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Textbook on Medicolegal Issues

Related to Various Medical Specialties



Editors
Satish Tiwari • Mahesh Baldwa
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3rd Edition

JAYPEE

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12 CHAPTER

Difficult Situations in Practice

Girish Kumthekar

INTRODUCTION

All hospitals, one or the other day, face anticipated or unexpected difficult situations. The difficult situations can diffuse easily or may take a bad turn. When these problems arise in small individual proprietary hospitals or small-to-medium multispecialty hospitals, the situation and circumstances are different, and we will delve more into this sector. The big or multispecialty corporate hospitals have a different and faceless channel to settle these matters and no one is personally involved. However, in a small proprietary hospital, the consultant is directly across the table and must tackle the situations that may prove to be a nightmare.

The difficult situations one can face are as follows:

- Emergency patient from a road accident
- Patient's ailment not related to specialty
- Shifting a critically ill patient
- Sudden death and mob violence
- Brought dead
- Settlement of bills or recovery of dues

EMERGENCY ACCIDENT ADMISSION

This is a relatively mild situation wherein road accident victims are brought to the nearest hospital.

After a Supreme Court (SC) judgment (Parmanand Katara v. Union of India), you are duty-bound to treat the victim of an accident. It is expected from doctor or hospital that at least first aid must be given and if necessary, stabilize the patient with the available resources and guide the kins of the victim to shift to a proper hospital and counsel them accordingly. Please remember that in such situations, one is not expected to give extraordinary treatment or do some heroic efforts but must try to give the maximum possible support and shift the patient promptly to an appropriate clinical care facility.

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PATIENT'S AILMENT NOT RELATED TO SPECIALTY

If the patient does not belong to your specialty, unless you are confident that an on-call specialist will be able to come on time and handle the patient, do not venture into this just to keep admission with you. You may lose the golden hour in such a situation and put yourself in trouble.

Whenever you are treating such a patient, take sufficient time to talk to the relatives or concerned person in detail about the situation, need for further action, and referral. If you are giving preliminary treatment and injectables, explain everything to the relatives and document everything. It may so happen that you will get unnecessary blame that death is caused by the medications you have given. Counseling of the relatives and chronological documentation of events are absolutely necessary in such cases.

SHIFTING A CRITICALLY ILL PATIENT

One more not-difficult-but-tricky situation wherein a critically ill patient is admitted, or becomes critical during treatment, or the infrastructure is not adequate to treat such patient, it is in the best interest of the patient and treating doctors to shift the patient to a tertiary care center. There are two things to be settled here:

1. Convince the relatives and counsel them for referral.
2. Do this without damage to one's own image and ego.

The first one is simple and relatives usually get convinced but the second part is image and ego. This is where one must compromise. Identify your own and hospital's limitations and shift the patient. Anticipate the problem in advance and shift the patient in time so that further allegations can be avoided. Learn to say "NO" to relatives and more importantly to yourself.

In this situation, it is prudent to give correct options to relatives. Never compel them for admission to a specific center. It is wise to call for an ambulance as a help to relatives. The ambulance must be well equipped to handle such patients during transfer. Give a referral chit to the concerned center explaining the necessity, provisional diagnosis, and treatment given. Keep a copy of the referral chit for your record and if the patient is on life support, accompany the patient or ask your clinical assistant doctor to accompany. This requirement of accompanying doctor is specifically enumerated by SC in one of the judgments.

SUDDEN DEATH

Sudden is defined as happening quickly and without any warning while sudden death is defined as instantaneous and unexpected death not caused by violence.

The important ingredient here is "not caused by violence". Unexpected death occurring during the course of treatment is sudden death. The sudden death could be caused during ward treatment or on an operation table. We have to deal with these two deaths differently.

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Death in a Ward or Room During the Course of Treatment

We are not going to deal with causes of death in detail as this is not the purpose of this chapter.

However, just to enumerate, the causes of sudden death may be the following:

- Hemorrhagic shock
- Neurogenic shock
- Cardiogenic shock
- Endotoxic shock
- Anaphylactic shock
- *Other causes:*
  - *Embolism:* Amniotic fluid, air, or thrombus
  - *Anesthesia complications:* Mendelson's syndrome
- *More than one factor such as*:
  - Hemorrhagic and endotoxic shock
  - Hemorrhagic and neurogenic shock

Such death is usually postoperative or due to an undesired response or turn in the health of a patient being treated in a ward or room. Such death usually happens when the treating physician and nursing staff are not around and is invariably witnessed by the family member or attendant of the deceased. Sudden death itself constitutes a shock to the family. It is equally shocking to the treating doctor. Intense efforts are usually made by treating doctors or nursing staff on the site with available resources. In small nursing homes, this is the time when certain deficiencies are noticed by the bystanders or the relatives of the deceased. Usually, there is shouting, loud orders by the doctors, commotion, and a lot of hurry and worry in the body language of all those who are trying to resuscitate the ailing patient. This all is witnessed by the relatives of the patient and when death is declared, the efforts go unnoticed and it is only the deficiencies that are pointed out.

