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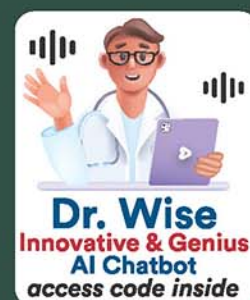
**36th
Edition**

The Essentials of Forensic Medicine & Toxicology

*Includes the Latest Criminal Laws—BNS,
BNSS and BSA*

As per the Revised Competency-based Medical Education Curriculum (NMC)

Revised by
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Genuine?
Scratch, Scan
& Validate



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The medical profession is governed by legislation and by a code of ethics and etiquette. **Ethics is a voluntarily self-imposed code of conduct by the medical profession.** The broad principles of medical ethics are formulated by National and State Medical Councils and the World Medical Association. Enforcement of the Code is done by the Medical Councils.

MEDICAL ETHICS AND ITS HISTORICAL EMERGENCE

FM10.1 Describe medical ethics and explain its historical emergence.

Ancient Origins: The **Code of Hammurabi** (Babylonia, 1750 BCE) is one of the earliest documented texts outlining standards for medical practitioners.

In Indian mythology, **Dhanwantari**, emerging from the Sagara Mathana (churning of the ocean of milk), is revered as the God of medicine and Ayurveda. He is associated with “immortal life” or “long life” and is worshipped annually on Dhanteras, which since 2016 has also been observed as “National Ayurveda Day” by the Ministry of AYUSH.

Charaka’s Oath (200 BCE), found in the *Charaka Samhita* by Maharshi Charaka (regarded as the Father of Indian Medicine), and **Sushruta’s Oath** (1500 BCE), from the *Sushruta Samhita* by Sushruta (Father of Indian Surgery and Plastic Surgery, known for early rhinoplasty), represent foundational ethical standards in ancient Indian medicine. In 2022, the National Medical Commission (NMC) in India introduced the Charaka oath for the white coat ceremony.

The **Hippocratic Oath** (5th century BCE), attributed to Hippocrates (Father of Medicine and Medical Ethics), begins with invocations to deities like Apollo and Asclepius. It established core principles such as beneficence, non-maleficence, and justice. The modern iteration of this oath is the Declaration of Geneva.

Evolution of Modern Medical Ethics: A German medical school (University of Wittenberg) initiated the practice of oath-taking for graduating medical students in 1500.

Thomas Percival (English physician, 1803) is credited with writing the first “modern code of medical ethics” and coining the terms “medical ethics” and “medical jurisprudence.” The American Medical Association (AMA) adopted its first code of ethics in 1847, based on Percival’s work.

The **Declaration of Geneva** (1948), adapted by the World Medical Association (WMA) in Geneva, Switzerland, serves

as a contemporary version of the Hippocratic Oath. It has undergone several amendments (1968, 1984, 1994, 2006, 2017) and is typically administered to new MBBS students on their first day of admission.

The **International Code of Medical Ethics** (1949), formulated by the WMA in London, delineated a physician’s duties in general, to the sick, and to colleagues, emphasizing that “A physician shall act in the patient’s best interest when providing medical care.”

The Indian Council of Medical Research (ICMR) has also issued guidelines on ethical considerations in human research.

World Medical Association (WMA) and Key Declarations: The WMA, founded on September 17, 1947, with its headquarters in Paris, France, is a global confederation of national medical associations. It has issued numerous declarations addressing various ethical aspects of medical practice:

Declaration of Helsinki (1964): Focuses on ethical principles for human experimentation.

Declaration of Oslo (1970): Pertains to therapeutic abortion.

Declaration of Tokyo (1975): Addresses torture, supplemented by the Declaration of Hamburg (1997), which supports physicians who refuse to participate in torture.

Declaration of Venice (1983): Concerns terminal illness.

Declaration of Madrid (1983): States that euthanasia is unethical.

Declaration of Malta (1991): Defines the doctor’s role concerning hunger strikers.

Declaration of Sydney (1968): Deals with the declaration of death and organ harvesting for transplantation.

Declaration of Lisbon (1981): Outlines the rights of patients.

Declaration of Munich (1973): Prohibits discrimination in medicine based on race, political views, etc.

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Declaration of Ottawa (1998): Affirms the child's right to healthcare.

Declaration of Taipei (2002): Addresses ethical considerations for biobanks.

Declaration of Delhi (2009): Explores the health effects of global climate change.

Declaration of Chicago (2017): Focuses on quality assurance in the medical profession.

BIOETHICS AND MEDICAL ETHICS

FM10.16 Describe and discuss Bioethics.

Bioethics and Medical Ethics Defined: Ethics: The study of moral behaviour, guiding actions based on values like truth, justice, integrity, and honesty.

Bioethics: Coined by Fritz Jahr in 1927, this is a broad field encompassing ethics related to biological research (on non-human organisms) and medical research (on humans). It includes animal ethics, environmental ethics, and medical ethics.

Medical Ethics: Refers to the "moral principles" or "code of conduct" that govern medical professionals' interactions with each other, their patients, and the State. It is a self-imposed code designed to uphold the noble traditions of the medical profession. Adherence to these codes is expected, and violations, while not always legally punishable, are considered unprofessional and unethical.

Medical Etiquette: Signifies courtesy among members of the same profession. **The Role of a Doctor:** Philosophically, a physician is considered an assistant to a higher power, whether divine or natural, in alleviating pain, suffering, and striving to preserve life. While doctors facilitate healing by providing appropriate medical care (e.g., wound management, medication), the ultimate healing process is attributed to nature or a divine force. This unique relationship fosters an emotional bond, often leading patients to view their doctors as "next to God." To fulfil this role, a doctor must possess spiritual elevation and be proficient not only in medical skills but also in moral values and ethics. The medical profession's core objective is to serve humanity with utmost respect.

Education in Medical Ethics: The **Pond Report** (Sir Desmond Pond, 1984, UK) reviewed the teaching and implementation of medical ethics in UK medical schools and made recommendations. Subsequently, in 1993, the General Medical Council (Education Committee in London) recommended integrating ethics and legal issues into medical curricula to ensure doctors are fully aware of their moral and ethical responsibilities in patient care.

NATIONAL MEDICAL COMMISSION

FM10.3 Describe the functions and role of National Medical Commission and State Medical Councils.

FM10.28 Demonstrate respect to laws relating to medical practice and Ethical code of conduct prescribed by National Medical Commission and rules and regulations prescribed by it from time to time.

National Medical Commission (NMC) is a statutory body established under The National Medical Commission Act,

2019 (NMC Act). NMC came into existence on 25th September 2020 as the country's apex regulator of medical education and profession after dissolution of 63-year-old, Medical Council of India (MCI).

Composition: NMC comprises of thirty-three members, including: (1) One chairman. (2) Ten ex-officio members and twenty-two part-time members. (3) Out of the twenty-two part-time members, a total of nineteen are nominated by States and Union Territories. (4) The chairperson, certain part-time members and the secretary of the NMC are appointed by the Central Government on the recommendation of a Search Committee.

Powers/Functions: NMC has been empowered to lay down policies and regulation to ensure: (1) **Professional Ethics and Etiquette.** (A) The observance and promotion of professional ethics in the medical profession and provision of care by medical practitioners. (B) Assess requirements in health care, including human resources for health and healthcare infrastructure. (C) Develop a road map for meeting such requirements. (2) To **frame guidelines** for determination of fees and all other charges in respect of fifty percent of seats in private medical institutions and 'deemed to be universities', which are governed under the provisions of the NMC Act, (3) To **grant a limited license** to practice medicine at mid-level as a Community Health Provider (CHP) who is qualified as per the prescribed criteria and can prescribe specified medicines, independently, in primary and preventive health care, (4) Conducting the **National Eligibility-cum-Entrance Test (NEET)** and regulating the manner of conducting common counselling by the designated authority for admission to undergraduate and postgraduate, super-specialty seats in all the medical institutions. (5) For conducting the **National Exit Test (NEXT)**, a common final year undergraduate medical examination, to be known as the (NEXT), to be held for granting licenses to practice medicine as medical practitioners and for enrolment in the State Register or the National Register.

The basic difference between new NMC and old MCI is given in **Table 3.1**.

STATUTORY BODIES UNDER NATIONAL MEDICAL COMMISSION: There are following boards constituted for smooth functioning to reach desired goals of NMC. Each of such Autonomous Boards consists of a President, two whole-time members and two part-time members.

Functions: (1) **Under-Graduate Medical Education Board** grants recognition to a medical qualification at the undergraduate level. It develops competency-based dynamic curriculum for addressing the needs of primary health services, community medicine and family medicine. It frames guidelines, minimum requirements and standards for setting up of medical institutions, conducting course and examinations and norms for infrastructure, faculty and quality of education. It also facilitates faculty training and development, research and the international student and faculty exchange programs. (2) **Post-Graduate Medical Education Board** grants recognition to a medical qualification at the postgraduate and super-specialty level. It also develops competency-based dynamic curriculum to develop appropriate skill, knowledge, attitude, values and ethics. It frames guidelines, minimum requirements and standards for setting up of medical institutions, conducting course and examinations

TABLE 3.1: Differences between the NMC Act and the Indian Medical Council Act (MCI Act).

S. No.	NMC Act	MCI Act
(1)	The governing body under the NMC Act is the NMC	The governing body under the IMC Act is the MCI
(2)	All the members of the NMC will be appointed or nominated by the Central Government	MCI is majorly comprised of members who are elected from amongst members of the medical faculty of Universities and State Medical Registers/Council
(3)	Section 5 of the NMC Act provides for the composition of a seven-member Search Committee, which shall include, the Chairperson, part-time Members [in terms of Section 4(1) and 4(4)(a) of the NMC Act] and the Secretary (in terms of Section 8 of the NMC Act), who shall be appointed by the Central Government upon the recommendation of the Search Committee	No such provision is provided under the IMC Act
(4)	Constitution of Autonomous Boards	No such boards
(5)	Introduction of exit exams for all candidates	Only for FMGE candidates

and norms for infrastructure, faculty and quality of education. It also facilitates faculty training and development, research and the international student and faculty exchange programs. It promotes and facilitates postgraduate courses in family medicine. (3) **Medical Assessment and Rating Board** grants permission for establishment of a new medical institution, or to start any postgraduate course or to increase number of seats and carries out inspections of medical institutions for assessing and rating. (4) **Ethics and Medical Registration Board** maintains National Registers of all licensed medical practitioners. It regulates professional conduct, promotes medical ethics and exercises appellate jurisdiction with respect to the actions taken by a State Medical Council. EMRB maintains 'National Registers' of all licensed medical practitioners which should contain their name, address and all recognized qualifications possessed by them. It shall be a public document, that is it shall be on the website of EMRB. EMRB shall ensure electronic synchronization of National register and State register in such a manner that any change in any change in one register is automatically reflected in other register. Every SMC shall maintain and regularly update the State Register in the specified electronic format. The person, who is not enrolled in the State register, shall not be allowed to practice medicine; hold office as a physician or surgeon; sign or authenticate a medical or fitness certificate; or give evidence at any inquest or in any court of law as an expert.

MEDICAL ADVISORY COUNCIL

Composition: (1) The Chairperson and all members of the NMC (as ex-officio members), (2) Chairman of the University Grants Commission, (3) Director of the National Assessment and Accreditation Council, and (4) Various other members to be nominated by the State Governments, Ministry of Home Affairs in the Government of India, State Medical Council, and the Central Government.

Functions: (1) It acts as the primary platform through which the States and Union Territories may put forth their views and concerns before the NMC and helps in shaping the overall agenda. (2) Policy and action relating to medical education and training. It advises the NMC on measures to determine and maintain, and to co-ordinate maintenance of the minimum standards in all matters relating to medical education. (3) Training and research, and measures to enhance equitable access to medical education.

STATE MEDICAL COUNCILS

FM10.2 Describe the Indian Medical Register.

The **State Medical Councils are autonomous bodies** established under the State Medical Council Act. Each of these Medical Councils consist of: (1) Members elected by the registered medical practitioners and (2) Those nominated by the State Government. (3) The president and the vice-president of the Council are elected by the members from among themselves.

Functions: (1) **Medical register:** The Council appoints a Registrar, who keeps a Register of medical practitioners. **Any person having any of the recognized medical qualification and completes formal training or clears exams that are made mandatory from time to time, can get his name registered.** The name, residence, qualifications and the date on which each qualification was granted of every person who is registered under this Act are entered in the Register on payment of prescribed fees. (2) After passing the qualifying examination, it is necessary to undergo a period of training, before such qualification is granted to him/her. (3) **A provisional registration in a State Medical register is given to such person on application to enable him to practice medicine in an approved institution under senior Doctor to the satisfaction of them for the required period. Then only one can register permanently in the state or national register.** (4) **Any additional qualification obtained later, can also be registered.** The Registrar should inform the Indian Medical Council without delay of all additions and other amendments in the State Medical Register made from time to time. (5) **As per present prevailing rule every registered medical practitioner shall renew register every 5 years on submissions of prescribed fee and 30 credit hours of updating knowledge by attending conference, CME, Workshops and being a teacher in recognized Medical College under NMC.**

"PLEDGE OF OATH"

FM10.22 Explain Oath—Hippocrates, Charaka and Sushruta and procedure for administration of Oath.

Every medical student at the time of admission to medical college shall take an oath.

The general principles mentioned in the **Hippocratic Oath** have been brought up to date by the World Medical

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Association. The modernized versions of the Hippocratic Oath are the **Declaration of Geneva**, as adopted by the Second General Assembly of World Medical Association at Geneva, Switzerland, in September 1948 (amended in 22nd World Medical Association, Sydney, August 1968 and in 68th World Medical Association General Assembly, Chicago, United States, October 2017), and the **International Code of Medical Ethics (ICME)**, as adopted by 3rd General Assembly of the World Medical Association held in London, in October 1949. ICME was amended in 1968 (Sydney) and 1983 (Venice), the issue with respect to patient confidentiality was not addressed until the 57th WMA General Assembly Convent in October 2006 (Pilanesberg, South Africa), now the text reads:

“A physician shall respect a patient’s right to confidentiality. It is ethical to disclose confidential information when the patient consents to it or when there is a real and imminent threat of harm to the patient or to others and this threat can be removed by a breach of confidentiality.”

THE DECLARATION OF GENEVA

- FM10.23** Describe the modified declaration of Geneva and its relevance.
- FM2.26** Demonstrate ability to work in a team for conduction of medico-legal autopsies in cases of death following alleged negligence medical dowry death, death in custody or following violation of human rights as per National Human Rights Commission Guidelines on exhumation.
- FM2.27** Demonstrate ability to exchange information by verbal, or nonverbal communication to the peers, family members, law enforcing agency and judiciary.

At the time of registration, each applicant shall be given a copy of the following declaration by the registrar concerned and the applicant shall read and agree to abide by the same. The applicant shall submit a duly signed declaration as per the amendment made by the 68th WMA General Assembly, Chicago, United States, October 2017 as follows:

The Physician's Pledge

AS A MEMBER OF THE MEDICAL PROFESSION:
 I SOLEMNLY PLEDGE to dedicate my life to the service of humanity;
 THE HEALTH AND WELL-BEING OF MY PATIENT will be my first consideration;
 I WILL RESPECT the autonomy and dignity of my patient;
 I WILL MAINTAIN the utmost respect for human life;
 I WILL NOT PERMIT considerations of age, disease or disability, creed, ethnic origin, gender, nationality, political affiliation, race, sexual orientation, social standing or any other factor to intervene between my duty and my patient;
 I WILL RESPECT the secrets that are confided in me, even after the patient has died;
 I WILL PRACTISE my profession with conscience and dignity and in accordance with good medical practice;
 I WILL FOSTER the honor and noble traditions of the medical profession;
 I WILL GIVE to my teachers, colleagues, and students the respect and gratitude that is their due;

I WILL SHARE my medical knowledge for the benefit of the patient and the advancement of healthcare;
 I WILL ATTEND TO my own health, well-being, and abilities in order to provide care of the highest standard;
 I WILL NOT USE my medical knowledge to violate human rights and civil liberties, even under threat;
I MAKE THESE PROMISES solemnly, freely, and upon my honor.

DISCIPLINARY CONTROL

- FM10.5** Rights/privileges of a medical practitioner, penal erasure, infamous conduct, disciplinary committee, disciplinary competencies, warning notice and penal erasure

Disciplinary control over the medical practitioners: (A) Issue **warning notice** similar to that of the Indian Medical Council. (B) The power to remove the names of medical practitioners permanently or for a specific period from registers when after due enquiry they are found to have been guilty of serious professional misconduct. (C) Authorized to direct the restoration of name so removed.

Judicial Procedure of State Council: These proceedings are started: (1) When information reaches the office of the Council that a registered medical practitioner has been convicted of a cognizable offence or has been censured by judicial or other competent authority in relation to his professional character or has been found guilty of conduct which *prima facie* constitutes serious professional misconduct. (2) By a complaint being made by some person or body against the practitioner. (3) *Suo moto*. The Council has the same powers as Civil Courts under Code of Civil Procedure, 1908. This makes all the enquiries on the misconduct of doctors to be judicial proceedings within the meaning of **Sections 229, 257 and 267, BNS.**

Procedure of Enquiry on Complaint: The Registrar of the Council submits the complaint to its president. The matter is referred to the Sub-committee or to the Executive Committee, which considers the complaint, causes further investigation and takes legal advice. (1) **If no prima facie case is made out, the complainant is informed accordingly.** (2) If an enquiry is to be made, a notice is issued to the practitioner specifying the nature and particulars of the charge and directing him to answer the charge in writing, and to attend before the Council on the appointed day. (3) At the hearing, the complainant or his legal adviser, and the practitioner must be present. (4) **After the conclusion of evidence, vote is taken and the judgement given.** (5) **If the majority vote confirms that the charge has been proved, the Council must vote again and decide whether the name of the practitioner should be removed from the register or he should be warned, not to repeat the offence.**

Deletion from the register shall be widely published in local press as well as in the publications of different Medical Associations/Societies, Bodies so that this registered medical practitioner shall not practice.

Erasure of Name from Medical Register: The name of the doctor is removed from the medical register: (1) After the death of the registered practitioner. (2) Entries which are made in error or as a result of fraud. (3) **Penal erasure:** The main cause for erasure is serious professional misconduct, and this is known as penal erasure. It is sometimes termed “**the**

professional death sentence", which deprives the practitioner of all the privileges of a registered practitioner.

Serious professional misconduct (infamous conduct in professional respect)

Any conduct of the registered medical practitioner which might reasonably be regarded as disgraceful or dishonorable. The conduct of the Doctor is judged by professional men of good repute and competence. It involves an abuse of professional position.

WARNING NOTICE: A registered medical practitioner is required to observe certain prescribed rules of conduct contained in Code of Medical Ethics, published by the **National Medical Commission** and by several State Medical Councils.

The Council gives examples of offences which constitute serious professional misconduct, but it stresses the fact that it is not a complete list. The Council can also consider any form of alleged professional **misconduct**, which does not come within any of the offences contained in the Warning Notice. Each case has to be decided on its specific facts and merits.

