civil, criminal or consumer, can only set the outer limits of acceptable conduct, i.e. Minimum standards of professional care and skill, leaving the question of ideal to the profession itself.

In recent years there have been a number of malpractice suits based on lack of consent or inadequate consent from the patient for procedures used in treatment. The common meaning of consent is permission, whereas the law perceives it as a contract, that is, an agreement enforceable by law.1

One of the essential features of establishing a contract is consent, which means "an agreement, compliance or permission given voluntarily without any compulsion".2 The medical graduate (Registered Medical Practitioner) must know what is consent, its types, who can give consent, its relevance in medical practice, how to safeguard oneself from malpractice suits based on lack of consent or inadequate consent.

Obtaining consent is not only an ethical obligation, but also a legal compulsion. Hence, it is necessary to understand the importance of consent in medical practice and its legal framework..

Consent

Consent is an agreement, compliance or permission given voluntarily without any compulsion. The consent is valid only if it is given after knowing the nature and consequence of the consent and those of the act for which it is given. 3

- The police has already been informed about the case
- Death within 24 hours of admission to casualty.
- Sudden deaths
- Suspect of starvation, exposure or neglect.
- Intra or postoperative deaths and
- Suspicion of foul play

Postmortem examination must be carried out to ascertain cause of death in above cases. In cases of death occurring in Police Custody, Prison, Children Home, Mental hospital, police firing etc. in all these cases magistrate's inquest should be carried out before postmortem examination.

Sudden natural death: Death is said to be sudden or unexpected when a person not known to have been suffering from any dangerous disease, injury or poisoning is found dead within 24 hrs after the onset of terminal illness (WHO).

- Incidence is 10% of all deaths.
- No period in life is exempt.
- Aetiology: Cardiovascular problems (45-50%), Respiratory problems. (15-25%),CNS problems(10-15%), alimentary causes (5%), .Genitourinary causes (5%), 10% Mmscelaneous (10%), and obscure (5-10%) causes.

Tips for issuing Death Certificate

- Issue free of charge,
- Don't delay issuing certificate,
- Do utmost to arrive at the cause of death,
- Take into consideration all your findings,
- Cause of death should be arrived at only on the basis of findings and not on extraneous facts,
- Do not write two or more conditions on a single line,
- Write legibly to avoid being misread,
- Do not use abbreviations to state the cause of death.
- Issue the certificate if attended the patient within past 7 days prior to his / her death,
- Issue a single copy of the certificate,
- Retain a carbon / duplicate copy for future reference.
- Do not sign blank certificate leaving the particular details to be filled by someone else.
- Fill in the appropriate forms (as per Registration of Birth and Death Act 1969),
- Never yield to plea, pressure, price, threat or to humanitarian grounds,
- Suspicious / unnatural deaths - certify death and inform police.

When you should not issue death certificate

- Cause of death is not known
- Unnatural deaths
- Brought dead cases
- A crime has been already been registered by the police

Role of physician in certification of cause of Death

- It is obligatory for a medical practitioner who last attended the deceased, to issue a death certificate
- Forward it to the registering authority.
- Must verify all relevant facts,
- Do utmost to arrive at the cause of death,
- The cause of death is recorded according to international conventions; the sequence that being adopted by the WHO.
- To be based only on clinical findings and not on extraneous factors,
- Suspicion / unnatural death - certify death (not cause of death) and inform police,
- Death certificate not to be withheld/ delayed or refused because of not having received his professional fees.

Prerequisites for certification of cause of Death

- Institutional doctors should fill Form No. 4 along with Form No. 2
- Non-Institutional doctors should fill Form No. 4(A) along with Form No. 2

Social aspects of certification of cause of death; Relatives may plead, persuade, pressurize, offer a price or threaten to issue death certificate.

Legal Aspects of certification of cause of Death

- Death certificate is a legal document which is proof of death,
- To be issued free of cost
- Failure to provide death certificate and cause of death, Physician can be prosecuted under Section 39 Cr.P.C.,175 I.P.C. or 176 I.P.C.

Ethical Aspects of certification of cause of Death

- Preserve confidentiality except in cases of public interest (HIV / AIDS).

of death may be.

i. Coma

ii. Syncope

iii. Asphyxia

Manner of death

1. Natural, and

2. Unnatural

If death occurs exclusively from disease or ageing process, the manner of death is Natural. If Death occurs by injury or is hastened due to Injury in a person suffering from natural disease, the manner of death is unnatural or violent. Unnatural death may be suicidal, accidental, homicidal, undetermined or un explained origin.