The gravity of this situation can be diluted by the following:

- Keep all resuscitative measures ready 24 × 7. These include emergency drug tray with drugs within expiry date, resuscitation equipment, oxygen cylinder if there is no central oxygen, tubes, defibrillator, and pulse oximeter.
- All the relatives and bystanders must be asked politely to leave the ward or room.
- Inform the seriousness of the health and give assurance that all measures are being taken to revive the patient.
- Break the bad news in a highly polite and dignified way. By dignified way means doctor is not supposed to show extreme emotions like crying in front of the relatives. The doctor must keep his composure and show confidence. He must share sorrow with the relatives but only professionally. This may appear odd to begin with but one must remember, the more extreme emotions you show the relatives become more suspicious.

After the death is declared, all the responsible relatives must be called upon to share information. At this point, remember to call out only responsible relatives and talk to them in a separate room, preferably in your consulting room. The relatives must be taken into confidence, the situation explained and if the cause of death is obvious, it must be explained properly. If there is doubt on the cause of death, medicolegal (ML)/clinical postmortem examination must be done. It takes a lot of effort to convince the relatives about the necessity of postmortem, but it is worth taking the efforts than to land in trouble later. If you feel postmortem

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is a must and relatives are not giving consent, you can take help of the police and get it done.

Intraoperative Death in Operation Theater or Immediate Postoperative Death in Recovery Room and Mob Violence

This really is a very difficult situation, particularly in elective operation, more so for the gynecologists where majority of the operations are elective and performed on a healthy patient. Most of the times, the patient enters the operation theater (OT) in good physical and mental condition and a lifeless body is brought out on a gurney. This is really shocking to relatives who are not prepared for such an eventuality. The story is different in high-risk cases, accidents, and complicated surgeries wherein the relatives are prepared for eventuality one way or the other.

The anticipated reactions of the relatives to such sudden death are:

- Anger and anguish
- *Immediate explanation:* Relatives demand immediate explanation on the spot, which is not possible for the doctors and the agitation and suspicion in the minds of relatives aggravates.
- Financial waver and immediate compensation
- *Immediate police action:* This usually is demanded by the so-called leaders of that particular area or community. They pressurize the police to register crime and arrest the doctor immediately. However, after SC's "Jacob Mathew judgment", which has prescribed a procedure to arrest a doctor, State governments have issued a directive to police, which are followed in most incidents.
- Verbal or physical abuse and immediate retaliation with destruction of property

Immediate reactions of the treating doctor that should be avoided:

- *Run away from the situation*: Never do this. It will only make things worse.
- *Immediate cover-up and unnecessary explanations:* This should be avoided. The doctors should not face multiple relatives immediately and start giving explanations to each and everyone. The paramedical staff should also be told to remain silent and avoid different versions of the situation. One should keep his nerves, take a break for a few minutes after exhaustive resuscitative efforts have failed, organize the things in OT, pool all the empty vials used during resuscitative measures, and collect all the papers and take them into your custody (this is to prevent unauthorized copying of the papers without knowledge of anybody). Later, one should call only the responsible relatives separately into the counseling or consulting room and explain the situation.
- *Settle the matter as early as possible by political or financial means*: This is the most common practice adopted by doctors but this should be avoided under any circumstances as this sets a precedence for future mischief mongers and political leaders.
- *Fight the situation overconfidently*: This is to be avoided not only verbally but even with body language. Dismissing the relatives, not giving a proper explanation, or challenging them by any means aggravates the situation further.
- *Retaliate the abuse by abusive language*: This possibly is the worst thing a doctor can do. The dictum is that relatives may abuse in any language, you cannot reply in the same

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language as your abusive language shall be capitalized immediately and more and more abuses will start getting hurled at you. This also increases the tension in the atmosphere and temperatures start getting very high. Many times, relatives do it on purpose just to provoke you and capitalize on it later on.

