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INDIAN MEDICO LEGAL & ETHICS ASSOCIATION

Aims & Objectives

- 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.

Medico-legal Aspects of Failed Tubal Sterilization

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Tubectomy or female sterilization is the most popular method of contraception in India. It is an important part of National Family Welfare Program & has played a major role in controlling population as compared to male sterilization. It is performed by junior most resident doctor to medical officer and senior most consultant. Though it looks simple in the expert's hands, is associated with risk of morbidity and mortality. There are different names given to this method of sterilization depending upon the name of the surgeon who performed it for the first time, route, instrument and the period when it is performed e.g. Modified Pomeroy's/ Irving/ Parkland/ Uchida/ Madleners Method, Puerperal /Interval/ Concurrent sterilization, Laparoscopic/ Hysteroscopic sterilization, Laparotomy/ Minilap/ Colpotomy etc. Each method has its own advantage, risk, failures and limitations. Ideally the surgeon should select the method which suits most to the patient and to himself, simple, safe and effective.

Failed tubal sterilization includes intra-uterine pregnancy any time after sterilization operation. The occurrence of ectopic pregnancy does not amount to failed sterilization The incidence of failed tubal sterilization is 1 in 2000 – 3000 sterilizations irrespective of method used. It is said that only removal of ovaries can give 100% protection from further pregnancy. Still ectopic ovarian tissue if present (? Hypothetical) can lead to conception. Failure rate is higher with LSCS, Puerperal, MTP, Young age & Madlener's method.

Causes of failed tubal sterilization

- Surgery during luteal phase
- Patient may already be pregnant
- Inappropriate or inadequately performed procedure leading to continuation of fertility and pregnancy in less than 1 year
- Spontaneous recanalization or proximal tubo-peritoneal fistula

Potential areas of legal action

- Consent/ Investigations/ Medications
- Choice of / Place of / Person doing the procedure
- Anesthesia and Anesthetist
- Follow up
- Tubectomy failure & death

Consent

Written informed consent is a must preferably in the format provided by government and in the local language .Consent for sterilization operation should not be obtained under coercion or when the client is under physical or mental stress. The client must be told that there is a chance of failure of varying percentage with any procedure and that reversal of this surgery is possible, but the reversal involves a major surgery and its success cannot be guaranteed. Undertaking of immediate follow up in case of complications or if misses menstrual cycle should also be taken.

What preoperative investigations are required?

Routine and basic investigations required are hemoglobin level and complete urine report. The pregnancy should be ruled out before selecting the patient for operation. If there is any medical

illness and still tubectomy is to be done then physician's advice is taken.

Medications/Anesthesia and the Anesthetist

The Anesthetist must be qualified and competent to handle the emergency. Local anesthesia is the first anesthesia of choice as per government directives. But the medications to be used and the type of anesthesia entirely depend upon the Anesthetist and the Gynecologist so far as it comes under standard practices. In case of local anesthesia presence of Anesthetist as a standby is recommended. In other types of anesthesia, presence of Anesthetist is a must.

Choice of method of sterilization

Choice of method to be used such as minilap or laparoscopic should be left solely to the beneficiary and the family. Proper counseling is a must and in that advantages, associated risks, failures etc. must be explained to the patient in details. However the choice of ligation procedure is solely left to the operating surgeon. One should not forget to mention the method used in the operative notes.

Who should perform the procedure?

Gynecologists are authorized. Any other who has learned modern medicine including other specialties can perform conventional female sterilization provided he has undergone training. For laparoscopic sterilization a proper training in an authorized institute is needed.

Whether the place needs registration?

Registration with the local body is required for performing sterilization or the statistical data collection and for the purpose of insurance by Government. Government has now a days published standards for accreditation.

When to perform the operation?

Puerperal sterilization can done up to six weeks post partum. Interval sterilization is done immediately after menstrual periods as the pregnancy is automatically ruled out. Age of children is in not a contraindication but the operation can be delayed if the children are very young.

Follow up

As per the Government recommendations first follow up should be done after 7 days of discharge or in case of emergency anytime after surgery. Second follow up should be one month later or after first menstrual period. Subsequent follow up should be as and when complaints or complications arise. At the time of discharge, the patient should be warned to report immediately in case she misses the menstruation.

Legal implications of failed tubal ligation

Civil suit for compensation can be filed under Tort while in Consumer court there can be suit for Negligence and deficiency in service. Criminal proceeding has no place as far as failed tubal ligation is concerned.

If there is a sterilization death then,

Post mortem is a must. Information must be sent to DHS, CS, DHO, HS, Dy. Health Secretary by telegram. It is mandatory for government as well as private hospitals to send full report including clinical PM attended by pathologist and Gynecologist.

Prevention of litigation

- Take maximum possible precautions in selecting the case and the procedure.
- Take informed consent after proper counseling as per State Family Welfare Bureau.
- Good and effective communication with patient, relatives, staff
- Document everything what we have done

and further follow up notes. Also document the need to report immediately in case of complications or in case she misses the menses for MTP, repeat sterilization or husband's vasectomy

- If we come together and force the Government to formulate a clear policy as regards protection to doctors in this important national program.

If you receive legal notice from the patient, consumer forum, or any other court then

- Contact medico-legal cell of your association (FOGSI, IMLEA etc.)
- Enclose copy of notice along with Xerox copy of insurance policy of concerned and current year
- Brief case summary should be made in consultation with medico-legal expert.
- Select proper advocate, discuss the case and prepare reply
- Burden of proof always lies with the patient
- Apart from above precautions,Tubectomy guidelines 2006 also protect us.

Case Law

Eskkimuthu vs Dr. Dhanam.I (2008) CPJ 130 (NC)

A woman became pregnant eight and half years after tubectomy. For that she consulted doctor who diagnosed as non-pregnant. USG was advised by another doctor which revealed 5 weeks of pregnancy. Subsequently patient delivered a female child. Negligence was held against 1st doctor for missing a diagnosis of pregnancy. District forum held doctor negligent. The doctor went to higher forum. State commission held doctor not negligent. The patient went in to appeal. But the National Commission too held doctor not negligent.

Findings of National commission

1. In the above case, Supreme Court's land mark judgment in case of State of Punjab vs Shiv Ram, (VI(2005) SLT 498-III(2005)ACC 717 (State Commission) = IV (2005) CPJ 14(SC)—AIR 2005 State Commission 3280 was taken as a case law by National Commission. Supreme Court has held that no method of sterilization is 100 percent safe and secure. In spite of successful operation , woman can become pregnant due to natural causes. If she misses a period she is expected to consult doctor immediately and if she does not want pregnancy she can get it terminated legally as per the MTP Act1971.
2. In view of above judgement of a Supreme Court, no sterilization operation is 100 percent full proof. Therefore government has formulated a scheme to pay Rs. 5000 to patient in case of pregnancy after tubectomy.
3. In this case the patient had consulted the concerned doctor in December 2000 and she got delivered in September 2001. It is not possible to detect pregnancy at such earlier stage.
4. Doctor had not given any medicine to terminate the pregnancy.
5. The order of State Commission is correct.

Thus one should not hesitate to do sterilization operation for the possibility of failure since it is a national program. At the same time operate with competency on a properly selected, well counseled patient, keep proper records, advise proper follow up and take the help of medico-legal expert if the need arises.

Medical Certificates

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Medical certificate is the document related to the illness, treatment, subsequent care & fitness. It is an integral part of day to day medical practice. Therefore it must be issued with request and utmost care. Any medical practitioner who is registered under respective Medical Council Act can issue medical certificate. Following are the do's and don'ts which one must know before issuing it.

- Please examine the patient thoroughly before issuing a certificate. Maintain complete medical record of history, clinical examination notes, diagnosis, investigations if any and the treatment given.
- Do not issue medical certificate to a patient who has not been treated by you.
- Do not issue certificate to a patient who is suffering from a communicable disease unless you have informed to concerned authority and the diagnosis is confirmed.
- Please write date, nature and duration of illness clearly along with your Medical Council's registration number. Do not forget to take patient's signature or left hand thumb impression on the certificate issued by you before handing it to the patient.
- Issue illness certificate and fitness certificate separately. Ideally fitness certificate should be issued by the same doctor who has issued illness certificate.
- Do not give certificate regarding operation unless you have operated upon the patient. If required charges should be mentioned clearly and correctly.
- Do not issue death certificate unless you have personally confirmed the death. Do not issue it if you have any doubt regarding cause of death even if patient is known to you. Inform the police in writing and request for post mortem to know the cause of death.
- Inform the police in case of sudden death (Death on table/ indoor death), accidents, medico-legal cases, brought dead, dog bite, snakebite cases. Maintain clinical records of such cases as the court of law or police department may demand them to investigate the case. Do attend the court if required in these cases.
- Do not issue receipts for the fees you have not charged.
- MTP, Vasectomy or Tubectomy certificates are valid only if issued by authorized medical practitioner who has undergone special training program as required by government guidelines and respective legislation. No compensation is awarded by the government if the operation is carried by unauthorized doctor at unauthorized centre.
- Always keep a copy of certificate issued and preserve it for the period required by law.

If one follows these instructions carefully, there should be no fear for the possible legal wrangles in the future.

Refereneces

Medical certificates: Do's & Don'ts in Legal Reporter: Gupte S.: 2012 Edition: Sethi S L Maharashtra Law agency, M.G. Road, Nasik,26-27

Medical Examination in Sexual Assault

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The World Health Organization (WHO) defines Sexual Violence as "any sexual act, attempt to obtain a sexual act, unwanted sexual comments/ advances and acts to traffic, or otherwise directed against a person's sexuality, using coercion, threats of harm, or physical force, by any person regardless of relationship to the victim in any setting, including but not limited to home and work." (WHO, 2003)

Exposure to sexual violence is associated with a range of health consequences for the victim. Rape may result in the following:

- Extragenital injury
- Genital injury
- Psychologic symptoms-"Rape Trauma Syndrome" has been first described by Burgess and Holmstrom in the year 1974. (Burgess and Holmstrom1974)
- Sexually transmitted diseases (STDs—eg, hepatitis, syphilis, gonorrhea, chlamydial infection, trichomoniasis, HIV infection [rarely])
- Pregnancy (uncommonly)

New guidelines were released for circulation on December 16, 2013 which mandate that every hospital must have a designated room to deal with Medico Legal Cases (MLC) of sexual assault to provide privacy to the victim and must have essential equipments (couch, lighting, magnifying glass, swabs, specimen containers, water) listed in the guidelines.

