

'ACCIDENTS, PRECAUTIONS & EMERGENCIES' PROTOCOL – FOR DOCTORS AND HOSPITALS

'APE' Protocol is a pioneering effort of Institute of Medicine & Law in the service of the medical fraternity. It is regularly updated and freely accessible on the Institutes website – www.imlindia.com.

'APE' Protocol is designed to remain incomplete. It needs to be regularly updated. New problems in new areas and new solutions will keep on coming in both medicine and law and newer 'do's' and 'don't' will have to be formulated to effectively deal with them. You are expected to keep on updating your own 'APE' Protocol whenever you come across something new.

You can also email such new precautions at apeprotocol@imlindia.com so that it can be put on the website and made available to the entire medical fraternity.

1. Precautions - General

1.1. Qualifications

- ✓ You must have qualifications recognized by the Medical Council of India (MCI) to practice medicine.
- ✓ Display as suffix to your name on letterheads, signboards, etc., only recognized medical qualifications.
- × Don't practice in a branch of medicine without having statutory prescribed qualifications relevant to that branch.
- × Don't claim to be a specialist unless you have recognized qualification of that specialty.

1.2. Registration

- ✓ You must be registered with any of the state medical councils or MCI.
- ✓ Display your registration number accorded by the medical council —
 - on all prescriptions, certificates, bills, money receipts; and
 - at the clinic/consulting room/hospital.
- You can practice only in the state in which you are registered.

1.3. Fees

- ✓ You are within your rights to —
 - fix your fees,
 - charge different fees for different types of services, or
 - give concessions.
- ✓ Convey the amount of fees in advance.
- ✓ Display schedule of fees at a conspicuous location in the clinic/hospital.
- ✓ Take adequate deposit before admitting a patient.
- ✓ Raise bills periodically/daily in IPD patients and ensure that payments are actually made.

- ✓ You can recover unpaid fees only by filing a civil suit.
- × Doctors employed by the government shall not accept any fee directly from the patient.
- × Don't charge more than what has been displayed/stated.
- × Don't correlate fees with cure or charge fees only if the patient gets relief.
- × Don't detain the patient for non-payment of fees.

1.4. Out-of-turn patients

- ✓ You can examine patients out of turn.
- ✓ Accord priority by nature of injury and to emergency cases.

1.5. Procedure beyond skill

- ✓ Practice according to your qualifications, special training (if any) and experience.
- ✓ Practice only in that branch of medicine in which you are properly qualified.
- ✓ Procedures requiring expertise must be performed only by doctors having the requisite expertise.
- ✓ Treating serious emergency patients, complicated cases and patients with rare diseases and performing complicated procedures/surgeries must be in the hands of doctors having longer years of experience.
- × Don't offer, undertake or even attempt treatment beyond competence.
- × Don't perform surgery if not duly qualified to perform that surgery.
- × Don't practice other 'pathies' or prescribe treatment or drugs of other 'pathies.'

1.6. Taking history of patient

- ✓ Ask the patient to fill in his or her handwriting your form that has a detail questionnaire on medical history of the patient.

1.7. Examining a patient

- ✓ At the time of examining a female patient, a male doctor must ensure the presence of another woman.
- ✓ Get patient-related information by physically examining the patient and not merely from medical records.
- ✓ Specifically record wound, abnormality or disfigurement found during the clinical examination of the patient.

1.8. Advising diagnostic procedures/investigations

- ✓ Advice appropriate investigations —
 - when indicated;
 - neither early nor late;
 - justified by the science of medicine;
 - solely in the interest of the patient;
 - to confirm diagnosis, especially before starting sensitive drugs; or

- in cases of patients having known history of asthma, diabetes, etc.
- ✓ Rule out pregnancy before advising x-rays of uterus/abdomen in women.
- ✓ In case of doubts, repeat investigations without the slightest hesitation.
- ✓ After getting investigation reports,
 - read investigation reports properly,
 - correlate investigation reports *inter se* as well as with clinical findings,
 - consult the radiologist/sonologist/consultant in case of any doubt,
 - duly record findings in medical records
 - act promptly, and
 - preserve investigation reports.
- ✓ If the investigation report is not produced within the stipulated time,
 - enquire with the patient; and
 - record noncompliance in medical records along with reasons given by the patient for noncompliance, if any.
- ✓ Whenever scans/films/x-rays are handed over to the patient,
 - check whether reports have been duly recorded in the patient's medical records,
 - record the date and time of handing over,
 - ensure that it is handed over to the patient or to a person duly authorized by the patient,
 - get a proper receipt from the person who receives, and
 - preserve this receipt in the patient's medical records.

