ISSN: 2347-7458 I RNI No.: MAHENG13471/13/1/2013-TC

Journal of INDIAN MEDICO LEGAL and ETHICS ASSOCIATION

Quarterly
Medical Journal

Vol.04 I Issue : 02 I April-June 2016

www.imlea-india.org

JIMLEA (Journal of Indian Medico Legal & Ethics Association) is quarterly official publication of the **IMLEA** (Indian Medico Legal & Ethics Association). This journal is for complimentary circulation to members of IMLEA and on subscription to individuals and institutions.

Subscription

Annual subscription rates are:
Rs. 1000- only (for subscribers in India)
Rs. 2000/- only (for subscribers abroad)
Payment can be made by DD or multi city cheque drawn in favour of IMLEA, to be sent to Dr. Satish Tiwari, Yashoda Nagar No.2, Amravati - 444606, Maharashtra, India.

Address for correspondence:
Dr. Sushma Pande
C/o. Dr. S. R. Pande,
Dr. Pande Children's Hospital,
Kalyan nagar, Amravati - 444606. (M.S.)
e-mail: drsushmapande@gmail.com
Phone no: 07212674211, 9922914782

Journal of Indian Medico Legal And Ethics Association

Vol.04 I Issue : 02 I April-June 2016

CONTENTS

Indian Medico Legal And Ethics Association

Aims & Objectuves

- To promote, support and conduct research related to medico-legal, ethical and quality care issues in the field of medicine.
- To help, guide, co-ordinate, co-operate and provide expert opinion to the government agencies, NGO, any semi-government, voluntary, government agencies, legal bodies / institutions and judiciary in deciding settled or unsettled laws or application of laws / rules related to medico-legal or ethical issues.
- To train the medical professionals in doctor-patient relationship, communication skills, record maintenance and prevention of litigations.
- To promote and support the community members and individuals in amicable settlements of the disputes related to patient care, management and treatment.
- To provide specialized training in related issues during undergraduate or postgraduate education.
- To organize conferences, national meets, CME, updates, symposia etc related to these issues.
- To identify, establish, accreditation and promote organizations, hospitals, institutes, colleges and associations working on the related and allied issues.
- To promote goodwill, better care, quality care, professional conduct, ethical values.
- To establish and maintain educational institutes, hospitals, medical colleges, libraries, research centers, laboratories etc. for the promotion of its objects and to provide scholarships, fellowships, grants, endowments etc. in these fields.
- To print and publish the bulletins, books, official journal/newsletters or periodicals etc on related and allied subjects.
- To co-operate, co-ordinate, affiliate and work with other bodies, agencies or organizations to achieve the objects.

Editorial:
Time to prevent catastrophe in medical practice

*** Dr. Piyali Bhattacharya**
****Dr. Satish Tiwari**

Key Words:

Doctor- patient relationship, Medical negligence, Medical Practice, Medical services, Role of government, Judiciary, Medical Protection Act,

Introduction:

Being a good doctor is like being a goal keeper
No matter how many goals we save
People will remember
Only the one that you missed……..

As urbanization, globalization, wars, civil conflicts and disease outbreaks increased sharply, medical care has become a necessity in a civilized society. It is because of this reason the nations, medical schools and teaching hospitals are expected to send physicians, nurses, medical trainees and medical students to fill the health care gap to support vulnerable population. During the last few decades, there has been increasing incidents of attack on doctors and other health workers in case of any casualty during the treatment. Reports are coming daily in newspapers and media reporting attacks on doctors and health care personnels by the attendants of patients in case of any casualty and in such cases doctors are held responsible for the conditions. It has become a general presumption by the attendants of the patients that the casualty has occurred because of negligent acts of doctors and other medical care personnels. Such unfortunate incidents of attacks on doctors and other health workers are on the rise and domestic and foreign medical workers have been threatened, arrested, injured and such unfortunate incidents have even become of global concern among the medical professionals and the government. Efforts are being made to prevent such incidents and protect the medical professionals. Physicians for Human Rights (PHR), has been documenting such attacks since 2011 in effort to end the abuses amid growing international concern.

International Scenario:

Geneva Convention as early as in 1864 recognized the need for protection of medical personnel. It was emphasized in Rule 25 categorically that "medical personnel exclusively assigned to medical duties must be respected and protected in all circumstances". This rule, which dates back to 1864 Geneva Convention, was repeated in the subsequent Geneva Convention of 1906 and 1929. In the fourth Geneva Convention of 1949 (1), its scope was expanded to cover civilian medical personnel in addition to military medical personnel in all circumstances. Respect and protection for medical personnel is also included in military manuals of many countries. It is offence under the legislation of large number of states to violate this rule.

In order to protect the medical professionals, U.S Govt. has brought out Medical Neutrality Protection Act, 2011 (2) which refers to a principle of noninterference with medical services in times of armed conflict and civil unrest: "Physicians must be allowed to care for the sick and wounded and soldiers must receive care regardless of their political affiliations; all parties must refrain from attacking and misusing medical facilities, transport and personnel". Concepts comprising the principles of medical neutrality derive from international human rights law, medical ethics and

** Pediatric Consultant, Sanjay Gandhi Postgraduate Institute of Medical Sciences, Lucknow 226014*
*** Professor of Pediatrics, Editor, Text Book on Medico-legal Issues,*
Founder President, Indian Medico-legal and Ethics Association

humanitarian law. Medical neutrality may be thought of as a kind of social contract that obligates societies to protect medical personnel in both times of war and peace, and obligates medical personnel to treat all individuals regardless of religion, race, ethnicity, or political affiliation.

Indian Scenario:

In India also there has been a sharp increase in the incidents relating to assault on medical professionals. For the last few decades frequent reports have been appearing in the newspapers / media, highlighting the attacks on medical professionals by the attendants of the patient, followed by the strikes by the residents/doctors and appeals by the medical bodies in the country to the government for providing adequate protection to the medical professionals to enable them to carry out their duties with dedication and without fear. The society will have to protect the sincere, dedicated, service oriented medical professionals. The members will have to look into the competency rather than the quantity of the practitioners and health facilities. In the era of advertisement and globalization most of the commodities are of "use and throw" variety. Can we also have "disposable doctors" for our health care needs? Can we dispose off a doctor and select another one if we are not satisfied with the services of the previous one? What about the damage already caused to the patient? Can doctors and health care system become commodities, which can be hired or purchased with money? Doctors can be pulled up by society every now and then, with or without reason. Who will tell the society about its responsibilities? People will have to act as a 'watch-dog'. If they shirk their responsibilities today, they may not have a second chance tomorrow.

Factors Instigating Attacks on Medical Professionals:

It is a matter of common knowledge that after happening of some unfortunate event, there is marked tendency to look for a human factor to blame for an untoward event, a tendency which is closely linked with the desire to punish. Things have gone wrong and, therefore, somebody must be found to answer for it. Public anger and emotions may be the reasons given for such acts but if a mistake has been committed by any medical professional or hospital there are legal avenues to investigate the same and punish the guilty.

The Supreme Court order that no doctor can refuse any patient in an emergency and has to offer first aid, puts the onus on physician to treat cases for which his center may not be equipped or he is not professionally skilled to handle (for example a defibrillator may not be available in every clinic to treat a patient who may have a cardiac arrest and he may die in the clinic before he is referred to a tertiary care specialty center). If any such mishap occurs in such cases again the doctor is considered to have committed negligence by the relatives of the patient and many times has to face crowd anger and later legal consequences for negligence.

In Jacob Mathew's case (3), court observed that higher the acuteness in emergency and higher the complication, more are the chances of error of judgment. The court further observed as under: - "……At times, the professional is confronted with making a choice between the devil and the deep sea and he has to choose the lesser evil. The medical professional is often called upon to adopt a procedure which involves higher element of risk, but which he honestly believes as providing greater chances of success for the patient rather than a procedure involving lesser risk but higher chances of failure.

However, if there are genuine cases where doctors are negligent there are plenty of avenues wherein the affected public can raise their allegation, they can request an inquiry from the Grievance cell of local IMA branch, they can file a police case against the doctor or file a consumer grievance case where it would be investigated and due justice given.

Role of Media:

The media is supposed to be one of the pillars of democracy. But in the present era of yellow journalism even the credibility of media is questionable. We are in the era of "Paid news" where one can publish or transmit the news favorable to him/ her by paying some amount to

media. It is also possible to defame someone by pressurizing the media. Because of the technical advances it is very easy to create 'media hype'. But unfortunately the technological explosion has also some drawbacks which we forget to understand. Doctor- patient relationship is probably one area where involvement of media has probably resulted in negative impact rather than a positive outcome. It has been observed that some of the law fearing or media shy doctors have started defensive practice in order to minimize future problems. It is well accepted fact that a positive aspect should be highlighted more than the negative aspect. But, in order to increase their viewership the media is giving more exposure to negative changes in the society. The media too instead of delivering facts in many instances succumb to sensationalism and induce crowd anger, they hardly make any effort to present the version from the physician's side and they also ignore the achievements of the medical profession.

Medical Jousting:

Medical Jousting can fuel violence or Medico-legal cases against doctors also. Jousting is one doctor making direct or indirect critical comments about another doctor who has treated the patient, or 'Bad mouthing' the previous doctor. When a patient hears a doctor criticize another doctor, the patient may suddenly feel that the care he or she received was inappropriate. The practice of medicine is a careful balancing of scientific judgment and professional instincts. Every decision a doctor makes is potentially vulnerable to attack from a colleague who may disagree. Even in this day of protocols and evidence-based medicine, standards of care are not black-and-white static concepts, but instead, are nebulous and subject to change. Although physicians understand that differences of opinion are healthy and should even be encouraged, patients may see open dissention as an opportunity for a malpractice claim or violence and even the doctor who is criticizing can become one of the victims.

Why Physicians Should Seek Asset Protection:

Asset protection is another facet of the threat to doctors. Asset protection for physicians is of tremendous importance because they are seen as deep-pocketed targets. Physicians have lawsuit targets on their backs because they have in their hands the thing that society values most: human health. The medical profession is filled with tremendous legal liability. According to a survey conducted by the IMA, during 2007 and 2008, there were 95 lawsuits per 100 physicians.

As a physician, you are seen as a "Deep Pocket Defendant." In addition, the same survey concluded that physicians that are 55 years and up suffer eight times more lawsuits than those that are under 40. It is not that the older physicians are eight times more likely to commit malpractice. It is that they are seen to have deeper pockets. A concern that appears is also that the insurance companies search for loopholes once a claim is filed. Moreover, many lawsuits today are for far more than the insurance will cover. This is the case both in terms of coverage and policy payout limits.

The Medical Protection Act:

The Medical Protection Act (MPA) has been passed by several states expressly for the purpose of protecting the physician and his clinic or hospital from violence but we hardly have examples of guilty people who do this being punished under the Medical Protection Act. Clamor for its implementation grows louder each day with an Allahabad-based doctor beaten up by patient's kin who thrashed doctors inside ICU oblivious of the fact that other patients are put through equal amount of torture due to such mindless acts. It is so easy to be wise after the event and to condemn as negligence that which was only a misadventure.

These incidents of violence are very demoralizing and scare away youngsters from joining this profession. Doctors often think twice before treating an emergency case, especially an accident or a severe cardiac arrest case. Doctors would be led to think more of their own safety than of the good of their patients. Initiative would be stifled and confidence shaken. Women doctors are at a huge risk when patient's relatives go out of control. Sometimes, relatives come fully drunk and create nuisance in the hospital. Though now Section 12 of Consumer Protection Act, 1986 (4) enables a

patient or his/her family to move the consumer court if they feel it's a case of medical negligence, but people often opt for violence and boil out their anger on doctors and nurses.