As per the guidelines, while carrying out medical tests no third person must be present in the room other than the doctor. If the doctor is male, a female attendant must be there. The examination should be conducted in private but the patient should be allowed to request a support person (e.g. family member or rape councilor) to be present. If the patient does not request the presence of a support person, a female nurse or other suitable chaperone should be present during the examination.There must be provisions to provide alternative clothing for the victims and smooth collection of MLC evidence keeping in mind the sensitivity of the circumstances. Also, there must be training sessions for sensitizing doctors and other medical staff for the protocols and guidelines for MLC examination/reporting of such cases.

Whenever such cases reports to the hospital, it shall be registered as MLC whether patient comes on her own or is brought by the police. If patient comes on her own then decision to inform the case to police shall be taken after obtaining due consent from the patient and or guardian. The consent form must be signed by the person him/herself if s/he is above 12 yrs. of age. Consent must be taken from the guardian/ parent if the survivor is under the age of 12 years or if the survivor is unable to give his/ her consent by reason of mental disability. (Section 89 IPC) The consent form must be signed by the survivor, a witness as well as the examining doctor. Any refusal for examination and evidence collection must be documented (Section164 (A) CrPC).

Supreme Court has clarified in case of Manjanna v State of Karnataka (2000) that police requisition is not mandatory for a sexual assault survivor to seek medical examination and care. The doctor should examine such cases even if the survivor reports to the hospital first without FIR.

General Information and Consent

1. Enter the OPD number/ IPD Number.
2. Enter the MLC number.
3. Enter the full name of the patient/ victim or survivor.
4. Enter the age/ sex of the patient. Also enter the marital status of the patient i.e., whether single, married, divorced etc.
5. Enter the patients address with contact number if any.
6. Enter the date and time of arrival of the patient or victim at the hospital.
7. Brought by:
   a. If the patient is accompanied by a police or

law enforcement officer, enter the officer's name, buckle/ identification number and police station of accompanying police with letter no/date etc.

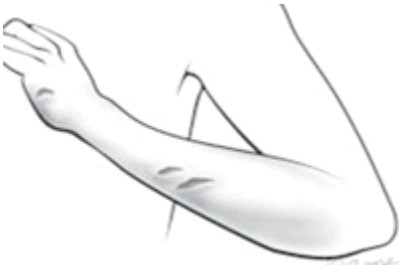
b. If the patient comes on her own then enter the name of the person (if any) with relation who accompanied the patient.

***The doctor should examine such cases if the survivor reports to the hospital first without FIR. He then informed the police accordingly as per the request of the patient.

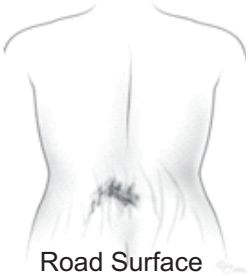
***A survivor may come to the hospital only for treatment for effects of assault. Under section 39 CrPC the doctor is not bound to inform such cases to the police. Informed refusal for not informing the police should be documented. Neither court nor police can force the survivor to undergo medical examination.

Examination of a rape victim includes

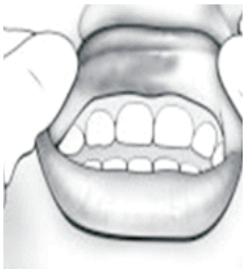
- Consent- Consent of the patient to be taken for the following purposes:
  - Medical Examination & treatment
  - Forensic medical examination & Collection of the evidence
  - Informing police for purposes of investigation
  - Treatment
- History
- Physical Examination
  - general examination
  - genito-anal examination
- Sample collection
- Documentation and reporting
- Physical Examination-
- General appearance
- Bruises and contusions (e.g. inner aspect of thighs, scalp, face, lips);
- Lacerations (e.g. scalp, forearm);
- Ligature marks (e.g. ankles, wrists and neck);
- Pattern injuries (i.e. fingertip marks, scratch marks, bite marks, factitious self-inflicted injuries)



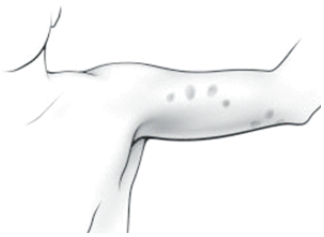
Defensive Injuries



Road Surface Injuries



Bruising inner upper lip



Bruising upper arm

Genito-anal Examination

- Inspection, labial traction
- Swabs
- Speculum examination
- Anal +/- digital +/- proctoscope

Forensic Specimens

- Vulval / vaginal / endocervical swabs
- Buccal swabs – for DNA profiling Other swabs (e.g. anal, oral, breasts)
- Fingernail (clipping / scraping)
- Pubic hair
- Clothing / debris
- +/- Toxicological samples (blood, urine)

Time frame for collection-The nature of forensic evidence collected will be determined by three main factors - nature of assault, time lapsed between assault and examination and whether the person has bathed/washed herself since the assault. If a woman reports within 96 hours (4 days) of the assault, all evidence including swabs must be collected without fail, in keeping with the history of assault. The likelihood of finding evidence after 72 hours (3 days) is greatly reduced.

- Oral swab: up to 1 day (usually few hours)
- Drugs and alcohol:
  - blood up to 4 days (usually half-day)
  - urine up to 7 days

- Rectal swab: 3 days (usually 1 day)
- Vaginal swab: up to 7 days (usually < 72 hours)
- Skin swab: before washing
- Dry material (panties): before washing

Request the survivor to stand on a large sheet of paper, so as to collect any specimens of foreign material e.g. grass, mud, pubic hairs or scalp hairs etc. which may have been left on her person from the site of assault or from the accused. This sheet of paper is carefully folded and preserved in a bag to be sent to the FSL for trace evidence detection.

Describe each piece of clothing in the table provided. Presence of stains - semen, blood, foreign material etc. - should be properly noted. Also note if there are any tears or other marks on the clothes. If clothes are already changed then the survivor must be asked if s/he has the clothes that were worn at the time of assault and these must be preserved

Collect blood and urine for detection of drugs/alcohol as the influence of drugs/ alcohol has a bearing on the outcome of the entire investigation. If such substances are found in the blood, the validity of consent is called into question. In a given case, for instance, there may not be any physical or genital injuries. In such a situation, ascertaining the presence of drug/alcohol in the blood or urine is important since this may have affected the survivor's ability to offer resistance.

In the case of any suspected seminal deposits on the pubic hair of the woman, clip that portion of the pubic hair; allow drying in the shade and placing in an envelope. Pubic hair of the survivor is then combed for specimens of the offender's pubic hair. Take two swabs from the vulva, vagina, anal opening for ano-genital evidence.

Swabs must be collected depending on the history and examination. Swabs from orifices must be collected only if there is a history of penetration. One vaginal smear is to be prepared on a glass slide provided, air-dried in the shade and placed in an envelope. This extra wet smear prepared should be examined for spermatozoa under the microscope. Swabs for microbiological tests for infections may be sent as per institutional policy and availability.

Discharge & Follow up

Health care personnel (preferably examiners) should address the following issues with patients prior to discharge.

Provide patients with oral and written medical discharge instructions. Include a summary of the exam (e.g., evidence collected, tests conducted, medication prescribed or provided, information provided, and treatment received) and medication doses to be taken.

Follow-up appointments

For patients with evidence of acute trauma: A short-term follow-up appointment to reexamine and document the development of visible findings and photograph areas of injury; and an exam 2 to 4 weeks later to document resolution of findings or healing of injuries.

Repeat exams for STIs / pregnancy according to facility policy or for long term care as in administering doses of Hepatitis B vaccine. Follow-up tests for the following are done:

* At 6 wk: Gonorrhea, chlamydial infection, human papillomavirus infection (initially using a cervical sample from a Papanicolaou test), syphilis, and hepatitis
* At 90 days: HIV infection
* At 6 mo: Syphilis, hepatitis, and HIV infection
* If the vagina was penetrated and the pregnancy test was negative at the first visit, the test is repeated within the next 2 wk.

References

1. Guidelines for medico-legal care for victims of sexual violence. Geneva, World Health Organization (WHO), 2003
2. Draft manual submitted by Dr Indrajit Khandekar, Assistant Professor, Dept of Forensic Medicine, Mahatma Gandhi Institute of Medical Sciences (MGIMS), Sevagram to Bombay High Court Nagpur Bench under PIL filed on his extensive study report. (WP) no. 1/2010 (Dr Ranjana Paradhi & Adv Vijay Patait Vs Union of India & others).
3. Manual for Medical examination of sexual assault by CEHAT 2010.
4. The comprehensive health sector response to sexual assault. CEHAT working paper no.1, 2010
5. Manual for medical officers dealing with medico-legal cases of victims of trafficking for commercial sexual exploitation and child sexual abuse. Department of Women and Child Development, Government of India.
6. Modi's Medical Jurispridence and Toxicology, 23rd Ed.
7. Dr. K. S. Narayan Reddy's, The Essential of Forensic medicine and Toxicology, 29th Ed.
8. J.B.Mukherjee's Forensic medicine and Toxicology, 3rd Ed.
9. The Criminal Law (Amendment) Bill, 2013 As Passed By Lok Sabha On 19 March, 2013

FAQs related to Medical Record Keeping & Documentation Issues

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Q. What is the peculiarity about medical records?