1.9. Legible handwriting

- ✓ Prescriptions, case papers, orders, medical records must be written in legible handwriting.

1.10. Prescription

- ✓ Write prescriptions on letterheads (either printed stationery or a rubber stamp put on simple paper) only.
- ✓ Letterheads must have your —
 - name;
 - recognized qualifications;
 - titles, if any;
 - name of your specialty; and
 - registration number with name of the state medical council or MCI.
- ✓ Record in prescriptions —
 - complaint of the patient,
 - history,
 - symptoms,
 - vitals,
 - diagnosis (provisional/final),
 - investigations,

- treatment,
 - other directions and precautions,
 - the manner in which each of the medicines must be taken and frequently occurring side effects,
 - if the drug is a poison, and
 - affix your signature with date and time.
- ✓ Clearly state if you have dispensed any medicine.
 - ✓ Prescribe drugs by their proprietary formulae as well as generic names.
 - ✓ Doctors practicing in government hospitals, where the patient-load is heavy, can merely write their name below the signature on the prescription.
 - × Don't prescribe on plain paper or telephone except in emergencies.
 - × Don't write anything in codes or unfamiliar short forms.
 - × Don't prescribe without conducting necessary tests to confirm diagnosis.

1.11. Drugs

- ✓ Prescribe drugs rationally.
- ✓ Use of drugs must be limited and judicious.
- ✓ Advice requisite investigations to confirm diagnosis, especially before starting sensitive drugs.
- ✓ Take contraindications into account before prescribing. Record reason, if any, for advising a contraindicated drug.
- ✓ Ensure that the patient is not pregnant by recording LMP before prescribing drugs that are contraindicated in pregnancies.
- ✓ Prescribe drugs by their proprietary formulae as well as their generic names.
- ✓ Duly inform the patient and give adequate directions about —
 - side effects, if any;
 - dose, mode and time of taking the drug;
 - food, alcohol, etc., that should be avoided; and
 - other precautions that need to be taken.
- ✓ Continuously monitor and regulate dosage, especially of sensitive drugs or drugs having serious side effects.
- ✓ Change or discontinuation of drugs requires extra care and proper justification. Specifically record the reasons for the same.
- ✓ Specifically inform the patient and record about drugs that have to be tapered and should not be stopped suddenly.
- ✓ Inform the patients about drugs that have to be taken in case of an emergency, its dose, precautions, etc.
- ✓ In case of drug reaction, take appropriate remedial steps immediately.
- ✓ Purchase medicines having a late expiry date.
- ✓ Stock drugs of standard quality only.
- ✓ You can supply drugs, remedies and appliances to your patients only.

- ✓ Avoid drugs and treatment protocols that are not easily available in India.
- ✓ Avoid drugs and treatment protocols that are still in experimental stages.
- ✓ Hospitals must duly stock drugs required in emergencies.
- ✓ Life-saving drugs must always be available in Operation Theatres (OT).
- × Don't prescribe steroids/psychotropic drugs in the absence of medical indications.
- × Don't sell Schedule 'H' and Schedule 'L' drugs (under Drugs and Cosmetics Act, 1940) and poisons to public.
- × Don't run an open shop for sale of medicine or of medical or surgical appliances prescribed by other doctors.

1.12. Prognosis

- ✓ Always give guarded prognosis.
- × Don't exaggerate or understate the patient's condition.

1.13. Consultations/second opinion — precautions for the referring doctor

- ✓ Advise consultations —
 - only in the patient's interest;
 - in doubtful or difficult conditions; or
 - in case of request from the patient. Specifically record this fact.
- ✓ Taking advice from consultants on telephone is acceptable in case of emergency.
- ✓ Explain to the patient, frankly and impartially, any irreconcilable difference of opinion with the consultant. The patient can be advised to seek further advice in such situations.
- ✓ Make subsequent variations in the treatment advised by the consultant only if any unexpected change occurs; but at the next consultation, reasons for the variations should be explained/discussed with the consultant.
- ✓ Take suitable care and provide treatment to the patient even if he/she has been referred to another doctor.
- × Don't delay in advising consultations when indicated.
- × Don't advise unnecessary consultations.
- × Don't advise consultations in a routine manner.
- × Don't reveal to the patient minor differences of opinion amongst doctors.