A professional deserves total protection. The Indian Penal Code has taken care to ensure that people who act in good faith should not be punished. Sections 88, 92 and 370 of the Indian Penal Code give adequate protection to the professional and particularly medical professionals. Doctors must be allowed to perform their professional duties with a free mind to bring out their maximum potential. Medical science has conferred great benefits on mankind, but these benefits are attended by considerable risks as well. One has to remember that in such a vast country like India with such a huge population and great poverty, reasonable and economic medical care both primary and tertiary has been possible only because of the unstinted efforts of this community making India one of the most economic for medical care comparable to many countries.

Role of Government:

India is a federal country, Central Govt. and the State Govt. works in coordinate and independent manner. In India, "medical services" have been mentioned in the state list and hence only the state legislatures can make the law relating to any aspect of "medical services". It is worthwhile to note that serious considerations have been given to the need of protecting the medical professionals by the State Governments, and from 2008 onwards many State Governments have brought out ordinance/acts for protection of medical professionals in the State.

Serious legislations have been laid down by many States in the direction of meeting a long-pending demand of medical practitioners for a law to protect them while discharging their duties and are termed the Medical Protection Act. This act aims to protect doctors, nurses and hospitals from violent attacks. It seeks to extend the benefit of the Act to all medical service persons, including registered medical practitioners, registered nurses, medical or nursing students, paramedical workers as well as any person employed in a medical institution. The provisions in the act in various States (18 states) are inspired from each other and have similar provisions.

This act which replaced the initial ordinance, offers benefit to all medical service persons, including registered medical practitioners, nurses, medical students, paramedical workers as well as any person employed in a medical institution. It has been provided in the Act that whoever commits an act of violence against a Medicare Service person or causes any damage to the property of any Medical Service Institution shall be punished with imprisonment for a term which may extend to three years or with fine which may extend to fifty thousand rupees or with both.(5)

It has been further provided in this act that an offence punishable under section 3 shall be cognizable and non-bailable. This act does not only provide for punishment and fine but additional provisions were also be made for compensation, for damaged medical equipment and loss caused to the property of the medical service institutions. The accused has been made liable to penalty of twice the amount of purchase price of medical equipment damaged, the loss caused to the property. Another significant provision has been made in this act under section and sub-clause of the act which provides that with the order of compensation has been made under section 5 sub-clause 1 and the same is not paid by the accused, the compensation may be recovered under the provisions of Land Revenue Act 1950 from the accused person as an arrear of land revenue. The idea behind the act is to create a deterrent for the offenders who indulge in acts of violence against medical service providers.

Role of Society or Community:

Doctors rue the wrong approach of people who think that doctors were God. As stated "They initially follow quacks and bring patients to us when things go out of control. Later when all efforts fail, they harm doctors". Besides, doctors are beaten up not only if a patient dies, but also if medical bills shoot up. Quackery is carried on in our country with ease and the rules have been made flexible for cross specialty practice. Health authorities close their eyes and the crowd does not differentiate between them and qualified doctors,

these ill trained quacks add to the negative image of the profession.

We do our job with honesty and sincerity! No doctors deliberately ill-treat any patient. However, though unacceptable in any civilized country, even today in spite of MPA, the spate of attacks on doctors damaging their property and causing bodily injury continues! Cases of violence and ill treatment of medical professional by family members of patients had been rising in the country which undermines the respectability of medical professionals, cause mental problems to them and leads to blockade of medical services across the States. Such attacks raise questions e.g. How can a doctor work under threat?

Doctors must be allowed to perform their professional duties with a free mind to bring out their maximum potential. One has to remember that in such a vast country like India with such a huge population and great poverty reasonable and economic medical care both primary and tertiary has been possible only because of the unstinted efforts of this community making India one of the most economic for medical care comparable to many countries.

Conclusion:

The third millennium has seen many turbulent changes in the society. The "Zero tolerance" is obvious in the behavior of each and every citizen in the community. The more we are educated the more we are moving away from each other as far as human relations are concerned. This deterioration has resurfaced the principle of 'eye for eye' 'hand for hand' or 'life for life' concept of the ancient era before law and judiciary had evolved. In those days, every man was constituted a judge in his own cause, and might was the sole measure of right. (6) The respect for human life has declined at the cost of 3 'M' i.e. "Money, Material and Muscle power". The doctor- patient relationship has also been affected by these negative changes in the last few years. Every relationship is a dynamic process and doctor patient relationship is no different. It has gone a sea change since its beginning thousands of years back. It will be a futile exercise to look back and remember the good old days when the doctor was an all powerful "demigod". (7) The relations between doctors, patients and police are on the verge of breakdown if definitive and constructive efforts are not initiated by all concerned with immediate effect. We cannot overlook the fact that two wrongs do not really make a right. A wrong done over and over again by a large number of people, and highly educated people at that, soon becomes the order of the day. The present situation of mob inquisitions and violence is not befitting to our society, nation and hence, there is urgent need to prevent catastrophe in medical practice.

References

1. Society of Professional Journalists: Guidelines to the Geneva Conventions: (1949, 1977) http://www.icrc.org/IHL.nsf/1595a804df7efd6bc125641400640d89/6756482d86146898c125641e004aa3c5. Accessed on12 June 2016
2. Physicians for Human Rights. "Introducing Medical Neutrality Protection Act of 2011: Representative Jim McDermott's Statement for the Record". http://physicians forhuman rights . org/ library/ other/ introducing- medical-neutrality- protection- act.html. Retrieved February 21, 2012
3. Jacob Mathews vs State of Punjab (2005) 6 SCC-1
4. Consumer Protection Act (1986) Section 12.
5. The Uttar Pradesh Medicare Service Persons And Medicare Service Institutions (Prevention Of Violence And Damage To Property) Act, 2013 [U.P. Act No. 16 OF 2013] (As passed by Uttar Pradesh Legislature) No. 1032(2)/ LXXIX-V-1-13-1(Ka)10-2013, Lucknow, September 26, 2013.
6. Jhabwala NH. Indian penal code 13th edition Mumbai, C. Jamnadas & company 1997 page 1-16
7. Tiwari M, Bansal CP. Doctor- Patient relationship In: Tiwari S, Baldwa M, Tiwari M, Kuthe A editors; Text Book on medico-legal issues related to various medical specialties: 1st edition, Jaypee brothers medical Publishers, New Delhi 2012; 35-46.

Original Research Article

A profile of road traffic accidents & head injury in central India

*** Dr. Ashish Salankar, **Dr. P. N. Murkey, **Dr.B.H. Tirpude, ***Dr. I L Khandekar, ***Dr. Pravin Zopate, ****Dr. Vishal Survade, *Dr Ranjan Ambedkar**

Key words:

Cranio-cerebral injuries, Fatal vehicular accidents, RTA, deaths.

Abstract:

Among all type of accidents, those caused by motor vehicle claims the largest toll of life and tend to be the most serious. The present prospective study was conducted in the Department of Forensic Medicine and Toxicology, Mahatma Gandhi Institute of Medical Sciences, Sewagram, Wardha, Maharashtra. from 1st August 2013 to 31st August 2015 on 618 cases. The primary aim of this study was to find out nature and types of cranio-cerebral injuries (CCI) sustained in fatal road traffic accidents (RTA) and make an attempt to establish various causative factors, patterns and distribution of CCI and thereby to plan successful measures against it.

Introduction:

The term 'ACCIDENT' has been defined as an occurrence in the sequence of events which usually produces unintended injury, death or property damage. (1) It is also defined as "an unexpected, unplanned occurrence which may involve injury". (2) Among all types of accidents, those caused by motor vehicles claims the largest toll of life and tend to be the most serious.

Over 1.2 million people die each year on the world's roads and between 20 and 50 million suffer non-fatal injuries. Over 90% of the world's fatalities on the roads occur in low-income and middle-income countries, which have only 48% of the world's registered vehicle (WHO, 2004). The most of such deaths are among "vulnerable road users" such as pedestrians, pedal cyclists and motorcyclists. (3) Developing countries bear the brunt of the fatalities and disabilities from road traffic crashes, accounting for more than 85% of the world's road fatalities.

Craniocerebral injuries are world's most serious health problem. The development of science in various aspects of human life like household items, atomic energy etc. have evolved far more superior, sophisticated, and lethal weapon of assault. The motorized transportation media like vehicles, trains, aeroplanes etc., with fast moving vehicular traffic, vast urbanization and changing social patterns, have contributed to increase in the incidence of craniocerebral injury. Traffic accident is an endemic disease which affects mainly young population to cause craniocerebral injury. A middle aged male is more likely to die from craniocerebral injuries received in traffic accident than from any other cause and motor vehicle accidents are single most leading cause of death.

Aims and objectives:

1) To assess and evaluate the pattern of craniocerebral injuries as a result of occurrence of incidence in Central part of the India with other part of India on the basis of previous studies.
2) To study the pattern of head injuries.
3) To assess age specific difference in craniocerebral injuries as a result of road traffic accidents in all subjects.
4) To compare bisexual difference in craniocerebral injuries as a result of occurrence of incidence in all subjects.

** Resident Department of Forensic Medicine MGIMS, Sewagram, Dist Wardha, Maharashtra 442012*
Email – drashishsalankar@gmail.com
***Professor Department of Forensic Medicine MGIMS, Sewagram,*
****Assistant Professor Department of Forensic Medicine MGIMs, Sewagram,*
*****Assistant Professor Department of Forensic Medicine RDGMC, Ujjain*

5) To study the incidence of vehicular accidents causing craniocerebral injuries.

Materials and methods:

This study was undertaken in the Department of Forensic Medicine and Toxicology of MGIMS, Sewagram, Wardha, Maharashtra from 1st August 2013 to 31st August 2015. During this period, total 6931 cases of medicolegal significance are noted out of which 618 cases are of medicolegal head injury cases designated as reported head injury cases. During the same period, post mortems of total 752 cases were conducted at our Institute's mortuary, out of which 146 post mortem cases of fatal head injuries with positive findings of intracranial traumas (on gross autopsy) were considered for this study that includes both polytrauma cases (where head injury is also one of the contributing factors of the fatality) and head injury cases (where injury to other parts of body are not significant).The cases without any intracranial finding of traumatic origin on gross autopsy have been excluded. The cases with intracranial findings of some disease pathology also were not considered.

The relatives of the victims of the accidents and accompanying police were interviewed to obtain the information about the circumstances leading to death. A proforma specially designed for this purpose was used at the time of autopsy. The details about the victim regarding the name, age, sex, address, date, time and place of death, type of vehicle involved and the cause of sustaining the injury were noted from the police records. Position of the victim during accident (driver/ pedestrian/ occupant) was noted. Post-mortem (both external and internal) findings were recorded in the same proforma and analysed.

1) The software for graphs and calculation of statistical values is – SPSS
2) The software used during creation or modification of some of the diagrams-
   a) ADOBE PHOTOSHOP(R) 7.0
   b) COREL DRAW X3
   c) WINDOWS -10

Exclusion criteria:

a) The cases without any intracranial finding of traumatic origin on gross autopsy have been excluded.
b) The cases with intracranial findings of some disease pathology also were not considered.