If anyone is found guilty of any of the following acts of commission or omission mentioned in the list Warning Notice is issued by the Medical Council of India, shall constitute professional misconduct rendering him liable for disciplinary action.

- (1) **Improper conduct with a patient** or by maintaining an improper association with a patient. Adultery has been decriminalized.
- (2) Conviction by a Court of Law for offences involving moral turpitude/criminal acts.
- (3) Issuing a false, misleading or improper certificate in connection with sickness benefit, insurance, passport, attendance in court, public services, etc.
- (4) **Contravening the provisions of the Drugs and Cosmetics Act and regulations.**
 - (a) Prescribing steroids/psychotropic drugs, when there is no absolute medical indication.
 - (b) Selling Schedule 'H' and 'L' drugs and poisons to the public except to his patients.
- (5) Issuing certificates of efficiency in modern medicine to unqualified or non-medical persons. (**Note:** The foregoing does not restrict the proper training and instruction of Bonafede students, midwives, dispensers, surgical attendants or skilled mechanical and technical assistants and therapy assistants under the personal supervision of physicians).
- (6) A physician may patent surgical instruments, appliances and medicines or copyright publication methods and procedures. The use of such patents or copyrights or the receipts of remuneration from them, which retards or inhibits research or restrict the benefit derivable therefrom are unethical.
- (7) Running an open shop for sale of medicines, for dispensing prescriptions of other doctors or for sale of medical or surgical appliances. Manufacturing or sale of proprietary medicine whose formulae are not displayed on the label.
- (8) **Advertising:**
 - (a) A physician should not contribute to the lay press articles and give interviews regarding diseases and treatments which may have the effect of advertising himself or soliciting practices; but is open to write to the lay press under his own name on matters of public health, hygienic living or to deliver public lectures, give talks on the radio/TV/internet, chat for the same purpose.
 - (b) He should not advertise himself

- through manufacturing firms directly or indirectly.
- (9) An institution run by a physician for a particular purpose such as a maternity home, nursing home, private hospital, rehabilitation center or any type of training institution, etc., may be advertised in the lay press, but such advertisements should not contain anything more than the name of the institution, type of patients admitted, type of training and other facilities offered and the fees.
- (10) **Display of sign board:**
 - (a) It is improper for a physician to use an unusually large signboard and write on it anything other than his name, qualifications obtained from a university or a statutory body, titles and name of his specialty, registration number including the name of the State Medical Council under which registered. The same should be the contents of his prescription papers.
 - (b) It is improper to affix a signboard on a chemist's shop or in places where he does not reside or work.
 - (c) A physician can announce in lay or professional press, his starting of practice, interruption or restarting of it after a long interval, or a change of his address, but such an announcement shall not appear more than twice.
- (11) **Dichotomy or fee-splitting,** i.e. receiving or giving commission or other benefits to a professional colleague or manufacturer or trader in drugs or appliances or a chemist, dentist, etc.
- (12) **Covering, i.e. assisting someone who has no medical qualification to attend, treat or perform an operation on some person in respect of matters requiring professional discretion or skill.**
- (13) **Association with manufacturing firms:**
 - (a) A physician should not have any personal ownership in patents for any drug, apparatus, or instrument used in medicine or surgery. He should not ask or receive rebates or commission from prescribing of any agent used therapeutically.
 - (b) A physician must not write prescriptions in private formulae of which only he or a particular pharmacy has the key. He can keep certain lotions or mixtures as long as the formulae of the same are available.
 - (14) Disclosing the secrets of a patient that have been learnt in the exercise of his/her profession except
 - (i) in a court of law under orders of the presiding judge;
 - (ii) in circumstances where there is a serious and identified risk to a specific person and/or community;
 - (iii) notifiable diseases.
 In case of communicable/notifiable diseases, concerned public health authorities should be informed immediately.
 - (15) Refusal on religious grounds alone to give assistance in or conduct of sterility, birth control, circumcision and medical termination of pregnancy when there is medical indication, unless the medical practitioner feels himself/herself incompetent to do so.
 - (16) Failure to obtain consent from the patient for an operation or from guardians in case of a minor.
 - (17) Failure to obtain consent of both husband and wife for an operation which may result in sterility.
 - (18) A registered medical practitioner shall not publish photographs or case reports of his patients without their permission, in any manner by which their identity could be made out. If the identity is not to be disclosed, the consent is not needed.
 - (19) In the case of running of a nursing home by a physician and employing assistants to help him, the ultimate responsibility rests on the physician.
 - (20) A physician shall not use touts or agents for procuring patients.
 - (21) A physician shall not aid or abet torture.
 - (22) A physician should observe

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the laws of the country in regulating practice of medicine and will not assist others to evade such law. (23) A physician shall not claim to be specialist unless he has special qualification in that branch. (24) Drunk and disorderly so as to interfere with proper skilled practice of medicine. (25) No act of in vitro fertilization or artificial insemination shall be undertaken without the informed consent of the female patient and her spouse as well as the donor. Such consent shall be obtained in writing, only after the patient is provided, at her own level of comprehension, with sufficient information about the purpose, methods, risks, inconveniences, disappointments of the procedure and possible risks and hazards. (26) Clinical drug trials or other research involving patients or volunteers as per the guidelines of ICMR can be undertaken, provided ethical considerations are borne in mind. Violation of existing ICMR guidelines in this regard shall constitute misconduct. (27) If he/she does not display the registration number accorded to him/her by the State Medical Council or the Medical Council of India in his clinic, prescriptions and certificates, etc. issued by him. (28) If he/she does not maintain the medical records of indoor patients for a period of three years and refuses to provide the same within 72 hours when the patient or his authorized representative makes a request for it. (29) On no account sex determination test shall be undertaken with the intent to terminate the life of a female fetus developing in her mother's womb, unless there are other absolute indications for termination of pregnancy. Any act of termination of pregnancy of normal female fetus amounts to female feticide.

The Most Serious "Misconducts" in Nature—"The 6 A's": (1) **Adultery** arising out of professional relationship. (2) **Advertising.** (3) **Abortion (unlawful).** (4) **Association** with unqualified persons in professional matters. (5) **Addiction** to drugs. (6) **Alcohol:** Consumption of Alcohol at workplace.

RIGHTS AND PRIVILEGES OF REGISTERED MEDICAL PRACTITIONERS

(1) Right to practice medicine. (2) Right to choose a patient. (3) Right to dispense medicines. (4) Right to possess and supply dangerous drugs to his patients. (5) Right to add title, descriptions, etc., to the name. (6) Right to recovery of fees. (7) Right for appointment to public and local hospitals. (8) Right to issue medical certificates. (9) Right to give evidence as an expert.

Medical practitioners can suffix to their names only recognized medical degrees/diplomas and membership/honors, which confer professional knowledge or recognize any exemplary qualifications/achievements.

Red Cross Emblem: It is the distinctive sign of the medical services of an army, whose members, buildings, equipment and vehicles it protects in time of war (protective sign). In war, it also covers the formations of national Red Cross Societies and other recognized relief societies assisting the medical services of an army. (1) The sign is conferred on national Red Cross Societies in the exercise of their other humanitarian activities. This entitles them, in peace as well as in war, to

mark their persons and properties with the sign. (2) Its use is permitted to the members of Army Medical Corps and to the Red Cross Society during war and also during rendering their service to the human society in peace time. (3) The red Crescent emblem is used in 33 Islamic countries and Red Crystal emblem is used in Israel, in place of Red Cross. (4) The Geneva Convention Act, 1960, under S. 12, prohibits use of Red Cross and other allied emblems such as "Red Crescent", "Red Crystal" for any purpose without approval of the Government of India. (5) S. 13, lays down the penalty for unauthorized use with a fine up to ₹500/- and forfeiture of the goods upon which emblem was used. (6) **The use of the Red Cross and allied emblems by medical practitioners is prohibited.**

DUTIES OF MEDICAL PRACTITIONERS

FM10.6 Describe the Laws in Relation to Medical Practice and the duties of a medical practitioner towards patients and society.

Duty refers to the obligation to act or refrain from acting in such a way that a patient's medical condition is appropriately diagnosed and managed so that a patient is not exposed to an unreasonable risk of injury.

The following are the various types of duties:

(I) Duty to Exercise a Reasonable Degree of Skill and Knowledge: (1) **The duty of care arises simply by examining someone for signs of illness or trauma or even by accepting a patient onto a list of existing patients.** As soon as a doctor gives advice and counselling over the telephone, a legal duty to the patient arises. If no advice is given, no duty arises. Exception might be made in cases of acute emergency where life-saving instructions are given over the telephone. (2) **For hospitals, a duty will usually arise once the patient has been admitted, but in the case of an accident or emergency unit, a general duty of care is owed to the patient.** RMP owes this duty to the child even when engaged by his father. RMP owes this duty even when patient is treated free of charge. It neither guarantees cure nor an assured improvement. A practitioner is not liable because some other doctor of greater skill and knowledge would have prescribed a better treatment or operated better in the same circumstances.



CASE(S)

Whiteford vs Hunter and Glead (1950)

A consulting engineer of London was examined by a consulting surgeon who diagnosed enlarged prostate by doing rectal examination and advised operation. The surgeon did not use a cystoscope or make a biopsy. On opening the bladder, he found an inoperable carcinoma and opined the expectancy of life to be only a few months. The patient gave up his business and went to the United States of America, where a cystoscopic examination showed a prostate with a median bar, and the pathological examination revealed chronic cystitis. An operation was performed, and the calcareous material was removed from the diverticulum. There was no evidence of cancer. The patient sued the doctor for negligence and was awarded damages. The surgeon appealed and the Court of Appeal held that a mistake in diagnosis was not enough to justify negligence.

Wood vs Charing Cross Hospital

A drunken person was hit by a lorry. The doctor who examined him found no clinical evidence of bone injury or any abnormality, but the stethoscope was not used. The patient died 2 days later, and the autopsy showed fracture of one clavicle and 9 ribs on each side and congestion of lungs. The Court found the doctor negligent in not exercising reasonable care in his examination.

Payne vs Helier

A patient was kicked in the abdomen by a horse. He went to the hospital 9 hours after the injury, where he was examined by the Casualty officer, who was qualified 2 years ago. He found a bruise in the right iliac fossa, but did not find any body or visceral injury. The patient was sent home, who became very ill after some days and was operated but died later. The Court found the doctor negligent as he made a wrong diagnosis due to his failure to exercise reasonable skill and care.

(II) Duties with Regard to Attendance and Examination:

When a practitioner agrees to attend a patient, RMP is under an obligation to attend to the case as long as it requires attention. (1) RMP can withdraw only after giving reasonable notice or when he is asked by the patient to withdraw. Doctor cannot withdraw from duty of care without the consent of the patient except for valid reasons, such as: (a) That he/she, **him/herself becomes sick**. (b) That Doctor is convinced that the patient is **malingering**. (c) Remedies other than those prescribed by him are being used. (d) That his instructions are being ignored. (e) That previous **financial obligations** are not being fulfilled by the patient except in case of medical emergency. (f) That **another practitioner** is also attending the patient. (g) That the patient persists in the use of **intoxicants or poisons**. (2) If a physician is unable to treat the patient when his services are needed, he may provide a qualified and competent substitute doctor to give the services. (3) If the practitioner cannot cure a patient, he need not withdraw, if the patient desires his services. (4) Patient **should not get himself examined or operated upon by another doctor** without his permission. (5) If the doctor is called by the police to attend a case of accident, Doctor may give first aid and advice, but here no doctor-patient relationship is established. (6) A medical practitioner need not accept as patients all who come to him for treatment. Doctor may arbitrarily refuse to accept any person as a patient, even though no other physician is available except in case of medical emergency. (7) **Doctor should know that the Code of ethics requires that in an emergency, no physician should refuse to treat a patient.** There is no law to compel a doctor to attend a patient except during military necessity.

**CASE****Newton vs Central Middlesex GHMS**

Newton was taken to the hospital after an accident. A doctor examined him but failed to diagnose the fractured patella and wrote, 'No clinical fracture' on the hospital card. Later, the patient saw two other doctors at the hospital, who relying on the hospital card, did not examine the knee, though the patient

had complained of pain in the knee. The patient sued both the doctors for negligence. The Court held that the first doctor was not guilty because the patient went to him only for a dressing. The second doctor was held negligent as he failed to examine the knee himself.

(III) Duty to Prescribe Proper and Suitable Medicines: If the doctor has his own dispensary, he should furnish the patient with suitable medicines. Otherwise, **he should give a legible prescription, mentioning full and detailed instructions.** The doctor is held responsible for any temporary or permanent damage in health, caused to the patient due to wrong prescription.

(IV) Duty to Give Instructions: The doctor should give full instructions to his patients or their attendants regarding the use of medicines and diet. He should mention the exact quantities and precise timing for taking medicines. Patients should be instructed regarding the adverse reactions and to stop the drug in case of reaction, and to approach the doctor immediately.

**CASE****Ball vs Howard**

The plaintiff was operated for appendicitis. The surgeon did not call another surgeon for consultation (though the patient requested for the same as he developed some complications) and went away without leaving proper instructions as to what was to be done. The patient called another surgeon, who performed a second operation after which the patient made a good recovery. The Court held that the first surgeon was negligent in not attending to the patient with reasonable promptness and in going away without giving instructions.

(V) Duty to Control and Warn: A physician must warn patients of the dangers involved in the use of a prescribed drug or device. If the doctor fails to inform the patient of the known or reasonably foreseeable dangerous effects of a drug or device, he becomes liable not only for the harm suffered by the patient, but also for injuries his patient may cause to third parties. If a drug is administered which might affect a patient's functional ability, such as driving a car or operating machinery or equipment, the doctor should explain the danger to the patient, and/or to someone who can control the patient's activities, such as the family, an employer, or the authorities. Similarly, when a doctor detects a medical condition that may impair the patient's ability to control his activities, the doctor has a duty to warn the patient, family, employer or authorities. The doctor has a duty to warn the patient about his medical condition and treatment that could injure others, e.g., the doctor treating epileptic patient may be liable for injury to others caused by his patient, due to failure to advice the patient of the risks of engaging in dangerous activities, under the concept of "Reasonable foreseeability."

Duty to Third Parties: If a patient suffers from an infectious disease, the doctor should warn not only the patient, but also third parties known to be in close contact with

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the patient. These include relatives, friends, co-workers, and/or proper authorities who can protect these potential victims.

Duty Towards Children and Adults Incapable of Taking Care of Themselves: When applying hot water bottles to children, special care should be taken, for the child may be injured. Special precautions should be taken in case of adults who are incapable of taking care of themselves due to insanity or some physical disability. Precautions should be taken to prevent accidents or harm.



CASE

A woman was placed in a bed after an operation in which a hot water bottle was negligently left, due to which she was severely burnt between her shoulders. The surgeon came to see her while she was recovering from the anesthetic. She complained to the surgeon about the pain between her shoulders, but he paid no attention to her. The Court held the doctor negligent and awarded damages.

(VIII) Duty to Inform Patient of Risks: A mentally sound adult patient must be told of all the relevant facts. If the treatment or operation proposed carries special risks which are known to the doctor but are probably not known to the patient, the doctor should inform the patient of these risks and obtain his consent. The inherent risk is one of a number of known adverse effects (or injuries) that may result from the mere use of an individual drug or the mere proper performance of a diagnostic procedure or surgical operation. **A material risk is a particular inherent risk, i.e., one known adverse effect or complication associated with a drug, procedure or treatment, that physician knows would be a significant factor in a person's decision whether to reject or accept treatment. But under certain conditions arising out of psychological factors, some facts must be withheld.**



CASE

Kankan vs Beharilal

A prescription was given to Kankan for ear trouble, which was used as directed by the doctor. The patient developed pain and acute sensation in the ear after a year, and on examination, the drum of his right ear was found destroyed. The evidence showed that the doctor has prescribed a new and dangerous mixture for a petty complaint, and if the mixture had been used after thorough shaking, no harm would have resulted. The high Court held the doctor negligent, as he failed to warn the patient of the risk involved.

(IX) Duty with Regard to Poisons: Poisons should be handled carefully. Each poison should be kept in a separate bottle, properly labelled and kept in a separate cupboard or upon a separate shelf. When a doctor is called upon to treat a case of poisoning: (1) he should give immediate treatment, and (2) **he should assist the police in determining whether the poisoning is accidental, suicidal or homicidal.**

(X) Duty to Notify Certain Diseases: A doctor is bound to give information of communicable diseases (smallpox, chickenpox, cholera, plague, typhoid, measles, diphtheria,

yellow fever, food poisoning), births, deaths, etc., **to the Public Health authorities.** If a doctor fails to conform to the statutory or administrative requirements, he will be liable not only for criminal penalties, but also for negligence in civil suits brought by injured parties.

Legal and ethical issues: (1) Informed consent autonomy of patient. (2) Poor communication. (3) Unexpected outcome. (4) Retained foreign bodies. (5) Surgery on wrong site. (6) Extended hospital stays.

(XI) Duties with Regards to Operations: (1) He should explain the nature and extent of operation and take consent of the patient. (2) He should take proper care to avoid mistakes, such as performance of operations on the wrong patient or on the wrong limb. (3) When a surgeon undertakes to operate, he must not delegate that duty to another. (4) He must not experiment. (5) He must be well-informed of current standard practice and must follow it. (6) He must operate with proper and sterilized instruments. (7) He should make sure that all the swabs, instruments, etc., put in are removed. (8) He should take proper postoperative care and should give proper directions to his patient when discharging him.

(XII) Duties Under Geneva Conventions: In Geneva, in 1949, four conventions were agreed upon. Each convention lays down that the persons it protects, whether the wounded or sick of the armed forces (first convention), ship-wrecked persons (second), prisoners of war (third), or civilians of enemy nationality (fourth), are **to be treated without any adverse distinction based on sex, race, nationality, political opinions or any other similar criteria. Priority is authorized only for urgent medical emergencies.**

(XIII) Duties with Regard to Consultation: Consultation should be advised preferably with a specialist in the following conditions. (1) If the patient requests consultation. (2) In an emergency. (3) When the case is obscure or has taken a serious turn. (4) If the quality of the care or management can be considerably enhanced. (5) When an operation or a special treatment involving danger to life is to be undertaken. (6) When an operation affecting vitality of intellectual or generative functions is to be performed. (7) When an operation of mutilating or destructive nature is to be performed on an unborn child. (8) When an operation is to be performed on a patient who has received serious injuries in a criminal assault. (9) In homicidal poisoning. (10) When a therapeutic abortion is to be procured. (11) When a woman on whom criminal abortion has already been performed has sought advice for treatment.

The consent of the patient must be taken. The doctor must tell the patient, whether he is being transferred to the consulting physician or only consulting, or it will be joint participation, and whether it will be on a continuous or intermittent basis. **A referring physician is relieved of further responsibility when he completely transfers the patient to another physician. The referring physician may be held liable under the doctrine of 'negligent choice', if it can be proved that the consultant was incompetent or had a reputation as an "errant" physician. All information about the patient must be transferred to the consultant by the referring physician.** The consultant should advise the

patient to return to the practitioner who has referred him. If the patient refuses, the consultant should talk to the referring doctor and settle the matter.