1.14. Consultations/second opinion — precautions for consultants

- ✓ Remain punctual.
- ✓ Visit the patient at requisite intervals and also when the condition of a patient is serious or worsening.
- ✓ Duly record that you have referred to diagnostic/investigation reports.
- ✓ Convey opinion in writing to the attending physician.
- ✓ All consultants involved in treating a patient must try to have face-to-face consultations, one-on-one or in a group, rather than referring to each other's notes in medical records.

- ✓ The first examination of a patient after admission, especially in an emergency, must be carried out at the earliest.
- ✓ Request another qualified consultant to attend an emergency patient if you are unable to attend within reasonable time.
- ✓ Give directions on phone if unable to reach the patient in an emergency. Record the reasons for doing so; and at the first opportunity, examine the patient and duly record this fact also.
- ✓ Prescribe medicines only in case of emergency or when specifically requested by the referring doctor.
- ✓ Discuss the diagnosis and treatment plan with the referring physician and not with the patient.
- ✓ Consultant's statement to the patient after consultation must be made in the presence of the consulting physician.
- × Don't leave a dying/serious patient unless absolutely necessary and absence at such a crucial junction can be justified.
- × Don't discuss or reveal minor differences of opinion to the patient, but any irreconcilable differences of opinion with the referring doctor can be disclosed.
- × Don't criticize the referring doctor in any way, especially about his professional skills, in front of the patient.
- × Don't take charge of the case.
- × Don't indulge in insincerity, rivalry or envy.

1.15. Communication with patients

- ✓ Guarantee care and not cure.
- ✓ Listen patiently.
- ✓ Be sympathetic.
- ✓ Be frank.
- ✓ Inform the patient well in advance about your absence.
- ✓ While communicating with the patient or the patient's relatives,
 - exchange patient-related information,
 - involve relatives of the patient in the treatment, and
 - keep relatives of the patient properly and regularly informed.
- ✓ Speak local language, if possible.
- ✓ Accept mistakes honestly, offer sincere apologies and show repentance for any untoward incident.
- ✓ Always give a minimum level of respect even to a patient who may have initiated legal proceedings against you, and maintain decorum while dealing with such patients too.
- × Don't assure patients of specific results or complete cure.
- × Don't enter into arguments with patients.
- × Don't give assurance to a patient that he/she would receive treatment exclusively from a particular doctor if it is not possible to fulfill it.
- × Don't speak about differences of opinion among doctors in the presence of patients unnecessarily

- × Don't confront irritated patients or relatives. Wait for an appropriate opportunity to clear misunderstanding or any grievance.
- Good communication and good rapport with the patient and his/her relatives reduce risk of litigation by 80%.

1.16. Professional colleagues

- ✓ Communicate and exchange information about the patient.
- ✓ Communicate with the previous doctor/s of the patient in case of any problem rather than making loose comments.
- × Don't criticize professional colleagues in front of patients.
- × Don't blame or find fault with the treatment or diagnosis of another doctor.
- × Don't accept professional fees from doctors and their immediate family and dependants.

1.17. Update knowledge/Continuing Medical Education (CME)

- ✓ Get regularly updated about the latest developments in medicine, worldwide, at least in the field in which you specialize.
- ✓ Keep yourself updated with recent medical literature.
- ✓ Participate in CMEs, for at least 30 hours every 5 years.
- ✓ Make your knowledge available to patients and colleagues.

1.18. Red cross

- ✓ The symbol of red cross can be used only by members of medical service of any army.
- × Don't use it on letterheads, visiting cards, hospitals.

1.19. Advertisement

- ✓ You can make a formal announcement in press —
 - on starting practice,
 - on change of type of practice,
 - on changing address,
 - on temporary absence from duty,
 - on resumption of another practice,
 - on succeeding to another doctor's practice, or
 - for public declaration of charges.
- ✓ You can advertise about —
 - new procedures or machines or
 - the disease intended to be cured.
- ✓ You can print sketches, diagrams, pictures of the human body systems on —
 - letterheads and
 - signboards.

✓ Medical institutions for a particular purpose (maternity home, nursing home, private hospital, rehabilitation center, any type of training institution, etc.) can advertise —

- the name of the institution,
- type of patients admitted,
- type of training and other facilities offered, or
- structure of fees.