Results:

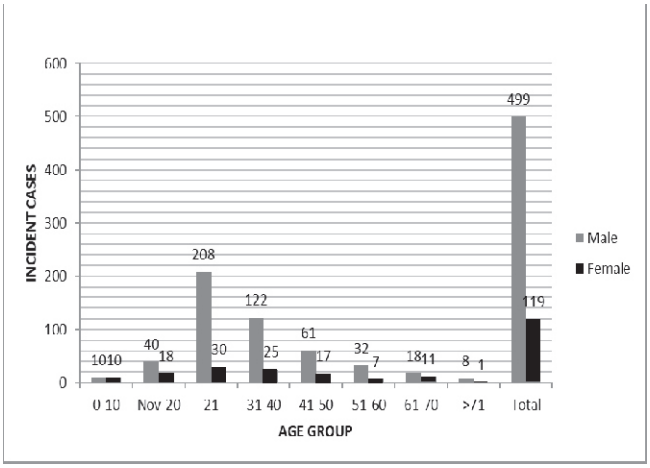
The study includes total 618 medico-legal head injury cases out of total 6931Cases. Out of 618 medicolegal head injury cases 146 cases were fatal due to head injuries of which post mortem examinations were conducted; that comprises of both head injury cases(where injury to other parts of body are not of much significance) polytrauma cases (where head injury is also one of the findings). Maximum emphasis is given to study of fatal cases of which post mortem examinations were conducted and head injury in cases of road traffic accident reported to rural medical college in central India. Out of 146 fatal head injury cases 24 cases were brought directly to mortuary and 3 head injury cases were died immediately in casualty which are also involved in study. Out of 618 cases of head injury there were 100 cases of road traffic accident which are elaborately involved in this study.

TABLE- 1: Age wise and gender wise distribution of reported cases (n=618)

Age Group (Yrs.)	Male	Female	Total	p value
0-10	10 (1.62%)	10 (1.62%)	20 (3.24%)	
11-20	40 (6.47%)	18 (2.91%)	58 (9.38%)	
21-30	208 (33.65%)	30 (4.85%)	238 (38.5%)	
31-40	122 (19.74%)	25 (4.04%)	147 (23.78%)	
41-50	61 (9.87%)	17 (2.75%)	78 (12.62%)	0.004
51-60	32 (5.17%)	07 (1.13%)	39 (6.3%)	
61-70	18 (2.91%)	11 (1.77%)	29 (4.68%)	
>71	08 (1.29%)	01 (0.16%)	09 (1.45%)	
Total	499 (80.74%)	119 (19.26%)	618 (100%)	

P value: calculated by chi square test

Figure - 1 : Age and gender wise distribution of cases.



Discussion

In the present study, out of 618 cases of head injury, there were 499 males and 119 females. Male, female sex ratio is 4.19:1. Out of 618 head injury cases reported 146 were dead out of which 118 were male and 28 were female. Male, female sex ratio is 4.21:1

Tirpude B.H and Naik R.S (Tirpude et al, 1998) in the study of craniocerebral injuries in road traffic accidents observed that male to female ratio was 4.4:1.(4) Pathak A, Desania N.L, (Pathak &Desania, 2008) at their study done in year 2003-2004, on 120 cases of head injury deaths, also observed the ratio of Male and female as 4:1 for Road traffic accident cases (5) (Gupta et al, 2007)- In a study on fatal craniocerebral cases, conducted at North Bengal Region, West Bengal, in 2003 (6), Gupta S. et al observed that male, female ratio is 7.3:1. Govekar et al, 2009 in another study of road traffic accidents at Surat city (7), showed that out of 243 cases, males were 90.5% and females 9.5%, i.e. male : female is approx.10:1. Murkey et al, 2011, conclude that preponderance of male victim is higher i.e. 148 (85.55%) over 25 (14.45%)female . Sex ratio is 5.92:1.

Thus the findings of sex ratio 4.19:1 in head injury reported cases and 4.21:1 in head injury death cases at present study are nearly similar to related studies. High preponderance of males in fatal head injury cases may be because males are bread earners, for which they go outside more than females. Such bulk of activities and assignments make them more prone to high risk factors leading to head injuries.

No age is immune for head injury to occur. It is clear from this study that victims of head injury cases reported to medical college in central India that cases from age group 21-30 years are maximum (38.50%) out of which (33.65%) are male and (4.85%) are female followed by 31-40 age group (23.78%) out of which (19.74%) are male and (4.04%) are female followed by 41-50 age group (12.62%) out of which (9.87%) are male and (2.75%) are female followed by 11-20 age group (9.38%) out of which (6.47%) are male and (2.91%) are female as compared to other age groups .The victims of age group more than 71 are least affected by head injuries (01.45%) with close similarity to the victims of age group 0-10 (03.24%) and of age group of 61-70 years (04.68%) and 51-60 year age group(06.3 %).

It is also clear from this study that fatal cases reported to medical college in Central India for autopsy that cases from age group 21-30 years are maximum (53.42%) out of which (45.89%) are male and (7.53%) are female followed by 31-40 age group (19.86%) out of which (17.12%) are male and (2.74%) are female followed by 11-20 age group (10.27%) out of which (6.85%) are male and (3.42%) are female, there is preponderance of female patient as compared to 31-40 age group followed by 41-50 age group (6.85%) out of which (4.79%) are male and (2.05%) are female as compared to other age groups .The victims of age group more than 71 are least affected by head injuries (01.37%) with close similarity to the victims of age group 61-70 (02.05%) and of age group of 0-10 years (02.74%) and 51-60 year age group (03.42 %).

(Tirpude et al, 1998) Tirpude B.H and Naik R.S. in the study of cranio cerebral injuries in road traffic accidents observed that the incidence of fatal road traffic accidents was found to be maximum in the age group 21-30 years (38.88%) followed by 31-40 years (18.51%), lowest incidence being at the age group 61 and above (5.55%). In a study (Eqbal et al, 2005) on 100 cases on pattern of head injury in Aligarh, U.P. Eqbal. M.Z. et al observed that the maximum number of casualty occurred in age group of 0-10 years, both in male and female. (Gupta et al, 2007)- In another study on fatal craniocerebral cases, conducted at North Bengal Region, West Bengal, in 2003, Gupta S. et al observed that the incidence of fatality was seen to

be maximum in 21-30 years (23%) followed by 31-40 years (19%), lowest incidence being at above 70-year age (2%). (Sheikh et al, 2008)- In a study of death due to railway accident(2006), Sheikh M.I. et al observed that out of 262 cases, highest no of victims(80) were of age group 21-30 years(30.53%), followed by 31-40 years , 71 cases(27.09%)(8). (Murkey et al, 2011) Murkey P, Mujumdar A in study conducted at MGIMS Sewagram rural hospital of Central India studied 173 fatal head injury cases of various causative manner, during the period 2008 to 2011, commonest age group involved was 21-30(21.39%) least involved age group was 0-10(04.62%) years.(9)

The maximum number of cases of head injury in the age group of 21-30 years can be explained by the fact that this age group is supposed to be the most active group to move out of house for day to day activities. The less incidence at above 70year age group is probably explained by the Indian rural scenario of habit of avoiding outside activities and to enjoy a sedentary retired lifestyle.

Summary and conclusion:

The first recorded pedestrian accident was in Britain in 1896, where a man was killed by a car traveling at 4 miles/hour. Today hundred times the number of vehicles that were playing in 1896, travel at speed of nearly 100 miles/hours. This comparison is enough to throw light on rate of increase in road traffic accidents.

In our study, the triad of middle aged-male pedestrians being most accident prone is very significant which other authors have also revealed. This is good indicator for a faulty traffic management system where pedestrian safety is always overlooked.

The finding that majority of the fatal victims of cranio-cerebral injury of road traffic accidents died on the spot of within 24 hours of accident highlights the prevalent poor traumatic management infrastructure. Hence, improvement of road surface infrastructure, strict compliance with road safety rules by drivers and pedestrians, rapid emergency services and establishment of trauma care centers are major factors to reduce this hazard.

There needs to be a proper national reporting system of road traffic accidents so that an overall picture can be drawn for proper traffic management planning.

It is seen that there is preponderance of fatal head injuries in males as compared to females. Male, female sex ratio is 4.19:1 in reported cases and 4.21:1 in fatal cases. While considering the age groups, it is observed, victims from age group 21-30 years are maximum in reported cases (38.5%) and (53.42%) in fatal cases the victims of age group above 71 years are least affected by head injuries (1.45%) and (1.37%) in fatal cases with also close similarity to the victims of 1-10 years of age (3.24%) in reported cases and (2.74%) in fatal cases.

References :

1. Park's Textbook of Preventive & Social Medicine. 19th edition 2007: p 340-345.
2. Hogarth, J. Glossary of Health Care Terminology, WHO, Copenhagen (1978).
3. WHO (2004), The World Health Report 2004, Changing history: ROAD Safety is no Accident: http://www.thinkraodsafety.gov.uk accessed on 02-08-2007.
4. Tirpude BH, Naik RS, Anjankar AJ, Khajuria BK. A study of the pattern of cranio-cerebral injuries in road traffic accidents. J Indian Acad Forensic Med. 1998; 20(1):9-12.
5. Pathak A, Desania NL, Verma R. Profile of road traffic accidents & head injury in Jaipur (Rajasthan). J Indian Acad Forensic Med. 2008;30(1):6-9.
6. Gupta BD. Evaluation of mechanical injuries in homicidal deaths (a retrospective study of 5 years). J Indian Acad Forensic Med. 2007;29(3):18-22.
7. Govekar G, Patel G, Rajdev B, Tailor C, Shilajiya D. Trends of road traffic accidents in Seurat city. J Indian Acad Forensic Med. 2009;31(4):326- 330.
8. Sheikh MI, Shah JV, Patel R. Study of death due to railway accident. J Indian Acad Forensic Med. 2008;30(3):122-127.
9. Murkey P, Mujumdar A in study conducted at MGIMS Sewagram rural hospital of Central India studied 173 fatal head injury cases of various causative manner, during the period 2008 to 2011.

Original research paper

Profile of poisoning cases and medicolegal formalities done at Clinical Forensic Medicine Unit (CFMU)

***Dr. T. D. Wankhade, **Dr. B.H. Tirpude, ***Dr. P. N. Murkey, ****Dr. I L Khandekar, **Dr. Pravin Zopate, *Dr. Deepak Bhagwat.**

Key Word:

Poisoning cases, CFMU, Medicolegal formalities.

Abstract:

Poisoning cases are one of the main medicolegal issues to which medical person encounter while doing his duty at casualty. Our objective of the present study is to measure the magnitude and epidemiology of poisoning cases presented in the accident and emergency department (casualty) of the hospital of medical college and various medicolegal formalities to be followed while dealing of such cases. The present study was conducted at Clinical forensic Medicine Unit (CFMU) of the Rural Hospital of MGIMS, Sewagram. This unit is working under department of Forensic medicine and is situated at accident and emergency department of the hospital (casualty) and it deals with all medicolegal cases presented to the Hospital. In this study total 241 cases of poisoning were observed during the period of one year. Cases were analysed under various parameter like age and sex, type of poison consumed, residential status, month wise distribution, manner of incidence etc. Data is compared with available literature and conclusion was drawn thereafter. Various medicolegal formalities done while dealing with these cases like informing the police, making injury report, preserving sample of medicolegal importance are also discussed in the article.

Introduction:

Poisoning cases constitute a major public health problem, especially among the rural area where most of the population have agricultural background. Poisoning is the common method of suicide adopted in India. In a casualty of Hospital duty medical officer has to face number of cases of poisoning. Apart from treatment of such cases medical practitioner has some legal duties towards these patients. It includes informing the police, arrange for dying declaration and preserving the samples of medicolegal importance.

In present study focus is on profile of various poisoning cases coming to hospital and how to deal these cases medico legally. Present study is conducted at clinical forensic medicine unit of MGIMS, Sewagram. This unit is situated at accident and emergency department (casualty) of the hospital of the MGIMS, Sewagram. It looks for all medico-legal formalities of the medico-legal cases brought in the Hospital. This unit is manned by postgraduate Student posted in department of Forensic medicine under the supervision of the forensic medicine consultant.