CASE

Molseworth's Case

The patient engaged a senior surgeon for hernia operation, but he was operated upon by a house-surgeon. The Court held that the house-surgeon had operated without the plaintiff's consent; that for an unauthorized person to do, in competent manner, an act which another was authorized to do, was technical form of trespass and patient was awarded nominal damages.

(XIV) Duty in Connection with X-ray Examination:

As far as possible, **all cases of accident, unless they are very minor, should be X-rayed.** The radiologist should take precautionary measures against X-ray burns, pain or scars and other complications while giving therapy to patient.



CASE

Fraser vs Vancouver General Hospital

A patient was X-rayed after a traffic accident. The casualty officer, who was not competent, gave opinion that the neck was not broken. The Court held him negligent in not diagnosing a broken neck.

CONSUMER PROTECTION ACT, 2019

FM10.8 Describe the Consumer Protection Act-1986 (Medical Indemnity Insurance, Civil Litigations and Compensations).

The Consumer Protection Act (CPA) originated in 1986 and was later updated by the CPA, 2019 to address modern consumer concerns. In 1995, the Supreme Court in the landmark case of **Indian Medical Association vs VP Shantha** ruled that medical services fall under the ambit of the CPA, thereby recognizing patients as consumers entitled to legal remedies for deficient services. This position was further reinforced in April 2022, when the Supreme Court clarified that healthcare services, whether provided on a paid basis or free of charge to poor patients, are also covered under the CPA, 2019.

Key Provisions of CPA, 2019: (1) Definition of Consumer: Goods/services for consideration (offline, online, e-commerce, teleshopping, MLM).

(2) Three-Tier CDRC System: (a) **District CDRC:** ≤ ₹1 Cr; appeal to State (45 days). (b) **State CDRC:** ₹1–10 Cr; appeal to National (30 days). (c) **National CDRC:** > ₹10 Cr; appeal to Supreme Court (30 days).

(3) Consumer Mediation Cells (CMC): At all levels for settlement.

(4) CCPA: Regulates unfair trade practices, misleading ads.

(5) Complaint Procedure: (a) **Filing:** Online/offline. (b) **Fees (District only):** Nil (<₹5 Lakh), ₹200 (₹5–10 Lakh), ₹400 (>₹10 Lakh). (c) **Limitation:** Within 2 years (Sec. 69). (d) **Representation:** With/without lawyer.

New Inclusions in CPA, 2019: E-commerce and telemarketing, Unfair contracts, Higher pecuniary limits,

Formal mediation process, Stricter rules on misleading ads and Expanded product liability.

NATIONAL HUMAN RIGHT COMMISSION (NHRC)

FM10.9 Describe the medico-legal issues in relation to family violence, violation of human rights, NHRC and doctors.

NHRC Protocol for Custodial Death Autopsies (1993, amended 2001): (1) **Notification:** All custodial deaths must be reported to NHRC within 24 hours. (2) **Magistrate Inquest:** Mandatory before autopsy. (3) **Body Handling:** Hands wrapped in white paper bags; body transported in zippered body bags. (4) **Medicolegal Autopsy:** (a) Conducted by a board of ≥3 forensic physicians (PG in Forensic Medicine, ≥5 yrs experience, preferably from different institutions). (b) Use NHRC pro forma. (c) Firearm deaths: mandatory X-ray/CT before autopsy. (d) Videography with narration plus submission of cassette & report to NHRC. (e) 20–25 photographs (before/after removing clothes), with postmortem number, date, and scale. (f) Clothing removal, documentation, sealing by physician only; send to FSL. (g) Each injury described with reference to heel and midline. (h) Report must be typed/computerized; fingerprints appended. (5) **Submission:** Magistrate's inquest, autopsy report, and video to reach NHRC within 2 months. (6) **FSL Reports:** Toxicology, histology, or other lab results to be forwarded promptly to NHRC. (7) **Compensation:** Next of kin entitled to compensation from State Government and offending officer.

CLINICAL TRIALS

FM10.25 Clinical research and Ethics Discuss human experimentation including clinical trials.

FM10.27 Describe and discuss Ethical Guidelines for Biomedical Research on Human Subjects and Animals.

FM10.29 Demonstrate ability to conduct research in pursuance to guidelines or research ethics.

Clinical trials (also called *human experimentation* or *clinical research*) are systematic investigations on human participants designed to evaluate the **safety, efficacy, and effectiveness** of new drugs, medical devices, surgical procedures, or preventive interventions. These trials are usually sponsored by government agencies, pharmaceutical industries, or NGOs after formal approval of the research protocol. To promote transparency, the **International Clinical Trials Registry Platform (ICTRP)** was established globally. In India, all clinical trials must be registered with the **Clinical Trials Registry-India (CTRI)**, a free, public, online portal (<http://www.ctri.nic.in>). Trial monitoring is overseen by **Data and Safety Monitoring Boards (DSMBs)**, which safeguard patient safety, ensure data integrity, and review treatment efficacy. In India, regulations for new drug trials are laid down under **Schedule Y of the Drugs and Cosmetics Rules, 1945.**

Controlled Clinical Trials: Most trials use a **control group** (placebo or standard-of-care) and a **test group** (experimental treatment). **Types: (1) Randomized Controlled Trials**

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(RCTs): Subjects are randomly allocated (via random number tables, computer programs), ensuring equal chance of assignment and minimizing bias. This is the gold standard, especially for **Phase III**. **(2) Non-randomized Trials:** Lack random allocation, hence more prone to bias. **(3) Open Trials:** Both investigator and subject know the treatment received. **(4) Blinded Trials:** Treatment is concealed to prevent bias. **(a) Single-blind:** Subject unaware. **(b) Double-blind:** Both subject and investigator unaware. An independent team manages treatment codes until study completion. Medications are matched in appearance, count, taste, and packaging to ensure concealment.

Informed Consent: Participation requires **written informed consent**. The form must clearly explain the purpose, potential benefits, risks, and confidentiality safeguards.

Phases of Clinical Trials: Phase 0 (Microdosing)

(a) Newer approach using very small, sub-therapeutic doses in humans. (b) Accelerates early drug development, reducing cost and time.

Phase I: (1) Purpose: First human testing; determines safety, maximum tolerated dose (MTD), pharmacokinetics (ADME), and early toxicities (e.g., effects on BP, heart rate, seizures, organ function). **(2) Subjects:** 20–80 healthy volunteers. **(3) Design:** Usually open label; conducted in highly monitored settings with resuscitative facilities. **(4) Procedure:** Dose escalation begins at 1/100th–1/10th of the highest non-toxic animal dose. **(5) Duration:** 3–12 months. **(6) Success rate:** ~70% proceed to Phase II.

Phase II: (1) Purpose: Establish efficacy in patients with the target disease; expand toxicity profile. **(2) Subjects:** 100–500 patients. **(3) Design:** Mostly randomized, controlled, and blinded (placebo or standard therapy as control). **(4) Duration:** Several months–2 years; conducted in 2–4 specialized centers. **(5) Success rate:** High failure rate; only ~25% move to Phase III.

Phase III: (1) Purpose: Confirm effectiveness, compare with existing treatments, further define side effects, and determine safe usage. **(2) Subjects:** Large sample (500–3000 patients). **(3) Design:** Multicentric, randomized, double-blinded; highly complex, long-term, and costly. **(4) Advantages of multicentric design:** Faster recruitment, diverse populations, global regulatory acceptance, improved credibility. **(5) Duration:** Several years. **(6) Success rate:** 70–90% progress to Phase IV. **(7) Outcome:** Submission of **New Drug Application (NDA)** to regulators (e.g., FDA). If approved, drug enters the market.

Phase IV (Post-Marketing Surveillance): (1) Purpose: Longest phase, initiated after market approval; ensures long-term safety and real-world effectiveness. Detects rare, delayed, or idiosyncratic adverse effects and evaluates drug use in wider populations. **(2) Subjects:** Broad clinical practice population, including groups excluded earlier (children, elderly, pregnant/lactating women, renal/hepatic disease). **(3) Activities:** (a) Adverse event monitoring and drug utilization studies. (b) Exploration of new indications, dosage forms, and fixed-dose combinations. (c) Assessment of drug interactions, patient quality of life, and cost-effectiveness. **(4) Rationale:** Continuous monitoring across diverse settings ensures optimal, safe, and effective therapeutic use.

In summary, clinical trials progress systematically from **Phase 0 to Phase IV**, moving from safety evaluation in small groups to widespread real-world monitoring. At every stage, **informed consent, randomization, blinding, and ethical oversight** remain crucial for ensuring patient safety and generating reliable data.

INSTITUTIONAL ETHICAL COMMITTEE (IEC)

FM10.26	Discuss the constitution and functions of ethical committees.
FM10.27	Describe and discuss Ethical Guidelines for Biomedical Research on Human Subjects and Animals.
FM10.29	Demonstrate ability to conduct research in pursuance to guidelines or research ethics.

The **Institutional Ethical Committee (IEC)**, also known internationally as an **Institutional Review Board (IRB)**, **Ethical Review Board (ERB)**, or **Research Ethics Board (REB)**, is an independent body established to protect the **rights, safety, and well-being of human participants** in biomedical research. In India, all institutions conducting human research are required to have an IEC in accordance with **ICMR guidelines**, ensuring ethical standards and preventing malpractice.

Composition of IEC: An IEC is multidisciplinary, generally comprising **8–12 members**, with representation from both scientific and non-scientific backgrounds: **(1) Chairperson, (2) Member Secretary, (3) Basic Medical Scientists, (4) Clinicians/Scientists from Medical Practice, (5) Legal Expert, (6) Social Scientist/Social Activist, (7) Lay Person(s) from Community**

Functions of IEC (1) Reviews research protocols and proposals in scheduled meetings. (2) Assesses **ethical acceptability** of the study. (3) Provides **guidance and suggestions** to investigators for ensuring compliance with ethical principles. (4) Grants approval only after ensuring participant protection and scientific justification.

CATEGORIES OF REVIEW (BASED ON RISK ASSESSMENT)

FM2.26	Demonstrate ability to work in a team for conduction of medico-legal autopsies in cases of death following alleged negligence medical dowry death, death in custody or following violation of human rights as per National Human Rights Commission Guidelines on exhumation.
FM2.27	Demonstrate ability to exchange information by verbal, or nonverbal communication to the peers, family members, law enforcing agency and judiciary

(1) Full Review: For proposals involving **more than minimal risk** or studies with **vulnerable populations** (children, pregnant women, prisoners, etc.).

(2) Expedited Review: For studies involving minimal/moderate risk under defined conditions, such as: (a) Minor protocol amendments. (b) Research in disaster/emergency situations. (c) Use of materials collected during routine care (e.g., CT scans, blood samples).

(3) Exemption from Review: For studies with **less than minimal risk**, including: (a) Observational research without

intervention. (b) Secondary data analysis of publicly available or anonymized datasets.

Summary: The IEC ensures that biomedical research is conducted **ethically, transparently, and responsibly**, balancing scientific advancement with protection of participants' rights and dignity.

Medico-legal autopsies in sensitive cases (medical negligence, dowry death, custodial death, human rights violations) demand a **multidisciplinary, team-based approach** as per **NHRC guidelines** to ensure accuracy, transparency, and legal validity.

(1) Team Composition: (a) **Forensic Experts:** Lead autopsy, document findings. (b) **Pathologists/Scientists:** Histopathology, toxicology sampling. (c) **Radiologists:** Pre-autopsy imaging (X-ray/CT). (d) **Photographer/Videographer:** Mandatory photo/video recording. (e) **Police/Magistrate:** Inquest, chain of custody. (f) **FSL Experts:** Analyze samples (toxicology, histology, DNA). (g) **Support Staff:** Assist in body handling, labelling, preservation.

(2) Roles and Responsibilities: Pre-Autopsy: NHRC notified (within 24 hours), Magistrate's inquest, proper transport of body (sealed, hands in paper bags, zippered bag). **During Autopsy:** Conducted by 3 forensic experts; NHRC pro forma used; videography + 20–25 photographs; injuries measured from fixed landmarks; clothing handled only by doctors, sealed, and sent to FSL. **Exhumation:** Done under NHRC supervision with videography and fresh report. **Post-Autopsy:** Typed/computerized report with fingerprints; reports, video, and FSL findings submitted to NHRC within 2 months; compensation matters referred to State Government.

(3) Principles of Teamwork: (a) **Collaboration:** Each expert contributes their domain skills. (b) **Transparency:** Videography, photography, and external oversight. (c) **Accountability:** strict documentation and chain of custody. (d) **Communication:** Regular coordination between doctors, investigators, and NHRC.

DOCTORS, PUBLIC AND MEDIA

FM10.10	Describe communication between doctors, public and media.
FM10.24	Enumerate rights, privileges and duties of a registered medical practitioner. Discuss doctor-patient relationship: Professional secrecy and privileged communication

Doctors should individually and collectively influence medical content of the media since media has an important influence on the attitudes and actions of their audience. Doctors can: (a) Volunteer services to media (print, radio and television) as an expert. (b) Contribute medical-related articles to local dailies. (c) Organize events to interact with public such as health camps, blood donation drives and invite media to cover them.

PROFESSIONAL SECRECY (CONFIDENTIALITY)

(1) It is an implied term of contract between the doctor and his patient. The relationship of doctor and patient requires utmost trust, confidence, fidelity and honesty. (2) The

doctor is obliged to keep secret, all that he comes to know concerning the patient in the course of his professional work. Everything said by a patient or his family members to a physician in the context of medical diagnosis and treatment is confidential. **Its disclosure would be a failure of trust and confidence.** It assumes that without confidentiality, patients will not reveal everything during a consultation, especially intimate details, due to which the clinical history may be deficient or even misleading. **(3) The patient can sue the doctor for damages** (mental suffering, shame or humiliation), **if the disclosure is voluntary, has resulted in harm to the patient and is not in the interest of the public.**

Examples: (1) A doctor **should not** discuss the illness of his patient with others without the consent of the patient. (2) *If the patient is major*, the doctor **should not** disclose any facts about the illness without his consent to parents or relatives even though they may be paying the doctor's fees. *In the case of a minor or a person of unsound mind*, guardians or parents should be informed of the nature of the illness. (3) A doctor **should not** answer any enquiry by third parties, even when enquired by near relatives of the patient, either with regard to the nature of the illness or with regard to any subsequent effect of such illness on the patient without the consent of the patient. (4) A doctor **should not** disclose any information about the illness of his patient without the consent of the patient, even when requested by a public or statutory body, except in case of notifiable diseases. If the patient is a minor or insane, consent of the guardian should be taken. (5) Even *in the case of husband and wife*, the facts relating to the nature of illness of the one, must not be disclosed to the other, without the consent of the concerned person. (6) *In divorce and nullity cases*, no information should be given without getting the consent of the person concerned. (7) Medical officers in government services are also bound by the code of professional secrecy, even when the patient is treated free. (8) When a doctor examines a **government servant** on behalf of the government, he cannot disclose the nature of illness to the government without the patient's consent. (9) When a **domestic servant** is examined at the request of the master, the doctor should not disclose any facts about the illness to the master without the consent of the servant, even though the master is paying the fees. (10) The medical officer of a firm or factory **should not** disclose the result of his examination of an employee to the employers without the consent of the employee. (11) *A person in police custody* as an undertrial prisoner has the right not to permit the doctor who has examined him, to disclose the nature of his illness to any person. If a person is convicted, he has no such right and the doctor can disclose the result to the authorities. (12) **In reporting a case in any medical journal, care should be taken that patient's identity is not revealed from the case notes or photographs.** (13) *In the examination of a dead body*, certain facts may be found, the disclosure of which may affect the reputation of the deceased or cause mental suffering to his relatives, and as such, the doctor should maintain secrecy. (14) The medical examination for taking out life insurance policy is a voluntary act by the examinee and therefore consent to the disclosure of the finding may be

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taken as implied. A doctor should not give any information to an insurance company about a person who has consulted him before, without the patient's consent. Any information regarding a dead person may be given only after obtaining the consent from the nearest relative. (15) **The sex of unborn detected during ultrasonography should not be disclosed.**

PRIVILEGED COMMUNICATION

(1) **It is a statement made Bonafide upon any subject matter by a doctor to the concerned authority, due to his duty to protect the interests of the community or of the State.**
 (2) **To be privileged, the communication must be made to a person having interest in it, or in reference to which he has a duty.** If made to more than one person, or to a person who has not a direct interest in it, the plea of privilege fails.
 (3) **The doctor should first persuade the patient to obtain his consent before notifying the proper authority. If the doctor discloses professional secrets for the purpose of protecting the interest of the community, (under a moral and social obligation), he will not be liable to damages.**

Examples: The following are the examples of privileged communication, or in other words, exceptions to the general rule of professional secrecy. (1) **Infectious diseases:** If a patient suffering from an infectious disease is employed as cook or waiter in a hotel, or a food-handler with an enteric infection, or a teacher with tuberculosis or other infective disease, or as children's nurse, etc., **he should be persuaded to leave the job until he becomes non-infectious. If the patient refuses to accept this advice, the doctor can inform the employer about the illness of his patient.** (2) **Servants and employees:** An engine driver or a bus driver or a ship's officer may be suffering from epilepsy, high blood pressure, alcoholism, drug addiction, or color blindness. The doctor should persuade the patient to change his employment, because of the dangers of his present occupation, both to himself and to the public. If this fails, the doctor should inform the employer, that the patient is unfit for that kind of employment. (3) **Notifiable diseases:** A medical practitioner has a statutory duty to notify births, deaths, infectious diseases, etc., to the Public Health authorities. (4) **Venereal diseases:** If a person is suffering from syphilis and is about to marry, it is the duty of the doctor to advise the patient not to marry till he is cured; if the person refuses, the doctor can disclose the syphilitic condition of the patient to the woman concerned or to her parents. Swimming pools should be prohibited to those having syphilis or gonorrhoea, but if the person refuses, the authorities can be informed. The doctor can inform the warden of a hostel, if any boarder is suffering from venereal

disease. (5) **Patient's own interest: The doctor may disclose the patient's condition to some other person, so that he may be properly treated,** e.g., to warn the parents or guardians of signs in the patient of melancholia, suicidal tendencies, etc. (6) **Self-interest:** Both in civil and criminal suits by the patient against the doctor, evidence about the patient's condition may be given. (7) **Negligence suits: When a physician is employed by the opposite party to examine a patient who has filed a suit for negligence, the information thus acquired is not privileged** (no physician-patient relationship), and the doctor may testify to such information. (8) **Suspected crime: Every person, aware of the commission of, or of the intention of any other person to commit any offence shall immediately give information to the nearest Magistrate or police officer of such commission or intention [Section 33, BNSS].** If the doctor learns of a serious crime, such as murder, assault, rape, etc. by treating the victim or assailant, he is bound to give information to the police. Thus, if a doctor treats a person suffering from gunshot or stab wounds due to criminal assault, he must inform the police. (9) **Courts of law: In a Court of law, a doctor cannot claim privilege concerning the facts about the illness of his patient, if it is relevant to the inquiry before the Court.** The doctor should appeal to the Court if he is asked to reveal any professional secret. If the Court does not accept this plea, he may request the Court that he may be allowed to give the answer in writing so that the public may not know it. If this is denied by the Court, the doctor has to answer the questions about the patient's confidential matters to avoid risk of penalties for contempt of Court. **In all cases, the doctor should appeal to the Judge before disclosing a professional secret. The witness should not voluntarily disclose information either in Court or out of it, but for the actual evidence demanded by the Court, he is protected from civil action against breach of confidence.** Under **Section 132 (1) and (2), 134 BSA**, a lawyer can claim privilege in a Court of law with regard to any communication made to him by his client. (10) A doctor can disclose and discuss the medical facts of a case with other doctors and paramedical staff, such as nurses, radiologist, physiotherapist, etc. to provide better service to the patient.