✓ Hospitals inserting a public advertisement about professional services must ensure that they can deliver what is being promised.

× Don't write degrees and qualifications that are not recognized by the MCI on your letterheads, signboards, etc.

× Don't advertise that you can cure a disease.

× Don't make false claim of availability of round-the-clock emergency service.

× Don't solicit patients directly or indirectly.

× Don't make use of your name in any form of advertising or publicity.

× Don't give any approval, recommendation, endorsement, certificate, report or statement with your name as the issuing person, signature or photograph in any form of advertising.

× Don't boast about or permit the publication of reports of cases, operations, cures or remedies.

× Don't print your own photograph on letterheads or signboards.

1.20. Signboards

✓ Must be of normal size;

✓ Can include —

- name,
- recognized qualifications,
- titles,
- name of your specialty, or
- registration number (including name of the state medical council that has allotted the number);

× Must not be affixed at any location in a chemist's shop;

× Must not be affixed in places where you do not reside or work.

1.21. Media exposure

✓ You can write articles, deliver public lectures, give talks on radio/TV, and chat on the internet on matters concerning public health and hygienic living.

✓ You can comment on medical subjects for creating public awareness.

✓ You can reveal your identity only when involved in media activities primarily aimed at doctors.

✓ You can use your own name in connection with subjects other than medicine.

× Don't contribute press articles and give interviews regarding diseases and treatments, which have the effect of advertising yourself or soliciting practice.

× Don't publicly discuss your own ability in a particular field so as to imply that your methods are superior to those of other doctors.

1.22. Legal compliance

- ✓ Take efforts to know laws, especially those directly affecting medical profession.
- ✓ Observe and enforce sanitary laws.
- × Don't assist others to evade law.

1.23. Registration of births and deaths (Registration of Births and Deaths Act, 1969)

- ✓ Every hospital and doctor (even midwives) must give information
 - about death, birth and still-birth,
 - to the Registrar (usually local municipality or panchayat),
 - in the prescribed form, and
 - within 21 days.

1.24. Biomedical waste — Biomedical Waste (Management and Handling) Rules, 1998

- These rules apply to all persons who generate, collect, receive, store, transport, treat, dispose or handle biomedical waste in any form.
- ✓ Know what type of biomedical waste is generated in your clinic/hospital and how it has to be disposed.
- ✓ Train your staff to handle biomedical appropriately.
- ✓ Biomedical waste should be stored, transported, treated and disposed in accordance with prescribed standards.
- ✓ Biomedical waste should be handled so as not to have any adverse effect on human health and the environment.
- ✓ Biomedical waste should be segregated in containers/bags at the point of generation.
- ✓ Containers containing biomedical waste must be labeled.
- ✓ You should use different types of containers/bags with prescribed color codes for different categories of biomedical waste.
- ✓ You should transport all biomedical waste in authorized vehicles only.
- ✓ You should set up your own biomedical waste treatment facility or ensure treatment of biomedical waste at an authorized biomedical waste treatment facility.
- ✓ Organizations providing treatment/service to more than 1,000 patients per month must make an application to the prescribed authority for grant of authorization.
- ✓ You should maintain records relating to generation, collection, receiving, storage, transportation, treatment, disposal and/or any form of handling of biomedical waste.
- ✓ Autoclaving, microwaving, incinerating, deep burial, treatment and disposal of biomedical waste must be in accordance with the prescribed standards.
- ✓ Devise and follow protocols in case of emergencies like accidental spills, delay in disposal or treatment, etc.

- × Don't mix biomedical waste with other wastes.
- × Untreated biomedical waste must not be stored beyond a period of 48 hours without obtaining permission of the prescribed authority.

1.25. Insurance

- ✓ Get proper insurance cover.
- ✓ Ensure that your policy is in continuity and is always renewed well before expiry.
- ✓ Fill insurance forms correctly and preserve a photocopy thereof.
- ✓ Make sure that you receive the original insurance policy document.
- ✓ Check the original insurance policy document and ensure that all the details mentioned therein are correct.
- ✓ Preserve the original insurance policy document after it has expired for a few years. An accident that may have occurred during the policy period may lead to a legal proceeding even after a few years.
- ✓ Inform the insurance company in writing and also send copies of any legal notice, summons, courts notice, etc. received by you along with copy of your policy. Duly preserve their acknowledgment of receipt.
- ✓ Ensure that your claim is registered and procure your claim number.
- ✓ Hospitals owned by doctors must have an 'Errors and Omission Policy' other than the 'Professional Indemnity Policy' of the owner-doctor.
- Insurance Company is liable to pay even in case of an out-of-court settlement.