Aims and objectives:

- To study the profile of poisoning cases brought to CFMU of Medical College.
- To study the various medicolegal formalities done while dealing with these cases.

Material and Methods:

The cases include only live reported cases which are registered by the author during his rotational duty at CFMU and which later got admitted at a Hospital for treatment purpose. Brought dead cases, not admitted cases and cases which are not reported during the rotational duty of author are excluded from the study. Total number of cases observed was 241 cases.

**Resident Department of Forensic Medicine MGIMS, Sewagram, Dist Wardha, Maharashtra 442012*
Email- drtoshalwankhade@gmail.com
***Professor and Head Department of Forensic Medicine MGIMS, Sewagram,*
****Professor Department of Forensic Medicine MGIMS, Sewagram,*
*****Assistant Professor Department of Forensic Medicine MGIMs, Sewagram,*

CFMU is situated at casualty (accident and emergency department) of Hospital. It is manned by PG student from department of Forensic Medicine under supervision of Forensic consultant. Whenever a patient comes to the casualty, Casualty medical officer examines the patient and if he feels that the case needs medico-legal formalities then he informs the case to CFMU apart from treating doctor. After that the duty doctor at CFMU examines the patient along with treating doctor as a part of team.

He notes down demographic details and history of the incidence, he examines the patient and does the needful medicolegal formalities like informing the police, making Forensic Medical Reports i.e. injury report, collecting needful sample after taking valid consent etc.

In the present study, information regarding the demographic details of the victim like age, sex, marital status, religion, domicile, time and place of incident were gathered by interviewing the patient or patient's attendants (parents, guardian, relatives, friends, etc.).

Information of type of poison consumed is drawn from laboratory investigation done and inference drawn by treating doctor during the Hospitalisation of the patient.

Findings :

Observation and Result:

In the present study maximum number of victims 108 (44.81%) were seen in the age group of 21-30 years, followed by 49 (20.33%) cases in the age group of 31-40 years. Males 191 (79.25 %) outnumbered the females 50(20.74%) cases.*(Table-1)*

In the present study among Poisoning cases, maximum cases 148 (61.41%) were from rural areas and 93 (38.58%) from urban areas. *(Table -2)*

In the present study, the commonest manner of poisoning *(Table-3)* is suicidal 198 (82.15%) cases followed by 43 (17.84%) accidental.

In the present study *(Table-4)* out of 241 cases of poisoning maximum number 95 (39.42%) cases occurred during March to Jun (summer season), followed by 90 (37.34%) cases in Nov to Feb (winter season) and least number of cases 56 (23.23%) occurred in July to Oct (rainy season).

In the present study out of 241 Poisoning cases maximum number 129 (53.52%) cases are of Agrochemical poisons, followed by Rodenticide 25 (10.37%) cases, Alcohol 24 (9.95%), and drug overdose includes 20 (8.29%) cases. *(Table -5)*

Out of 241 poisoning cases blood for chemical analysis and gastric lavage is preserved in all cases *(Table-6)*. Police information was done in all poisoning cases (100%) which are included in present study.

Discussion:

In the present study, out of total 241(100%) cases majority of poisoning victims, 191 (79.25%) were males. Maximum numbers of victims 108 (44.81%) cases were seen in the age group of 21-30 years and minimum number of victims 6 (02.48%) were found in 10 years of age group. Our results are similar to the results of studies conducted by Dash SK et al,(1) Unnikrishnan et al, (2) Shetty VB et al,(3) and Vanaja K et al,(4). The studies conducted by, Hettiarachchi et al,(5) and Bharadwaj DN et al,(6) revealed male dominance and common age group involved was 15-25 years. The present study along with many other studies mentioned above, gives the picture that it's the youth between the ages of 21-30 years who are more prone for poisoning. In most of these youths, it is suicidal intent rather than accidental which is killing factor and which is also a big loss to any society or nation. Reasons seem to be many, mental instability and inability to face adverse eventualities in life like unemployment in spite of being graduates, failure of crops, repeated failures in exams, love failures, family disputes and so on. It is evident from the present study and other studies, that the males are more prone for poisoning. Females are well guarded from adversities for life, starting from childhood up to old age, as daughter by parents, as wife by husband and as mother by son. The Indian society, traditionally and culturally, is sympathetic to women which boosts their morality and self confidence in life. Man being the bread earner of the family in most cases, all transactions go in his name. If failed to fulfil the basic requirements for the family, due to frustrations they end their lives.

In our study among Poisoning cases, maximum cases 148 (61.41%) were from rural areas and 93

(38.58%) from urban areas. This finding is similar to the findings of the study conducted by Dash SK et al (1) and Shetty VB et al, (3)

This is possibly due to illiteracy and poverty of agricultural farmers which mostly belongs to rural area and solely depends on the agricultural income for their living. Another reason may be due to either lack of water or flood they may not be able to generate the required income for their day to day living and commitments, they may get frustrated and resort to suicide by these agro-chemicals, which are readily available in their backyard.

As far as seasonal variations, maximum number of poisoning cases 95 (39.41%) occurred during March – Jun (summer season), followed by 90 (37.23%) cases in July to Oct (winter season) and least numbers 56 (23.23%) in July – Oct (rainy season). Our results are similar to the results of studies conducted by Dash SK et al (1), where maximum number of cases occurred in summer season.

This seasonal variation with summer season dominance can be attributed to agriculture and rain. In summer, there is scarcity of water for agriculture. In India rain is the main source of water for agriculture and failure of adequate rains has become a common phenomenon in most parts of the country with some exceptions. This drought situation is highly unsuited for cultivation. Thus, those families which are totally dependent on agriculture and rains for agriculture face the worst threat for basic needs. Finally, instead of starving to death, they cling on to this method of suicide. Obviously such people use agrochemicals present at home.

Considering the type of poison consumed, maximum numbers of cases were due to poisoning by agrochemicals 129 (53.52%). This result is similar to the results of the studies Hettiarachchi et al,(5) Unnikrishnan et al, (2) and Gupta BD et al,(7) But this result of agrochemical dominancy is in contrast with the result of the study conducted by Bharadwaj DN et al, (6) where the most common type of poisoning was Aluminum phosphide. Among the agrochemicals, in the present study, most common poison was Organophosphorus compounds. This result is similar to the studies conducted by Dash SK et al,(1) Shetty VB et al,(3) Vanaja K et al,(4) and Prakash C et al, (8)

In the present study out of 241 cases of poisoning, the commonest manner of poisoning was suicidal in 198 (82.15%) cases, followed by accidental 43 (17.84%) cases. No homicidal case of poisoning found during the study. Our results are similar to the results of studies conducted by Hettiarachchi et al,(5) Bhardwaj DN et al,(6) Unnikrishnan B et al,(2) Gupta BD et al,(7) and Shetty VB et al, (3)

It is evident from the present study as well as from other studies quoted above, that in most of the poisoning cases, suicide is the main intention of poisoning. Agrochemicals are the most commonly used agents in developing countries like India and Sri-Lanka. This can be attributed to the fact that, even for trivial problems, people have found suicide as best solution by agrochemicals which are easily available and which could be easily consumed.

Agrochemicals in general and Organophosphorus in particular are the agents commonly used, as seen in the present study. This can be attributed to a number of factors like easy availability as they are sold in open market without strict vigil and also much cheaper. The occupation of most victims being agriculture, these chemicals are almost always present in home and readily procurable. These can be easily consumed orally. Another thing that was noticed, upon inquiring the hospital victims, was they were sure of mortality due to these compounds as they have seen many die the same way in their vicinity. Thus people are more knowledgeable about agrochemicals than any other poison.

The samples like gastric lavage and blood for chemical analysis were collected after taking consent of patient in the ward where patient was admitted for treatment. Police information was done in all poisoning cases (100%) which were included in this study.

Conclusions:

- In case of poisoning male outnumbered females with ratio of 3.82 : 1 and maximum victims were seen, in the age group of 21-30 years with more suicidal intent than accidental. Maximum number of poisoning cases occurred during March to June (summer season) with

agrochemicals in general and organophosphorus in particular.

- Residence pattern of victim shows patients from rural area are more involved than urban area.
- Medicolegal formalities done at CFMU are complete and reliable as experts are involved and also various samples of medicolegal importance are preserved.
- Police information was done in all poisoning cases (100%) which were included in this study.
- As all medicolegal formalities like communication with police, medicolegal documentation and sample preservation done

Table - 1 : Distribution of Poisoning cases according to age and sex: (N=241)

Age in Yrs.	Male	Female	Total (%)
<10	3	3	6 (2.48%)
11-20	10	14	24 (9.95%)
21-30	88	20	108 (44.81%)
31-40	44	5	49 (20.33%)
41-50	29	7	36 (14.93%)
51-60	17	1	18 (7.46%)
Total	191 (79.25 %)	50 (20.74%)	241 (100%)

Table - 2 : Distribution of Poisoning cases according to the Urban/Rural pattern (N= 241)

Type of Medico -legal case	Urban	Rural	Total
Poisoning	93 (38.58%)	148 (61.41%)	241

Table - 3 : Poisoning cases according to Manner of poisoning : (N=241)

Months	Number of cases	Percentage
Suicidal	198	82.15%
Accidental	43	17.84%
Total	241	100%

Table - 4 : Distribution of poisoning cases according to Month: (N=241)

Months	Number of cases	Percentage
March to Jun	95	39.41%
July to Oct	56	23.23%
Nov to Feb	90	37.34%
Total	241	100%

Table - 5 : Distribution of poisoning cases as per type of poison consumed: (N=241)

Type of poison	Number of cases	Percentage
Alcohol	24	9.95%
Drug overdose	20	8.29%
Napthalene	6	2.48%
Agrochemicals	129	53.52%
Phenol	19	7.88 %
Rodenticide	25	10.37%
Unknown	18	7.46%
Total	241	100%

Table - 6 : Various sample of medicolegal importance preserved at CFMU in poisoning cases.

Sample	Preserved	Not Preserved	Total
Gastric lavage	241	0	241
Blood for chemical analysis	241	0	241

References :

1. Dash SK, Raju AS, Mohanty MK, Patnaik KK, Mohanty S. Socio-demographic profile of poisoning cases. Journal of Indian Academy of Forensic Medicine 2005; 27 (3): 133-137.
2. Unnikrishnan B, Singh B, Rajeev A. Trends of acute poisoning in south Karnataka. Katmandu University Medical Journal 2005 (cited 2014 July 13); 3 (2): 149-154. Available from: http://www.kumj.com.np/past/vol3/issue10/145-154
3. Shetty VB, Pawar GS, Inamdar PI. Profile of poisoning cases in district and Medical College Hospitals of north Karnataka. Indian Journal of Forensic Medicine and Toxicology 2008; 2 (2): 22-26.
4. Vanaja K, Jai prakash V, Rani SRH, Kiran N. Pattern of poisoning reported at south Indian tertiary care hospital. Indian Journal of Forensic Medicine and Toxicology 2008; 2 (2): 17-19.
5. Hettiarachchi J, Kodithuwakka GCS, Chandrasiri N. Suicide in southern Sri Lanka. Med Sci Law 1988; 28 (3): 248-251.
6. Bharadwaj DN, Dogra TD, Singh B, Reddiah VP. Status of poisoning in Faridabad district of Harayana. Medico-legal Update 2004; 4 (3): 79-83.
7. Gupta BD, Vaghela PC. Profile of fatal Poisoning in and around Jamnagar. Journal of Indian Academy of Forensic Medicine 2005; 27 (3): 145-148.
8. Prakash C, Joshi G, Nigam P, Joshi A, Joshi SC. Pattern of poisoning cases admitted at a Tertiary Care Centre in the Kumaon region of Uttarakhand. Indian Journal of Forensic Medicine and Toxicology 2010; 4 (1): 4-5.