Mechanism of death

The mechanism of death refers to the physiological derangement or biochemical disturbance in relation to death.

Medical certification of cause of death (MCCD)

- Cause of Death is the disease or Injury responsible for starting the sequence of events, which are brief or prolonged and which produce death.
- They are divided as follows:

1. Immediate Cause i.e. at the time of terminal event. eg: Septic shock, Trauma, Hemorrhagic shock etc.
2. Antecedent cause or Basic Cause: Pathological processes responsible for the death at the time of the Terminal event or prior to or leading to the event. eg: Gun shot wound of abdomen complicated by general p eritonitis.
3. Contributory Cause::Pathological process involved in or complicating but not causing the terminal event. eg: existing Diabetes mellitus, hypertension, anemia etc.

- Registered Medical Practitioner (RMP) in charge of hospital where brain death has occurred.
- An independent RMP -a specialist nominated by panel.
- A Neurologist / Neurosurgeon nominated by panel.
- RMP treating the patient.

Tests to be performed:

- Absence of brainstem reflexes -pupillary, corneal, vestibulocochlear, and gag reflex.
- Apnoea Test.

Before certifying brain stem death doctor should perform the tests twice with interval of time say 6 hours.

Transplantation of organs: the organs can be removed from dead body within specified time.

Lung	Within 15-30 min.
Heart	Within 1 hour.
Liver	Within 15 min.
Kidney	Within 45 min.
Cornea	Within 2 hours.
Skin & blood vessels	Within 2-4 hours.
Bone	Within 6 hourrs.

Modes of Death

- The mode of death refers to the abnormal physiological state that existed at the time of death. According to Bichat, there are three modes of death depending upon the system most obviously involved, irrespective of what the remote cause

of spontaneous breathing. It is caused by raised intracranial pressure cerebral oedema, intracranial hemorrhage etc.

b) Whole brain death: Combination of cortical death and brain stem death.

Brain stem death

Criteria (Harvard criteria)

- Unreceptivity and unresponsivity: Deep unconsciousness with no response to external stimuli or internal need, Unresponsive to deep painful stimuli.
- No movements and no spontaneous breathing
- No reflexes
- Flat isoelectrical electrocardiogram (EEG): Not essential but confirmatory

Diagnosis :

- Patient must be deeply comatose
- The cause of coma should be established.
- The cause must be irremediable structural brain damage.
- Patient must be maintained on ventilator

Exclusions: Where the patient is under the

1. Effect of drugs -Barbiturates, Benzodiazepines, Opium, Neuromuscular blocking Agents.
2. Core temperature of body below 35°C - Hypothermia
3. Severe metabolic such as uraemia, diabetic coma and Endocrine disease like hypothyroidism

Medically and legally the patient is considered dead when brainstem death has taken place. The same time should appear on death certificate.

Brain death needs to be certified by a board of doctor's consisting of :

- Takes place in about 3-4 hours after stoppage of vital functions
- Different tissues die at different times.
- Nervous tissues die rapidly, muscles live up to 1-2 hours.

Historically, medically and legally the concept of death was that of "Heart and Respiration Death". Heart Lung by pass machines, Ventilators and other devices, however have changed this medically in favour of new concept. "Brain Death" i.e. Irreversible Loss of brain functions.

The determination of brain death has assumed importance for two reasons:

1. the ability to support vegetative functions for prolonged periods after brain death, and
2. the need of organs for transplantation.

Transplantation of Human Organs Act (THOA) 1994 recognised and defined brain stem death.

Types of Brain Death

There are three types of brain death and they are:

- Cortical or cerebral death
- Brain stem death
- Whole brain death

a) Cortical/cerebral death :There is loss of power of perception by senses but brain stem is intact, so respiration continues person goes into deep coma It is caused by cerebral hypoxia, widespread brain injury or toxic conditions

b) Brain stem death: Brain stem death is the present criteria to diagnose death as adopted by UK and India.

Cerebral cortex may be intact though it is cut off functionally by brain stem. There is loss of vital centers that control respiration and the ascending reticular activating system that normally sustains consciousness. . Thus the victim is irreversibly comatose and incapable

DEATH AND ITS MEDICOLEGAL ASPECTS

Chandrashekar TN

Thanatology: is a branch of subject of Forensic medicine that deals with death in all its aspects.