1.26. Tele-medicine and cyber medicine

- Tele-medicine stands for 'medical practice across distance via telecommunications.'
- Cyber medicine stands for 'medical practice across distance via website or by e-mail.'
- Their legal status in India is not clear.
- Confidentiality is absent.
- × Don't prescribe over telephone.

2. Precautions – Consent

2.1. Consent — general precautions

- ✓ Take consent of conscious, well-oriented adult patients only.
- ✓ Take the patient's consent rather than not taking one if in a dilemma.
- ✓ Communicate to and counsel the patient in the language he/she understands.
- ✓ Provide all relevant information to the patient —
 - possible complications,
 - prognosis,
 - time required for recovery,
 - all the available 'acceptable' methods and their respective advantages and disadvantages,

- estimated cost of treatment.
- ✓ Ascertain whether there are any procedures/treatments to which the patient would object or on which the patient would prefer to give further thought.
- ✓ Consent must be in writing signed by the patient.
- ✓ The patient must be free to take decisions.
- ✓ Honor the patient's decision.
- ✓ Take consent of the patient in advance for extended procedure(s) that anticipated additional problems would warrant as the patient would probably be unconscious or otherwise be unable to make a decision.
- ✓ Take elaborate and specific consent for technique/medicine/protocol that are —
 - experimental,
 - new,
 - risky,
 - complicated,
 - capable of effecting sexual capacity or fertility, or
 - cosmetic in nature.

Getting two independent witnesses for such consent is advisable.
- ✓ Specifically record the fact that the patient disagrees or seeks further time to consider an option.
- ✓ Refusal to consent must also be duly recorded with proper time and date; signed by the doctor, the patient and the witnesses.
- × Don't take blanket consent for unspecified procedures, especially at the time of admission.
- × Don't reduce the act of getting consent to a mere formality or routine.
- × Don't apply any kind of pressure or coercion or create fear in the mind of the patient or indulge in fraud, or misrepresentation of facts.
- × Don't take consent from relatives or attendants except in emergencies or in cases of incompetent patients.

2.2. Consent form

- ✓ Consent forms must —
 - be filled by one doctor/nurse, in one sitting and, if possible, without changing the pen;
 - have blank space where name and description of the specific procedure must be handwritten;
 - preferably be filled in the language understood by the patient;
 - have a specific clause authorizing the doctor to switch over to any alternative procedure/surgery during the course of the agreed procedure/surgery according to his/her judgment and the situation;
- ✓ Consent forms must clearly record the following:
 - Nature of the patient's illness or injury
 - Procedure or treatment consented to by the patient
 - Nature and purpose of the proposed treatment
 - Inherent and special risks, known side effects, possible complications
 - Probable consequence of the proposed treatment

- Probability that the proposed treatment will be successful
 - Each alternative procedure that is contemplated and risks and benefits associated with it
 - Risks and prognosis if no treatment is rendered
 - The time required for recovery
 - Name(s) of surgeon(s) and anesthetist(s)
 - Signatures of the patient, doctor and witnesses
 - Date and time the consent is signed
- ✓ In problematic patients or in very complicated cases, if possible, two witnesses must attest the fact that complete information was given to the patient in the language understood by the patient, and further attest that the patient has consented.
- ✓ Take thumb impression of the other hand of the patient on the consent form if the patient is unable to sign the consent form with the hand that he/she usually uses to sign, in the presence of two witnesses, and specifically record the aforesaid fact.
- × Do not insert any 'exonerating clause' as it is inconsequential.

2.3. Risk information

- ✓ Inform the patient about —
- the 'material risk' involved,
 - risks of above 10% in a particular treatment/procedure,
 - risks if the patient specifically asks about the same, and
 - rare risks if the consequences are serious.

2.4. Unplanned, unforeseen extension during procedure/surgery

- ✓ Scope of the original consent can be expanded in unplanned, unforeseen emergency circumstances when —
- the patient is not in a position to give consent;
 - condition of the patient leading to extension could not have been diagnosed prior to treatment;
 - it is in the area of the original treatment/procedure/incision;
 - there is no indication that the patient would not consent to the extended procedure;
 - it is necessary to save the life or preserve the health of the patient;
 - it would be unreasonable to delay such extended procedure.
- ✓ Record the internal condition of the patient in intraoperative notes if the same warrants extension of the procedure/surgery to which the patient has consented.
- ✓ Take consent of the patient in advance for extended procedure(s) that anticipated additional problems would warrant as the patient would probably be unconscious or otherwise be unable to make a decision.