Contribution in JIMLEA

All the readers of this issue and the members of IMLEA are invited for contributing articles, original research work / paper, recent court judgement or case laws in the forth coming issues of JIMLEA. This is a peer-reviewed journal with ISSN registration. Please send your articles to Dr Sushma Pande, e-mail: drsushmapande@gmail.com.

Review Article :
Litigations in Anesthesia

***Dr Gaurab Maitra, **Dr Ankit Kedia, ***Dr Ravindra Wankhede**

Key Words:
Litigation, Compensation, Professional indemnity, malpractise, Negligance, Vicarious liability, Informed consent.

Introduction:

Litigation is defined as the pursuit of compensation through legal action. We live in a society with an increasing number of litigations and it has affected the community of medicine as well. Individuals frequently expect to have perfect healthcare outcomes, failing which, they opt for the course of seeking financial compensation. The spiraling costs of litigation has led to a huge financial burden on the taxpayer and a sharp increase in professional indemnity fees for individual doctors.

Malpractice is defined by Columbia Encyclopedia as the "failure to provide professional services with the skill usually exhibited by responsible and careful members of the profession, resulting in injury, loss, or damage to the party contracting those services"

The anaesthesiologists' understanding and knowledge of law has an important influence on anaesthesia practice. Lack of such knowledge could lead to misperceptions affecting both patient care and professional practices.

History:

The concept of litigation in medical practice is not new. More than a century ago, an editorial in the Boston Medical Journal (forerunner of the New England Journal of Medicine) mentioned the negative effects of increasing litigation in healthcare. It said, "Suits at law against reputable physicians for alleged malpractice have attracted unusual attention lately by reason of increasing frequency and absence of reasonable foundation of truth and justice in the charges against the defendant. It would be difficult to devise a scheme or mode of practice more conducive to the instigation and presentation of bogus claims than is the so called contingent fee of the present day."(1)

Medical malpractice litigation appeared in the United States around 1840 for reasons specific to that period. Those reasons were in the context of market place professionalism, an environment that did not provide sufficient quality controls over medical practitioners.(2) It has been sustained for over a century and a half because of various factors like spread of uniform standards in medical care, advent of medical malpractice liability insurance, contingent fees and nature of tort pleading.

Types:

The malpractice claims in the field of medicines can be classified into two types, a criminal case or a civil case. In a criminal case, the aggrieved party files a complaint against the physician or the institution in a police station, which investigates the case and the Government prosecutes the concerned physician or institution. This happens only when the offence is of a serious nature. The idea of judicial proceedings in criminal cases is to punish the concerned physician or institution for the lapse. Complainant does not get any compensation in these cases.

In a civil case the aggrieved party approaches the court directly to seek compensation for the harm caused by the action of the physician or institution

** Senior Consultant, Department of Anaesthesiology, Apollo Gleneagles Hospitals, Kolkata. gaurabmaitra@yahoo.in*
*** Post Graduate Trainee , Department of Anaesthesiology Apollo Gleneagles Hospitals, Kolkata.*
**** Senior Consultant, Department of Anaesthesiology Apollo Gleneagles Hospitals, Kolkata.*

involved. These cases can go to the common courts or to one of the consumer courts. After introduction of Consumer Protection Act (CPA), most of the cases relating to medical negligence go to the consumer courts. The reasons for this are the inexpensive and simple procedure along with speedy disposal of the cases in these courts.

Negligence:

In order to establish the presence of medical negligence in a given case, the patient or the plaintiff has to prove the following four points: (3)

1. Duty: that the physician(s) owed him or her a duty.
2. Breach of Duty: That the physician(s) failed to fulfill his or her duty.
3. Damages: That actual damage resulted because of the acts of the physician(s).
4. Causation: That a reasonably close causal relationship exists between the physician(s)' acts and the resultant injury.

In the context of practice in anaesthesiology, when the patient is seen preoperatively and the anaesthesiologist agrees to provide anaesthesia care for the patient, a duty to the patient has been established. A doctor when consulted by a patient owes him certain duties viz., a duty of care in deciding whether to undertake the case, a duty of care in deciding what treatment to give and a duty of care in the administration of that treatment. A breach of any of these duties gives a right of action for negligence to the patient. (4,5)

Standard of Care:

The standard of care is a general formula that describes how a physician should act in a particular case. It is usually employed by a court or a jury to determine if the physician performed his duty adequately or failed in doing so.(6) One standard of care cannot exist for all countries or hospitals in the same country or city. It is subjective to the locality of the case, and at times could be specific for an individual case. It is based on reference books and guidelines drawn by anesthesia societies. However, it is important that the anaesthesiologist follows the following basic guidelines: (7)

1. Personnel should be present throughout the conduct of general anesthesia, regional anesthesia and monitor anesthesia care.
2. Continuous evaluation of adequacy of ventilation and circulation, and temperature in specific situations.
3. Continuous monitoring of blood oxygen level.

Supervision:

In addition to their own acts, anaesthesiologists are responsible for those they supervise and who are employed by the hospital. This includes the resident doctors under training, anesthetic nurse and operating room technicians.(8) Delegation of responsibility to a junior with knowledge that the person was incapable of performing his/her duties properly will amount to negligence. (9)

Error in Judgement:

Lord Denning M.R. said "we must say and say it firmly, that, in a professional man, an error of judgment is not negligence" (10) Indian courts have also held the same view. Wrong diagnosis is not defined as deficiency in service. In the profession of medicine, as in others, there is scope of differences in opinion and practice; and a court's preference of one body of opinion over another should not be a basis for a conclusion of negligence. (11) However, all errors of judgment are not consistent with exercise of proper care. It is critical to know whether the concerned doctor in reaching his decision displayed a lack of clinical judgment that no other physician exercising proper skill and care could have reached the same decision. (12)

Risk Factors:

It was found that a higher frequency of litigation and a greater severity of injury in patients treated by anaesthesiologists in the age group of 65 or more. The reasons for these findings should become an active field of research. (13) Doctors who have a higher number of complaints tend to have more claims against them, reflecting the fact that many clinical negligence claims start as a result of poor communication. Most indemnifiers are now putting their high-risk doctors (i.e. those with a higher than average number of complaints and claims) through a membership governance plan,

like communication skill development programs, to reduce their risk profile. (14)

The specialty of anaesthesiology in particular is at increased risk of being sued because there is limited scope for interaction between the patient and the anaesthesiologist.(9) An anaesthesiologist should actively make efforts to communicate with the patient and their kins to reduce this risk factor. Appendix 1 highlights the common causes of claims for adverse events related to anaesthesia practice.

Reasons behind litigations

To examine the reasons patients and their relatives take legal action, Vincent et al (15) surveyed 227 patients and relatives who were taking legal action through five firms of plaintiff medical negligence solicitors. Over 70% of respondents were seriously affected by incidents with long-term effects on work, social life, and family relationships. Intense emotions were aroused because of the incident and continued to be felt for a long time. The decision to take legal action was also determined by insensitive handling and poor communication after the incident. Four main themes emerged from the analysis of reasons for litigation:

1. Concern with standards of care - both patients and relatives wanted to prevent similar incidents in the future;
2. Need for an explanation - to know how the injury happened and why;
3. Compensation - for actual losses, pain and suffering or to provide care in the future for an injured person; and
4. Accountability - a belief that the staff or organisation should have to account for their actions. Patients taking legal action wanted greater honesty, an appreciation of the severity of the trauma they had suffered, and assurances that lessons had been learnt from their experiences.

Benefits and Harms(14)

It is never a good experience for any physician to be called to court for the purpose of litigation. In most circumstances, it is a long process, requiring multiple court room attendances or representation leading to financial and professional losses. However, the lawyers and plaintiffs cite the following benefits of the process of litigation:

(i) It may lead to safer and more effective clinical practice. In addition to improvements in individual competence and performance, litigation may theoretically result in the provision of better facilities, staffing, or equipment within an institution

(ii) It could eventually reduce costs for the government and taxpayers, potentially releasing more money for front-line healthcare; it would also reduce costs for self-funding patients and the physicians who treat them.

(iii) It could, in the long run, reduce the amount of stressful and costly litigation faced by clinicians.

It is, however, questionable whether doctors and organisations are learning from litigation as significant barriers preventing this from happening. The improvement in facilities, staffing, or equipment within an institution as a result of litigation appears unlikely to be implemented nationally, unless very well publicised and endorsed by organisations such as the National Patient Safety Agency or the Department of Health. The individual clinician or, more particularly, their close colleagues are likely to learn from litigation, and it is hoped (but not proven) that these individuals would not make the same or similar error in the future. Experts providing opinion to the court are in a privileged position to be able to learn from other clinician's problems and errors. Overall, however, with the current system, it is likely that the harms of litigation outweigh the above potential benefits. The potential harms secondary to increasing litigations are as follows:

1. The costs associated with the process of litigation can be high.
2. In anaesthesia, this is likely to result in over-investigation, over-referral, and inappropriate cancellations, all of which have negative effects on patient care.
3. In critical care, practitioners may avoid making

difficult decisions (e.g. end of life care), over-investigate, and make unnecessary referrals, regionally or nationally, all with massive cost implications.

4. The risk of obstetric litigation has led to minimal provision of private obstetric care in United Kingdom. Restriction of other high-risk areas of private practice will predictably follow, for example, certain components of cosmetic surgery.
5. After severe adverse events, clinicians may change career or specialty or move abroad, worsening the quality of medical care in a given society.
6. Problems of anxiety, depression, drug abuse, and suicide have been highlighted.

Most clinicians will recognise these patterns, but it can be questioned whether these are the result of complaints or litigation, or if they just reflect the different characteristics and beliefs of individual practitioners.

Lessons:

The process of litigation is orientated towards compensation for a civil wrong instead of admission of fault, an apology or commitment to remedial action. As a result, it provides limited opportunity for learning beyond the individual clinicians and organisations involved.

As litigation progresses, the defendant practitioner may become increasingly resistant to acknowledgement of any short-fall in care provided, and is unlikely to embrace a contrary judgment with a sense of enlightenment and willingness to disseminate the learning opportunities with his colleagues and broader specialty.

A fundamental problem is that there is no systematic collection, processing, or publication of information in this field. Information can be obtained from anecdotal cases in the national press or medical journals, and the supplements produced from medical indemnity organisations. Closed-claim type analyses, practiced in western countries, currently offer the best source of information on healthcare litigation. These detailed investigations of closed clinical negligence claims are designed to identify major areas of loss, patterns of injury, and future preventative strategies. The process in anaesthesia started in the USA some years ago but more recently has been replicated successfully in other countries such as Canada(16) and the UK.(17)

Prevention:

The anaesthesiologists are invariably confused about how exactly they should prevent litigations or respond to them.(18) In order to decrease the likelihood of a lawsuit, the anaesthesiologist should practice the following:(7)

1. Improve the "doctor-patient" relationship: This is accomplished by spending time with the patient and their kin preoperatively describing the procedure, calming nerves and establishing a relationship of trust. The anaesthesiologist should be aware of the patient's condition perioperatively, be ready to follow up actively if any complications occur and explain it in full if. The anaesthesiologist should project a professional image and appear as a person to be trusted.
2. The anaesthesiologist should adhere to the "standards of care" by keeping their knowledge bank updated, being prudent in choosing agents of anaesthesia, and maintaining the patient's vital signs within an acceptable range.
3. The anaesthesiologist should maintain good records, adhering to the "If it is not written, it was not done" rule. They should always have a detailed preoperative note which is vital in differentiating between a bad result and actual negligence. They should not write notes admitting any wrongdoings nor accusing others.
4. The anaesthesiologist should respond appropriately when an incident does occur through obtaining consultations and following up on the patient until his/her services are no longer needed and document that in the medical record.
5. The physician should avoid "Vicarious Liabilities". They should supervise competent

staffs since supervising assistants makes them liable for their actions. They should specify what equipment and techniques are being used and avoid supervising more cases simultaneously than they can safely handle.