Patients and doctors may forget but records will always remember. Records are admitted as evidence to court of law. The written records produce evidence irrefutable in court of law.

Q. Why records are best defense against litigation?

Medical records are our best defense against allegations of negligence, deficiency of service and unfair trade practice and medical malpractice. But Records should be transparent, correct, clear, comprehensive, chronological manner written with use of contemporaneous method of abbreviations so the accountability becomes apparently clear.

Q. Why records improve quality medical care?

Quality improvement can be done by review of hospital records. Good quality records are desirable because of their importance in clinical management of patients and value in professional evaluation of quality care, decreasing morbidity and mortality.

Q. What does medical record includes?

Following is purported to be exhaustive list of various records yet it may vary from case to case

a. Outdoor case paper / register / booklet /card/ letterhead/loose prescription sheet/chit

b. Under treatment certificate/sick certificate / fitness certificate

c. Referral to other doctor /pathology lab/ x-ray / Sonography / CAT/ MRI

d. Record of Informed consent with patient name, name of procedure/surgery/anesthesia, date, place, duly signed and witnessed

   1. Is consent required for giving injections / immunization/internal examination like PV examination of breasts and PR ? routinely NO but presence of relative in the room is required, it does not mean the relative has to supervise doctor. Presence of female attendant is must for examination of females.

   2. In case of known allergy or hypersensitivity or specific contraindications in patient administration of injections need test dose and consent.

   3. Allergy to egg protein or neurological disorder children may require consent for immunizations.

Q. What constitutes reasonably good records of Indoor case paper?

Good IPD records should have one or more of following qualities:

1. Chronological order of progress of disease and treatment given
2. Monitoring of vitals, Minimum pulse, BP, RR and Temp. In patients with diabetes monitoring of blood sugar levels, CAD serial ECG's or continuous monitoring
3. Pathological test, when ordered and what are the positive findings to be recorded on case paper
4. X-Ray, Sonography with report, when ordered and what is the positive finding on case paper
5. Pre invasive procedure or pre-operative treatment or preparation, which is usually aimed at avoiding vagal shock averted by inj Atropine, aspiration during anesthesia averted by NBM, Ranitidine, Inj Metaclopramide
6. Details of invasive procedure or surgery or anesthesia given
7. Post procedure or post operative treatment

   a. Date wise record of investigations be it

radiological, pathological or reports of CAT or MRI or any other opinion of specialist or consultant

b. Record includes record of refusal of treatment or investigation or surgery

8. PM doctors give Postmortem notes

Q. What are the common problems of record retention?

Following are common problems of record retention:

a. Customarily patient retains OPD records

In India outpatient records, vast majority of doctors, write the history, clinical findings, and positive finding in investigation reports on letter heads and hand over to the patient.

b. Customarily patient retains investigation and imaging records

Reports of blood, stool urine and imaging investigation are retained by patient party in original.

Q. What are the storage problems of OPD records?

No doubt if all OPD patients' records are retained by doctor then it shall create shortage of storage space in doctor's clinic if maintained in physical form. The solution is to maintain records in electronic format. It is allowed as evidence under section 65 B of Indian Evidence Act as well as Information Technology Acts.

Q. What are the disadvantages of using conventional paper-based medical records?

The conventional paper-based medical record has several limitations. The limitations are

1. tracking down patients and
2. coordinating healthcare process
3. indexing
4. illegible
5. Errors and fragmentation.
6. Accessible to only one person at a time.

Q. What are the reasons, explanations for Loss of OPD record?

Customarily retention of OPD records by patients. Practically it is observed that a majority of patients, when asked for their records (especially after some length of time), they will very casually inform you that they have has lost the papers. This is what happens to your painstakingly taken history and physical findings written on OPD case papers. The standard explanations are: paper lost from in rickshaw, taxi, motorcar, bus. OPD case papers are also lost in shifting of residence and eaten by rats. More sophisticated patients will give more plausible replies. But the fact of the matter is that very few patients place a value on the medical records and may not produce them when required, so that the very purpose of using them for future treatment is defeated. This is the non-medico legal dimension of parting with the records, which is helpful to a litigant doctor.

Q. How records are best defense in medico legal cases?

Remember medical records are our best defense when we have to reply to allegations against us. We have to give more importance to OPD records. If the choice is between the patient and you having the records, it is better for you to have the records. If both can have them, it is ideal. EMR or electronic medical record keeping is a also good option. And finally, as always, better to be safe than to be sorry in maintaining proper records.

Q. How long To maintain records?

Following are the time limits for Maintaining Records:

1. Ideally records of adult patients are maintained for 3 years and children, for 21 years. (3 + 18 years). Mentally retarded forever till the person is practicing.
2. From Income tax point of view for seven years
3. As per code of medical ethics April 2002 for 3 years

Q. How to destroy records?

Following are the guidelines to destroy records:

1. Give a public notice in one English and one vernacular newspaper, with a time limit of usually one month from date of publication in which any one wants the relevant paper can come and take a copy of record needed.
2. After one month destroy record for every one save and except,
   a. Where litigation is going on
   b. Pre-litigation process of notice exchange is going on
   c. Mentally ill or retarded patients
   d. Where you expect that there could be future trouble.

Q. How should destroy the hard copy of paper records?

The only safe methods for destroying paper records are incineration or shredding and should not be given to RADDIWALA. A destruction method for electronic medical records is by electronic method.

Q. Where can medical records be stored?

Inactive records may be separated from the active patient cases and stored outside the office premises. Take the following safety majors into consideration when making arrangements for long-term storage by outsiders:

Privacy— will the records be protected from unauthorized persons?

Safety— will the records be protected from fire or flood damage and unauthorized access or theft?

Accessibility—will the records be easy to retrieve and copy?

Q. When to avoid electronic format of record keeping?

Avoid electronic format of record keeping in following situations

1. Frequent monitoring of vitals parameters and investigations on heat labile paper.
2. Document Moribund patient
3. Document complications of disease, drug, surgery, anesthesia or procedure
4. Document if Patient suddenly take a serious turn
5. Document Patient's transfer to other hospitals/doctors
6. Document for police Accident / suicide / attempted homicide /poisoning/ burns /fracture / tetanus and cases involving violence causing disease or injury

Q. When is hard copy of the records essential in medico legal point of view?

In following situations hard copy of records is essential

1. Consent needs to be on hard copy
2. Transfer to other hospital needs hard copy
3. Referral to doctor / investigations need hard copy
4. Police cases need hard copy
5. Certificate of leave / sick certificate /fitness certificate needs hard copy
6. All registers needed by various authorities like birth, death, MTP,PNDT, tubal ligation / vasectomy registers, Indoor admission, Outdoor registers, police information, OT registers, sterilization of registers /autoclave registers/ notifiable disease / Nursing /order book or register, bill books etc need hard copy
7. Highlight Risks and warnings - This is vital information which the physician is to be made aware of quickly. These need to be highlighted before seeing or treating the patient; for example, allergies, and drug sensitivities or high risk medical conditions. This should also include legal status of the patient. An important risk would also be history of violent tendencies, HIV status or known abuser of health care services.

Q. Which records need to be kept ready for inspection always?

Following are the records need be kept ready for inspection always :

1. Degree certificates,
2. MMC/MCIM Registration,
3. approvals, licenses,
4. Nursing home
5. Shop establishment registration etc.
6. biomedical waste act,
7. MTP act,
8. PNDT act,
9. spirit licence,
10. Narcotic drugs licence etc.

Q. Which records are to be kept in duplicate?

Following are the records need be kept in duplicate

1. Patients that are referred to other doctors with signature of patient/rep.
2. Patients that are transferred to other hospitals with signature of patient/rep.
3. Information to police / MLC cases with signature of patient

Q. Which eventualities are covered by keeping duplicate records?

Following are covered by keeping duplicate records

a. Patient alleging that he kept on taking treatment to overcome the legal limitation clause for time bar.

b. Some case papers of particular date are not annexed with complaint to suit allegations.

c. Allegations that investigations, referral to doctor, transfer or MLC case registration was not done

Q. Who has a legal right to retain medical documents?

This is a vexed question and needs to be addressed. But generally OPD records are customarily held by patient and IPD records are customarily retained by doctor. Does a physician or a hospital have the right to retain documents that contain information relating to the patient? There is one view, which holds that since information contained in a document is privileged the physician/hospital has the right to retain such document. A contrary view holds that the information, for future reference should be given when specifically sought. It is submitted that information, though privileged, is about the patient who seeks the document. The same cannot be withheld since there cannot be a privilege against a person who seeks information about him contained in a document. A physician or hospital may retain a photocopy of the document given to the patient Alternately; the patient could be supplied with a photocopy of the document sought while retaining the original with the physician/hospital. A similar approach should be adopted regarding X-ray plates and other information about a patient. A physician/hospital is bound to disclose information when ordered by a court or agencies concerned in the administration of justice. In Bombay High court decision in Radhyeshyam Raheja v. Maharastra Medical council that the patient should be supplied with required Xeroxed documents at reasonable charge.

Q. Is information stored in other formats, such as videos, x-ray films, ECGs, fetal monitor strips, and photos, part of the medical record?

Yes. Regardless of format, any and all data collected at the time of a patient encounter is part of the medical/legal document.

Q. How long should billing records, telephone calls/messages, and appointment registers be kept?

The Doctors Company recommends the following:

a. Billing records in all states should be retained for seven years according to Internal Revenue Service standards. They may be kept in a separate file.

b. Telephone calls that pertain to medical care

should be documented in the medical record and kept according to the above medical record retention guidelines.

c. Appointment register may be kept for 3 year.

Q. Can records be transferred to microfilm or disk or stored in a computer?

Yes. The factors in the previous question can also guide you on transferring records to microfilm or disk and on storing records in a computer. Protected health information (PHI) transferred or stored electronically must be encrypted. Computer data should be backed up at regular intervals and stored off site, as in the previous question.