2.5. Consent in emergency

- ✓ If a patient is unable to give consent, then —

- take consent of the patient's relative/friend or the accompanying person, if available;
 - proceed without waiting for consent if no one is available to give consent at the relevant time and the case demands urgent intervention;
 - transfuse blood without consent except in cases where the patient has given advance directives prohibiting blood transfusion.
- ✓ Action taken must be such as a reasonable person would in all circumstances take in the 'best interests' of the emergency patient and which is judged to be the best in that emergency situation.
- ✓ Take consent from the Administrative Medical Officer or Medical Superintendent, especially in government hospitals.

2.6. Consent in cases of minors

- ✓ Below 12 years — consent of guardian only
- ✓ Between 12 and 18 years — consent of both guardian and the patient
- ✓ Above 18 years — consent of patient only

2.7. Consent in cases of incompetent patients — Proxy consent

- Following persons are considered incapable of consenting:
 - Minors (below 18 years of age)
 - Mentally unfit patients
 - Those under influence of alcohol or drugs
 - Unconscious patients or those under sedation
- Following persons can act as a legal guardian of an incompetent person:
 - Father
 - Mother
 - A relative
 - A friend
 - A court-appointed guardian
 - Accompanying person(s) (in case of unconscious patient/patient under influence of alcohol or drugs)
- A guardian's right of control exists only for the benefit of the patient.
- ✓ Take consent of the legal guardian, only if the patient is legally considered incompetent.
- ✓ If there is disagreement between parents, consent of one of the parents is valid.
- ✓ In case a patient is mentally unfit, insist on certification by his/her psychiatrist.
- ✓ Clearly record the reasons for taking proxy consent.

2.8. Consent for intervention/procedure/surgery

- ✓ Express consent is necessary for all interventions/surgeries/procedures.
- ✓ Take consent at a date near the date fixed for intervention/procedure/surgery.
- ✓ Disclose identity of the surgeon and anesthetist if other than the attending doctor.
- ✓ Take specific and separate consent

- for each and every intervention/procedure/surgery,
 - for epidural/general/local/spinal anesthesia,
 - if postoperative care is to be managed by another consultant or hospital,
 - of both husband and wife if intervention/procedure/surgery may result in sterility.
- ✓ Inform the date and time of elective procedure/surgery to the patient well in advance.
- ✓ Specifically record time of advising surgery/procedure in emergency/serious patients, especially if there is any delay on the part of the patient to give consent.

2.9. Consent for family planning procedures

- ✓ Specifically inform that family planning operations are not 100% successful and record the fact that you have informed this to the concerned couple.

2.10. Consent when sterility is anticipated

- ✓ Taking consent of both husband and wife is necessary if operation may result in sterility.

2.11. Consent for clinical examination of living persons for medicolegal purpose

- ✓ Before conducting examination, take express consent of the patient or his/her guardian.
- ✓ In case of an unconscious patient unable to give consent,
- carry out necessary clinical examination;
 - don't give report to anyone, least of all, the police;
 - obtain a valid consent retrospectively.
- ✓ In civil cases, consent is absolutely necessary.
- ✓ Exception — A person accused of, and arrested for, a criminal offence —
- can be examined without consent or
 - can be examined even by force.

In such cases, however, insist on a copy of FIR/arrest memo.

2.12. Consent for medical termination of pregnancy

- ✓ Consent only of the woman (above 18 years of age) is required.
- ✓ In case of minors and lunatics, consent of the guardian is required.
- Even husband's consent not required
 - No proof of age required — a mere formal declaration in writing by the woman is sufficient

2.13. Consent for assisted reproductive techniques

- ✓ Take informed consent of the recipient and the donor —
- after duly counseling and
 - in writing.
- ✓ In case of donor,
- take written consent for unrestricted use of sperm or eggs and
 - insist on written consent of spouse in case of a married donor.

- ✓ Record specifically the fact that the couple has been counseled.

2.14. Consent in cases of transplantation of human organs

- ✓ Ascertain before removing organs that —
 - it is not against the expressed wish of the donor,
 - a valid consent of the donor's near relatives is obtained, and
 - the donor is clinically dead.