Death:

Indian law defines death as permanent cessation or disappearance of all

evidence of life at any time after live birth has taken place (Sec. 2 (b), Registration of Births and Deaths Act, 1969).has considered death as irreversible cessation of life and has classified it into two types

- Somatic /systemic/clinical
- Molecular/cellular

Somatic Death: It is the Complete and irreversible stoppage of circulation, respiration and brain functions (Bishop's tripod of life). Diagnosis of somatic death is difficult in conditions like suspended animation/apparent death.

Moment of death: The moment at which brain stops to work is the moment of death rather than respiration or cardiac function.

- Death is a process, and not an event.
- Medical advances- Ventilators, heart lung bypass machine have given rise to concept of brain death.

Molecular Death:

Death of cells and tissues occurs individually.

care, skill and caution expected of a reasonable and prudent medical practitioner may not be the same during an emergency.

In Amid Ali Shakir V St John's Medical College Hospital, Bangalore, it was held that reasonable delay in shifting the accident victims to the operation theater because of the necessity to correct the shock is not negligent.

Recommendations

The three member commission, headed by Justice Mr. Jagannadha Rao, drafted a bill pertaining to the private hospitals and practitioner on accident victims and emergency patients; if implemented the following guidelines are to be followed by the doctors.

a) The Hospital can't refuse the accident victim even on the ground that it was a medico-legal case.

b) The bill also stipulates punishment for refusing to admit, treat or transfer a patient after emergency treatment to another hospital.

c) The commission lays down the punishment of six months imprisonment along with fine of Rs. 10,000/- to the doctor or persons running the hospital if an emergency treatment is denied.

d) The commission says doctor would ensure provision of sufficient medical support en route for an unharmed transit of patient from one hospital to another.

e) In case ambulance is not available, then doctor will seek the help of police to transfer the patient.

examine first and even out of turn, depending on the condition of the patient.

Triage means allocation of injured patients into certain categories, a common scheme being as follows:

1. Critical: within seconds
2. Immediate: within minutes
3. Urgent: within the "golden hour"
4. Deferred: as soon as practical.

What the IPC says

Sections 80 and 88 of the Indian Penal Code (IPC) contains defenses for doctors accused of criminal liability. Under Section 80 (accident in doing a lawful act) nothing is an offence that is done by accident or misfortune and without any criminal intention or knowledge in the doing of a lawful act in a lawful manner by lawful means and with proper care and caution. According to section 88, a person cannot be accused of an offence if he/she performs an act in good faith for the other's benefit, does not intend to cause harm even if there is a risk, and the patient has explicitly or implicitly given consent.

Section 92 of the IPC offers legal immunity for a registered medical practitioner to proceed with appropriate treatment even without the consent of the patient in an emergency, when the victim is incapable of understanding the nature of the treatment, or when there are no legal heirs to sign the consent.

If the patient is conscious and refuses treatment without which the person might endanger his/her life, then the surgeon can inform the judicial magistrate and get the sovereign power of guardianship over persons under disability.

In New India Assurance Co. Ltd. V Dr. Kritkumar S Shera case, it was held that there is a difference in the degree of care, caution and skill in normal times and in the care of an emergency, nobody can expect the same degree and amount of care, caution and skill. The amount of

waste time unnecessarily. It is also expected that where the facts are so clear it is expected that unnecessary harassment of the members of the medical profession either by way of requests for adjournments or by cross examination should be avoided".

Correct observations made by the Supreme Court are not only gratifying but also make sense. The public needs to be educated about the fact driven by the court that no sensible professional would intentionally comment an act of omission which would request in loss or injury to the patient as the professional reputation is at stake. A single failure may cost the doctor dear in his career; medical practitioner faced with emergency situation ordinarily tries his best to redeem the patient out of suffering.

In an emergency or a critical case, it is the implicit duty of a noble profession to treat the injured person without waiting either for consent or for fees. The refusal to give treatment would even be violative of the provisions of the code of medical ethics and would constitute a deficiency in service.

In a concurring judgment it said, 'when a man in a miserable state hanging between life and death reaches the medical practitioner either in a hospital run or managed by the state, public authority or a private person or a medical professional doing only private practice he is always called upon to rush to help such an injured person and to do all that is within power to save life. It is a duty coupled with human instinct which needs neither decision nor any code of ethics nor any rule or law'.

Triage and Emergency

Stedman's Medical Dictionary defines 'Triage' as the medical screening of patients to determine their relative priority for treatment; the separation of a large number of casualties, in military or civilian disaster medical care, into three groups.