Q. Is it sufficient to back up a copy of an electronic health record (EHR) onto a disk?

Yes. However, you should store a copy of the EHR software, along with the data itself, to make sure the records can be read in the future. Alternatively, you could save the data in PDF format so it can be read without special software. Regardless, all PHI stored electronically must be encrypted.

Q. If a patient requests original record, can I hand over the original record?

No. The original is the property of the physician, who has a duty to maintain the record.

Q. If someone claiming to be a representative of a deceased patient's estate requests a copy of the chart, what should I do?

You must verify that the individual is a authorized representative of the decedent's estate (for example, heir, the executor etc). The individual should provide a copy of an official document prove his claim of heir, the executor.

Q. can physician disclose data for secondary purposes like research, from TPA managers, private companies providing risk management services.

Yes, but permission of patient by special consent is required

Q. Who should Retain IPD health records in original?

Doctors should be keep IPD records in original.

Q. How to "record" and "maintain" medical records pertaining to "visual and audio recordings" of patients?

Yes, but permission of patient by special consent is required

a. Recordings made as part of a patient's care

b. Recordings made for research, teaching, training and other healthcare-related purposes

c. Recordings for use in widely accessible public media (television, radio, internet, print)

d. Telephone and other audio recordings

e. Making recordings covertly

f. Deceased patients

g. Storing and disposing of recordings

Q. Is doctor obliged to give records under right to information Act 2005?

Private doctor is not covered by right to information Act 2005; doctors in public sector must seek the permission/special consent of the patient before giving records under right to information Act 2005

Q. Why should doctor use EMR Software?

Electronic medical record software can help you effectively maintain your medical records. Using EMR software can help you effectively overcome the disadvantages of the conventional paper-based method. EMR software can be accessed by many at the same time. EMR software eliminates errors, fragmentation and wrong indexing. It is permitted by 65 B of Indian evidence act.

Q. What are the advantages of using EMR software?

a. The EMR software enables the input, storage, transfer and the retrieval of medical information within a practice and enables the interfacing with other data providers outside the practice.

b. Using the EMR software can result in financial benefits such as, savings on transcription, recording and proof reading.

c. The electronic medical records software enables healthcare physicians to spend their time with patients without wasting time on transcription.

d. The PDA interface of the EMR software enables the doctor to capture super bill details for hospital visits, ensuring that no billing information for a patient is lost. This feature also enables the doctor to track appointments while on the move.

e. The electronic medical record solution can effectively use the charts database to optimize claim documentations, thereby ensuring higher returns for each claim.

f. The EMR software solution can be integrated with different insurance providers.

g. The electronic medical record software has built-in integration points with other financial and ERP/products.

Q. What makes the EMR software different?

a. The EMR software can effectively handle and manage large practices and healthcare centers

b. The EMR software can proficiently addresses the main needs of a hospital information system, since it is a knowledge based system

c. The electronic medical record software can incorporate all the departments of a practice

d. The EMR software can provide 24x7access to comprehensive information across the enterprise

e. The EMR software can competently perform medical billing functions

f. Using the EMR software can help you reduce errors

Q. What are the characteristic features of EMR software?

The electronic medical record software usually has the following characteristic features.

a. The EMR software can competently address issues regarding security, confidentiality and privacy

b. The EMR software can store data according to the related regulation acts

c. The EMR software is cost-effective and easy to use. You can also save on time and effort by using EMR software. The EMR software can be easily merged into your existing processes without any hassles

d. The EMR software can efficiently store, transfer and retrieve medical information within a practice.

Q. Will EMR software be able to enhance the functionality of a practice?

Yes. The EMR software can increase and improve your efficiency as it has an electronic patient check-in. The EMR software can also be effectively used to access any records on a 24x7 basis.

Q. How can the EMR software benefit my healthcare organization?

By employing the use of the EMR software at your hospital you can benefit from the following.

a. doctor/hospital can experience accurate and error-free coding with the help of the coding functions and templates in the EMR software

b. Your patients can easily access the results of their tests

c. Paperless records

Q. What are some of the modules in the EMR software?

The following are some of the modules in the EMR software.

a. Appointment Scheduling Module

b. Medical Billing Module

c. Messaging Module

d. Archiving Module

e. Drug Interaction Module

f. Fax/Scanner Integration Module

g. Reports Module

Medico-legal awareness among delegates of MP State Conference 2012 (AMPOGS)

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Introduction

Consumer Protection Act and Medical negligence is a burning issue today. Each and every doctor and specialist of any field will be affected. The recent increase in litigation against doctors is an issue of immediate concern. The reasons for this are social, economic, professional and judicial. Social factors include increasing media awareness about medical facts and fallacies, professional accountability, and rights of patients in terms of information, decision-making and assessing outcomes. Negative publicity in the media about the profession has done further damage. Moreover, doctor-patient confrontations have been increasing in the recent past in the state. Doctors should familiarize themselves with the regulations and laws that concern their practice. Hence, this study was taken up to assess the knowledge and attitude of medical - legal awareness among doctors

Aims and objectives

(1) To know the knowledge of fellow doctors about CPA and Medical negligence. (2) To know the attitudes of fellow doctors about CPA and Medical negligence.

Subjects and method

A structured questionnaire was designed containing 25 items relating to knowledge of and attitudes towards medico-legal issues and distributed to delegates of AMPOGS (Association of Madhya Pradesh Obstetric & Gynecological Societies) at Gwalior in 2012. Distribution was entirely random and personally after explaining the concept Confidentiality was maintained. Some forms were also distributed as a part of delegate kits. After filling the forms they were collected from the conference hall and through some exhibition stalls. 400 forms were distributed out of which only 180 forms were returned back, completely filled while 100 were half and incompletely filled. Only the fully completed forms were taken for analysis. These were analyzed, tabulated and conclusions were drawn.

Results, analysis and discussion

On asking whether in their opinion knowledge of CPA and Medical negligence, is available in medical syllabus all the respondents replied negatively. 96% replied affirmatively about need for knowledge to be imparted regarding CPA and Medical negligence during MBBS course and not later at level of post-graduation.

Table 1. Perception about knowledge of CPA and Medical negligence of individual doctor in percentage

Percentage of knowledge	Number of respondents
0 - 10 %	05
11 - 25 %	56
26 - 50 %	72
51 - 75 %	31
> 75 %	16

Majority considered themselves to have less than 50% knowledge about CPA and Medical negligence

On asking their major source of knowledge about

CPA and Medical negligence, 90% mentioned CMEs and conferences, rest 5% answered from friends and remaining mentioned magazines and media. On further asking about preferred source of knowledge 96% said conferences and CMEs. Asking about their attendance at lectures related to CPA and Medical negligence in conferences 84% said yes, they attend such sessions and approximate duration of CME attended by the majority is 10 hours till date.

Table 2. Attendance in hours at medico-legal CMEs and lectures

Hours attended	Number of respondents
0-10	112
11-20	28
20-30	36
>30	04

Last CME related to CPA and Medical negligence attended was more than 12months ago by majority (71%)

Table 3. Duration since last medico-legal CME

Duration since last medico-legal CME	Number of respondents
> 12 months	128
< 12 months	52

Most of the delegates (87%) did not know when CPA was implemented. Likewise regarding landmark cases related to CPA most of them are ignorant. Majority did not know about hierarchy of Consumer Forum, location of their district and State Forum, about procedure and further steps nor were they aware about name of any local jury members of the Consumer Forum. Many were not aware whether a doctor too can be a jury member. Most of them were not able to define consumer (76%) and medical negligence (63%). Many did not know about detailed terms and condition of their Professional indemnity (66%). On asking whether they were a member of any professional organization, 97% said yes ie mainly FOGSI (Federation of Obstetric & Gynecological Societies of India) and IMA (Indian Medical Association).

Conclusion

From this study, I have concluded that doctors feel an urgent need to sensitize for knowledge related to CPA and Medical negligence and their major source is CMEs and conferences. Most of them are not updated regarding details of their day to day relation with medico-legal matters. Compared to other topics in obstetrics and gynecology less importance is given to attendance at medico-legal sessions. The study also highlights the importance of seminars, conferences and continuing medical education as a source of knowledge.

Take Home Message

More CMEs and conferences should include sessions to spread awareness on medico-legal issues and sensitize authorities to incorporate this field along with Forensic Medicine into the medical curriculum. The major advantage of medico-legal awareness would be that though a lawyer may not be able to work well with little knowledge of medicine however a doctor may work safely and in a better way with some useful knowledge of law related to our profession.

Legal Issues and Medical Errors

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"Errors are an inevitable and unfortunate reality of medical practice"

Medical error is said to have occurred when a medical professional chooses an inappropriate method of treatment or chose the right treatment but carried it out incorrectly. Common preventable medical errors are wrong site surgery, leaving a gauze or artery forceps in body cavity during surgery, administering the wrong medication, or transplanting wrong organs, transfusing wrong blood and resulting reactions, transposing anesthetic gas pipes causing death etc. Today healthcare delivery has become a very complex and tightly inter-locked system. A lapse at any one step is bound to have repercussions on the next steps. Medical errors happen when something that was planned as a part of medical care doesn't work out. In this era patients have soaring expectations and due to legal activism it is important to know that even a minor error can be considered as negligence, deficiency in service or unfair trade practice. Various Courts or Consumer forum also expect average, standard and error free care from qualified medical fraternity. The scientific and technical advantages have increased the chances of errors related to newer and newer electronic gadgets.