Informed Consent (9):

There are certain general duties which, all physicians have to their patients, and breaching these duties may also serve as the basis for a lawsuit. Informed consent is one of the most important of these issues. Consent may be written, verbal or implied. Oral consent is just as valid, but harder to prove years after the fact, than a written consent.(8) It means shared decision-making. It means patients right to self-determination and autonomy.

The extent of the requirement for disclosure of risk is a subject of changing legal interpretations. Duty to disclose risk is not limitless, but it extends to those risks that are more likely to occur in any patient under the given circumstances.(8) There is no obligation to inform the patient about the risk of death from general anaesthesia. (19) Thus, whilst it may be unnecessary or, perhaps, even a disservice to warn a patient of any minimal risk, where an operation is either essential or advisable for the patient's medical welfare and continued good health, it may be otherwise, when the intended operation is not one, which is medically necessary but is totally elective, e.g. a sterilisation operation.

Ethically valid consent is a process of shared decision-making based on mutual respect and participation. It is not a ritual of recitation of the content of a form that details the risk of a particular treatment or intervention. It is important to understand if the patient has sufficient mind to reasonably understand the condition, the nature and effect of the treatment proposed, associated risks in pursuing the treatment or not pursuing the treatment. It is the duty of a doctor to explain to the patient what he intends to do and the implications of that action in a way, which a careful and responsible doctor would do, so that the consent given by the patient was, indeed, a real consent.

Conclusion:

Litigation is an increasing problem in the field of medicine, and anaesthesiologists are at a higher risk of facing them compared to many other specialists. It is important for anaesthesiologists to understand the legal aspects of their practice as lack of such knowledge can have a negative impact on their patient care. It is important to identify the risk factors that can lead to litigations and take appropriate preventive measures like detailed patient counseling, effective communication, obtaining informed consent and maintaining clear records. The potential benefit of knowledge enrichment through litigations can be reaped by having platforms to disseminate information obtained from adverse events.

References -

1. Gay G. Suits for alleged malpractice (editorial). Bost Med Surg J (forerunner N Engl J Med. 1911;165:406–11.
2. Mohr JC. American medical malpractice litigation in historical perspective. JAMA. 2000 Apr 5;283(13):1731–7.
3. Poonam verma v Ashwin Patel & others, II(1996) CPJ 1 (Supreme Court):1996(3) CPR 205 (Supreme Court).
4. Lakshman Balkrishna Joshi v. Dr. Trimbak Bapu Godbole and another, AIR 1969 SC 128.
5. Indian Medical Association v V. P. Shantha &)Ors III 1995 CPJ I (Supreme Court): 1995(3) CPR 412.
6. Kragie S, Mather K. Standards of Care and Spcialists. Am Soc Anesthesiol Newsl. 2002;66(2).
7. Tabbarah R, Tabbarah S, Kanazi GE. Medico-legal aspects in anesthesia: How to lead a happy life. Middle East J Anesthesiol. 2006;18(5):985–94.
8. Medicolegal Aspects of Anaesthesia Practice. Chapter 2, Fredrick W. Cheney and Donald A. Kroll P 35. P 41.
9. Parakh SC. Legal Aspects of Anaesthesia Practice. Indian J Anaesth. 2008;52(3):247–57.
10. Early v. Newham Health Authority (1994) 5 Med. L.R. 214.
11. Crawford v. Charing Cross Hospital (1953), The Times Dec. 8, 1953.

Appendix 1: Categorization of claims for adverse events related to anaesthesia(14)

I.	Failure to achieve goals of a general anaesthesia or regional technique including: Pain during a procedure under regional techniques Awareness Unacceptable movement during complex surgery
II.	Failure to achieve essential interventions including: Failure to intubate Misplacement of a tracheal tube
III.	Inappropriate technique including: No rapid sequence induction despite indications Adverse drug reactions after a previous episode (known or unknown previously)
IV.	Complications of interventions including: Regional techniques (a) Subsequent to a recognized technique (b) Subsequent to deviation from current standards Invasive monitoring (a) Subsequent to a recognized technique (b) Subsequent to deviation from current standards
V.	Complications of positioning including: Compartment syndrome: focal or limb Neurological injury Skin injury Ophthalmic injury
VI.	Failure to ensure physiological stability including: Ventilation Oxygenation Oxygen delivery (a) Circulating volume (b) Haemoglobin Temperature Coagulation status Biochemistry Adequate BP
VII.	Errors: Drug administration error Delay in intervention Misdiagnosis and inappropriate treatment Deviation from appropriate treatment algorithm
VIII.	Failure to respond appropriately to recognized complications of anaesthesia: Cannot intubate, cannot ventilate Difficulty in ventilation Anaphylaxis Malignant hyperpyrexia
IX.	Failure to ensure adequate postoperative care
X.	Complications of equipment failure.

12. Raj Kumar Agrawal v. Dr. B. Mukhopadhyay (1995) CPJ 260 Bihar SCDR Commission.
13. Tessler MJ, Shrier I, Steele RJ. Association between anesthesiologist age and litigation. Anesthesiology. 2012 Mar;116(3):574–9.
14. Adams JP, Bell MDD, Bodenham AR. Quality and outcomes in anaesthesia: Lessons from litigation. Br J Anaesth. 2012;109(1):110–22.
15. Vincent C, Young M, Phillips A. Why do people sue doctors? A study of patients and relatives taking legal action. Lancet (London, England). 1994 Jun 25;343(8913):1609–13.
16. Peng PW, Smedstad KG. Litigation in Canada against anesthesiologists practicing regional anesthesia. A review of closed claims. Can J Anaesth = J Can d'anesthésie. 2000 Feb;47(2):105–12.
17. Cook TM, Bland L, Mihai R, Scott S. Litigation related to anaesthesia: an analysis of claims against the NHS in England 1995-2007. Anaesthesia. 2009 Jul;64(7):706–18.
18. G MS. Survey of anaesthesiologists' reactions to implementation of laws related to anaesthesia practice. Indian J Anaesth. 2015;59(2):103–9.
19. Taylor v. Worcester & District Health Authority (1991) 2 Med. L.R. 215).

Indian Medico- Legal Ethics Association

Professional Assistance / Welfare Scheme

1) The scheme shall be known as PAS "Professional Assistance Scheme".
2) ONLY the life member of IMLEA shall be the beneficiary of this scheme on yearly basis. The member can renew to remain continuous beneficiary of this scheme by paying renewal fees every year. The scheme shall assist the member ONLY as far as the medical negligence is concerned.
3) This scheme shall be assisting the members by:
   i) Medico-legal guidance in hours of crisis. A committee of subject experts shall be formed which will guide the members in the hours of crisis.
   ii) Expert opinion if there are cases in court of law.
   iii) Guidance of legal experts. A team of Legal and med-legal experts shall be formed which will help in guiding the involved members in the hours of crisis.
   iv) Support of crisis management committee at the city / district level.
   v) Financial assistance as per the terms of agreement.
4) The fund contribution towards the scheme shall be decided in consultation with the indemnity experts. The same will depend on the type and extent of practice, number of beds in case of indoor facilities and depending upon the other liabilities.
5) The financial contribution towards the scheme shall be as follows:

Admission Fee (One Time, non-refundable)		
1.	Physician with Bachelor degree	Rs. 1000
2.	Physician with Post graduate diploma	Rs. 2000
3.	Physician with Post graduate degree	Rs. 3000
4.	Super specialist	Rs. 4000
5.	Surgeons, Anesthetist etc	Rs. 5000
6.	Surgeons with Super specialist qualification	Rs. 6000

		Annual Fee for Individual
1	Physician / doctors with OPD Practice (Non Consultants/ Experts)	Rs/- 65 per lakh
2	Physician / doctors with Indoor Practice / Consultants	Rs/- 125 per lakh
3	Physician / doctors with Indoor Practice of Surgery	Rs/- 250 per lakh
4	Physician / doctors with super-specialty, Anesthetist etc	Rs/- 360 per lakh
5	● Rs/- 1000 (One thousand) per year shall be collected to develop the fund of the IMLEA towards emergency assistance, risk management and conducting trainings, CME, workshops etc. ● Physician / doctors visiting other hospitals shall have to pay 5% extra ● For unqualified staff extra charges of 8% shall be collected ● The additional charges 15 % for those working with radioactive treatment. ● The additional charges can be included for other benefits like OPD/ indoor attendance, instruments, fire, personnel injuries etc.	

	No. of Beds	Five Lakhs	Ten Lakhs
1	< 5	Rs/- 7500	Rs/- 12000
2	6 – 10 beds	Rs/- 10000	Rs/- 18000
3	11- 25 beds	Rs/- 15000	Rs/- 26000
4	26- 50 beds	Rs/- 25000	Rs/- 45000
5	51 – 100 beds	Rs/- 35000	Rs/- 65000
6	101- 200 beds	Rs/- 70000	Rs/- 120000
7	> 200 beds	Rs/- 2 Lakhs	Rs/- 3.5 Lakhs
Medical colleges/ Corporate hospitals after discussing with hospital administration.			
This scheme is for single case; amount shall be calculated on individual to individual basis for extra assistance.			
5% concession on payment for three years and 10% concession for payment for five years on individual to individual basis.			

6) The hospital can become the member of this scheme only if all the members associated with the hospital have their personal professional indemnity under the scheme.
7) A trust / committee / company/ society shall look after the management of the collected fund. The scheme shall initially be run in collaboration with the New India Assurance or National Insurance Company.
8) The Financial assistance will be like Medical Indemnity welfare scheme, where indemnity part shall be covered by government / IRDA approved companies or any other private company.
9) The amount shall be deposited in the Central Indemnity Reserve Fund (CIRF) of the association. The association shall be responsible only for the financial assistance. Any compensation/ cost/ damages awarded by judicial trial shall be looked after by government / IRDA approved insurance companies or any other similar private company.
10) Experts will be involved so that we have better vision and outcome of the scheme.
11) The payment to the experts, Legal and med-legal experts shall be done as per the pre-decided remuneration. Payment issues discussed, agreed and processes shall be laid down by the members of these scheme.
12) If legal notice / case is received by member he should forward the necessary documents to the concerned person.
13) Reply to the notice/case should be made only after discussing with the expert committee.
14) A discontinued member if he wants to join the scheme again will be treated as a new member.
15) Most of the negligence litigations related to medical practice EXCEPT the criminal negligence cases shall be covered under this scheme. The scheme will also NOT COVER the damages arising out of fire, malicious intension, natural calamity or similar incidences.

(Continue pg.no.58.....