2.15. Consent in cases of blood transfusion

- ✓ Take separate and specific consent —
 - in writing; and
 - of both the recipient and the donor.
- ✓ Take consent for transfusion of blood for all surgeries/procedures along with the consent for the surgeries/procedures, rather than not taking it.
- × Do not transfuse blood in any circumstances (even if it may prove to be fatal) in patients who have given advance directives prohibiting blood transfusion.

2.16. Consent in cases of managed health care

- 'Employer or the government or the health insurer pays the bill and not the patient.
- You may have to take prior approval for —
 - fees or
 - a particular procedure.
- There is constraint on both the patient's discretion and the choice available to doctors.
- ✓ Disclose to the patient all 'restrictions' before accepting to treat the patient. Duly record the same.
- ✓ Disclose and record after diagnosis, all options of medical care, even the ones which are outside the purview of managed health care.

2.17. Refusal to consent/compulsory treatment

- A competent patient has the right to refuse treatment.
- Controversy — 'whether a Gillick child (between 12 and 18 years) who has a right to give consent for a treatment also has a right to refuse it.' Refusal requires a higher level of maturity.
- Incompetent patients retain their right of refusal through their guardian.
- Even prisoners have the right to refuse treatment.
- ✓ First, try to understand the reasons for refusal; thereafter, persuade.
- ✓ Take help from family members.
- ✓ Be extra alert in controversial procedures like abortion, sterilization, psycho-surgery.
- ✓ Record specifically the patient's refusal, especially when the consequences are likely to be fatal.
- ✓ Release form must be executed by the patient.
- ✓ You can refuse further treatment in case of refusal to consent.
- × Don't coerce to give consent.

- × Don't get frustrated or irritated.
- × Don't take refusal as a personal insult.

2.18. Advance directives or living wills

- There is a marked distinction between —
 - 'let nature take its course' (advance directives or living wills) and
 - choice to commit suicide (refusal to consent).
- Under the above, preferences can be expressed by patients about treatment in anticipation of mental incapacity or terminal illness. Even a proxy decision maker can be appointed through a power of attorney by the patient to take decisions at such time.
- A living will should be dated and signed by two witnesses who are not blood relatives of the patient or beneficiaries of the property.
- Generally about life-sustaining procedures
- In India usually, 'do not resuscitate' (DNR) instructions are given.
- Invasive procedure inspite of such directives would amount to battery.
- ✓ Always keep a copy in the patient's case papers/medical records.

3. Precautions - Confidentiality

3.1. Confidentiality — general precautions

- ✓ Make every effort to maintain confidentiality.
- ✓ Inform public health authorities immediately in case of communicable/notifiable diseases.
- ✓ In case of an insurance company seeking information about a dead person, take consent from the nearest relative, heirs or legal representatives.
- ✓ Instruct hospital staff not to disclose any information about the patients illness, diagnosis or treatment to anyone.
- × Don't divulge information of competent adults to anyone — not even to their parents, spouses or guardians.
- × Don't publish photographs or case reports of patients without their permission, especially if it discloses their identity.
- × Don't give medical records of a patient even to another doctor or hospital without express written consent of the patient.

3.2. Medicolegal reports

- ✓ Medicolegal reports are absolutely confidential.
- ✓ Transmit carefully only to the requesting authority.
- ✓ In case of any request for a copy of the report by a person or an organization other than the requesting authority:
 - Such request must be directed to the requesting authority.

– Any other person or an organization can be given a copy of the report only after receiving a clear written direction from the requesting authority.

3.3. Blood donation

✓ Maintain confidentiality about the donor.

3.4. HIV/AIDS patients

✓ Take special efforts to maintain higher degree of confidentiality.

✓ Maintain medical records separately and keep them secure.

✓ Keep AIDS diagnosis confidential.

✓ Try to get the patient's consent to disclose this fact to his/her partner. In spite of refusal, inform the sexual partner.

✓ Share medical records with other health professionals strictly on a need-to-know basis.

✓ Report to appropriate authorities.

× Don't disclose identity of the patient to public.