PHYSICIAN'S RESPONSIBILITY IN CRIMINAL MATTERS

(1) **In medicolegal cases, treatment gets priority. Thereafter, procedural criminal law will operate in order to avoid negligent death.** A doctor who is aware of the commission of crimes, such as murder, dacoity, waging war against the lawful Government, helping the escape of prisoners, etc., is legally bound to report them to the nearest Magistrate or police officer [**Section 33, BNSS; Section 211, BNS**]. The doctor knowing or having reason to believe that an offence has been committed by a patient whom he is treating, intentionally omits to inform the police, shall be punished with imprisonment up to 6 months [**Section 239, BNS**]. (2) **If he/she treats a person who has attempted to commit suicide, he is not legally bound to report, but if the person dies, he must inform the police.** The practitioner's responsibility in case of criminal abortion



CASE

AVD specialist saw a young man suffering from syphilis about to enter a public bath. The specialist tried to dissuade the person from entering the bath, but he refused. The physician reported the matter to the attendant who did not allow the young man to bathe. The patient brought a suit against the doctor for breach of professional confidence, but the Court dismissed the case on the ground that the doctor acted in the interest of the community.

and poisoning have been described in the relevant chapters. **(3) Special duty of a doctor in Emergency Cases:** In emergency, he has moral, ethical and humanitarian duty to do his best to help the patient in saving his life. **In medicolegal injury cases, a doctor is obliged to give necessary medical aid and to save the life of the patient and render all help to see that the person reaches the proper expert/institution as early as possible.**

DUTIES OF A PATIENT

(1) He should furnish the doctor with complete information about past illness, and family history of diseases and the facts and circumstances of his illness. (2) He should strictly follow the instructions of the doctor as regards diet, medicine, mode of life, etc. (3) He should pay a reasonable fee to the doctor.

PRIVILEGES AND RIGHTS OF THE PATIENTS

Every patient has right to: **(1) Choice:** To choose his own doctor freely. **(2) Access:** (a) To healthcare facilities available regardless of age, sex, religion, economic and social status, (b) to emergency services. **(3) Dignity:** To be treated with care, compassion, respect and dignity without any discrimination. **(4) Privacy:** To be treated in privacy during consultation and therapy. **(5) Confidentiality:** All information about his illness and any other be kept confidential. **(6) Information:** To receive full information about his diagnosis, investigation and treatment plans and alternative. **(7) Safety:** Right to information should also include safety of procedures/diagnosis/therapeutic modality, complications/side-effects/expected results as well as facilities available in the institution and other places. **(8) Right to know:** Day to day progress, line of action, diagnosis and prognosis. **(9) Refusal:** Right to consent or refuse any specific or all measures. **(10) Second opinion:** At any time. **(11) Records:** Access to his records and demand summary or other details pertaining to it. **(12) Continuity:** To receive continuous care for his illness from the physician/institution. **(13) Comfort:** To be treated in comfort during illness and follow up. **(14) Complaint:** Right to complain and rectification of grievances. **(15) Compensation:** Obtain compensation for medical injuries/negligence.

TYPES OF PHYSICIAN-PATIENT RELATIONSHIP

(I) Therapeutic Relationship: A doctor is free to accept or refuse to treat the patient subject to constraint of his professional obligations in emergencies. Some of the examples where doctor may refuse to treat the patient could be: (1) Beyond his practicing hours. (2) Not belonging to his specialty. (3) Illnesses beyond the competence and qualification of the doctor or beyond the facilities available in his set-up/institution. (4) Doctor is unwell, or any other family member is ill. (5) Doctor having important social function in the family. (6) Doctor has consumed alcohol. (7) Patient has been defaulting in payment. (8) Patient or his/her relations are non-cooperative, violent or abusive. (9) Malingerer. (10) Patient refuses to give consent/accept risk. (11) Patient demanding specific drugs like amphetamine,

athletics/bodybuilders demanding steroids, etc. (12) Patient rejecting low-cost remedies in favor of high-cost alternatives. (13) At night, on grounds of security, if the patient is not brought to him. (14) An unaccompanied minor patient or female patient. (15) Any new patient, if he is not the only doctor available.

(II) Formal Relationship: (1) The formal relationship between the doctor and the patient pertains to the situations where the third party has referred the person for impartial medical examination, like pre-employment, insurance, yearly medical check-ups, cases of rape, victims of crimes, intimate body searches and other medicolegal cases, in certain psychiatric/mental illnesses referred by courts/police. (2) In these situations, the doctor is not under obligation to provide any information about his report and has to comply with the directives of the party demanding such examinations. (3) However, if a clinical fact requiring urgent treatment is detected which is not known to the patient earlier, it may be conveyed to his family physician or the third party who has sent the patient with instructions to inform the patient.

PROFESSIONAL (MEDICAL) NEGLIGENCE (MALPRACTICE)

FM10.18

Describe and discuss medical negligence including civil and criminal negligence, contributory negligence, corporate negligence, vicarious liability, Res Ipsa Loquitur, prevention of medical negligence and defenses in medical negligence litigations.

“Professional negligence is defined as absence of reasonable care and skill, or willful negligence of a medical practitioner in the treatment of a patient, which causes bodily injury or death of the patient”. *Negligence is defined as doing something that one is not supposed to do, or failing to do something that one is supposed to do.*

Medical negligence is a part of the law of torts. A tort is a civil wrong for which the sufferer can seek compensation through legal action.

Due Care: It means such reasonable care and attention for the safety of patient as their mental and physical condition may require. It should be proportionate with the known inability of the patient to take care of himself. Due care anticipates and appropriately manages known, expected or foreseeable events and complications of the patient's disease or treatment.

Breach of Standard of Care Occurs Either by Omission or Commission: A physician fails to comply with the standard of care applicable to him in two situations: (1) When he improperly, i.e., unjustifiably deviates from accepted practices (methods, procedures, and treatments), and (2) When he employs accepted practices but does so unskillfully.

Types of Medical Negligence: (1) Civil. (2) Criminal. (3) Corporate. (4) Contributory.

What amounts to Civil or Criminal Negligence is a matter of choice of patient, if he/she wants compensation only then it is civil or if patient wants the doctor to be punished then it

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is criminal or in a given case patient wants both, then both cases complaint may be lodged.

CIVIL NEGLIGENCE

The question of civil negligence arises: (1) When a patient, or in case of death, any relative brings suit in a civil Court for getting compensation from his doctor, if he has suffered injury due to negligence. (2) When a doctor brings a civil suit for getting his fees from the patient or his relatives, who refuse to pay the same alleging professional negligence.

Elements of Negligence: Liability for negligence arises if the following conditions are satisfied: (1) **Duty: Existence of a duty of care by the doctor.** (2) **Dereliction:** The physician must conform to the standard of a "prudent physician" under similar circumstances. **The failure on the part of the doctor to maintain applicable standard of care and skill.** (3) **Direct causation: The failure to exercise a duty of care must lead to damage.** The patient must show that a reasonably close and causal connection exists between the negligent act or omission and the resulting injury without any intervening cause. This is referred to as **legal cause or proximate cause.** (4) **Damage: The damage should be of a type that would have been foreseen by a reasonable physician.**

Burden of Proof: The patient should prove all four elements of negligence by a preponderance of the evidence. It requires enough proof to show that it is more likely than not, that each of the four elements of a negligent claim is true. **Proof of cause in fact:** (1) **"But for" test:** If it is more likely than not, that but for the doctor's breach of duty the patient would not have been injured. (2) **Increased the risk or multiplied the risk test:** If it is more likely than not, that the doctor's breach of duty increased the risk of the patient being injured.

Injury: Any absence of proper skill or care that causes the patient's death, diminishes his chances of recovery, prolongs his illness, causes physical harm, bodily impairment, disfigurement or increases his suffering, constitutes injury in a legal sense.

Injury is a wrong done to one's person, property or rights. **Even if the doctor is negligent, patient cannot sue him for negligence if no damage has occurred.** The patient must show the existence of an actual physical, psychological or emotional or other injury. Which can be measured and compensated in terms of money.

Liability: The amount of damage done is a measure of the extent of the liability. Some examples are: (1) **Loss of earning,** either due to absence from work or prevention or impairment of his ability to carry out his occupation. (2) Medical expenses including medical rehabilitation, vocational rehabilitation, retraining or other incidental expenses like transportation, additional surgical procedures, daily nursing care and medications for a severely brain-damaged baby for the remainder of baby's life. (3) **Reduction in expectation** of life. (4) Reduced enjoyment of life, such as loss of function of limb or sense. (5) Pain and suffering, either physical or mental. Suffering includes **fright**, humiliation,

mental anguish, grief and embarrassment. (6) Loss of potency. (7) Aggravation of a preexisting condition. (8) Death.

Personal injuries include any disease or any impairment of a person's physical or mental conditions.

Instances Examples of Medical Negligence: It is impossible to give a complete list of negligent situations in medical practice. (1) Refusal to admit patients requiring urgent hospitalization. (2) Failure to obtain informed consent to any procedure. (3) Failure to examine patient himself. (4) Failure to inform the patient of the risks of refusal for treatment. (5) Failure to immunize and to perform sensitivity tests when indicated. (6) Not ordering X-ray examination where the history suggests the possibility of a fracture, or dislocation or presence of a foreign body in a wound. (7) Not reading the X-ray film correctly or in failing to get it read by a competent person. (8) Failure to act on radiological or laboratory reports. (9) Inadequate clinical records and failure to communicate with other doctors involved in the treatment of a patient. (10) Administration of incorrect drugs, drugs intended for another patient, especially by injection. (11) Mistakes in labelling of bottle for infusion of blood and other IV fluids. (12) Failure to attend the patient in time, or failure to attend altogether. (13) Failure to keep well informed of advances in medical sciences. (14) Making a wrong diagnosis due to absence of skill or care. (15) Negligent management of procedures. (16) Failure to provide a substitute during his absence. (17) To delegate his duty of treating or operating upon a patient to another doctor without the consent of the patient. (18) Failure to give proper post-operative care. (19) Failure to give proper instructions. (20) Failure to warn the patient of side-effects. (21) Failure to obtain consultation where appropriate. (22) Experimenting on patient without consent. (23) Giving overdose of medicine and giving poisonous medicines carelessly. (24) If his negligence causes others to catch a disease from his patient. (25) Continue a practice regarding which several warnings as to its dangers have been given. (26) Prescribing a drug that had previously resulted in an adverse reaction. (27) Administration of an addiction forming drug for a long period. (28) Iatrogenic medical complications during diagnosis or treatment. (29) Prematurely discharging the patient. (30) To cover up an error of judgement.

The fact that the unauthorized additional treatment or surgery is beneficial to the patient, or that it would save considerable time and expenses to the patient or would relieve the patient from pain and suffering in future are not grounds of defense and amount to an act of assault and therefore deficiency in service.

A doctor is not liable for: (1) **For an error of judgement or of diagnosis,** if he has acted with ordinary care and secured all necessary data on which to base a sound judgement. For the treatment of a disease or injury, the doctor may adopt the one which in his judgement, will be more effective and appropriate. In such a case, the doctor is not liable for an injury resulting from an error in his judgement. (2) **For failure to cure or for bad result** that may follow, if he has exercised reasonable care and skill. (3) **If he exercises reasonable care and skill,** provided that his judgement conforms to the accepted medical practice, and does not result in the failure

to do something or doing something contrary to accepted medical practice.

No doctor ensures success either in his diagnosis or in his treatment nor guarantee the cure. There is always room for a difference of opinion among doctors. **Bad results are not necessarily due to negligence**, e.g., some patients may be keloid formers.

The law considers the doctor negligent only when:

(1) **Doctor did not consider the possibility that such a complication might occur**, (2) **That he failed to watch for it carefully or to recognize it promptly**, or (3) **To treat in a timely and appropriate fashion.**

In order to establish liability by a doctor, where a departure from normal practice is alleged, it must be established that: (1) The procedure done is a usual and normal practice, (2) The practice was not adopted as a routine and (3) The course adopted is one, no professional man of ordinary skill would have taken, if acting with ordinary care.

Inherent Risks: Some risks are inherent in any form of treatment and the doctor will not be negligent if damage is caused, if Doctor has taken proper precautions, e.g., broken needle during injection. If the needle breaks, the patient should be informed and arrangements made to remove the broken piece. The doctor becomes negligent, if he fails to observe that the needle has broken, or having noted this, does not inform the patient or make arrangements to prevent further damage.

Duty of Care: A doctor who agrees to give medical advice and treatment, impliedly undertakes that he is possessed of skill and knowledge for the purpose. Such a person when consulted by a patient owes him certain duties, viz. a duty of care **in deciding whether to undertake the case**, a duty of care **in deciding what treatment to give**, or a duty of **care in the administration of that treatment.** A breach of any of those duties becomes negligence. The doctor in no doubt has a discretion in choosing treatment, which he proposes to give to the patient, and such discretion is relatively ample in cases of emergency.

Degree of Competence: (1) The doctors are expected to keep well-informed of changing concepts and new developments and to follow general lines of treatment, though they are not expected to be aware of every development in medical science. (2) **The degree of competence is not a fixed quality but varies according to the status of the doctor.** A house-surgeon is not expected to possess the same skills as a consultant surgeon, but he is expected to limit his activities (except in emergencies) to a level of medical care which is within his competence. (3) A general medical practitioner is expected to have and use only the **average degree of skill and knowledge** possessed by doctors with the same or similar training, experience and knowledge in the same or similar circumstances in the specific geographic location in which the physician provides medical treatment (locality rule).

Standard of Care: The practitioner must possess a reasonable degree of knowledge and skill, must exercise a reasonable degree of care. (1) Neither the very highest nor a very low degree of care and competence, judged in the light of the particular circumstances of each case, is what the law requires. The same high degree of skill or standard of care is

not expected from a doctor practicing in some remote village or town, as is expected of a doctor on the staff of a hospital in a city. A specialist must maintain standards of skill in diagnosis and treatment above those of the ordinary general practitioner. (2) **If a doctor claims to possess superior skill, knowledge, experience or training, he will be judged according to those standards even in its absence.** If a general practitioner treats as a specialist, a case that clearly lies within a specialized medical field, he will be held liable for failure to use skill equal to that of a specialist. (3) **The standard of care while assessing the practice as adopted, is judged in the light of knowledge available at the time of the incident, and not at the time of trial.** Similarly, when the charge of negligence arises out of failure to use some particular equipment, the charge would fail, if the equipment was not generally available at that particular time, i.e., at the time of incident. (4) In a personal injury case, the fact that the patient's injuries become serious by his own predisposition or weakness does not diminish the extent of damages.

Liability for Injury to Third Parties: When a doctor performs an examination at the request of a third party for sole use by third party, e.g. to determine eligibility for employment, evaluation of disability, insurance, drunkenness, etc., i.e., **to examine the patient for non-therapeutic purposes, no physician—patient relationship is established. The employed physician owes no duty to the examinee other than to avoid causing an injury but is under a duty to use reasonable care to avoid injury. Physician's duty is owed to his employer.**

Proof: The burden of proving negligence lies on the plaintiff (patient). Burden of proof is the need or duty to establish proof of the facts at trial. To establish negligence, it is not necessary to prove that the negligent party had bad motive or intention. The essential issue that decides a case of negligence is whether a reasonably competent medical man would have acted in more or less the same manner in which the doctor against whom negligence is alleged had acted.



CASE(S)

Whitmore vs Rao

A suit was filed against the doctor for negligent treatment. The charge was that the doctor injected sulphostab or sulfarsenol, though the patient was not syphilitic. Evidence was given by the defendant doctor and other doctors that patient's blood contained parasites of malignant malaria, and he had sores on his face. The Court held that the doctor was not negligent.

Crivon vs Barret Group Hospital Committee

The plaintiff was operated for the removal of a small breast tumor, and the pathologist reported that it looked like cancer. Intensive radiotherapy was given to the patient, due to which the skin surface was destroyed and there was the possibility of potential hazards. The patient on knowing the diagnosis suffered great pain and worry. Later it was found that the diagnosis was not correct. An expert pathologist gave evidence that he might have also given the same diagnosis. The Court held that the pathologist was not negligent as the interpretation of the slide was difficult and debatable. It also held that surgeon was not negligent in not taking a second opinion, as the speed of treatment was essential in the case.

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Roe vs Ministry of Health

Two persons were operated upon under Nupercaine spinal anesthetic, who developed permanent spastic paraplegia. The Nupercaine was contained in glass ampoules, which was responsible for the paraplegia. At that time this risk of percolation was not known to anesthetists in general, and the Court held that it was only a misadventure and not negligence.

DOCTRINE OF RES IPSA LOQUITUR

Res ipsa loquitur is a rule of evidence which belongs to the law of torts. Ordinarily, the professional negligence of a physician must be proved in Court by the expert evidence of another physician. The patient need not prove negligence in case where the rule of *res ipsa loquitur* applies, which means **“the thing or fact speaks for itself”**. The patient has to merely state what according to him was the act of negligence.

Conditions to be satisfied: (1) In the absence of negligence, the injury would not have occurred ordinarily. (2) The doctor had exclusive control over the injury producing instrument or treatment. (3) The patient was not guilty of contributory negligence. This enables the patient's lawyer to prove his case without medical evidence.

Examples: (1) Prescribing an overdose of medicine producing ill-effects. (2) Giving poisonous medicine carelessly. (3) Failure to give anti-tetanic serum in cases of injury causing tetanus. (4) Burns from application of hot water bottles or from X-ray therapy. (5) Breaking of needles. (6) Failure to remove the swabs during operation which may lead to complications or cause death. (7) Blood transfusion misadventure. (8) Loss of use of hand due to prolonged splinting.

Application: This doctrine is applied both to civil and criminal negligence. It does not apply where common knowledge or experience is not sufficiently extensive to know that the patient's condition would not have existed but for the doctor's negligence. It cannot be applied against several defendants only one of whom, who cannot be identified could have caused patient's injury. The doctrine is rarely used successfully by patients.