The spectrum

Worldwide there is increasing awareness of the high incidence of medical errors and their significant associated morbidity. A study focusing 2002-2004 hospitalization in US reveals that about 83,000 potentially preventable deaths occurred each year. Preventing medical errors and injuries among hospitalized children is studied by Landrigan in detail [1]. Beside hospitals, medical errors also occur in other health care settings such as clinics, physicians' offices, pharmacies, nursing homes, urgent care centers and the care delivered in the home [2]. The Commonwealth Fund, 2002 suggests that one in five Americans (22%) report that they or a family member have experienced a medical error of some kind. The office of the medical inspector at the Veterans Administration (VA) reported a total of 2,927 medical errors from June 1997 to December 1998, more than 700 of which resulted in accidental patient deaths or suicides. According to agency for healthcare research and quality, 2002, about 7,000 people are estimated to die each year from medication errors - about 16 percent more deaths than the number attributable to work-related injuries. Findings of Institute of Medicine, 1999 appreciate that in all US hospitals, the increased costs of preventable medication errors costs the economy about $2 billion each year. One extrapolation suggests 180,000 people die each year partly as a result of iatrogenic injury, the equivalent of three jumbo-jet crashes every 2 days [3]. A study was conducted in a teaching hospital to identify and analyze medical errors in pediatric practice. All admitted children underwent surveillance for medical errors. Of 457 errors identified in 1286 children, medication errors were 313 (68.5%), those related to treatment procedures were 62 (13.6%) and to clerical procedures 82 (17.9%). Physiological factors accounted for 125 (27.3%) of errors, equipment failures in 68 (14.9%), clerical mistakes 118 (25.8%), carelessness 98(21.4%) and lack of training for 48 (10.5%). Morbidity was nil in 375 (82%), mild in 49 (10.7%), moderate in 22 (4.8%) and severe in 11 (2.4%) errors [4].

Is it error of judgment?

Error of judgment can be considered if there is error in interpretation of some of the symptoms, signs or investigations in any particular patient. This may lead to wrong diagnosis or treatment. Error of judgment is accepted defense in most of the courts

in cases of medical negligence. In a recent Supreme Court judgment (Martin F D' Souza v. Moh Ishfaq Civil Appeal no. 3541 of 2002), the Apex court has agreed that while doctors who cause death or agony due to medical negligence should certainly be penalized, it must also be remembered that like all professionals doctors too can make errors of judgment but if they are punished for this no doctor can practice his vocation with equanimity. Indiscriminate proceedings and decisions against doctors are counter-productive and serve society no good. They inhibit the free exercise of judgment by a professional in a particular situation.

Incidence of errors

Although about 1% of hospital admissions have an adverse event due to negligence [5], mistakes are actually much more common as these studies only identify mistakes that lead to measurable adverse events occurring soon after the error. The Institute of Medicine (IOM) called for a broad national effort to include establishment of a center for patient safety, expanded reporting of adverse events, development of safety programs in health care organizations, and attention by regulators, health care purchasers, and professional societies [6].

Common medical errors & case laws

They are several types of errors related to planning or performance, active or latent, and in relation to diagnosis, treatment or prevention. The consequences of the errors are potentially serious for both the patient and the doctor. The federal government's Agency for Healthcare Research and Quality (AHRQ) found that 18 categories of medical errors, such as postoperative infections, accidental reopening of surgical wounds, and medical objects left inside patients, result in 32,500 hospital deaths, cost $9.3 billion in additional hospital charges, and lead to over 2.4 million extra days spent in hospitals. The following list of potential causes is not exclusive, but it does cover the main areas and most medical errors could be avoided if the doctors, nurses, dentists and other practitioners took more care. Some of the common medical errors along with the views of different courts are discussed below:

- *Diagnostic errors:* This type of error could be a direct mistake of a doctor or caused when the doctor is acting on incorrect information supplied by some other person. The national commission in; Bombay Hospital v. Sharifabai Ismail I (2008) CPJ 432 (NC) held that consultant is liable for errors in interpreting report. Senior consultant is not expected to sign whatever junior staff suggests, without reading the same. The consultant radiologist who signed the report is responsible for misreading / non-reading of MRI films correctly. The duty of consultant begins and ends with correct interpretation of reports of film/scan.
- *Inappropriate communication between various medical service providers:* In an important and interesting judgment S Sharma v. Bombay hospital II (2007) CPJ 9 (NC); National commission has observed that there was lack of co-ordination between surgeon, anesthetist and cardiologist resulting in improper evaluation and assessment. It was also observed that in such a renowned hospital no efforts were made to bring co-ordination between various specialists and ICU residents.
- *Incorrect record keeping:* The medical records can be the friends or foes of the practitioners especially in cases of legal adversaries. In, Dr Sri Mohan v. Sukhpalsingh I (2008) CPJ 458 (NC) the petitioner doctor, adopted for traction as surgery was refused by the complainant. But it was found that the document showing "advised surgery but refused" is not genuine. This was considered as clever and unbecoming effort on part of petitioner to conceal the fact of one leg getting shortened. This manipulation was declared as professional failure and violation of professional ethics by the national commission.
- *Errors in prescribing medication, mishandling of medications:* In, Dr Sham Lal v. Saroj Rani I (2003) CPJ 47 (NC), negligence was accepted and compensation was granted when a patient

died of cardiac embolization due to Intravenous administration of injection. In a recent judgment, Seth Pukhraj Gen Hospital v. M Rajput I (2009) CPJ 114(NC) negligence was held and compensation awarded when the child developed gangrene due to administration of injection and the hand had to be amputated.

- *Lack of more safe guards or checking points of healthcare system:* A patient who remained unattended in a recovery room eventually succumbed due to post operative shock. The hospital authorities and doctors explained that this is only "System Failure" and no one is individually negligent for the death of the patient. In, LT Kotgiri v. Union of India (Railway Hospital) I (2007) CPJ 491 National commission observed that it is not explained / disclosed that how the system failed and what was the exact cause of system failure and though the individual doctor may not be negligent but post-operative care was negligent.
- *Misdiagnosis of an illness, failure to diagnose or delay of a diagnosis:* In, Sudhakar Gupta v. Anugraha Nursing Home I (2008) CPJ 57 (NC); patient was suffering from leukemia but received treatment for typhoid. Bone marrow aspiration was advised by the doctor but complainant himself refused repeatedly. Patient ultimately succumbed to his illness. It was held that complainant himself was negligent.
- Failure of hospital staff or a pharmacist to dispense the right medicine to the right patient in the correct amount. In, D Gokaran v. Mahant G Singh Charitable hospital I (2003) CPJ 518; the doctors and hospital staff were held negligent for incorrect / defective administration of medicine without checking the correctness of the medicine supplied by the pharmacist located in the hospital premises. Though there was no damage or injury to the patient but the hospital was penalized for medical error.
- *Inappropriate or substandard treatment or Failure to provide treatment:* A patient of respiratory distress was advised and admitted for inter costal drainage (ICD). The procedure was not performed on the ground of its non-availability. In this case between Dean, Tirunveli Med College v. U Subramaniyan I (2008) CPJ 188; the State commission held that the non-providing of ICD may not be the cause of death but the fact remains that the treatment prescribed was not provided and this amounts to deficiency in service.
- *Failure to follow-up on a patient:* A patient was started anti-tubercular drugs without conducting mandatory tests for tuberculosis. Condition of patient deteriorated, no instructions were given regarding side effects of the drugs. The patient ultimately died due to drug induced hepatitis. In this case, Shyamsunder v. Pandharinath I (2008) CPJ 53; principle of res ipsa loquitur was applied and negligence was held.
- *Failure to informed consent:* In, Samira Kohli v. Prabha Manchanda I(2008) CPJ 56 (SC) the Supreme Court has held that performance without proper consent is unauthorized invasion and interference with appellants body and amounts to tortuous act of assault and battery. In this case the apex court has commented that the consent should be real and valid. The doctor should communicate all inherent and potential hazards of the proposed treatment, the available alternatives, if any, and the likely effect if patient remained untreated.
- *Anesthesia-related complications including failure to safely administer anesthesia:* In a case, St. Gregarious hospital v. Raji George I (2008) CPJ 68 (NC) it was found that a local anesthesia (Xylocaine and Adrenaline) was administered though the patient was under general anesthesia. This was done by the surgeon though stopped by anesthetist in this case the negligence was held.

- Failure to prevent patient injuries (such as falls) on medical facility property.
- *Failure to follow Advance Directive:* An advance directive tells your doctor what kind of care you would like to have if you become unable to make medical decisions. Do not resuscitate (DNR) is permissible in USA and some western countries but it may amount to culpable homicide in India.
- Giving two or more drugs that interact unfavorably or cause poisonous metabolic byproducts;
- *Wrong-site surgery, such as amputating the wrong limb:* These are the cases of gross negligence punishable usually under the principle of res ipsa loquitur.
- Gossypiboma, a surgical sponge left behind inside the patient after surgery.
- Overwork and tiredness of medical staff called on to perform extra duties.

Medical error definitions are subject to debate, as there are many types of medical error from minor to major [7].

Epidemiology of medical errors

Lot of circumstances lead to the errors which could not be avoidable; some such situations are - ambience and organization of the work, type of institution and task. Medical errors are associated with inexperienced physicians, new procedures, extremes of age, complex care and urgent care [8]. Poor communication (whether in one's own language or, as may be the case for medical tourists, another language), improper documentation, illegible handwriting, inadequate nurse-to-patient ratios, and similarly named medications are also known to contribute to the problem. Patient actions may also contribute significantly to medical errors. Falls, for example, are often due to patients' own misjudgments.

Sleep deprivation has also been cited as a contributing factor in medical errors. One study found that being awake for over 24 hours caused medical interns to double or triple the number of preventable medical errors, including those which resulted in injury or death [9]. The risk of car crash after these shifts; increased by 168% and the risk of near miss by 460% [10]. Interns admitted falling asleep during lectures, during rounds, and even during surgeries.

This is an era of globalization and health tourism is the in thing these days. This has given rise to another problem- the language barrier. It is not possible to treat a patient unless a doctor can understand the problem. Though services of trained interpreters are available at places but just imagine a small mistake on the part of interpreter can play havoc with patient's life. Paid, trained, medical interpreters are a must in health care facilities to avoid such language barriers.