The members of Professional Assistance Scheme

	Name	Place	Speciality
1	Dr. Dinesh B Thakare	Amravati	Pathologist
2	Dr. Satish K Tiwari	Amravati	Pediatrician
3	Dr. Rajendra W. Baitule	Amravati	Orthopedic
4	Dr. Usha S Tiwari	Amravati	Hospi/ N Home
5	Dr. Yogesh R Zanwar	Amravati	Dermatologist
6	Dr. Ramawatar R. Soni	Amravati	Pathologist
7	Dr. Rajendra R. Borkar	Wardha	Pediatrician
8	Dr. Alka V. Kuthe	Amravati	Ob.&Gyn.
9	Dr. Vijay M Kuthe	Amravati	Orthopedic
10	Dr. Neelima M Ardak	Amravati	Ob.&Gyn.
11	Dr. Vinita B Yadav	Gurgaon	Ob.&Gyn.
12	Dr. Balraj Yadav	Gurgaon	Pediatrician
13	Dr Kiran Borkar	Wardha	Ob & Gyn
14	Dr Prabhat Goel	Gurgaon	Physician
15	Dr Sunil Mahajan	Wardha	Pathologist
16	Dr Ashish Jain	Gurgaon	Pediatrician
17	Dr Neetu Jain	Gurgaon	Pulmonologist
18	Dr V P Goswami	Indore	Pediatrician
19	Dr Bhupesh Bhond	Amravati	Pediatrician
20	Dr R K Maheshwari	Barmer	Pediatrician
21	Dr Jayant Shah	Nandurbar	Pediatrician
22	Dr Kesavulu	Hindupur AP	Pediatrician
23	Dr Ashim Kr Ghosh	Burdwan WB	Pediatrician
24	Dr Narasimha Vathsalya	Banglore	Pediatrician
25	Dr Lalchand Charan	Udaipur	Pediatrician
26	Dr Ashish Satav	Dharni	Physician
27	Dr Kavita Satav	Dharni	Opthalmologist
28	Dr D P Gosavi	Amravati	Pediatrician
29	Dr Narendra Gandhi	Rajnandgaon	Pediatrician
30	Dr Apurva Kale	Amravati	Pediatrician
31	Dr Prashant Gahukar	Amravati	Pathologist
32	Dr Asit Guin	Jabalpur	Physician
33	Dr Sanjeev Borade	Amravati	Ob & Gyn
34	Dr Usha Gajbhiye	Amravati	Pediatric Surgeon
35	Dr Satish Agrawal	Amravati	Pediatrician
36	Dr Ashwin Deshmukh	Amravati	Ob & Gyn
37	Dr Anupama Deshmukh	Amravati	Ob & Gyn
38	Dr Jyoti Agrawal	Amravati	Pediatrician
39	Dr Sonal Kale	Amravati	Ob & Gyn
40	Dr Gopal Belokar	Amravati	ENT
41	Dr Amit Kavimandan	Amravati	Gastroenterologist
42	Dr Vinamra Malik	Chhindwara	Pediatrician
43	Dr Rishikesh Nagalkar	Amravati	Pediatrician
44	Dr Rashmi Nagalkar	Amravati	Ob & Gyn
45	Dr Ramesh Tannirwar	Wardha	Ob & Gyn
46	Dr Sameer Agrawal	Jabalpur	Pediatrician
47	Dr Sheojee Prasad	Gwalior	Pediatrician
48	Dr V K Gandhi	Satna	Pediatrician
49	Dr Shyam Sidana	Ranchi	Pediatrician
50	Umesh Khanapurkar	Bhusawal	Pediatrician
51	Dr Sushma Khanapurkar	Bhusawal	Gen Practitioner
52	Dr Sanjay Ghuse	Amravati	Gen Practitioner
53	Dr Kausthubh Deshmukh	Amravati	Pediatrician
54	Dr Pratibha Kale	Amravati	Pediatrician
55	Dr Milind Jagtap	Amravati	Pathologist
56	Dr Varsha Jagtap	Amravati	Pathologist
57	Dr Rajendra Dhore	Amravati	Physician
58	Dr Veena Dhore	Amravati	Dentistry
59	Dr Nilesh Toshniwal	Washim	Orthopedic
60	Dr Swati Toshniwal	Washim	Dentistry
61	Dr Subhendu Dey	Purulia	Pediatrician
62	Dr Dinakara P	Bengaluru	Pediatrician
63	Dr Laxmi Bhond	Amravati	Pediatrician
64	Dr Sangeeta Bhamburkar	Akola	Dermatologist
65	Dr Aniruddh Bhamburkar	Akola	Physician

Medico Legal News

Dr. Mukul Tiwari

Radiologists ordered to pay Rs 15 lakh for alleged negligence in ultrasound scan during pregnancy.

The National Consumer Disputes Redressal Commission (NCDRC) has ordered a Hospital of Indore and two of its radiologists to pay Rs 15 lakh as compensation to the parents of a child who was born without her left hand and a kidney. The hospital and the radiologists, however, denied negligence and claimed before the commission that as the foetus was lying on its side, with upper limbs tucked underneath, it was impossible to see if any limb was missing.

The order said "As per their own submissions, if opposite parties 2 and 3 (the radiologists), because of tucked position of the foetus, have not seen the limbs, then how both opined in their reports as 'foetal spine, trunk and limbs are normal'. Thus, it proves the negligent and casual approach of the radiologists while performing USG. It was a dereliction of duty of care."

According to complainant, father of the child, his wife was pregnant and under consultation of a gynaecologist. She advised ultrasonography (USG) to ensure well-being of the child. The USG was done in January 2009 by one of the Radiologists who reported that the foetal spine, trunk and limbs are normal. After three months, i.e. at 32 weeks of pregnancy, a second USG was performed by another Ultrasonologist, who also reported that the foetal spine, trunk and limbs are normal.

On May 18, 2009, complainant's wife gave birth to a female baby whose left arm and kidney were missing and even lungs were not completely developed. The foetal weight was 1500 gm only, instead of 2500 gm. In this regard the complainant expert opinion from a forensic medicine expert, who opined that it was a gross negligence.

The report said that "It appears that the doctors are often reluctant to testify against their colleagues (as the 'conspiracy of silence'), hence it is difficult to find an unbiased expert willing to testify against a negligent doctor or label the care as substandard. The opinion of a forensic expert is acceptable"

"Had the anomaly been detected the parents would have been referred to a tertiary foetal medicine unit for further investigations which would have revealed the presence of other anomalies in addition to the abnormalities of the foetal limbs. The existence of two serious anomalies would have resulted in the pregnancy being terminated," added the bench.

A Physician is free to decide whom he will serve treat, save in case of Emergency

Court rejected 2.5 Crore petition against Doctor and Hospital in Suman Taneja V/s. Metro Hospital and Heart Institute. Decided on 02/02/2016.The order observed "It was in the interest of Patients that Doctors should not be dragged to the Court unnecessarily, it prevents Doctors from discharging their duty to a suffering person who needs their assistance utmost".

The Complainant, widow of deceased patient, claimed her husband died of Inferior Wall Myocardial Infarction (IWMI) and did not receive the emergency treatment in Golden Hours. The Doctor refused to do initial stenting initially on the ground that he was on leave for holiday and thus Doctors violated the Hippocratic Oath.

2. The National Commission, after going through

Pediatrics Consultant, Gwalior., Founder Editor-in-Chief, JIMLEA

the entire record and medical literature, held that there is no Medical Negligence. The primary (Percutaneous Coronary Intervention) PCI was not done due to non-availability of cardiologist, with explained consent and patient was referred to higher center. It should be borne in mind that, every cardiologist is not capable or experienced to the extent to perform PCI. The record shows the proper treatment given to the patient.

No doctor will assure full recovery or give guarantee that result of surgery would be 100% cure" – National Commission. Rajesh Taneja V/s. Kaiser Hospital, Haryana.

The Complainant had undergone Total Hip Replacement (THR) of both sides. After few years, he suffered pain in the right hip and difficulty in walking and after check up, he followed the recommendation for replacement of acetabular cups, but in vain. Hence he approached PGI and was advised there for another THR, but Doctors at PGI expressed before complainant that due to infection, the complainant would need extensive treatment for removal of wire.3.Hence he arrayed the Doctors as opponents for medical negligence case thereby claiming compensation of Rs.90 lacks and alleged that the hospital had no necessary instruments, skill. It was not well equipped to perform such operations. The State Commission dismissed the complaint, hence the Appeal.

Doctors contended that Hospital is modern, well equipped, having high class medical services and doctors are well qualified. The patient was already a known case of Ankylosing Spondylosis (AS) for more than 20 years and in past had undergone three surgeries in PGI before coming to opponents. The operation was a complicated one. Due to Ankylosing Spondylosis, the spinal anaesthesia could not be administered, but it was given through tracheostomy. As the condition of hip was not satisfactory, Doctor successfully performed alternate procedure of Girdle stone arthroplasty. The patient recovered and achieved pain free hip. Hence there was no negligence.

Decision - The National Commission dismissed the Complaint, after perusing the entire record and after listening to arguments of the parties. It observed that The AS is not completely a curable disease and that only corrective surgeries will be helpful for mobility of patient. The allegations regarding negligence during induction of anesthesia is also not sustainable, because it is always difficult to give anesthesia in such patient of AS. Girdle stone is a standard procedure which can be done alternatively, where THR cannot be done and such switching to alternate procedure is not a negligence. It is known that no doctor will assure full recovery or give guarantee that result of surgery would be 100% cure. The Apex Court in number of cases has observed that negligence cannot be attributed to a doctor, so long as he is performing his duties to the best of his ability and with due care and caution and merely because the doctor chooses one course of action in preference to the other one available, he would not be liable, if the course of action chosen by him was acceptable to the medical profession.

"M.D. Medicine Doctor is not negligent when he gives Neurological treatment to a patient in emergency" – National Commission

Pankaj Singh Chouhan V/s. Dr. Sushila Tiwari Memorial Forest Hospital, Uttarakhand. Revision Petition No. 1332 OF 2016. Decided on 18th May 2016.

This judgment can be compared with earlier judgment which observed that M.D. Medicine cannot practice cardiology. This issue is required to be decided finally i.e. the area of practices of M.D.

Case - The Complainant's mother was admitted in the Hospital as a case of emergency. The patient was having high B.P. and was type II diabetic patient. After examination of the patient, it was found that there was blood clotting in various places of the brain of the patient. Therefore, treatment was started accordingly with higher antibiotic, anti-convulsant drugs.

After improvement in condition, the patient was discharged from the Hospital and patient was taken to SRMS Medical Institute, where it was diagnosed as Herpes Simplex Encephalitis. However after 16 days from the discharge of opponent hospital, the patient expired.

Complainant's allegation was that the M.D. Medicine Doctor who was on emergency duty was not a Neurologist and hence he failed to diagnose the neurological condition and had not treated the patient properly and hence filed a complaint before the Nainital District Forum and prayed for compensation of Rs.15,00,000/-. His compliant was partly allowed, but in appeal, State commission dismissed the Complaint and hence the Revision.

Defense :

1. The Hospital and the Doctors denied all the charges of negligence. It was contended that the Doctor was a qualified M.D. Medicine Doctor and he attended, the said patient in 'emergency', as per standard norms and started all the required treatment.

Decision-

1. The National Commission came to the rescue of Doctors and rejected the Complaint. After going through the medical records, it observed that on the basis of ECG, CT scan and other tests, it was clear that due to uncontrolled blood pressure and diabetes of the patient, the possibility of brain fever was expressed and advised CSF study also.

2. CSF report suggested possibility of viral encephalitis and it was discussed with the relatives of patient and advised them to take the patient to a higher neurology centre and accordingly the patient was discharged.

3. The complainant failed to add any evidence to prove that the treatment given by the Doctor was wrong or it further deteriorated the condition of patient.