Probable actions the relatives may take in such a situation:

- Manhandle the doctor and destruction of the property and hospital equipment.
- Threaten the doctor.
- Lodge a criminal complaint.
- Insist on arrest of the doctor (we have some solace from this after SC directives).
- Invite the media to spread the news (though very traumatic situation, just do not worry, the publicity does not affect your reputation in a long run and remember public memory is less than 24 hours).
- Demand for money (this probably is the ulterior motive of relatives).

These situations are self-explanatory and we have to deal with them instinctively.

What a Doctor Should Do?

- *Call colleagues and seniors for help*: This probably works more than anything else. Prepare a task force on the platform of organizations like Indian Medical Association (IMA) or Specialty society. All seniors and colleagues from all specialties should rush to the troubled spot at the shortest notice. This diffuses the situation very fast. There may be many people in the mob who happen to be patients of one or the other doctor from the task force and such senior consultant can diffuse the situation and mediate on behalf of the treating doctor.
- If the situation is going out of hands, call the police.
- Different visitors or relatives at different times may ask explanation afresh. This should be avoided and an explanation must be given only once and only to responsible relatives.
- Involve only the responsible persons from the aggrieved family.
- Involvement of local politician is quite controversial and depends on the situation. Personally, we do not recommend it as you put yourself in a vulnerable position later on when the politician demands his pound of flesh. But in the past many doctors have benefitted after getting help from politicians.
- Be a patient listener to the allegations and abuses.
- Discuss the problem with colleagues who have come in to help and prepare a logical sequence of events.
- Take time to prepare the case paper and put proper notes.
- Cooperate with the legal arm.
- In case, a cause of death can be given, certify the death.
- Ideally, ML postmortem is a must. It substantiates your diagnosis and actions.

Breaking the News

Breaking the bad news should be handled very carefully. Each case deserves to be handled by its merits. The various ways in which the bad news can be broken are as follows:

- *Immediate:* Sometimes it is necessary to declare death immediately. This method has both its pros and cons. It can bring around immediate violent reaction as stated earlier. Sometimes

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immediate declaration reflects transparency and relatives do not grumble much. This all is circumstantial and a doctor must use his/her utmost management skills.

- *After cover-up*: Cover-up does not mean manipulations or fabrications. It means the place where the patient has died, in OT or ward, there is a lot of mess around like maybe a pool of blood or blood-stained sponges, etc. This should be cleaned and tidy up. Preserve all material in an orderly manner so that your efforts can be accounted for. The procedure of keeping the patient on artificial means and pretending that the patient is alive does not work in the true sense. It is a common practice to keep the patient on a ventilator and break the news slowly after intensifying the situation step by step. The problem here is many of the bystanders and witnessing relatives are wise enough to realize that things have gone wrong. They feel that extensions and pretensions are a drama for other causes (mostly financial) and then they retaliate.
- *Conveniently by another person may be a staff nurse or servants*: This probably is the simplest way but sometimes agitated relatives are not happy, and they want a direct interaction with the doctor. Though not an everyday situation in small hospitals, the staff must be well briefed and trained to break the news if delegated to do so.
- *After asking all the responsible relatives to gather and then explain in the presence of colleagues*: This probably is the safest way to break the news. This should be done preferably in your own consulting room. Remember that your consulting room is the most comfortable place for such thing. You happen to be the most powerful person in your own consulting room. Sit comfortably on your chair, ask your colleagues to sit by your side, and ask the relative to sit across the table. This creates a wall of power between you and relatives and keeps you safe. Never go directly toward the mob. This makes you vulnerable and may precipitate direct manhandling.

Medicolegal Aspects of Sudden Death

- Sudden death is treated as an accidental death and it requires a very high degree of negligence to prove that it was caused by a negligent and rash act.
- It invites the Indian Penal Code (IPC) section 304A/304 or BNS Sections 106 (1)/105, which means death caused due to rash and negligent acts by several persons with a common intention.
- It is a cognizable and bailable offense. Bail can be granted by the investigating officer, no court is needed.
- On request of the doctor, or in case of medicolegal case, custody of the human remains is taken by the police and shifted for postmortem.
- The investigating officer can demand copies of all documents and charts related to the case. It is not necessary to provide them immediately. You can ask for some time. Complete the papers to the last detail and provide the officer with Xerox copies. In fact, never hand over original papers to the authorities. You may lose your defense forever.