How to Approach?

Traditionally, errors are attributed to mistakes made by individuals who may be penalized for these mistakes. The usual approach to correct the errors is to create new rules with additional checking steps in the system, aiming to prevent further errors. The various strategies that can be applied include:

a) Look-alike or sound-alike (LA/SA) health products refer to names of different health products that have orthographic similarities and/or similar phonetics (i.e. similar when written or spoken). These medication errors may be more likely to occur because of contributing factors such as identical doses, dosage forms or routes of administration, similar packaging or labeling, incomplete knowledge of drug names, illegible handwriting, verbal order errors and even lack of an appropriate knowledge-base.

b) Critical tasks should be structured so that errors cannot be made. A computer program that disallows the dispensing of a lethal medication dose is an example. Simply including pharmacists on hospital rounds is a low-cost

way to catch two of every three drug errors before they occur.

c) Remember the five rights - the right drug, right dose, right route, right time and right patient.

d) Use of standard protocols and guidelines coupled with academic education promote a more consistent approach to patient care and these should be put in place.

e) Breakdown in communication is a common cause of harm to patients and this need to be addressed at several levels.

f) It is vital to evaluate the prescription writing skills acquired by students at undergraduate and postgraduate levels.

g) Consumer education is the "secret weapon" in the war against medical errors. It's unfortunate that people research buying a car better than they research health-care decisions.

h) Finally, it is important to work in conjunction with the most important stakeholder- the patients and help them understand the risks involved in healthcare and work with them to reduce harm.

Disclosure of medical errors

Medical errors may result from lapses in judgment or lack of prudent care by individual physicians, from system errors inherent in the medical-care delivery model or, more frequently, from a combination of the two. Medical error reporting is a sensitive topic for physicians, institutions, and patients. The veil of secrecy that surrounds medical errors deprives health-care practitioners of knowledge that may help prevent similar adverse outcomes for patients in the future. Disclosure of serious medical errors to patients generally is the best ethical and clinical course. Patients have a fundamental right to know about their health, particularly when a major error has occurred in their medical care. Fear of lawsuits, feelings of guilt, shame, loss of self respect, loss of reputation among colleagues, fear of loss of job in hospitals and loss of reputation of hospitals are some of the reasons preventing truthful disclosures by individual doctors and hospitals.

Errors in medical practice are not uncommon. Majority, usually go unnoticed and are largely underreported for various reasons at individual and even institutional level. Efforts to create awareness among doctors should begin at undergraduate and postgraduate levels by including it in teaching curriculum. "It may be part of human nature to err, but it is also part of human nature to create solutions, find better alternatives, and meet the challenges ahead."

References

1. Landrigan CP. The safety of inpatient pediatrics: preventing medical errors and injuries among hospitalized children. Pediatr Clin N Am 2005; 52: 979-993
2. Health Grades Third Annual Patient Safety in American Hospitals Study http://www.healthgrades .com/, retrieved on 2009-12-02
3. Leape LL (1994). "Error in medicine". JAMA 272 (23): 1851–7.
4. Parihar M, Passi GR. Medical errors in pediatric practice. Indian Pediatr, 2008; 45: 586-589.
5. Brennan T, Leape L, Laird N, Hebert L, Localio A, Lawthers A, Newhouse J, Weiler P, Hiatt H (1991). "Incidence of adverse events and negligence in hospitalized patients. Results of the Harvard Medical Practice Study I". N Engl J Med 324 (6): 370–6
6. To Err Is Human: Building a Safer Health System, 2000, Institute of Medicine, The National Academies Press.
7. Helmreich, Robert, On error management: lessons from aviation, BMJ.2000; 320: 781-785
8. Weingart, Saul; Ciara Wilson, Bob Marley, Karina (2000). "Epidemiology of medical error". BMJ Publishing Group.
9. Barger LK, Ayas NT, Cade BE, Cronin JW, Rosner B, et al. (2006) Impact of Extended-Duration Shifts on Medical Errors, Adverse Events, and Attentional Failures. PLoS Med 3(12): e487, retrieved on 2009-12-02
10. When Doctors Don't Sleep, Talk of the Nation, National Public Radio, 13 December 2006. retrieved on 2009-12-02

Medico-legal News

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Hospitals directed not to charge medico-legal fees

The Ahmedabad city police commissioner has issued a notification on the basis of a state-wide notice by the state DGP that the medico-legal fee charged by government and private hospitals will be illegal henceforth.

It came to notice of the senior officials recently that a hospital had charged Rs 3,000 from a patient towards a medico-legal case. When questioned, the hospital trust officials said that the money goes to the doctors as they have to go to the courts in connection with the case - leaving their work at the hospital behind and they are not paid anything additional.

"As per the notification, all private hospitals are banned from taking such fees as it is illegal. The state medical council will be involved in the decision and such activities would be brought to the notice of the Medical Council of India for punitive action," said a senior city police official.

[Source- TNN | Jul 19, 2014: Ahmedabad]

Professional incompetency to blame for rise in medical negligence, medical varsity VC says

The unchecked rise in the incidents of medical negligence cases are the result of professional incompetency, said Tamil Nadu Dr MGR Medical University vice-chancellor during an international seminar, titled "Ethico - Legal aspects in medical negligence - a human rights perspective,". He said the quality of medical education had come down in recent days. The number of efficient and skilled doctors was dwindling, he added.

"Medical negligence cases surge due to the heavy disease burden which is placed on the shoulders of inadequate manpower in the healthcare sector," he said.

He pointed out that communication gap between doctors and the relatives of the patient was another main reason why medical negligence cases were taking an ugly turn.

Shantaram added that a lot of ethical issues could be avoided in medical practice if the doctors put patient's interest as priority above theirs. "The good thing is that courts have a more holistic approach when it comes to the medical profession, and this allows doctors to practice medicine without fear," he said.

Speakers at the seminar discussed various aspects of medical negligence and cases that made news. Though cases of medical negligence and ethical issues crop up every now and then in India, there is no centralized collection of data on such cases filed in the country or their outcome. According to People for Better Treatment, an RTI enquiry filed by the association found that just 515 cases were filed against doctors for either medical negligence or ethical violation in one decade (2001-10), barely four cases a month. And action was taken in just 9% of cases — 15 doctors were removed from the council's list of registered practitioners and 30 let off with a warning. In 91% of cases, either the case was closed or the accused let off.

People for Better Treatment was started by Dr Kunal Saha, who recently won the record settlement of over Rs 6 crore by the Supreme Court for the death of his wife due to medical negligence.

[Source-TNN | Jul 24, 2014 : Chennai]

Belgian King Urged to Stop Euthanasia Law

CitizenGo, a pro-family and anti-abortion organisation, a Spanish conservative lobby group, has given Belgian King Philippe a petition urging him not to sign the controversial child euthanasia legislation passed by parliament. This petition has been signed by more than 200,000 persons, as part of a Europe-wide campaign against the legislation, which was passed on February 14. One of the petition's organisers, Alvaro Zulueta, says more than 5,000 Belgians signed this petition , although Italians made up the largest number of respondents. If approved, the bill would make Belgium the first country to allow euthanasia for terminally ill children of all ages, although in the neighbouring Netherlands euthanasia is already permitted for children older than 12. The Belgian Catholic Church has opposed the bill , describing it as a "step too far", and European Catholic groups are now appealing directly to King Philippe not to sign the bill into law. Belgian king has not yet signed the bill but he is not likely to reject it .The bill was adopted by 86 votes to 44 in Belgium's parliament. The online petition, which has now closed, was launched two weeks ago and calls on Philippe to listen to "the many voices at home and abroad warning you of the dangers of this law". "Listen to your conscience and stand as a monarch with ethical principle," the petition says, warning that if the legislation is enacted it will send a message to other countries that child euthanasia is morally acceptable.

[Source- Medindia http://www.medindia.net/news/accessed 20.8.14]

Poor staff skills are top cause for claims

Poor staff knowledge, skills or competency were by far the top root cause identified for the clinical risk claims completed in 2010, having been cited in more than 40 per cent of cases, Irish Medical Times reports.The clinical risk team of the State Claims Agency reviewed the 166 cases closed in 2010. They found poor staff knowledge, skills or competency was the top root cause identified in 44.2 per cent of the cases.Communications failure came a distant second (14.4 per cent of cases).A lack of effective leadership (9.6 per cent), safety culture issues (8.7 per cent), the lack of protocols or guidelines (6.7 per cent), lack of supervision (5.8 per cent) and inadequate staffing levels/skill mix (in 2.9 per cent) followed next.Debbie Dunne, Clinical Risk Advisor, State Claims Agency, said: "As practitioner error is cited as a contributory factor in 18.8 per cent of closed cases reviewed, it is unsurprising that staff knowledge/skills/ competency is identified as a factor when looking at the root cause of the event."

Delay or failure to treat was a contributory factor in 11.2 per cent of cases, delay/failure in recognising complication was cited in 10.6 per cent, while ineffective treatment and inadequate medical documentation were each at 5.3 per cent. Misdiagnosis and failure to undertake clinical assessment were cited in 4.7 per cent. Failure to monitor and failure to seek consent were contributory factors in 4.1 per cent and 2.9 per cent of the cases. By specialty, surgery again had the most cases closed in 2010 (27.1 per cent), followed by emergency medicine (25.9 per cent), obstetrics (18.7 per cent), medicine (11.4 per cent) and gynaecology (5.4 per cent).This is consistent with the trend in 2009. Over 50 per cent of these cases were within the specialties of surgery and emergency medicine.

[Source- www.imt.ie/news]

Research Briefs

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Treatment without consent: A medico-legal precedent

Source- The Lancet, Volume 356, Issue 9223, Page 69

A Jehovah's Witness (a sect of Christian who oppose military service & blood transfusion among other things), aged 14 years, suffered 58% burns and was admitted in a hospital. It was clear that blood transfusion would be needed. He did not consent to a transfusion. His decision was also confirmed by his parents. The hospital then decided to approach the court.