**CASE****Mohn. vs Osborne**

An abdominal operation was performed by resident surgeon and at its conclusion, the surgeon was informed that the swab count was correct. Two months later, a further operation was done, and a swab was found under the liver. The patient died later. The mother of deceased sued the surgeon for damages. The Court held the doctor negligent on the ground that the doctrine of *res ipsa loquitur* applied to the case.

DOCTRINE OF CALCULATED RISKS

“Calculated risk” cases: The theory of the calculated risk doctrine is that *res ipsa loquitur* should not be applied when the injury complained is of a type that may occur even though reasonable care has been taken. This doctrine

is an important defense to any doctor sued for professional negligence, who can produce expert evidence or statistics to show that the accepted method of treatment he employed had unavoidable risks.

DOCTRINE OF COMMON KNOWLEDGE

This doctrine is based on the assumption that the issue of negligence in the particular case is not related to technical matters, but are within the knowledge of the medical profession, e.g. the doctor will be held responsible for the lack of application of common sense, such as failure to give fluids in dehydration, or failure to give ATS in case of injuries, or failure to apply an antiseptic to an open cut. It is a variant of *res ipsa loquitur*. In *res ipsa loquitur*, the patient need not produce evidence as to both the standard of care and specific act or omission. In doctrine of common knowledge, the patient must prove the causative (negligent) act or omission, but he need not produce evidence to establish the standard of care.

Composite Negligence: It occurs when a patient suffers from any injury due to negligent acts of more than one person without the negligence of patient. In such case, patient may claim compensation from any one negligent person. The defendant negligent person may claim contribution from other negligent persons.

Assumption of Risk-volenti Non-fit Injuria: The doctor will not be held responsible for the injury suffered by the patient, which is caused by some particular type of treatment given by the doctor, being compelled by the patient even after physician's warning.

MEDICAL MAL OCCURRENCE

Medicine deals with human beings, and there are many biological variations which cannot always be explained, expected or prepared for. It is well said that **“In biology always variation is the rule, while stability is the exception.”** (1) In some cases, in spite of good medical attention and care, an individual fails to respond properly or may suffer from adverse reactions of the drug. **This is called medical mal occurrence.** The injured person cannot get monetary compensation in every mishap or accident which results in injury, if the doctor was careful in selection of the drug and has taken appropriate measures to overcome the undesirable foreseeable effects. (2) **Accident** can be defined as an unpredictable event resulting in a recognizable injury. **Inevitable accident is an accident, not avoidable by any such precautions as a reasonable man can be expected to take,** e.g., breaking of a needle during intramuscular injection due to sudden muscular spasm, or damage to the recurrent laryngeal nerve during thyroidectomy.

NOVUS ACTUS INTERVENIENS

A person is responsible not only for his actions, but also for the logical consequences of those actions. This principle applies to cases of assault and accidental injury. Sometimes, such a continuity of events is broken by an entirely new and unexpected happening, due to negligence of some

other person. (1) If the doctor is negligent, which results in a deviation from the logical sequence of events, then the responsibility for the subsequent disability or death may pass from the original incident to the later negligent action of the doctor by the principle of “*novus actus interveniens*” (an unrelated action intervening). (2) Most of such interventions are of a medical nature, e.g., leaving of a swab or a surgical instrument in the abdomen after the repair of an internal injury, accidental substitution of poisonous drug for therapeutic drug, etc. **For a plea of novus actus, an element of negligence is essential.** (3) It will depend on the extent to which it comes to be regarded as causally significant. In such case, the assailant will not be fully responsible for the ultimate harm. This plea is rarely accepted by the courts.

CONTRIBUTORY NEGLIGENCE

Contributory negligence is, any unreasonable conduct, or absence of ordinary care on the part of the patient, or his personal attendant, which combined with the doctor's negligence, contributed to the injury complained of, as a direct, proximate cause and without which the injury would not have occurred. These include (1) Failure to give the doctor accurate medical history. If the patient provides incomplete or inadequate information, it could result in misdiagnosis, mistreatment and harm. (2) Failure to cooperate with his doctor in carrying out all reasonable and proper instructions. (3) Refusal to take the suggested treatment. (4) Leaving the hospital against the doctor's advice. (5) Failure to seek further medical assistance, if symptoms persist.

As such, the doctor's negligence is not the direct, proximate cause (actual or legal cause) of the injury suffered by the patient. Proximate cause means, that which in natural and continuous sequence, unbroken by any efficient intervening cause produces the injury, and without which the result would not have occurred. If the doctor and the patient are negligent at the same time, it is a good defense for the doctor. **The doctor cannot plead contributory negligence, if he fails to give proper instructions.**

Liability of the Doctor: The extent of contributory negligence may vary and with it will vary the doctor's liability, from complete non-liability to a substantial liability for damages. Normally, **contributory negligence is only a partial defense**, and the Court has right to fix liability between the parties (**doctrine of comparative negligence**), and damages awarded may be reduced accordingly. The burden of proof lies entirely on the doctor. If a patient consents to take the risk of the injurious event actually taking place, he cannot claim damages. If a doctor is not negligent, but if a patient is negligent which results in injury, it is called negligence of the patient.

The term **aggravation** is applied to the injury that hastens death, leads to permanent disability or introduces features or complications that do not normally develop in the natural course of the disease process. In such case, the doctor cannot plead contributory negligence in civil cases.

Good Samaritan Doctrine: One who assists another who is in serious danger cannot be charged with contributory negligence, unless the assistance is reckless or rash.

Limitations to Contributory Negligence: THE LAST CLEAR CHANCE DOCTRINE: Under this rule: (1) A person who has negligently placed himself in a position of danger may recover damages, if the doctor discovered the danger while there was still time to avoid the injury or failed to do so. **(2) THE AVOIDABLE CONSEQUENCES RULE:** It is the negligence of the patient which aggravated the damage already caused by negligence of the doctor, which could have been avoided if the patient was not negligent afterwards. In such case, the doctor cannot plead contributory negligence in civil cases.



CASE

Maynard vs West Midlands Regional Health Authority" (1984)

A surgeon was sued for not removing a swab from the vagina of patient. The patient complained about pain in the vagina to a nurse some time after the operation. The nurse examined the vagina and removed the swab. The patient did not inform the surgeon about the swab in the vagina. The Court held that the doctor was guilty of contributory negligence.

CRIMINAL NEGLIGENCE

FM10.8

Describe the Consumer Protection Act-1986 (Medical Indemnity Insurance, Civil Litigations and Compensations).

FM10.9

Describe the medico-legal issues in relation to family violence, violation of human rights, NHRC and doctors.

The question of criminal negligence may arise: (1) When a doctor **shows gross absence of skill or care** during treatment resulting in serious injury to or death of the patient, by acts of omission or commission. (2) When a doctor **performs an illegal act**. (3) When an assaulted person dies, the defense may attribute the death to the **negligence or undue interference in the treatment of the deceased by the doctor.**

Conditions to be satisfied: Criminal negligence occurs if any one of the following are satisfied: (1) Indifference to an obvious risk of injury to health, (2) Actual foresight of the risk, but continuation of the same treatment, (3) Appreciation of the risk and intention to avoid it, but showing high degree of negligence in the attempted avoidance, (4) Inattention or failure to avoid, a serious risk which went beyond mere inadvertence in respect of an obvious important matter.

It is criminal negligence: (1) When the doctor shows gross lack of competence, or gross inattention or inaction, gross recklessness, or wanton indifference to the patient's safety, or gross negligence in the selection and application of remedies. **(2) It involves an extreme departure from the ordinary standard of care.** Criminal negligence cases are very rare and **are practically limited to cases in which the patient has died.** In order to establish criminal liability, the facts must be such that the negligence of the accused went

TABLE 3.2: Differences between civil and criminal negligence.

Trait	Civil negligence	Criminal negligence
Offence	No specific and clear violation of law need be proved	Must have specifically violated a particular criminal law in question
Negligence	Simple absence of care and skill	Gross negligence, inattention or lack of competency
Conduct of physician	It is compared to a generally accepted simple standard of professional conduct	Not compared to a single test
Consent for act	Good defense; cannot recover damages	Not a defense; can be prosecuted
Litigation	Between two parties	Between state and doctor
Trial by	Civil Court	Criminal Court
Evidence	Strong evidence is sufficient	Guilt should be proved beyond reasonable doubt
Punishment	Liable to pay damages	Imprisonment with or without fine

beyond a matter of compensation between persons and showed such disregard for the life and safety of others as to amount to a crime against the State and conduct deserving punishment. (3) **A doctor will not be criminally liable if a patient dies due to an error of judgement or carelessness or want of due caution, though he can be liable to pay compensation.** Most of such cases are associated with drunkenness or with impaired efficiency due to the use of drugs by doctors (Table 3.2).

Punishment for Death caused by medical negligence (culpable Homicide not amounting to murder, is mentioned under **Section 106, BNS**). If such act is done by Medical Practitioner while performing medical procedure shall be punished with imprisonment of either description for a term which may extend to two years and shall also be liable to fine. (**Old law—S. 304, A., I.P.C deals with criminal negligence.** “Whoever causes the death of any person by doing any rash or negligent act not amounting to culpable homicide shall be punished with imprisonment up to 2 years, or with fine, or with both”). According to **Bharatiya Nagarika Surksha Sanhita 395 (S. 357, Cr.P.C.)**, in addition to imprisonment or other penalty prescribed under the BNS, compensation may also have to be paid to the victim of criminal negligence).

Examples: (1) Amputation of wrong finger or operation on wrong limb or wrong patient. (2) Leaving instruments, tubes, sponges or swabs in abdomen. (3) Grossly incompetent administration of a general anesthetic by a doctor addicted to the inhalation of anesthetic. (4) Gross mismanagement of the delivery of woman especially by a doctor under the influence of drink or drugs. (5) Performing criminal abortion. (6) Administration of a wrong substance into the eye causing loss of vision. (7) Death resulting from an operation or injection of any drug producing anaphylaxis by a quack is considered criminal negligence.

Prosecution: Criminal negligence is more serious than the civil. (1) To prosecute a doctor for criminal negligence, it must be shown that the accused did something or failed to do something which in the given facts and circumstances no medical doctor in his ordinary senses and prudence would have done or failed to do so. (2) For criminal negligence, the doctor may be prosecuted by the police and charged in criminal Court with having caused the death of the patient by a **rash or negligent act not amounting to culpable**

homicide. The prosecution must prove all the facts to establish civil negligence (except monetary loss), and gross negligence and disregard for the life and safety of the patient. (3) **Contributory negligence** is not a defense in **criminal negligence.**

Investigation: Note the circumstances in which death occurred and the facilities available for treatment. Samples of drugs and IV fluids should be collected and sent to the laboratory to exclude adulteration, contamination and chemical identification. Statement of witness should be recorded. A team of doctors should conduct autopsy, and all necessary laboratory investigations should be done. An impartial expert in the same field should study the case sheet.

Supreme Court Guidelines: According to the guidelines of the Supreme Court of India: (1) A private complaint against a doctor may not be entertained unless the complainant has produced *prima facie* evidence before the court in the form of credible opinion given by another competent doctor to support the charge of rashness or negligence. (2) The investigating officer (IO) before proceeding against the doctor accused of rash or negligent act, **should obtain an independent medical opinion preferably from a doctor in government service. A doctor accused of rashness or negligence might not be arrested routinely**, unless his arrest is necessary for furthering investigation or for collecting evidence or the IO is satisfied that the doctor would not make himself available to face prosecution.

A physician may be liable to **both civil and criminal negligence by a single professional act**, e.g., if a physician performs an unauthorized operation on a patient, he may be sued in civil Court for damages and prosecuted in criminal Court for assault.



CASE

SC; 2009. Nanavati Hospital vs Md Isfaque whenever complaints were received against a doctor or hospital, the consumer forum or criminal court, before issuing notice, should first refer the matter to a competent doctor or a committee of doctors, specialized in the field where negligence was attributed, the court stressed.

Dr Suresh Gupta vs Govt of NCT Delhi, AIR 2004, SC 4091: (2004)6 SCC 42, The Full bench of the Supreme Court of India consisting of Chief Justice RC Lahoti, Justice G.P. Mathur, and Justice PK Balasubramaniam declared while reviewing the previous

order that extreme care and caution should be exercised while initiating criminal proceedings against medical practitioners for alleged medical negligence.

Jacob Mathew vs State of Punjab in August 2005, Simple lack of care, Error in judgment Accident is not a proof of negligence.

- ◆ **State vs Hakim (1947):** A hakim gave a penicillin injection to a person who died due to it. The Court held that the ignorance of the hakim alone about penicillin injections, would make his act of giving treatment rash and negligent.
- ◆ **Kobiraj vs Empress:** A quack cut the internal piles of a patient with an ordinary knife, who died of hemorrhage. he was charged under section 304-A, I.P.C. The quack contended that he had performed similar operations before, and that he was entitled to the benefit of section 88, I.P.C., as he operated in good faith, and patient had accepted the risk. The Court held the accused criminally negligent as he was not educated in surgery.
- ◆ **Desouza vs Emperor:** The accused was in charge of a dispensary which was badly managed with mixing up of poisonous and non-poisonous medicines. To prepare a mixture of quinine hydrochloride, the accused removed a bottle from the non-poisonous medicines cupboard and tore open the wrapper without looking at it, on which the word 'poison' was printed. Then, without reading the label on the bottle, on which was printed 'Strychnine hydrochloride', prepared a mixture and gave it to several persons, all of whom except one died within a short time. He was convicted for criminal negligence under Sec. 304-A, I.P.C.
- ◆ In 1958, a German doctor went on a trip to India without getting himself vaccinated against smallpox. on return to Germany, he resumed his practice, although he showed symptoms of smallpox, he did not take any precautionary measures to see that he did not infect others. 18 of the patients caught the disease and two of whom died. The doctor was charged with criminal negligence and was punished with four months' imprisonment and fine.
- ◆ A doctor while he was drunk, operated upon a woman for eclampsia. Two days later, the woman died due to the injuries produced during operation. The doctor was sentenced to one year imprisonment for want of reasonable care and skill due to intoxication.

CORPORATE NEGLIGENCE

The theory of corporate liability is typically applied in cases involving hospitals and their staff physicians. (1) Hospitals have independent duty to their patients to investigate adequacy and review the competence of staff physicians. (2) **This theory is based on the principle that hospitals are in a far better position than their patients to supervise a physician's performance and provide quality control.** This legal theory has been used to attack the allegedly negligent selection, retention, or supervision of its participating physicians, that is negligent credentialing. (3) **It is the failure of those persons who are responsible for providing the accommodation, facilities and treatment to follow the established standard of conduct.** (4) It occurs when the hospital provides defective equipment or drugs, selects or retains incompetent employees, or fails in some other manner to meet the accepted standard of care, and such failure results

in injury to a patient to whom the hospital owes a duty. (5) **In the corporate sector (hospital, nursing home, etc.), where more than one person in more than one level fails to render appropriate service to the patient, may result in some damage to patient. Here the treating doctor and also other category of persons who were negligent will be held responsible.**

If a hospital knows or should have known, that one of the patients is likely to be a victim of professional negligence by a doctor on its staff, the hospital is liable, even though that doctor is an independent with staff privilege at the hospital. If the doctor is employed by a patient in his private capacity, and the hospital only provides facilities for treatment, the doctor alone is held responsible for any negligence.

ETHICAL NEGLIGENCE

- FM10.4** Describe the Code of Medical Ethics 2002 conduct, Etiquette and Ethics in medical practice and unethical practices and the dichotomy.
- FM10.27** Describe and discuss Ethical Guidelines for Biomedical Research on Human Subjects and Animals.

Ethical negligence is the violation of the Code of Medical Ethics. In this, no financial compensation is payable unless there is also civil negligence. If a complaint is made and the facts proved, the name of the doctor may be erased from the Medical Register (Table 3.3). **This term should be better avoided.**

CAUSES OF TAKING NEGLIGENT ACTION AGAINST THE PHYSICIAN BY THE PATIENT/RELATIONS: They are discussed below.

(I) Physician Related: (1) Breakdown in physician-patient relationship; or utter disregard for the life and safety of the patient (poor and ineffective communication with the patient and his relatives). (2) Rude behavior of the physician. (3) Less frequent house calls. (4) Complex invasive procedures for diagnosis and treatment with resulting death or disability.

(II) Patient Related: (1) Unrealistic expectations of cure. (2) Poor compliance with medical recommendations. (3) Frequent self-destructive behavior (heavy smoking, drinking, use of drugs, poor dietary management). (4) Increasing awareness of rights. (5) Comments on the treatment by another doctor. (6) Lack of consent. (7) Lack of documentation, such as provisional diagnosis, relevant

TABLE 3.3: Differences between professional negligence and infamous conduct.

Trait	Professional negligence	Infamous conduct
Offence	Absence of proper care and skill or willful negligence	Violation of Code of Medical Ethics
Duty of care	Should be present	Need not be present
Damage to person	Should be present	Need not be present
Trial by	Courts; civil or criminal	State Medical Council
Punishment	Fine or imprisonment	Erasure of name or warning
Appeal	To higher Court	To State and Central Governments

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findings, etc. (8) Not taking second opinion whenever there is a problem and not informing relatives if patient is serious. (9) Misperception of physician's role in the society, or his affluence.

(III) Media Related: Biased publicity of negligent suits and the size of awards.

(IV) Attorney Related: (1) Lack of experience. (2) Monetary considerations.

(V) Economic: (1) Increased cost of medical care. (2) Payment by insurance companies.

(VI) Social: (1) Mobile population. (2) Consumers rights. (3) General increase in litigation.

Defensive Medicine: Defensive medicine is ordering every test or X-ray on a patient to have a good background of hard data and avoiding using a potentially risky treatment which may offer much benefit to the patient. This may lead to withholding of beneficial treatment to the majority of patients, because of a statistical risk to the minority. The physician must not practice "defense by denial", and claim that the patient is not his, which becomes abandonment.

Iatrogenic Diseases: Iatrogenic disease can be defined as a disease that results from administration of a drug, or medical or surgical acts for prophylaxis, diagnosis or treatment.