Most of the time, in cases of mob violence and difficult situations after sudden death, the demand of the agitating relatives of the deceased is to file a case and arrest the doctor immediately. Fortunately for us, the Honorable SC in its judgment directed the Central/State governments to frame statutory rules or executive instructions as regards prosecution against doctors (Jacob Matthews vs. State of Punjab delivered on 5th August, 2005). Until governments prepare such statutory rules, the Honorable SC has given directives that govern the prosecution

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of doctors for offenses of which criminal rashness or criminal negligence is an ingredient. Remember these directives are to be followed only when the death has occurred during the course of treatment.

The Honorable SC says that:

- A private complaint may not be entertained unless the complainant has produced prima facie evidence before the Court in the form of a credible opinion given by another competent doctor to support the charge of rashness or negligence on the part of the accused doctor.
- The investigating officer should, before proceeding against the doctor accused of rash or negligent act or omission, obtain an independent and competent medical opinion preferably from a doctor in government service qualified in that branch of medical practice who can normally be expected to give an impartial and unbiased opinion.
- A doctor accused of rashness or negligence, may not be arrested in a routine manner (simply because a charge has been leveled against him/her). Unless his/her arrest is necessary for furthering the investigation or for collecting evidence or unless the investigating officer feels satisfied that the doctor proceeded against would not make himself/herself available to face the prosecution unless arrested, the arrest may be withheld.

The directives are self-explanatory and whenever there is imminent arrest, one can use the copy of this judgment and ask the police officer to abide by the directives.

Other legal actions a doctor can face after such a mishap are:

- Action under the Consumer Protection Act
- Action in civil court for compensation.

We are not going to go into details of these actions but in a recent judgment, the Honorable SC has again given us a great relief. The Court has said in its judgment that a case against doctors should not be admitted immediately by consumer court or civil court. Instead, the courts should serve notice to the concerned doctor and ask for an explanation or expert opinion from the competent medical board at the district place. If not satisfied with the reply or the recommendation of the competent board, the court may proceed to admit a complaint.

Recent amendments in the Code of Criminal Procedure (CrPC) are also a great relief as arrest can be avoided as per provisions.

BROUGHT DEAD

This situation is faced mainly by pediatricians, general practitioners, or general hospitals. The dilemma faced by attending physician is what to do in such cases. The doctor must see the patient anyway and declare the death. The question arises as to death certificate, cause of death, information to the police, and what records to keep. These are the few directives that may not be foolproof but may help to resolve the dilemma.

- Always attend the brought dead patient in your outpatient department (OPD) or emergency room (ER) (do not admit directly). Do not delegate the nursing staff or clinical assistants to attend the brought-in dead body and declare death and push the relatives to take away the body.
- Prepare an OPD case paper only with your OPD number and date and timing of arrival of the deceased. Put in detail the names of accompanying persons, their relation with the

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deceased, and at least two identification marks of each of them and take their signatures. Have two witnesses with you to sign, preferably other bystanders or relatives of the deceased. Avoid your own staff as witness.
- Write down the history given by the relatives verbatim.
- Record at least two identification marks of the dead body.
- Declare the death after careful examination and auscultation for at least 5 minutes and if possible, electrocardiograph (ECG) recording may be taken.
- In case of any suspicion, do not hesitate to inform the police and ask them to take necessary action.
- In case the deceased is known and under your treatment for a terminal illness, you may give a death certificate.
- Keep your OPD record carefully. The investigating officer may ask for a copy or you may have to attend court as a witness in case of eventuality.

The message is do not avoid attending brought dead cases, be careful with records and examination and cooperate with law whenever necessary.

SETTLEMENT OF BILLS AND RECOVERY OF BILLS

This is again a very difficult situation, and to tackle this situation you need more social, managerial, and manipulative skills rather than medical knowledge. Taking regular advance equivalent to the expected bill on that day is probably the best policy. But when it comes to sudden death or unexpected complications that drain the resources of patient and relatives, the situation arises. Doctors, currently, are at the receiving end of the society for many reasons. They never understand the use of intellectual property and its encashment and always feel that we are taking money unnecessarily. This misconception needs to be removed and it will take time.

So far, as the legal aspect of the recovery and nonpayment of bills is considered, we really have very few options, which are as follows:
- Forgo the bill and forget it once and for all.
- Take an advance cheque for the remaining amount so that some legal option remains with us.
- Reduce the bill, give concessions, etc.
- Use mediators or request acquaintances from both parties to mediate.
- File a civil suit for recovery of the bill which requires an advocate, court fees, and a long waiting period—not really advisable.
- In case, there are previous dues of bill from such patient, you have a right to refuse to see and treat such patient. Exercise this right if necessary.