The President of the Family Division in the High Court ruled that the injured child was not "Gillick competent". The Judge made an order to allow treatment, including blood transfusion. The patient underwent major procedures and was given blood and fresh-frozen plasma. Good relations were maintained with the patient and family at all times despite the contravention of their wishes.

("Gillick competency and Fraser guidelines refer to a legal case which looked specifically at whether doctors should be able to give contraceptive advice or treatment to under 16-year-olds without parental consent. But since then, they have been more widely used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions.")

The importance of this case is the remarks made by the judge, where he said that he would have made the same order even if the patient had been deemed "Gillick competent". This indicates that the Judge accepted the comment made by Lord Donaldson in 1991 that the courts can override the refusal of patient and relatives on religious grounds if the treatment proposed would clearly be in the best interests of the patient. The judgment described here does not allow the doctors to act against the wishes of a minor and his or her family but in certain grave circumstances the law might not regard such action as assault.

Retinopathy of prematurity malpractice claims: the Ophthalmic Mutual Insurance Company experience

Source- Arch Ophthalmol. 2009 Jun;127(6):794-8

A study was done to examine the causes of retinopathy of prematurity (ROP) malpractice claims filed with the Ophthalmic Mutual Insurance Company. All closed ROP malpractice claims were reviewed. Failure of transfer of care on patient discharge from the hospital was observed in eight cases involved .Three cases demonstrated inappropriately long periods between follow-up examinations, One case was due to failure of outpatient referral from screening to the treating ophthalmologist and one case concerned unsupervised resident provision of ROP care. It was concluded that numerous preventable factors can be addressed to improve ROP care. It is essential to ensure that ophthalmologists, neonatologists, paediatricians, and families are updated on current guidelines for ROP screening and treatment and to facilitate follow-up appointments before patient discharge from the hospital. Doing so can help avoid future malpractice claims and patient harm.

GPs' concerns about medico-legal issues - How it affects their practice?

Source- Aust Fam Physician. 2009 Jan-Feb; 38(1-2): 66-70

General practitioners' concerns about medico-legal issues have been shown to influence the practice of medicine. A study was done to look at GPs' beliefs about medico-legal issues and how medico-legal concerns affect their practice. A cross sectional self report survey was sent to 1239 GPs of which 566 responded (46% response rate). Responses were considered as a group, and then comparisons were

made between those who had experienced a medico-legal matter and those who had not. This data was sourced from surveys and medico-legal insurer records. General practitioners with previous medico-legal experiences were more likely than their colleagues to report believing the law required them to make perfect decisions and that medico-legal factor made them consider early retirement from medicine. They were also less likely to believe that inadequate communication is a factor in most complaints. More than half the GPs reported having made practice changes due to medico-legal concerns in the following areas: test ordering (73%); specialist referrals (66%); systems to track test results (70%); and communication of risk to patients (68%). Other changes were reported less frequently. It was concluded that GPs' concerns about medico-legal matters impact on their practise of medicine. While greater awareness of medico-legal issues may lead to positive impacts, the negative impact of their concerns is that some changes arise from anxiety about medico-legal matters rather than from the exercise of good clinical judgment.

Missed diagnoses by urologists resulting in malpractice payment

Source- J Urol. 2007 Dec;178(6):2537-9. Epub 2007 Oct 15

Missed diagnoses are a big patient safety concern and they can result in malpractice allegation. The specialist physician may be liable for missed or delayed diagnoses even if an abnormality in the physician area of expertise is ruled out. This largely unstudied area of medical malpractice was approached in an effort to increase physician awareness and identify opportunities for prevention.The study evaluated malpractice claims in urology that were closed with indemnity payment between 1985 and 2004 . All such claims resulting from alleged missed or delayed diagnoses by urologists were identified. Claims were divided into 2 main categories based on whether the missed diagnosis was primarily urological, i.e. testis torsion, or not urological, i.e. appendicitis.A total of 75 missed diagnosis claims were identified, overall representing 15% of claims. The total indemnity payment for missed diagnosis claims was $32,591,013, which represented 27% of all indemnity payments during the study period. They were divided into 58 missed urological diagnoses and 17 missed non-urological diagnoses. Cancer represented 71% of missed urological diagnoses and 41% of missed non-urological diagnoses. Urological cancer missed diagnosis claims were associated with the highest average indemnity payment of $526,460. The average indemnity payment for missed diagnosis claims was 92% greater than the average indemnity payment for all other claims ($434,546 vs. $226,133). An increase in the frequency of missed diagnosis claims closed with indemnity payment and in the amount of payment for missed diagnosis claims were observed during the 20-year study period.Indemnity payments resulting from missed diagnosis claims represent a disproportionately high percent of total indemnity payments (27%) due to a high average payment for such claims. Liability for the urologist resulted from missed diagnoses not only of urological conditions, but also of non-urological conditions.

Traumatic brain injury: risks of epilepsy and implications for medicolegal assessment.

Source- Epilepsia. 2012 Sep;53 Suppl 4:43-7

Traumatic brain injury (TBI) is an important and preventable cause of epilepsy.A review of selected studies dealing with the risks of TBI and the risk of posttraumatic epilepsy in humans was done . The incidence of persons admitted to hospital with TBI was found to have decreased in developed countries in recent years. But there is little change in TBI-associated deaths which meant the decrease in hospitalization was due to more patients being treated on out patient basis .Epilepsy is a known consequence of brain injury and may appear even several years after the injury. However, several well-controlled studies have been unable to identify treatment modalities that prevent the development of epilepsy after TBI.

Readers Ask, Experts Answer

Answer by

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Question: *(by PV Arya , Consultant Paediatrician, Gwalior)*

What are the latest rules about organisers of a conferences taking sponsorship from pharma companies in the form of exhibition stalls, assigned lecture halls, advertisements in souvenir, stay facility for faculties etc ?

This query raises a very important and debatable ethical issue. As per the text of the "Indian Medical Council (Professional Conduct, Etiquette and Ethics) (Amendment) Regulations, 2009 – Part-I" the summary guideline says that In dealing with Pharmaceutical and allied health sector industry, a medical practitioner shall not accept gifts,travel facilities, hospitality, Cash or monetary grants.

Medical Research: A medical practitioner may carry out, participate in or work in research projects funded by pharmaceutical and allied healthcare industries. A medical practitioner is obliged to know that the fulfilment of the following items (i) to (vii) will be an imperative for undertaking any research assignment / project funded by industry – for being proper and ethical. Thus, in accepting such a position a medical practitioner shall:-

i. Ensure that the particular research proposal(s) has the due permission from the competent concerned authorities.

ii. Ensure that such a research project(s) has the clearance of national/ state / institutional ethics committees / bodies.

iii. Ensure that it fulfils all the legal requirements prescribed for medical research.

iv. Ensure that the source and amount of funding is publicly disclosed at the beginning itself.

v. Ensure that proper care and facilities are provided to human volunteers, if they are necessary for the research project(s).

vi. Ensure that undue animal experimentations are not done and when these are necessary they are done in a scientific and a humane way.

vii. Ensure that while accepting such an assignment a medical practitioner shall have the freedom to publish the results of the research in the greater interest of the society by inserting such a clause in the MoU or any other document / agreement for any such assignment.

Maintaining Professional Autonomy: In dealing with pharmaceutical and allied healthcare industry a medical practitioner shall always ensure that there shall never be any compromise either with his / her own professional autonomy and / or with the autonomy and freedom of the medical institution.

Affiliation: A medical practitioner may work for pharmaceutical and allied healthcare industries in advisory capacities, as consultants, as researchers, as treating doctors or in any other professional capacity. In doing so, a medical practitioner shall always:

i. Ensure that his professional integrity and freedom are maintained.

ii. Ensure that patient's interests are not compromised in any way.

iii. Ensure that such affiliations are within the law.

iv. Ensure that such affiliations / employments are fully transparent and disclosed.

Endorsement: A medical practitioner shall not endorse any drug or product of the industry publicly. Any study conducted on the efficacy or otherwise of such products shall be presented to and / or through appropriate scientific bodies or published in appropriate scientific journals in a proper way. [1]

Endorsement is expressly forbidden by the code of ethics, which says that no doctor ought to endorse any commercial product or drug or therapeutic article. In November 2010, the MCI had initiated action against officer bearers of the IMA on the endorsement issue. When one of the office bearers challenged the removal of his name from the medical register for six months before the high court, the MCI had argued in its affidavit that "...what is not allowed to be done directly cannot be permitted to be done indirectly".

But, recently, the Medical Council of India (MCI) the apex regulatory body of doctors and the medical practice in the country has decided to shrink its own jurisdiction. It has reinterpreted its code of ethics regulations as being applicable only to individual doctors and not doctors' associations. Clause 6.8 of the Code of Medical Ethics Regulation 2002 clearly states that it pertains to "code of conduct for doctors and professional association of doctors in their relationship with pharmaceutical and allied health sector industry". However, the executive committee of the new MCI in its meeting on February 18, 2014 decided that the term "association of doctors" be deleted from the clause. It went on to add that any action it took it against any association of doctors by virtue of clause 6.8 shall be nullified and that such proceedings would stand annulled. In effect, the MCI has stated that the action it took against the Indian Medical Association (IMA) for endorsing products of Pepsi and Dabur in exchanges for crores of rupees or against the Indian Academy of Pediatrics for accepting funding from pharmaceutical companies will no longer be valid. [2]

References

1. Indian Medical Council (Professional conduct, Etiquette and Ethics) (Amendment) Regulations, 2002. http:// www. mciindia.org/ Rulesand Regulations/ CodeofMedical EthicsRegulations2002. aspx Accessed on May 20, 2014
2. Rema Nagarajan. MCI shrinks own ambit, doctor bodies out of ethics code. http://timesofindia.indiatimes.com/india/ MCI-shrinks-own-ambit-doctor-bodies-out-of-ethics-code/articleshow/30873980.cms Accessed on 25 Feb 2014.