PRECAUTIONS AGAINST NEGLIGENCE

To prove that reasonable care and skill has been exercised, the following precautions should be taken. (1) Obtain informed written consent of the patient. (2) Establish good rapport (relationship or communication) with the patient. (3) Keep full and accurate and legible medical records. (4) Employ ordinary skill and care at all times. (5) Confirm diagnosis by laboratory tests. (6) Take skiagrams in bone or joint injuries, or when diagnosis is doubtful. (7) Immunization should be done whenever necessary, particularly for tetanus. (8) Sensitivity tests should be done before injecting preparations which are likely to produce anaphylactic shock. (9) In suspected cases of cancer, all laboratory investigations should be done without delay to establish early diagnosis. (10) No female patient should be examined unless a third person is present. (11) Keep yourself informed of technical advances and use standard procedures of treatment. (12) Seek consultation where appropriate. (13) Do not criticize or condemn the professional ability of another doctor, especially in the presence of the patient. (14) Do not exaggerate nor minimize the gravity of the patient's condition. Avoid from overconfident prognoses and promising too much to patient. (15) Never guarantee a cure. (16) Do not make a statement admitting fault on your part. (17) Do not fail to exercise care in the selection of assistants and allotting duties to them. (18) The patient must not be abandoned. (19) Do not leave patient unattended during labor. (20) Inform the patient of any intended absence from practice, or recommend or make available, a qualified substitute. (21) Transfer the patient if facilities are inadequate to handle his problem. (22) Do not order a prescription over telephone, because of possibility of misunderstanding as to the drugs or their dosage. (23) The drug should be identified before being injected or used otherwise. (24) Obtain consent for an operation or giving anesthesia and to use discretion in obscure

cases. (25) Frequently check the condition of equipment and use available safety installations. (26) In a criminal wounding, operation should not be performed unless it is absolutely necessary. (27) Proper instructions should be given to the patient, and proper postoperative care should be taken. (28) In the case of death from an anesthesia or during operation, the matter should be reported to the police authorities for holding a public inquiry. (29) Anesthesia should be given by a qualified person. Only generally accepted anesthesia should be given after clinical and laboratory examinations of the patient. The patient should be watched until he fully recovers from its effect. (30) No experimental method should be adopted without the consent of the patient. (31) No procedure should be undertaken beyond one's skill. (32) Do not fail to secure the consent of both husband and wife, if an operation on either is likely to result in sterility. (33) Establish a hospital injury prevention program. (34) Insist on continuing education of physicians. (35) Participate in medicolegal seminars.

MALPRACTICE LITIGATION INVOLVING VARIOUS SPECIALITIES

Different medical specialties have greatly different risks. **The highly vulnerable specialties are orthopedic, obstetrics, anesthesia, neurosurgery, plastic surgery, and accident medicine.** Following is a brief list of some of the more important examples, apart from general errors, giving rise to malpractice litigation.

(1) Anesthesiology: (1) Giving anesthesia without the consent of adult patient or a child without consent of the guardian. (2) Failure to conduct physical examination or take patient's history. (3) Explosion (gaseous inhalation anesthetic agents only). (4) Contamination of anesthetic agent. (5) Substitution of toxic chemical for anesthetic agent. (6) Breakage of hypodermic needle. (7) Failure to produce total anesthesia. (8) Incorrect or excessive use of anesthetic agents. (9) Toxic properties of anesthetic agents: (halothane (hepatitis) and methoxyflurane (nephrotoxicity)). (10) Brain damage due to hypoxia. (11) Asphyxiation from exhaustion of oxygen supply. (12) Neurological damage from spinal or epidural injections. (13) Peripheral nerve damage from splinting during infusion. (14) Incompatible blood transfusion. (15) Allowing awareness of pain during anesthesia. (16) Paralysis following spinal anesthesia. (17) Leaving broken spinal needle in the spinal canal. (18) Cardiac arrest occurring during surgery precipitated by improper administration of anesthesia, e.g., improper airways, inadequate ventilation, excessive general anesthetic agents, or muscle relaxants.

General Surgery: (1) Leaving of instruments, swabs, sponges, etc. within the body cavities. (2) Operating on the wrong patient. (3) Operating on the wrong limb, digit or organ. (4) Operating on wrong side of the body. (5) Delayed diagnosis of acute abdominal lesions. (6) Failure to diagnose diabetes in complicated surgeries. (7) Failure to have a biopsy of a tumor. (8) Failed vasectomy, without warning of lack of total certainty of subsequent sterility. (9) Injection causing peripheral nerve damage. (10) Accidental ligation of vessels and ducts, such as suturing of the common bile ducts during partial gastrectomy.

(11) Perforation of intestines or organs. (12) Diathermy and cautery may cause skin burns and electrocution. (13) Cardiac monitors and defibrillators may cause damage and death. (14) Leaving catheters in place too long causing infection.

The complications produced by various powders used to lubricate the inside of surgical gloves are intestinal obstruction and peritonitis, draining sinus tracts, fistulae and granulomatous masses at the operation site simulating tumor.

(III) Orthopedics and Accident Surgery: (1) Failure to admit in hospital when required. (2) Missed fractures, especially of the scaphoid, skull, neck of femur and cervical spine. (3) Overtight plaster casts causing tissue and nerve damage. (4) Unnecessary surgery of fractures in children resulting in growth disturbances. (5) Inadequately treated hand injuries, especially tendons. (6) Undiagnosed intracranial hemorrhage. (7) Missed foreign bodies in eyes and wounds, especially glass. (8) Sciatic paralysis from operation on the hip. (9) Leaving a broken drill tip in the bone, with subsequent infection.

(IV) Obstetrics and Gynecology: (1) Brain damage in the newborn due to hypoxia from prolonged labor. These cases involve most expensive claims. This fear has resulted in high rate of caesarean births. (2) Failed sterilization by unsuccessful tubal ligation resulting in unwanted pregnancies. (3) Complications of hysterectomy, such as ureteric ligation and vesicovaginal fistula. (4) Management of delivery under the influence of alcohol/drugs. (5) Performing abortion without indication (criminal abortion). (6) Fetal and maternal deaths by certain drugs. (7) Hemorrhage during delivery. (8) Amniotic fluid embolism, pulmonary thromboembolism, cerebral thrombosis, sepsis. (9) Hypersensitive disease of pregnancy, cardiac conditions, diabetes, etc. can complicate pregnancy and cause death during advanced pregnancy or delivery. (10) Perinatal fetal death. (11) Cerebral palsy. (12) Fetal trauma such as fractures.

(V) General Medical Practice: (1) Failure to diagnose myocardial infarcts or other medical conditions. (2) Toxic results of drug administration. (3) Failure to take complete history resulting in wrong diagnosis and treatment. (4) Failure to take action on laboratory and other reports. (5) Allowing suicidally inclined patients in psychiatric wards to commit suicide. (6) Administration of incorrect type of drugs, especially by injection. (7) Fall from wheelchair, examination table or bed, causing injuries. (8) Injection of a drug resulting in infection or tissue necrosis. (9) Prescribing of a drug known to cause reactions.

(VI) Radiology: (1) During arteriography, damage to vessel walls may result in thrombosis or embolism. (2) Air embolism may occur, especially in carotid angiography. (3) Nerve damage may occur during axillary arteriography. (4) During barium enema, inflatable balloon catheters used to retain barium, may cause perforation of rectum. (5) Defective X-ray equipment may cause electric shock. (6) X-ray and radium burns.

MEDICAL NEGLIGENCE PREVENTION

The following help to decrease the incidence of medical negligence.

(1) Rapport: Maintain healthy rapport and communication with the patient and with patient's families, with fellow physicians, nurses and paramedical personnel who may commit errors. Lack of communication, and lack of thorough understanding of a diagnostic or therapeutic problems by all parties contribute to errors. If a patient or his family does not understand or feels that the doctor is careless and if there is a bad result, he will sue the doctor. An alert, responsible team member can spot a complication early.

(2) Rationale: The doctor should use all reliable and relevant information (history, physical examination, laboratory tests, x-rays, etc.) to make diagnosis and formulate the treatment. The physician will be negligent when he relies on inadequate data or uses that data to form unsupportable or untenable conclusion with respect to diagnosis or treatment. Diagnostic and therapeutic rationale should be adequately documented in the medical record. Seek consultation where appropriate.

(3) Records: The record should be carefully prepared: complete, accurate, legible, relevant, timely and generously informative. A bad result with bad records equals liability. In a professional negligence trial, the record will be the most important evidence, regardless of the facts and the standard of care practiced.

(4) Remarks: Do not reprimand the patient and his family. Do not criticize any nurse or laboratory or x-ray technician or any other health care personnel within the hearing of the patient. If necessary, take the involved person aside and be constructive in your comments. If a patient or his family overhears these remarks, they will sue the doctor. Do not criticize or condemn the professional ability of another doctor.

(5) Recipe: Do not prescribe any medicine unless there is an appropriate therapeutic indication for it. The doctor should be aware of side-effects of the prescribed drug and caution the patient appropriately. The physician must be aware of potential risks or complications, and must watch them carefully, diagnose them promptly when they occur and treat them in a timely and appropriate manner. He must be aware of possible contraindications to use of any drug associated with the patient's other diagnoses or other medications he may be using. He should inform the patient whether the drug should be taken in the fasting state or after food.

(6) Res ipsa Loquitur: If an untoward result occurs and it is thought to be due to negligence or deviation from the usual and customary standards of care, the doctor should admit the problem. Denial may cause the patient to become worse or to develop complications that may be irreversible or result in disability. Explain carefully to the patient and the family just what the problem is and why it has occurred. Assure the patient that he will solve the problem by further care or referral to another physician or medical center. When settlement is indicated, it should be prompt and adequate in amount. He should not charge for further medical care or charge additional fees if a second surgical operation is required or decrease the cost of hospitalization.

(7) Respect: An attitude of care and concern, a relationship that suggests thoughtful professionalism and a humanistic approach many times solves problems. Treat the patient as

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the physician would wish himself or a member of his family to be treated.

(8) Results: Obtain informed consent from the patient. If a bad result occurs, sincere close attention should be given.

(9) Risks: The patient and his family must be informed of all anticipated risks: (A) Serious risks or risks of serious disability or death which may occur rarely, (B) Lesser risks of short duration, but greater chance of occurrence.

He should be able to manage risks. The risks must be (a) identified carefully, (b) controlled and managed to prevent injury to the patient, (c) eliminated completely, if possible, i.e., (i) good patient care, (ii) desirable patient care, (iii) achievable patient care.

The reward for achievable patient care will be: (a) fewer damages paid, (b) cheaper medical indemnity premiums, (c) emotional and psychological benefits to the patient and satisfaction of practicing a noble profession and doing it well.

(10) Review: Routinely review cases involving morbidity and mortality. Review medical malpractice cases and the testimony by medical experts.

SUPREME COURT OF INDIA GUIDELINES ON MEDICAL NEGLIGENCE

The Court collated **11-point guidelines** for the courts to adjudicate complaints against doctors. They are:

(1) Negligence is a breach of duty or an act which a prudent and reasonable man will not do. (2) Negligence to be established by the prosecution must be culpable or gross and not merely based upon an error of judgment. (3) Medical professional is expected to bring a reasonable degree of skill and knowledge along with a reasonable degree of care but neither the highest nor the lowest degree of care and competence. (4) A doctor would be liable only where his conduct fell below the standard of a reasonably competent practitioner. (5) Difference of opinion cannot be cited as negligence. (6) Just because a professional looking at the gravity of illness had taken a higher element of risk to redeem the patient out of his suffering which did not yield the desired result, it may not amount to negligence. (7) Merely because a doctor chooses one course of action in preference to the other one available, he would not be liable if the action chosen by him was acceptable to the medical profession. (8) It would not be conducive to the efficiency of the medical profession, if no doctor could administer medicine without a halter round his neck. (9) It is our duty not to harass or humiliate medical professionals unnecessarily, so as to allow them to perform their duties without fear and apprehension. (10) Doctors at times have to be saved from such class complaints who use criminal process as a tool for pressurizing them or hospitals and clinics for extracting uncalled for compensation. (11) Doctors are entitled to get protection so long as they perform their duties with reasonable skill and competence and in the interest of the patients.

DEFENSES AGAINST MEDICAL NEGLIGENCE

(1) No duty owed to the plaintiff. (2) Duty discharged according to prevailing standards. (3) Misadventure. (4) Error

of judgement. (5) Contributory negligence. **(6) Res judicata [Section 337, BNSS]. If a question of negligence against a doctor has already been decided by a Court in a dispute between the doctor and his patient, the patient will not be allowed to contest the same question in another proceeding between himself and the doctor on the same set of facts in a different court. Only appeal can be made.** (7) **Limitation:** A suit for damages for negligence against the doctor should be filed within two years from the date of alleged negligence. A suit filed after 2 years will be dismissed as being beyond the period of limitation. Where breach of duty to provide care as per a particular contract between a patient and a doctor is committed, legal action can be initiated up to 3 years from the date of alleged negligence.

THERAPEUTIC MISADVENTURE

A **misadventure is mischance or accident or disaster**. Misadventure is of three types: (1) Therapeutic (when treatment is being given). (2) Diagnostic (where diagnosis only is the objective at the time). (3) Experimental (where the patient has agreed to serve as a subject in an experimental study). **Therapeutic misadventure is a case in which an individual has been injured or had died due to some unintentional act by a doctor or agent of the doctor or the hospital.**

Almost every therapeutic drug and every therapeutic procedure can cause death. (1) Injection of serum, antibiotics, etc., may cause anaphylaxis in sensitive persons. History of sensitivity should be obtained before injecting such substances. (2) **Negative history and negative test do not rule out rare possibility of anaphylactoid reaction and even death.** (3) **A physician is not liable for injuries resulting from adverse reaction to drug, unless some negligence on his part contributed to cause the injury in the form of no information or failed to take informed consent.** (4) **Ignorance of the possibility of a reaction, or continuation in the prescribing of a drug with adverse reaction amounts to negligence.** (5) While prescribing a drug that has adverse side-effects, the doctor must be certain that the prescribed drug was the proper one for the disease. If there is any other drug which would be effective in treating the disease and is less likely to cause an allergic reaction, it should be prescribed.

Examples: (1) Hypersensitivity reaction, sometimes serious or fatal, may be caused by penicillin, aspirin, tetracycline, etc. (2) Excessive administration of an antidote to a poisoned patient, may cause death. (3) Prolonged use of stilboestrol may cause breast cancer. (4) I^{131} therapy may cause thyroid cancer. (5) Electric equipment, hot water pads, and heating pads may produce burns. (6) Blood transfusion may cause serious or fatal complications from bleeding resulting from hemolytic reaction due to hypofibrinogenemia, hypothrombinemia and thrombocytopenia. Other complications are hemosiderosis, viral hepatitis, hyperkalemia and hypokalemia. (7) Radiological procedures used for diagnostic purposes may prove fatal, e.g., poisoning by barium enema, traumatic rupture of the rectum and chemical peritonitis during barium

enema. (8) Fetal and neonatal deaths in utero may occur from drugs administered to the mother during pregnancy, e.g., dicumarol, diabenese, serpasil, iodides, synthetic vitamin K, thiazide diuretics, etc.

Precautions: To avoid a therapeutic misadventure in prescribing drugs, the following points should be noted. (1) Before prescribing any drug known to cause any adverse reaction, the doctor should make a reasonable effort to determine if any adverse reaction is likely to occur. (2) Sensitivity tests should be done before injecting preparations which are likely to produce anaphylactic shock. (3) The doctor should warn the patient of side-effects particularly possible drowsiness or similar accident-producing reaction, which may occur while he is taking the drug. (4) The doctor should inform the patient about the possibilities of permanent side-effects.

Neoplasia Induced by Medical Treatment: It is difficult to prove a cause-and-effect relationship between the therapy and trauma: (1) **Hemangioendothelioma of liver** induced by thorium dioxide is the classic example. (2) **Radiation** will cause leukemia. (3) **X-radiation or radium application** to the head, neck or upper thorax for various non-malignant conditions during childhood have an increased risk of developing thyroid gland cancer and also of the salivary glands and other head and neck structures. (4) **Chlornaphazine and phenacetin** may cause urinary tract carcinoma. (5) **Contraceptive steroids** can cause adenomas of the liver in females, and if continued unintentionally during pregnancy, the infant may develop a benign liver tumor. (6) **Diethylstilbesterol** causes vaginal adenosis and clear cell carcinoma of the vagina. (7) **Exposure to pesticides** cause skin and vulvar carcinoma.

VICARIOUS LIABILITY (LIABILITY FOR ACT OF ANOTHER) (VICARIOUS = SUBSTITUTED)

An employer is responsible not only for his own negligence, but also for the negligence of his employees, if such acts occur in the course of the employment and within its scope, by the principle of **respondent superior (let the master answer)**.

Conditions to be Satisfied: (1) There must be an employer-employee relationship, (2) the employee's conduct must occur within the scope of his employment, and (3) while on the job.

Examples: (1) In general practice, the principal doctor becomes responsible for any negligence of his assistant. Both may be sued by the patient, even though the principal has no part in the negligent act. The same applies where the principal employs non-medical servants. (2) When two doctors practice as partners, each is liable for negligence of the other, even though he may have no part in the negligent act. (3) When two or more independent doctors are attending on a patient, each may be held liable for the negligence of others that he observes, or in the ordinary course should have observed and allows it to continue without objection. (4) **"Borrowed servant doctrine":** An employee may serve more than one employer, e.g., the nurse employed by a hospital to assist in operations may be the "borrowed servant" of the operating surgeon during the operation, and the servant of the hospital for all other purposes. In this case, the lending employer

temporarily surrenders control over his worker and the borrowing employer temporarily takes over control. (5) A doctor may be associated temporarily with another doctor with the establishment of an employee-employer relationship between them. Thus, if one doctor assists another in the operating room for a fee, the assistant is considered as an employee of the principal surgeon. (6) If a physician has supervisory control and the right to give orders to a hospital employee in regard to the particular act, in the performance of which the employee is negligent, the physician becomes legally liable for the harm caused by the employee. (7) If a swab, sponge, instrument, etc., is left in the patient's body after the operation, the surgeon is liable for damages. (8) A hospital, as an employer, is responsible for negligence of its employees who are acting under its supervision and control. It does not matter whether they are full-time or part-time, resident or visiting, permanent or temporary, because even if they are not servants, they are the agents of the hospital to give the treatment. (9) Hospital management will be held responsible for the mistakes of resident physicians and interns in training, who are considered employees when performing their normal duties. (10) A physician is responsible for the acts of the interns and residents carried out under his direct supervision and control. (11) When employers provide medical services to their employees, or conduct pre-employment examination of prospective employees, they may be liable for the negligence of their doctors. (12) Insurers who have contracted to provide medical services may be liable for the negligence of their physicians. (13) The employer or the insurer of employees covered by Workmen's Compensation Act, may be liable for the negligence of their doctors. (14) Ordinarily, a surgeon is not liable for the negligence of an anesthetist, and the anesthetist is not liable for the negligence of the operating surgeon. (15) Physicians and surgeons are not responsible for the negligent acts of competent nurse or other hospital personnel, unless such acts are carried out under their direct supervision and control. (16) When a doctor recommends another doctor to his patient after due care, he is not liable for the negligence of the new doctor, but he becomes liable if he knowingly refers his patient to an incompetent doctor. (17) When a sick or injured person consults his own doctor for diagnosis and treatment, and the latter recommends hospitalization, the hospital to which the patient is admitted is not liable for the doctor's negligence resulting in injury to the patient. (18) Hospitals cannot be held responsible for the negligent acts of members of the superior medical staff in the treatment of patients, if it can be proved that the managers exercised the due care and skill, in selecting properly qualified and experienced staff. (19) If a physician has written a prescription properly, he is not liable for a pharmacist's negligence in preparing it, but he may be liable when he orders a prescription over the telephone resulting in misunderstanding as to the drugs or their dosage.