1. Those who cannot be expected to survive even with treatment.
2. Those who will recover without treatment; and
3. Those who need treatment to survive.

The doctor has the absolute right to decide which patient he would

delay in referral by the doctor could constitute negligence. Remember, not to forget to inform the police if it is a medico-legal case.

Doctor in the court

Medical professionals harbour apprehensions about being witnesses facing police interrogation and having to repeatedly visit police stations and losing their valuable earning hours. Especially the private practitioners are under the wrong impression that emergencies which are mostly medicolegal cases are dealt with or are to be dealt with only by government doctors. For the government doctors there is no option but they are obliged to attend on medicolegal case (MLC). The private doctors usually refuse and refer such a case to a government hospital as there is no authority which can compel any doctor to attend on any particular case unless there is a military regime.

It is the duty of every human being to help others in case of emergency. This responsibility is accentuated in cases of medical profession and every attempt should be made to provide the patient emergency care required for his well being. No person shall be denied first aid and immediate management, once he walks into a clinic to the extent possible in that particular setup, irrespective of ability or inability to pay.

The doctors are also reluctant to be a witness in a court of law as they may be required to attend the proceedings on multiple occasions, wait for a long time and sometimes face long and unnecessary cross examination. There prevent a medical professionals from doing the needful when a person requires emergency treatment.

To allay these apprehensions the Supreme Court held in Paramanand Katara. V. Union of India that "The police, the members of the legal profession, law court and everyone concerned will also keep in mind that a man in the medical profession should not be unnecessarily harassed for purposes of interrogation or for any other formalities and should not be dragged during investigation at the police station. Our law cases will not summon a medical professional to give evidence unless the evidence is necessary and even if he is summoned, attempt should be made to see that the men in this profession are not made to wait and

If doctors indicate on their hospital or nursing home board "24 hours emergency services available" make sure this is really the case. Otherwise it may amount to misrepresentation and make them liable if someone is not attended and suffers damage.

In case doctors cannot always provide round-the-clock service always, though this may be possible on most of the days, it is better to avoid announcing 24 hours services etc.

There are certain important ethical and legal aspects of emergency medical care that medical professionals' needs to be aware of and these are as follows:

- The legal and ethical obligations of a medical practitioner to attend to the emergency medical needs of a patient are total, absolute and paramount.
- Every doctor, either in a government hospital or in private practice, is duty bound to immediately attend to and protect lives of injured victims brought before him.
- It is the constitutional obligation of the State to provide adequate medical services to the people.
- The Indian Medical Council (professional conduct, etiquette and ethics) Regulations, 2002 unambiguously states that a medical professional should attend to a patient in an emergency.

Necessary aid

Head injuries are very common in the traffic accidents. The doctor who was first approached would start giving first aid and apply stitches to stop the bleeding. However, what is often seen is that doctors act with fear of facing legal proceeding do not give first aid to the patient, and instead tell him to proceed to the hospital by which time the patient may develop other serious complications.

In cases of an accident, injury and emergency cases, after providing necessary first-aid, the patient is referred to the higher centre, but the patient dies during transport would not be the liability of the doctor. Rather,

MEDICO-LEGAL ASPECTS IN EMERGENCY CASES

Rajesh Sangram

Scenario in Emergency

Medico-legal problems in the practice of Medicine are common but relatively infrequent. Many-a- times, a patient accompanied by either parents or relatives, or friends enter breaking all the barriers uttering the words emergency so as to draw attention of the physician to be attended first leaving all the waiting patients in queue. This disturbing and unconvincing situation will be faced by all the practicing doctors at least once in their life time.

The word "Emergency" means a sudden unexpected happening or sudden unforeseen occurrence or condition where there is a question of life and death.

Neither Indian law nor the orders of the Supreme Court and various high courts of India have defined medical emergency. Therefore the definition of medical emergency is still largely left to the discretion of medical professionals. It is an accepted practice that injured and critically ill patients are attended on priority by the doctors to save life. Often there is reluctance on the part of doctors to attend to the emergency needs of patients who, in medical jargon are "Medico-legal cases". This unwillingness is largely due to medical professionals with the instinct to evade the inconvenience associated with subsequent legal proceedings.

Many patients come to a doctor believing him to be "God". This attitude must change. As of now people's expectations are sky high, and they expect nothing short of a miracle. When the doctor is obviously unable to work this miracle, their God is found to have feet of clay and is thus abused.