Ultimately, it is the skill you develop over the years of practice as to how to recover dues or settle the bill.

The doctors should not use harsh words and should never give ultimatums to patient. Stopping or discontinuing treatment for nonpayment of bills as well as keeping the patient waiting, at the door of OT before the operation starts, or asking for advance during the course of surgery is not a good practice. Things work until they are straight forward but once something goes wrong, they bounce back upon you.

Ultimately, all these difficult situations are going to stay and we must learn to live with them, tackle them as nicely as possible, and reduce our stress. My usual advice to my colleagues is,

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"instead *of losing sleep over how to increase footfall at the door of hospital, try to give good care to the patients who have come to you and enjoy a sound sleep".*

CONCLUSION

From the above discussion, one may get scared as to how to practice in future. But these situations do come up very infrequently in a lifetime. The seniors will realize that in decades of practice they have rarely come across such situations. When you face it, it is really very traumatizing. To certain extent, such write-ups help you in tackling such situations, but remember ultimately, it is the situation and your communication skills, your temperament, and the help you get all matter. A few key points to be repeated in conclusion are as follows.

- Try to use your skills to your comfort level. You must know when to stop and define your boundaries. You are not supposed to do something extraordinary or heroic unless the situation demands. Otherwise, routine management is good enough.
- Proper communication and counseling are very important. One must give sufficient time to each and every patient and such communication must be documented well.
- Try to be reasonable in practice. Remember, you are not God and near to God. You are just a simple human being entitled to do something different with human life because of your knowledge, training, and experience. It is important to believe, *"you do not cure patients; you only help them to get cured with the help of your knowledge and armamentarium".*
- Never hesitate to call for help. Prepare your own group as quick responders.
- Always work within the frame of established laws and cooperate with the legal arms as and when necessary.
- Record keeping, be it audio, video, or black and white; it is of utmost importance.

KEY LEARNING POINTS

- Every hospital and every practitioner is going to face difficult situations at least once in a lifetime.
- Be ready to face such situations with all your armamentarium like infrastructure, manpower, documentation, and above all help.
- Share your experience with others and learn from others' experience to subjugate the situation.
- Being totally submissive or overconfident and arrogant is equally damaging.
- Do not hesitate to call for help from colleagues and seniors and at times from police and other legal help.
- Never give importance to adverse publicity and damage to reputation. Remember, public memory is very short and things become normal the second day.
- It is not advisable to get depressed due to the incident, just treat it as collateral damage and proceed in life.
- Always have adequate insurance and indemnity.
- Prepare a uniform statement about the situation and always stick to it.
- Acquire adequate legal knowledge and remain updated.
- Comply with the legal requirements such as registration with authorities, pollution control board, and renew all the licenses in time.
- Keep your medical knowledge updated and use it as and when required.
- Proper communication with the patient and relatives is of utmost importance and spare a definite time for counseling, consent, and other documentation.

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The role of law is forever increasing in medical practice. Although doctors encounter the law at many points in the course of their practice, they generally have grossly insufficient knowledge of its ramifications and tend to make mistakes when faced with a legal challenge. The rapid technological advancements, corporate culture, and some other factors have brought about a sea change in the doctor–patient relationship. New enactments and legislations like Consumer Protection Act 2019, Bhartiya Nyay Sanhita (BNS), POCSO Act, and National Medical Commission have made the scenario even more complicated. Editors sincerely hope this third and latest edition, with about 10 new chapters and recent updates, will be quite useful for doctors to be well versed with updated medicolegal knowledge, and will enable them to practice their profession fearlessly, without the hassle of legal cases slapped on them. This book has been written to fulfill that objective. Editors also hope that, with contributions from more than 70 National and International faculties, this book will be a highly trustworthy comprehensive resource in medicolegal subject globally.

Satish Tiwari MD(Pediatrics) LLB FIAP is a Professor of Pediatrics, Founder President, Indian Medico-Legal and Ethics Association, and Founder Secretary, Medicolegal group of IAP. He is a believer in moral, ethical, and human values in medical practice. He is promoter and strong supporter of improving doctor–patient relationship and communication skills among various stake holders in healthcare delivery system. He is not only "doctor friendly" but also "patient friendly" in cases of medicolegal issues involving doctor–patient relationship. He is a regular contributor to various national/international journals and books on subjects related to medicolegal issues, human milk banking, child nutrition, breastfeeding, junk foods, etc.

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