Liability: Both the employer and employee are sued by the patient, because the employee may lack funds for paying the damages. **Usually, liability will be fixed upon those actually at fault, and those whose control over the negligent is proved. The employer may be ordered by the Court to**

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pay compensation to the injured patient. In such cases, the employer can engage in “third party proceeding”, against the negligent doctor or employee asking for repayment.

PRODUCTS LIABILITY

FM10.21 Describe products liability and medical indemnity insurance.

Products liability refers to the physical agent which caused the injury or death of the patient during treatment by the doctor. The injury or death of the patient may result from the unexpected by-product of faulty, defective, or negligently designed medical or surgical instruments or inadequate operating instructions. In such cases, the manufacturer becomes responsible for injury or death.

Proof: The doctor must prove that the manufacturer departed from standards of due care, with respect to negligent design, manufacture, assembly, packaging, failure to test and inspect for defects, or failure to warn or give adequate instructions. If the instrument functioned satisfactorily in previous operations or for several previous years in the hospital's possession, it is a proof that it was not defective at the time of supplying. Later, if the instrument develops a defect through ordinary and gradual wear and tear, or if the physician or the hospital misuses the manufacturer's medical products, the hospital or physician owner are liable for the failure to inspect, test and repair such defects. But the manufacturer becomes responsible, if the doctor can prove that the subsequent development of this defect was due to negligent design, structurally inferior component material, or improper assembly. An adequate warning cautions the user to follow directions and may also notify the risk of disregarding directions.

Drugs: The manufacturer of medicines has a legal duty to use care in research and development of drugs. The manufacturer is liable, if a patient is injured due to a drug reaction due to the negligence or breach of warranty on the part of manufacturer. The manufacturer is also liable due to the harm caused by the contamination, adulteration, incorrect dosage or mistaken labelling of a drug. **Once the physician has been warned about possible side-effects, the manufacturer has no duty to ensure that the warning reaches the patient under normal circumstances.** From the information received from the manufacturer, and other medical sources, the doctor is required to inform the patient of those reasonably expected side-effects likely to occur in the particular circumstances. The manufacturer is responsible for performing studies of its product when adverse reactions are reported in articles in scientific journals. The result of these studies must be reported to the physicians. **The manufacturer is not responsible for unforeseeable or unknown dangers, it is unable to discover with reasonable care.** If the doctor has or should have information, knowledge, or suspicion from any source that a certain drug is likely to produce serious side-effects, he may become legally liable for prescribing it, if any substituted drug would have been adequate and satisfactory.

The manufacturer of a drug keeps a “package insert” in the drug carton or attaches it to the label of the immediate

container. It bears adequate information for its use, including indications, effects, dosages, routes, methods and frequency and duration of administration, and any relevant side-effects, hazards, contraindications and precautions under which registered practitioners can use the drug safely and for the purposes for which it is intended, including all purposes for which it is advertised or represented. The burden of proving the safety and effectiveness of a new drug or new uses of an approved drug rests with the manufacturer.

Liability: The manufacturer, seller or anyone in the chain of sale, may be sued by the buyer, by another user of the product or by some third party, whose bodily injury is caused by the product. The patient has to prove that a defect in production and testing in the product existed, before it left the manufacturer's hands and that the defect was the proximate cause of the patient's injury. Evidence will have to be produced as to the drug's physical and chemical qualities, so as to show a need to warnings. **The product would be defective, if a drug manufacturer knew or should have known the presence of certain adverse effects and then failed to warn.** Causal connection should be established between the lack of warning and resulting harm.

MEDICAL INDEMNITY INSURANCE

It is a contract under which the insurance company agrees, in exchange for the payment of premiums, to indemnify (reimburse to compensate) the insured doctor as a result of his claimed professional negligence.

Objectives: (1) To look after and protect the professional interests of the insured doctor. (2) To arrange, conduct and pay for the defense of such doctors. (3) To arrange all other professional assistance including pre-litigation advice. (4) To indemnify the insured doctor in respect of any loss or expense directly arising from actions, claims and demands against him on grounds of professional negligence, misconduct, etc.

When any dispute or allegation of negligence arises, the society must be contacted before any admissions or correspondence are entered into.

MEDICAL RECORDS (MR)

Objectives: (1) To serve as the basis for the patient's care and for continuity in the evaluation of the patient's treatment. (2) To serve as documentation for reimbursement. (3) To provide data for use in medical education and clinical research. (4) To document communication between the doctor treating the patient and any other health care professional who contributes to the patient's care. (5) To assist in protecting the legal interests of the patient, the hospital and the practitioner responsible for the patient. (6) To follow-up the patients, evaluation of drug therapy and cost accounting. (7) Medical records may be required in cases of professional negligence, for claims of third-party payment under health and accident insurance, life insurance policies, policies for disability, accidental deaths, Workmen's compensation Act, traffic accidents, etc.

Mandatory Information Documentation: The minimum requirements of accurate medical records are (Figs. 3.1 and 3.2): (1) Name, father's name, age, sex, occupation and address. (2) Date and hour of visiting the doctor/nursing home/hospital. (3) Evidence of informed consent preferably in local language. (4) Brief history of present illness, relevant past history and family history. (5) Findings of general physical and systemic examination showing objective findings and subjective complaints. (6) Diagnostic aids used and any reports received concerning the patient. (7) Date and hour of consultation with details and opinion of consultant. (8) Clinical impression with provisional and final diagnosis. (9) Progress notes including clinical observations. (10) Instructions given to the patient including diet. (11) Complications, if any. (12) Notations concerning lack of co-operation by the patient. (13) Failure of the patient to follow advice or failure to keep appointments. (14) Details of treatment including any procedures/operations recommended or performed. (15) In emergency cases, specific clinical data, and observations should be noted periodically. (16) In case of in-patients, the condition at the time of discharge, i.e., whether cured or relieved of complaints or referred to any other hospital or discharged on request or absconded should be noted.

The medical records must be accurate, appropriate, chronological, factual, relevant and complete. Nothing should be altered, deleted, substituted or added from the record, i.e. tampering should not be done. If tampering is done patient may be awarded large sums, even though there has been no negligence. The omission of essential details from the notes may cast a doubt on the truthfulness of the witness. If a correction has to be made of a prior entry on the record, it should not be totally obliterated, but a single line should be drawn through the word to be changed, and the correct information should be written above with the date of the change and the person's signature or legible initials. Further, an explanation as to why the record is being altered should be noted.

Good notes are of great value, not only when handing a patient over to another doctor, but also in meeting any criticism that may arise. If a patient refuses to accept the advice of his doctor, this fact should be recorded in writing. When there is a conflict of evidence, the Court will attach importance to the notes written at the time. Good notes may be of the greatest importance in supporting the doctor's evidence as against that of the plaintiff and his witnesses.

Patient has the right to know what is in his/her records and is entitled to a brief report of his hospital record on discharge. The next of kin can get the record in case of patient's death. Hospital has the responsibility to supervise the maintenance of appropriate, accurate, timely and up-to-date patient's records. The rights of patients to have their hospital medical records regarded as confidential must be respected. If in the doctor's judgement making the record available to the patient would be harmful or dangerous to the patient, or not in his best interest (professional or therapeutic discretion), the hospital can

avoid issuing the record to the patient. The medical records of a patient (in-patient or out-patient) should not be given to any person without the consent of the patient. The police do not have a right to demand medical records except when there is statutory provision for such requisitions. The patient's record cannot be used in educational or diagnostic conferences or clinics or for publications, without the patient's consent. Hospitals have right to use the medical records without the consent of patient for statistical purposes and quality of care determinations. In the absence of agreement to the contrary, X-ray plates are the property of the treating doctor as part of his case record. The patient buys the skill and treatment rather than the X-ray films.

Regarding MR Medical Council states that: (a) A registered medical practitioner shall maintain a register of medical certificates giving full details of certificates issued with signature of patients and with at least one identification mark. (b) To maintain an MR pertaining to his/her indoor patients for a period of 3 years from the date of commencement of treatment. (c) Routine case records should be preserved up to 6 years after completion of treatment and up to 3 years after death of the patient. (d) Where there is a chance of litigation arising for medical purpose of negligence, record should be preserved for at least 25 years specially in case of minors. (e) Medicolegally important record should be preserved up to 10 years, after which they can be destroyed after making index and summary of the case. (f) There are certain records of hospital which are of public interest and are transferred to public record library after 50 years for release to public and those involve confidentiality of the individuals are released only after 100 years.

Format for Medical Record (FIG. 3.1):

**Format for medical record
(see regulation 3.1)**

1. Name of the patient:
2. Age:
3. Sex:
4. Address:
5. Occupation:
6. Date of 1st visit:
7. Clinical note (summary) of the case:
8. Prov. Diagnosis:
9. Investigations advised with reports:
10. Diagnosis after investigation:
11. Advice:

Follow up
Date:
Observations:
Signature in full
Name of treating physician

Fig. 3.1: Format for medical record.

(Source: Ethics & Medical Registration board Gazette Notification. Page: 83-84, dated 23 August 2023)

SECTION 1: Forensic Medicine

SABVMCARI
BOWRING AND LADY CURZON HOSPITALS
HOSPITAL ROAD SHIVAJINAGAR BANGALORE KARNATAKA PB-255

Inpatient Hospital Registration

UHD: 20240110545

Dept: General Medicine / UNIT Ward: Bed: Female Medical Ward: Floor IPD Fees: Rs. 25 NON-MLC Care

Treating Doctor: IP NO: 202414533

Date Of Admission And Time: 2024-10-02 4:16 pm Gender: Female

Patient Name: Age: 73 Years

Father's Name: Husband Name:

Address: Emergency Contact Address: Mobile No.:

Mobile No: *****3732

Religion: Caste: Unknown

Monthly Income: 0 to 10000 Occupation: OTHER

Billing Type: SENIOR-CITIZEN- BSN Updated Ration Card Number: Ration Card Type:

Admission Type: Routine Admitting Doctor: Final Diagnosis:

Provisional Diagnosis: Final Diagnosis:

Prepared: Signature Of Treating Consultant:

Dr. SHARAT ANGOYA KARNATAKA Reg No.: 23279613

2 A.MI.00009 BPL

3/10/24

Claims Processed 4/10/24

Shift to FMW & M3 5th floor

Fig. 3.2: Example of the information to be collected from the patient by the doctor.

CONSENT IN MEDICAL PRACTICE

(As per Ethics & Medical Registration Board NMC Gazette Notification dated 23 August 2023, Page 72.)

FM10.19 Define consent. Describe different types of consent and ingredients of informed consent. Describe the rules of consent and importance of consent in relation to age, emergency situation, mental illness and alcohol intoxication.

Consent means voluntary agreement, compliance or permission. Consent signifies acceptance by a person of the consequences of an act that is being carried out. To be legally valid, it must be given after understanding what it is given for, and of risks involved.

Benefits of Taking Consent: (1) Doctor is not supposed to violate personal rights of a given person, his/her rights, hence it is illegal or assault on patient if examined or treated without consent unless it is medical emergency. (2) Patient can sue the Doctor for not informing about the Procedure of medical examination and treatment, benefits or risk involved.

Kinds of Consent: (1) Implied. (2) Informed express consent may be (a) verbal, or (b) written.

Implied Consent: An adult patient of sound mind who knows or has been fully or fairly informed by his doctor as to what is to be done, then cooperated with the physician, has impliedly consented in words. The fact that a patient attends the hospital or calls the doctor to his house complaining

of illness, implies that he consents to a general physical examination, to determine the nature of the illness. Consent is implied when a patient holds out his arm for an injection. Such implied consent is the consent usually given in routine practice.

Informed Express: It is specifically stated by the patient.

Full Disclosure: The facts which a doctor must disclose depends on the normal practice in his community, and on the circumstances of the case. In general, the patient should ordinarily be told everything. The doctor has to decide, after taking into consideration all aspects of the patient's personality, physical and mental state, how much can be safely disclosed. The doctor need not disclose risks of which he himself is unaware. A physician need not inform the patient of risks that a person of average intelligence would be aware of, or in an emergency situation. The physician need not give information to those patients who waive their rights, but the waiver should be clearly written in the record.

Therapeutic Privilege: This is an exception to the rule of "full disclosure". Full disclosure of remote or theoretical risks involved could result in frightening a patient who is already fearful or who is an emotionally disturbed individual, and who may refuse the treatment when there is really little risk. It is only in the case of frank psychosis or extreme psycho-neurosis that the patient will be incapable of accepting the information. In these cases, the doctor may use discretion as to the facts which he discloses. The doctor should carefully note his decision in the patient's record, explaining his intentions and the reasons. He should request a consultation to establish that the patient is emotionally disturbed. The presence of a malignancy, or an unavoidable fatal lesion may not be disclosed, if the doctor feels the patient is not able to tolerate the knowledge. If possible, the physician should explain the risks to the patient's spouse or next of kin.

Prudent patient rule, i.e., what a prudent (reasonable) person in the patient's position would have decided, if adequately informed about all the reasonably foreseeable risks.

Informed Consent: Informed consent implies an understanding by the patient of: (1) The nature of his condition. (2) The nature of the proposed treatment or procedure. (3) Expectations of the recommended treatment and the likelihood of success. (4) The details of the alternative courses of treatment that are available. (5) The risks and benefits involved in both the proposed and alternative procedure. (6) The potential risks of not receiving treatment. (7) Particular known inherent risks that are material to the informed decision, so that he may accept or reject the procedure.

All disclosures must be in language the patient can understand. Physicians have a legal, moral and ethical duty to provide all relevant information that enables a patient to either accept or reject treatment. This disclosure will very much reduce litigation, when the results are unsatisfactory or unexpected. The patient must show that the doctor did not adhere to accepted medical standards to prove liability for lack of informed consent.

Exceptions to Informed Consent: (1) Emergency, (2) Therapeutic privilege, (3) When a patient waives his right

to informed consent and delegates the right to the doctor or a close relative.

Informed refusal: The physician has a duty to disclose adequately and appropriately to the patient, the risks or possible consequences of refusal to undergo a test or treatment admission or discharge. After understanding all the facts, the patient can refuse to submit to treatment or an operation, admission or discharge.

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

Paternalism: It is an abuse of medical knowledge so as to distort the doctor-patient relationship in such a way that the patient is deprived of his autonomy, or of his ability to make a rational choice. The doctor does not disclose the nature of the illness and the proposed treatment depriving the right of patient to accept or reject treatment. The doctor may be sued under **Section. 129, BNS (S. 350, I.P.C.)**. If patient complains to medical council, it can take action against the doctor.

Rules of Consent: (1) **Consent is necessary for every medical examination.** Ordinarily, formal consent to medical examination is not required, because the patient behaves in a manner which implies consent. (2) Oral consent should be obtained in the presence of a disinterested third party, e.g., nurse. (3) **Written consent is not necessary in any trivial medical examination of given case. However, it should be taken for proving the same in the Court if necessity arises.** (4) **Written consent should refer to one specific procedure, and not blanket permission on admission to hospital. Written consent should be in proper form and suitably drafted for the circumstances.** The consent form should include specific consent to the administration of a general anesthetic. The nature of the operation should be entered on the form as precisely as is consistent with the best interests of the patients. The wording should include a phrase to confirm that the patient has been informed of the nature of the procedure, before signing takes place. (5) The written consent should be witnessed by another person, present at the signing to prevent any allegation that the consent was forged or obtained under pressure or compulsion. (6) **Any procedure beyond routine physical examination, such as operation, blood transfusion, collection of blood, etc. requires express written consent.** It must be taken before the act, but not at the time of admission into the hospital. It should be ongoing process extending overtime. (7) The doctor should explain the object of the examination to the patient, and patient should be informed that the findings will be included in a medical report. (8) In medicolegal cases, the doctor should inform the patient that he has right to refuse to submit to examination and that the result may go against him. If the patient refuses, he cannot be examined. (9) **The consent should be free, voluntary, clear, intelligent, informed, direct, and personal.** There should be no fraud,

misrepresentation of facts, undue influence, compulsion, threat of physical injury, death or other consequences.

In criminal cases, the victim cannot be examined without his/her consent. The Court also cannot force a person to get medically examined, against his will. (1) In cases of rape, the victim should not be examined without written consent. (2) In medicolegal cases of pregnancy, delivery and abortion, the woman should not be examined without her consent.

LEGAL STATUS ON CONSENT: (1) Section 51, BNSS: **A person is arrested on a charge of committing an offence, and there may be reasons for believing that an examination of his person will provide evidence as to the commission of an offence. A registered medical practitioner can examine such person, even by using reasonable force, if the examination is requested by a police officer not below the rank of sub-inspector (or any other officer acting under his direction and good faith).**

"Examination" includes, examination of blood, blood stains, semen, swabs in case of sexual offences; sputum, sweat, hair samples, fingernail clippings, etc. using modern and scientific techniques including DNA profiling and such other tests that a medical practitioner thinks necessary in that particular case. **If the accused refuses examination, this may go against him in criminal proceedings.**

In the case of a female, the examination should be made only by or under the supervision of a female registered medical practitioner [Section 51, BNS]. (S. 53, (2) Cr.P.C.)

(2) Section 53, BNSS: It mandates **compulsory medical examination** in all cases of arrest by the police. A copy of the report of such examination is to be furnished by the medical practitioner to the arrested person or the person nominated by such arrested person.

In cases of **drunkenness**, the person should not be examined, and blood, urine, or breath should not be collected without his written consent. But, if the person becomes unconscious or incapable of giving consent, examination and treatment can be carried out. The consent of guardian or of relatives, if available, should be taken. **The person can be examined without consent, if requested by the sub-inspector of police.**

(3) Section 25, BNS: **A person above 18 years of age can give valid consent to suffer any harm,** which may result from an act not intended or not known to cause death or grievous hurt.

A person may be suffering from a disease which is certain to shorten his life. He can give free and informed consent to take the risk of operation, which though fatal in the majority of cases is the only available treatment. The surgeon cannot be held responsible, if the patient dies.

(4) Section 26, BNS: A person can give valid consent to suffer any harm which may result from an act, not intended or not known to cause death, done in good faith and for its benefit.

If a surgeon operates on a patient in good faith and for his benefit, even though the operation is a risk, he cannot be held responsible if the patient dies.

SECTION 1: Forensic Medicine

(5) Section 27, BNS: Act done in good faith for benefit of child or person of unsound mind, by, or by consent of guardian: Nothing which is done in good faith for the benefit of a person under 12 years of age, or person of unsound mind, by, or by consent, either express or implied, of the guardian or other person having lawful charge of that person, is an offence by reason of any harm which it may cause, or be intended by the doer to cause or be known by the doer to be likely to cause to that person: Provided that this exception shall not extend to: (a) The intentional causing of death, or to the attempting to cause death. (b) The doing of anything which the person doing it knows to be likely to cause death, for any purpose other than the preventing of death or grievous hurt, or the curing of any grievous disease or infirmity. (c) The voluntary causing of grievous hurt, or to the attempting to cause grievous hurt, unless it be for the purpose of preventing death or grievous hurt, or the curing of any grievous disease or infirmity. (d) The abetment of any offence, to the committing of which offence it would not extend.