It relied on the land mark judgement of Apex Court in the case of Kusum Sharma and Others V/s Batra Hospital and Medical Research Centre and others, AIR 2010 SC 1050, wherein Hon'ble Supreme Court observed "It is a matter of common knowledge that after happening of some unfortunate event, there is a marked tendency to look for a human factor to blame for an untoward event, a tendency which is closely linked with the desire to punish. Things have gone wrong and, therefore, somebody must be found to answer for it. A professional deserves total protection. The Indian Penal Code has taken care to ensure that people who act in good faith should not be punished"

Continue from pg.no.55)

16) All the doctors working in the hospital (Junior, Senior, Temporary, Permanent etc) shall be the members of the IMLEA, if the hospital wants to avail the benefits of this scheme.
17) The scheme can cover untrained hospital staff by paying extra amount as per the decision of expert committee.
18) A district/ State/ Regional level committee can be established for the scheme.
19) There will be involvement of electronic group of IMLEA for electronic data protection.
20) Flow Chart shall be established on what happens when a member approaches with a complaint made against him or her [Doctors in Distress (DnD) processes].
21) Telephone Help Line: setting up and manning will be done.
22) Planning will be done to start the Certificate / Diploma / Fellowship Course on med-leg issues to create a pool of experts.
23) Efforts will be made to spread preventive medico-legal aspects with respect to record keeping, consent and patient communication and this shall be integral and continuous process undertaken for beneficiary of scheme by suitable medium.

INDIAN MEDICO-LEGAL & ETHICS ASSOCIATION

PRESIDENT **Dr. Rishi Bhatia**

SECRETARY **Dr. Sudhir Mishra**

Website: www.imlea-india.org

"Humane Touch in Health Care"

Ref. No. Date:

To,
The Dean/ Principal
Medical College

Sub : **Subscription to the Journal of Indian Medico-Legal and Ethics Association.**

Dear Sir, warm regards,

We hope this letter finds you in good health and excellent spirit. The practice of medicine has changed drastically in the twenty first century. There have been many positive as well as negative changes. The good age-old doctor-patient relationship is in doldrums. Commercialization is the obvious agenda especially with the development of corporate culture in the health sector. This has resulted in soaring expectations. Because of all these, doctors are not only affected by medico-legal cases but many other legal problems.

The patient & the society are also many times misguided by friends, relatives etc & file a frivolous cases (as declared by various courts) further deteriorating the Dr-Patient relationship. We have experienced this on many occasions which prompted us along with some other colleagues & friends to create awareness & sensitization about these issues. In last few years we found various problems, which we were trying to solve single handedly. It was then, that we realized the need of a fleet of experts to work in co-ordination. This prompted us to form Indian Medico-legal & Ethics Association (The only Association of India working with the sole agenda of Medico-legal & Ethical issues in medical profession).

The JIMLEA is the official publication of this association with articles related to dr- pt relationship, communication skills, documentation, record keeping, medical negligence etc. We request you to include this journal in the Library of your institution, subscribe to it and also suggest your faculty to contribute original articles, review articles etc to this journal.

Thanking you in anticipation.

Yours,

Editorial Board Member

Enclosure: *Recent copy of the quarterly journal.*

INDIAN MEDICO-LEGAL & ETHICS ASSOCIATION

[Reg. No. - E - 598 (Amravati)]
Website - www.imlea-india.org , e mail - drsatishtiwari@gmail.com

LIFE MEMBERSHIP FORM

Name of the applicant : _____
(Surname) (First name) (Middle name)

Date of Birth : _____ Sex : _____

Address for Correspondence: _____

_____

Telephone No.s : Resi. : _____ Hosp. : _____ Other : _____

Mobile : _____ Fax : _____ E-mail : _____

Name of the Council (MCI/Dental/Homeopathy/Ayurved /BAR/Other) : _____

Registration No.: _____ Date of Reg. : _____

Medical / Legal Qualification	University	Year of Passing

_____ _____

Name, membership No. & signature of proposer Name, membership No. & signature of seconder :

A) Experience in legal field (if any) : _____

B) Was / Is there any med-legal case against you /your Hospital : (Yes / No) : _____
If, Yes (Give details) _____ (Attach separate sheet if required)

C) Do you have a Professional Indemnity Policy (Yes / No) : _____
Name of the Company : _____ Amount : _____

D) Do you have Hospital Insurance (Yes / No) : _____
Name of the Company : _____ Amount : _____

E) Do you have Risk Management Policy (Yes / No) : _____
Name of the Company : _____ Amount : _____

F) Is your relative / friend practicing Law (Yes / No) : _____
If Yes, Name : _____
Qualification : _____ Place of Practice : _____
Specialized field of practice (Civil/ Criminal/ Consumer / I-Tax, etc) : _____

G) Any other information you would like to share (Yes / No) _____ If Yes, please attach the details
_____

I hereby declare that above information is correct. I shall be responsible for any incorrect / fraudulent declarations.

Place : _____ _____

Date : _____ (signature of applicant)

Enclosures: True Copy of Degree, Council Registration Certificate & photograph.

Life Membership fee (individual Rs.3500/-, couple Rs.6000/-) by CBS (At Par, Multicity Cheque) or DD, in the name of Indian Medico-legal & Ethics Association (IMLEA) payable at Amravati. Send to Dr.Satish Tiwari, Yashodanagar No.2, Amravati-444606, Maharashtra.

IMLEACON 2016

2nd National Conference of Indian Medico Legal & Ethics Association

Registration Form

Full Name : .....

Age : ..... Designation/ Degree : .....

Place of work :.....

Mobile No: ..... E-mail ID : .....

Complete Address : .....

.....

City : ..... State : ..... Pin Code : .....

Registration Fees (Please -/ the appropriate option)

	Sigle	Couple
Conference	1200/-	1800/-
Conference + Workshop	1500/-	2000/-
Spot Registration	2000/-	2500/-

Payment Details :

Demand Draft (DD) ☐ NEFT ☐ Cheque ☐

Amount..... Cheque/ DD No .....

Name of Bank .....

Registration Information:

- DD/ at par Multicity Cheque will be accepted.
- Please get detailed information from the organizing Committee.

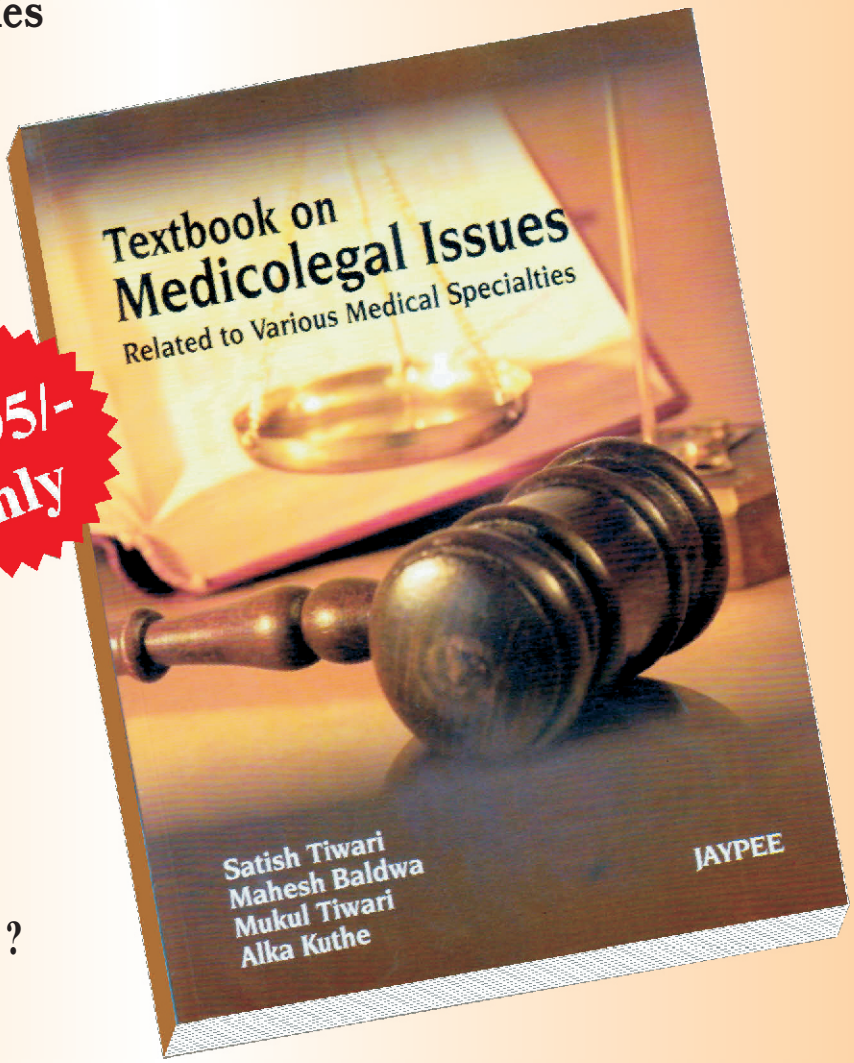
Please send the completed form with payment details (Cheque/ DD) to the following address:
Dr. Mukul Towari, Apex Hospital, University Road, Gwalior - 474011 (M.P.) India.
Phone : 2340910, 2340924 Mobile : 09827383008 or by Email to dr_mtiwari@rediffmail.com.

Printed and published by Editor in Chief of IMLEA (Indian Medico Legal & Ethics Association) and designed & printed at Abhinav Graphics, Ambadevi Road, Amravati. (M.S.) Mob. 9422890526

Textbook on Medicolegal Issues

A complete book on medico legal matters for doctors of all specialties

Publishers:
Jaypee Publishers



₹ 595/- only

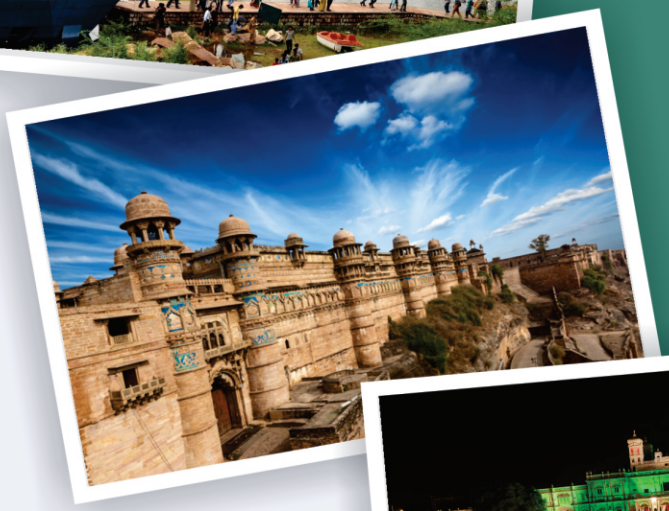
Available on
flipkart.com
amazon.in

Covers all Topics -

Consent
Documentation
How to fight a medico legal case ?
Medical errors and negligence
Criminal liability
Ethical issues
Medico legal issues in different specialties
What kind of indemnity policy should I take?
Doctor Patient Relationship
Communication Skills
Various Laws
and much more ...

SPECIAL DISCOUNT
for bulk/corporate purchase

Contact:
Dr. Satish Tiwari
(drsatishtiwari@gmail.com)
Dr Mukul Tiwari
(dr_mtiwarti@rediffmail.com)



IMLEACON 2016

Gwalior, 12-13 November

Invitation

The Historical City of Gwalior
Invites you to

IMLEACON 2016

2nd National Conference of
Indian Medico Legal &
Ethics Association

on 12-13 November, 2016
Workshop on 12th November
Main Conference 13th November

All interesting & relevant topics

- *Lectures*
- *Group Discussions*
- *Open House*

PLEASE BLOCK YOUR DATES

For information please contact:

- **Dr Mukul Tiwari - 9827383008**
- **Dr Prabuddhsheel Mittal - 9827301943**