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 & 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 & extent of practice, number of bed in case of indoor facilities & depending upon the other liabilities.
5. A trust / committee / company/ society shall look after the management of the collected fund.
6. 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. 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

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	**Annual Fee for Hospitals Establishment**
1	Physician / doctors with OPD Practice	Rs. 60 / lakh	Rs. 340 / lakh + Re. 1 / OPD Pt + Rs. 5 / IPD Pt + 7.5 % of basic premium + Service Tax 10.3 % on the Total
2	Physician / doctors with Indoor Practice	Rs. 115 / lakh	
3	Physician / doctors with Indoor Practice of Surgeon	Rs. 230 / lakh	
4	Physician / doctors with superspecialty, Anesthetist etc	Rs. 340 / 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.		

companies or any other similar private company.

7. Experts will be involved so that we have better vision & outcome of the scheme.
8. The payment to the experts, Legal & 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.
9. If legal notice / case are received by member he should forward the necessary documents to the concerned person.
10. Reply to the notice/case should be made only after discussing with the expert committee.
11. A discontinued member if he wants to join the scheme again will be treated as a new member.
12. 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.
13. 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.
14. The scheme can cover untrained hospital staff by paying extra amount as per the decision of expert committee.
15. A district/ State/ Regional level committee can be established for the scheme.
16. There will be involvement of electronic group of IMLEA for electronic data protection.
17. 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].
18. Telephone Help Line: setting up and manning will be done.
19. Planning will be done to start the Certificate/ Diploma/ Fellowship Course on med-leg issues to create a pool of experts.
20. 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 under taken for beneficiary of scheme by suitable medium.

List of Members
Professional Assistance Scheme
(PAS) IMLEA

Name	*Place*	*Speciality*
Dr Dinesh B Thakare	Amravati	Pathologist
Dr Satish K Tiwari	Amravati	Pediatrician
Dr Rajendra W. Baitule	Amravati	Orthopedic
Dr Usha S tiwari	Amravati	Hospi/ N Home
Dr Yogesh R Zanwar	Amravati	Dermatologist
Dr Ramawatar R. Soni	Amravati	Pathologist
Dr Rajendra R. Borkar	Wardha	Pediatrician
Dr Alka V. Kuthe	Amravati	Ob.&Gyn.
Dr Vijay M Kuthe	Amravati	Orthopedic
Dr Neelima M Ardak	Amravati	Ob.&Gyn.
Dr Vinita B Yadav	Gurgaon	Ob.&Gyn.
Dr Balraj Yadav	Gurgaon	Pediatrician
Dr Kiran Borkar	Wardha	Ob & Gyn
Dr Bhupesh Bhond	Amravati	Pediatrician
Dr R K Maheshwari	Barmer	Pediatrician
Dr Jayant Shah	Nandurbar	Pediatrician
Dr Kesavulu	Hindupur AP	Pediatrician
Dr Ashim Kr Ghosh	Burdwan WB	Pediatrician
Dr Apurva Kale	Amravati	Pediatrician
Dr Asit Guin	Jabalpur	Physician
Dr Sanjeev Borade	Amravati	Ob & Gyn
Dr Prashant Gahukar	Amravati	Pathologist
Dr Ashwin Deshmukh	Amravati	Ob & Gyn
Dr Anupama Deshmukh	Amravati	Ob & Gyn
Dr Umesh Khanapurkar	Bhusawal	Pediatrician
Dr Mrs Khanapurkar	Bhusawal	Gen Practitioner
Dr Pratibha Kale	Amravati	Pediatrician
Dr Milind Jagtap	Amravati	Pathologist
Dr Varsha Jagtap	Amravati	Pathologist
Dr Rajendra Dhore	Amravati	Physician
Dr Veena Dhore	Amravati	Dentistry

Instructions to Authors

Please read the following instructions carefully and follow them strictly. Submissions not complying with these instructions will not be considered for publication.

Communications for publication should be sent to the Chief Editor, Journal of Indian Medico-legal and Ethics Association (JIMLEA) and only on line submission is accepted and will be mandatory. In the selection of papers and in regard to priority of publication, the opinion of the Editorial Board will be final. The Editor in chief shall have the right to edit, condense, alter, rearrange or rewrite approved articles, before publication without reference to the authors concerned.

Authorship: All persons designated as authors should qualify for authorship. Authors may include explanation of each author's contribution separately if required. Articles are considered for publication on condition that these are contributed solely to JIMLEA, that they have not been published previously in print and are not under consideration by another publication. A statement to this effect, signed by all authors must be submitted along with manuscript.

Manuscript: Manuscripts must be submitted in precise, unambiguous, concise and easy to read English. Manuscripts should be submitted in MS Office Word, Use Font type Times Roman, 12-point for text. Scripts of articles should be double-spaced with at least 2.5 cm margin at the top and on left hand side of the sheet. Italics may be used for emphasis. Use tab stops or other commands for indents, not the space bar. Use the table function, not spreadsheets, to make tables.

The number of authors should not exceed three. Type of article must be specified in heading of the manuscript ie 1. Review article, 2. Original paper, 3. Case scenario / case report / case discussion, 4. Guest article, 5. Reader's ask and Experts answer, 6. Letter to editor. The contents of the articles and the views expressed therein are the sole responsibility of the authors, and the Editorial Board will not be held responsible for the same.

Title page: The title page should include the title of the article which should be concise but informative, Full names (beginning with underlined surname) and designations of all authors. with his/her (their) academic qualification(s) and complete postal address including pin code of the institution(s) to which the work should be attributed, along with mobile and telephone number, fax number and e-mail address and a list of 3 to 5 key words for indexing and retrieval.

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Length of manuscripts: No strict word or page limit will be demanded but lengthy manuscript may be shortened during editing without omitting the important information.

Tables: Tables should be simple, self-explanatory and should supplement and not duplicate the information given in the text. Place explanatory matter in footnotes and not in the heading. Explain in footnotes all non-standard abbreviations that are used in each table. The tables along with their number should be cited at the relevant place in the text.

Case scenario / case report / case discussion: Only exclusive case scenario / case report / case discussion of practical interest and a useful message will be considered. While giving details of cases please ensure privacy of individuals involved unless the case is related to a judgment already given by a court of law where relevant details are already available in public domain.

Letter to the Editor: These should be short and decisive observations which should preferably be related to articles previously published in the journal or views expressed in the journal. They should not be preliminary observations that need a later paper for validation.

Illustrations: Where necessary, graphs, charts, diagrams or pen drawings should be drawn by professional hands in Indian ink (black) on white drawing paper. In case of x-ray, miniature photo-prints should be supplied. Photographs should be supplied in high quality glossy paper not larger than 203 mm x 254 mm (8"x 10"). In case of microphotograph, stains used and magnification should be mentioned. Each illustration should bear on its back the figure number and an arrow indicating the top. All illustrations should be black and white and should be submitted in triplicate with suitable legends. In online submissions good quality scanned photographs and drawings only will be accepted.

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Reference from journal: 1) Cogo A, Lensing AWA, Koopman MMW, Piovella F, Sivagusa S, Wells PS, et al - Compression ultrasonography for diagnostic management of patients with clinically suspected deep vein thrombosis: prospective cohort study. BMJ 1998; 316: 17-20.

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Reference from electronic media: 3) National Statistics Online—Trends in suicide by method in England and Wales, 1979-2001. www.statistics.gov.uk/downloads/ theme_health/ HSQ 20.pdf (accessed Jan 24, 2005): 7-18.

The Editorial Process

All manuscripts received will be duly acknowledged. On submission, editors review all submitted manuscripts initially for suitability for formal review. Manuscripts with insufficient originality, serious scientific or technical flaws, or lack of a significant message are rejected before proceeding for formal peer review. Manuscripts that are unlikely to be of interest to the Journal readers are also liable to be rejected at this stage itself. Manuscripts that are found suitable for publication in the Journal will be sent to one or two reviewers. Manuscripts accepted for publication will be copy edited for grammar, punctuation, print style and format. Upon acceptance of your article you will receive an intimation of acceptance for publication.

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The purpose of the proof reading is to check for typesetting, grammatical errors and the completeness and accuracy of the text, substantial changes in content are not done. Manuscripts will not be preserved.

Protection of Patients' Rights to Privacy: Identifying information should not be published in written descriptions, photographs, sonograms, CT scan etc., and pedigrees unless the information is essential for scientific purposes and the patient (or parent or guardian, wherever applicable) gives written informed consent for publication. Authors should remove patients' names from text unless they have obtained written informed consent from the patients. When informed consent has been obtained, it should be indicated in the article and copy of the consent should be attached with the covering letter.

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  - ✍ Running title - upto five words
  - ✍ Structured abstract - 150 words
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  - ✍ Key words - 3 to 5 words
  - ✍ Tables - not more than 5
  - ✍ Figures with legends - 8 x 13 cm in size
  - ✍ Reference list: Up to 15 references in Vancouver style

Case scenario / case report / case discussion & letter to editor: 500 words without abstract with 2-3 references in Vancouver style, & 3-5 key words

Review article: 4000 words, unstructured abstract of 150 words with up to 30 references in Vancouver style & 3-5 keywords

Indian Medico Legal And Ethics Association
LIFE MEMBERSHIP FORM

Photograph

Name of the Applicant _____
Surname *First Name* *Middle Name*

Date of Birth _____ Sex _____

Address of Correspondence _____

_____

Telephone *Residence* _____ *Hospital* _____ *Other* _____

Mobile _____ *Fax* _____ *e-mail* _____

Name of the Council *(MCI/Dental/Homeopathy/Ayurved /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

_____

C. Do you have a Professional Indemnity Policy *(Yes / No)* : _____ If Yes, Give details

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