Illustration: A, in good faith, for his child's benefit without his child's consent, has his child cut for the stone by a surgeon knowing it to be likely that the operation will cause the child's death, but not intending to cause the child's death.

A is within the exception, in as much as his object was the cure of the child.

Loco Parentis (in place of a parent): In an emergency involving children, when their parents or guardians are not available, consent is taken from the person-in-charge of the child, e.g., a schoolteacher can give consent for treating a child who becomes sick during a picnic away from hometown, or the consent of the headmaster of a residential school.

(6) Section 28, BNS: A consent given by a person under fear of injury, or due to misunderstanding of a fact is not valid. The consent given by an insane or intoxicated person, who is unable to understand the nature and consequences of that to which he gives his consent is invalid.

To represent to a patient that an operation is necessary to save life or to preserve health, when that is not the case or to indicate that it will give greater relief than there is any reasonable prospect of obtaining is to perpetrate a fraud on the patient that vitiates his consent.

(7) Section 30, BNS: (S. 92, I.P.C.) Any harm caused to a person in good faith, even without that person's consent is not an offence, if the circumstances are such, that it is impossible for that person to signify consent and has no guardian or other person in lawful charge of him from whom it is possible to obtain consent in time for the thing to be done in benefit. Nothing is said to be done in good faith which is done without due care and attention.

A person may be involved in an accident, which may necessitate an amputation; if it is done without his consent, it is not an offence. In an emergency, the law implies consent. An emergency is defined as a medical situation, such as to render immediate treatment advisable either to save life or to safeguard health.

In an emergency, a comatose patient requiring immediate treatment, a mentally incompetent patient requiring treatment when a legal guardian is not available, an intoxicated patient who temporarily lacks the capacity to consent but requires treatment, consent is implied. A doctor may extend a procedure beyond the scope of consent to treat an emergency.

(8) Section 31, BNS (S. 93, I.P.C.): Any communication made in good faith for the benefit of a person is not an offence, if it causes harm to that person to whom it is made.

A physician in good faith informs a patient that his survival is not possible. The patient dies because of the shock. The physician has not committed any offence.

The doctor should inform reasonably to the patient about the nature, consequences and risks of the examination or operation before taking the consent. In an obscure case, the doctor should obtain an open consent to use his discretion for additional procedures needed to cope with unanticipated situations that endanger his health (extension doctrine). It is not applicable to non-essential procedures. When there are two or more methods of treatment, the patient should be allowed to choose and give consent for any method.

If in the course of an operation to which the patient has consented, the physician discovers conditions that had not been anticipated before the operation began, and which would endanger the life or health of the patient if not corrected, the doctor would be justified in extending the operation to correct them, even though no express consent was obtained. If an anesthetist administers a type of anesthetic expressly prohibited by the patient, he will be responsible for damages resulting from an unfortunate occurrence caused by the anesthetic, even though there is no negligence in its administration.

Consent of the inmates of the hostel, etc., is necessary if they are above 12 years. Within 12 years, the headmaster or warden can give consent. If an inmate above 12 years refuses treatment, and he is likely to spread the disease, he can be asked to leave the hostel. However, if he stays in hostel, he can be treated without his consent.

Miscellaneous circumstances and consents relating to the same: (A) When an operation is made compulsory by law, e.g., vaccination, the law provides the consent. (B) A prisoner can be treated forcibly without consent in the interest of the society. (C) Consent given for committing a crime or an illegal act, such as criminal abortion is invalid. (D) Consent is not a defense in cases of professional negligence. (E) The nature of illness of a patient should not be disclosed to any third party without the consent of the patient. (F) For contraceptive sterilization, consent of both the husband and wife should be obtained. (G) The consent of one spouse is not necessary for an operation or treatment of other. A husband has no right to refuse consent to any operation, including a gynecological operation, which is required to safeguard the health of his wife. The consent of wife is enough. It is advisable to take the consent of the spouse whenever practicable, especially if the operation involves danger to life, may destroy or limit sex functions, or may result in the death of an unborn child.

(H) It is unlawful to detain an adult patient in hospital against his will. If a patient demands discharge against medical advice, this should be recorded and his signature obtained. (I) A living adult person can give consent for donating one of his kidneys to be grafted into another person. The donor must be informed of the procedure involved and possible risks. The donation should not be accepted, if there is any risk of life of donor. (J) If any person has donated his eyes to be used for therapeutic purpose after his death, the eyes can be removed only with the consent of guardian or legal heirs. (K) If any person has donated his body to be used for therapeutic or research purposes after his death, it is not binding on his spouse or next of kin. For organ transplantation, the organs of the dead person, such as heart, kidney, liver, etc. should not be removed without the consent of the guardian or legal heirs. Precautions should be taken to preserve the anonymity of both donor and recipient. (L) Pathological autopsy should not be conducted without the consent of the guardian or legal heirs of the deceased. If the autopsy is done without consent, the doctor is liable for damages for the mental anguish suffered by heirs due to the mutilation of the body. Specific authorization should be obtained for retention of organs and parts of the body. In medicolegal autopsies (statutory authorization), consent is not required and the doctor can remove from the cadaver anything that is essential for purposes of examination.



CASE(S)

Moss vs Rishworth: An 11-year-old girl was taken to surgeon for removal of tonsils and adenoids by her two adult sisters. The child died under anesthetic. The Court held that there was no emergency which would excuse the need for parental consent, and the father could recover damages.

Jockovach vs Yocum: The arm of a 7-year-old boy was crushed by a train. The boy's arm was amputated immediately as the doctors could not contact parents. The consent of the parents was implied by the emergency.

Wells vs Mc Gehee: A 7-year-old child died under anesthesia for treatment of a broken arm, which was given without the consent of the mother as she could not be contacted. The Court held that an emergency existed.

Drummond's Case: Drummond sued a woman patient for recovery of fees. The patient counterclaimed damages as a drug was administered to her, without her consent. She alleged that phenobarbitone, which she refused to take, was mixed in soup and meat and given to her daily, which prolonged her stay in the nursing home, as a psychological consequence for 16 weeks. The Court held that the administration of a drug to a person without that person's knowledge and consent was assault, and awarded nominal damages as the drug did not cause substantial harm.

Types: Active or Positive: It is a positive merciful act, to end useless suffering or a meaningless existence. It is an act of commission, e.g., by giving large doses of drugs to hasten death. **Passive or Negative: Passive euthanasia means discontinuing or not using extraordinary life-sustaining measures to prolong life.** This includes acts of omission, such as failure to resuscitate a terminally ill or hopelessly incapacitated patient or a severely defective newborn infant. It is not using measures that would probably delay death, such as turning off a respirator, stopping medications or food and water and allowing the person to dehydrate or starve or not delivering cardio-pulmonary resuscitation, which permits natural death to occur.

Voluntary euthanasia means at the will of the person, and **involuntary** means against the will of the person, i.e., compulsory. **Non-voluntary refers to cases of persons incapable of making their wishes known**, e.g., in persons with irreversible coma or severely defective infants. **Euthanasia advocates the administration of lethal doses of opium or other narcotic drugs.**

The supreme court held that 'right to die with dignity' is a part of right to life, a fundamental right under Article 21 of the Constitution, and allowed "living will" where, an ailing adult in his conscious mind, is permitted to refuse medical treatment or voluntarily decide not to take medical treatment to embrace death in a natural way.

Guidelines: (1) The will can be executed only by an adult with a sound and healthy mind. (2) It should be voluntarily executed based on informed consent. (3) It should be expressed in clear and unambiguous terms. (4) The will should be signed by the executor before a first-class judicial magistrate. (5) The will should mention the circumstances in which the treatment should be withdrawn and the name of the guardian or close relative who can authorize for starting passive euthanasia. (6) The treating physician should ascertain the genuineness from the jurisdictional first-class magistrate. (7) The hospital medical board should authorize withdrawal or treatment.

The Netherlands was the first country to legalize passive voluntary euthanasia and assisted suicide in 2002, if the following conditions were met: (1) The disease is incurable. (2) The patient's suffering is unbearable. (3) The patient's condition is terminal. (4) The patient requests death. Another physician must be consulted first and life must be ended in a medically appropriate way.

Other countries which have joined this select group are Belgium, Luxemburg, Switzerland, Thailand.

Assisted Suicide: A person providing information to another with information, guidance and means to take his own life with the intention that it will be used for this purpose is assisted suicide.

Terminal Sedation: It includes the administration of morphine and similar medications, which have a dual effect of relieving of pain and hastening the death (**aid-in-dying**). If the patient requests the same medical treatment with its known dual effects, and if the physician knowingly provides that medication by prescription so that patient can end his life, it is considered **physician-assisted suicide**.

EUTHANASIA (MERCY KILLING)

FM10.11

Describe and discuss euthanasia.

Euthanasia (EU—good; Thanatos—death) means producing painless death of a person suffering from hopelessly incurable and painful disease.

SECTION 1: Forensic Medicine

Article 21 of the constitution of India guarantees "right to live" but does not imply "right to die".

Deaths under Medical Care: Deaths may occur due to:

- (1) Complications of anesthesia. (2) Complications of surgery.
- (3) Nosocomial infections. The use and/or misuse of urinary catheters, techniques and equipment employed in intravenous therapy; hyperalimentation, and respiratory therapy cause most of these infections. (4) Therapeutic misadventure.
- (5) Professional negligence: (a) Administration of wrong dose. (b) Pharmacist dispensing wrong medicine due to illegible prescription. (c) Abbreviations of drugs. (d) Confusing patients with similar names and to administer the correct dose to the wrong patient. (e) Susceptibility of children to medication errors. (f) New approved drugs may result in death from side-effects undetected in the study population. (g) Patient or specimen misidentification in laboratory testing can lead to inappropriate and potentially life-threatening therapy. (h) Errors in reporting abnormal values in electrolyte analysis. (i) Mismatched blood transfusion.

MALINGERING

FM10.20 Describe therapeutic privilege, malingering, therapeutic misadventure, professional secrecy, human experimentation.

Malingering or shamming means conscious planned feigning or pretending a disease for the sake of gain.

Reasons: Diseases may be feigned for several reasons, such as by soldiers or policemen to avoid their duties, by prisoners to

avoid hard work, by businessmen to avoid business contracts, by workmen to claim compensation, by beggars to attract public sympathy, by criminals to avoid legal responsibility, etc. The diseases that may be feigned are many, e.g., dyspepsia, intestinal colic, ulcers, spitting of blood, ophthalmia, diabetes, rheumatism, lumbago, neurasthenia, aphasia, sciatica, pain in the back, blindness, deafness, vertigo, epilepsy, insanity, paralysis of the limbs, burns, artificial bruises, etc. Patients can distort or exaggerate their symptoms, but true simulation is very rare.

Examples: (1) The patient may injure his nasopharynx with a sharp instrument, swallow the blood and regurgitate it in front of the doctor to mimic hematemesis. (2) A skillful puncturing of the anal or vaginal mucosa, may produce bleeding. (3) Excessive intake of digitalis may simulate a heart condition. (4) Eating of large amount of carrot will produce carotenemia and may simulate jaundice. (5) Chronic ingestion of coumarin will induce a hemorrhagic diathesis. In many cases detection is easy, but in some cases it is difficult.

Diagnosis: The history of the case should be taken from the person himself, and his relatives or friends, and any inconsistencies in his description of the symptoms noted. Usually, the signs and symptoms do not conform to any known disease. **Malingering can be diagnosed by keeping the patient under observation and watching him without his knowledge.** A complete examination is essential after removing the bandages if any and washing the part. Rarely an anesthetic may be given to detect malingering.

PENAL PROVISIONS APPLICABLE TO MEDICAL PRACTICE

BNS Sections/ Subsections	Subject/issue
S. 2 (11)	Good Faith (Nothing is said to be done in good faith which is done without due care and attention)
S. 25 to 31	Provides legal protection to medical doctors
S. 58	Concealing design to commit offence punishable with death or imprisonment for life. (imprisonment for 3 months if the offence is not committed and 7 years if the offence is committed).
S. 106	Causing death by negligence (imprisonment up to 2 years or with fine or both).
S. 125	Rash and negligent acts that endanger human life, or the personal safety of others (imprisonment from 3 months to 2 years, or fine, or both).
S. 211	Omission to give notice or information to public servant by person legally bound to give it (imprisonment up to one month or fine or both).
S. 212	Furnishing false information (imprisonment up to six months or fine or both).
S. 216	False statement on oath or affirmation to public servant or person authorized to administer an oath or affirmation (imprisonment up to 3 years and fine).
S. 227	Giving false evidence.
S. 228	Fabricating false evidence
S. 229	Punishment for false evidence (imprisonment up to 7 years or life).
S. 234	Issuing or signing false certificate (imprisonment up to 7 years).
S. 238	Causing disappearance of evidence of offence or giving false information to screen offenders (imprisonment up to 10 years).
S. 239	Intentional omission to give information of offence by person bound to inform (imprisonment up to 6 months or fine or both).
S. 240	Giving false information respecting an offence committed (imprisonment up to 2 years or fine or both).

Contd...

Contd...

BNS Sections/ Subsections	Subject/issue
S. 241	Destruction of document or electronic record to prevent its production as evidence. (imprisonment up to 2 years or fine or both).
S. 271	Negligent act likely to spread infection of disease dangerous to life (imprisonment up to 6 months or fine or both).
S. 272	Malignant act likely to spread infection of disease dangerous to life (imprisonment up to 2 years or fine or both).
S. 286	Negligent conduct with respect to poisonous substances (imprisonment up to 6 months or fine or both).
S. 33 BNSS	<ol style="list-style-type: none"> Every person, aware of the commission of, or of the intention of any other person to commit, any offence punishable under any of the following sections of the Bharatiya Nyaya Sanhita, 2023, namely: (i) sections 145 to 152 and section 156; (ii) sections 187 and 189; (iii) sections 272 to 278; (iv) sections 101, 102 and 103; (v) section 138; (vi) section 305; (vii) sections 307 to 311; (viii) section 314; (ix) sections 322 to 326; (x) section 330; (xi) section 329; and (xii) sections 176 to 180, shall, in the absence of any reasonable excuse, the burden of proving which excuse shall lie upon the person so aware, forthwith give information to the nearest Magistrate or police officer of such commission or intention. For the purposes of this section, the term "offence" includes any act committed at any place out of India which would constitute an offence if committed in India.
S. 179	Police officer has the power to summon any witness (doctor) to police station for recording a statement.
S. 181	Oral statements made to the police and recorded by the police should not be signed.



CONCEPT CHECK

Long Essay Questions

- Define medical negligence and describe what are the defenses available for the doctors in cases of medical negligence.
- Give an account of constitution and functions of National Medical Commission.
- Describe the disciplinary control over medical practitioners, including penal erasure, infamous conduct, and warning notices issued by the National Medical Commission.

Short Essay Questions

- Consent
- Professional misconduct
- Vicarious liability
- Professional secrecy
- Privileged communication

Short Answer Questions

- Write a short note on Dichotomy.
- State the difference between civil and criminal negligence
- Write a short note on Res judicata

Multiple Choice Questions

- What is the minimum period for maintaining a patient's case records as per NMC guidelines?
 - 1 year
 - 3 years
 - 5 years
 - 10 years
- Which body regulates medical education and practice in India?
 - Indian Medical Council
 - National Medical Commission
 - Supreme Court of India
 - Ministry of Health & Family Welfare
- The NMC Act came into force in:
 - 2018
 - 2019
 - 2020
 - 2021
- Which board under the NMC is responsible for maintaining the National Register of Doctors?
 - Post-Graduate Medical Education Board
 - Medical Assessment and Rating Board
 - Ethics and Medical Registration Board
 - Medical Advisory Council
- Which of the following statements is true about the NMC?
 - It has 50 members
 - It replaced the MCI in 2019
 - It does not regulate medical ethics
 - It is controlled by state governments
- Which of the following is an unethical practice?
 - Advertising one's services in newspapers
 - Issuing a medical certificate after proper examination
 - Attending continuous medical education (CME)
 - Teaching medical students
- The Geneva Declaration (Physician's Pledge) emphasizes:
 - Commercial aspects of medical practice
 - Prioritizing personal profit over patient care
 - Respecting patient autonomy and confidentiality
 - Keeping medical knowledge private
- A registered medical practitioner's name can be removed from the register for:
 - Practicing alternative medicine
 - Serious professional misconduct
 - Not attending CMEs
 - Refusing to treat patients
- Who has the power to erase a doctor's name from the medical register?
 - Medical College
 - National Medical Commission
 - Ministry of Health
 - Director of AIIMS

SECTION 1: Forensic Medicine

10. Malingering refers to:
- A. Faking symptoms for personal gain
 - B. Treating patients without a license
 - C. Misdiagnosing patients intentionally
 - D. Issuing false medical certificates
11. What is the punishment for issuing a false medical certificate?
- A. Warning notice only
 - B. Fine of ₹10,000
 - C. Disciplinary action by the medical council
 - D. Imprisonment under BNS
12. The therapeutic misadventure refers to:
- A. An intentional act of medical negligence
 - B. A medical mishap occurring despite proper care
 - C. A doctor experimenting without consent
 - D. A patient refusing treatment

Answers

- | | | | | | | |
|------|------|-------|-------|-------|------|------|
| 1. C | 2. B | 3. B | 4. C | 5. B | 6. A | 7. C |
| 8. B | 9. B | 10. A | 11. D | 12. B | | |

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Dharmaraya Ingale MD is a distinguished Professor of Forensic Medicine and Toxicology, with over 31 national and international publications to his credit. He has served at St. Paul's Hospital and Millennium Medical College, Addis Ababa, Ethiopia (2015–2017) under the Government of Ethiopia, where he played a pivotal role in establishing undergraduate and postgraduate programs in Forensic Medicine and Toxicology.

In India, he has been an active academic leader and has significantly contributed to the advancement of forensic medicine education. He has also served as President of Karnataka Medico-Legal Society (KAMLS) and was instrumental in organizing KAMLSCON 25 at SRPMC, fostering academic collaboration and professional excellence in the field.

With his rich academic experience, international exposure, and dedication to the specialty, he continues to be recognized as a mentor, researcher, and leader in Forensic Medicine.

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He has been a distinguished presenter at national and international conferences, earning several accolades, including the Best Faculty Paper Presentation Award at the *South India Medico-Legal Association Conference, Coimbatore*. His active involvement in medico-legal training programs, public health initiatives, and professional bodies such as the Indian Medical Association (IMA) and KAMLS reflects his commitment to advancing the specialty.

He also serves as a Board of Studies (BOS) member at RGUHS, contributing to the academic and curricular development of forensic medicine. Recognized as a teacher, researcher, and medico-legal expert, he continues to inspire students and professionals with his scholarship, leadership, and dedication to the discipline.

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