3.5. Exceptions

✓ Disclosures are permitted in the following circumstances:

- Consent of the patient
- Orders from court of law
- In criminal investigations
- To health care professionals working with the patient
- In cases of communicable diseases, gunshot wounds, child abuse, etc.
- In public interest
- For the purpose of research, statistical evaluation and education — exact identity of the patient must not be disclosed
- When assessing a patient on behalf of an insurance company or an employer — written consent of the patient must preferably be taken
- When assessing a patient under managed health care — written consent of the patient must preferably be taken

● Doctors (unlike advocates) do not have any privilege of not disclosing in a court of law professional secrets obtained from, or communicated by, the patient in the course of examination or treatment.

● Disclosures made pursuant to orders of court — you are immune from arrest or prosecution.

4. Precautions – Surgery/Procedure

4.1. Surgery/Procedure — general precautions

✓ Record completely and properly preoperative, intraoperative and postoperative notes.

✓ Write, note down, record the events as they unfold and not otherwise, except in emergencies.

✓ Record reasons, if any, for performing surgery/procedure in haste for bona fide reason(s).

× Do not perform a surgery/procedure merely because the patient insists.

4.2. Pre-surgery/Pre-procedure

- ✓ Take all necessary precautions in advance.
- ✓ Ensure that the hospital/OT has all the equipments, expertise and doctors necessary to perform the surgery/procedure.
- ✓ Ensure that there are emergency arrangements and management options in place, as also equipments and doctors, to meet any apprehended complications that may arise.
- ✓ Carry out adequate and requisite preoperative investigations and duly record the results and reports in preoperative notes.
- ✓ Ensure that mandatory investigations like HIV, HCV, HBsAg, have been performed and the results and reports are duly recorded in preoperative notes.
- ✓ Perform fresh preoperative tests where a patient is re-admitted for surgery after discharge.
- ✓ Take consent, especially to treat anticipated problems. Before you proceed, ascertain whether there are any procedures to which the patient would object or prefer to give further thought.
- ✓ Take specific consent if postoperative care is to be provided at another hospital or by another doctor/surgeon. Specify the name of the other hospital/doctor/surgeon, if possible.
- ✓ Explain during pre-surgery counseling that merely wheeling of the patient into the OT is not commencement of surgery, and wheeling out of the OT is not the end of surgery. Pre-operative preparations take time. Post-operation, the patient is kept in a recovery room for some time. At times, due to an emergency operation on another patient and consequent non-availability of operation table, the patient may even have to wait for hours inside the OT.
- ✓ Intimate well in advance the date and time to conduct a non-emergency procedure/surgery and duly record this fact.
- ✓ Anticipate complications that may arise and make necessary arrangements, especially in cases of high-risk patients.
- ✓ Make necessary preparations for extended operation period, beyond the estimated time.
- ✓ Keep emergency instruments, like artificial respirator, ready and carry out pre-operation dry run.
- ✓ Exercise special caution in cases of patients having known history of asthma, diabetes, allergies, heart diseases, etc.
- ✓ Record reasons, if any, for deferring a pre-scheduled procedure/surgery.
- ✓ For known complications during procedures/surgeries, consultants of the relevant specialty must be informed in advance and kept in readiness to meet any eventuality. In complicated cases, it is advisable to keep them present in the OT during the procedure/surgery.
- ✓ Ascertain the blood group of the patient.
- ✓ Keep blood in adequate quantity —
 - in complicated cases,
 - during risky procedures,
 - in cases of high-risk patients, or
 - in cases of rare–blood group patients.

- ✓ Send patients blood for grouping and cross matching and procure enough blood if there is a slightest chance of transfusion.
- ✓ Take adequate care for proper administration of oxygen during surgery.
- ✓ Ensure preoperative antiseptic bath and shaving of the patient.
- ✓ Make and preserve preoperative notes.
- × Don't rely upon tests or fitness reports carried out by other doctors.
- × Don't perform an elective procedure/surgery if there is even an iota of doubt on the fitness of the patient. In such cases, procuring a fitness certificate from a physician is mandatory.

4.3. Intra-surgery/Intra-procedure

- ✓ Perform the procedure/surgery on schedule.
- ✓ Record reasons for any deviation from agreed/advised/consented procedure.
- ✓ Record findings like the condition of blood vessels, organs, etc., especially if they are not healthy, in intraoperative notes.
- ✓ After observing the internal condition of the patient —
 - you can revise diagnosis during the course of a surgery/procedure,
 - you can deviate from agreed/advised/consented procedure,
 Explain and take consent of the patient's relatives/friends/attendants before proceeding further , if possible.
 Specifically record the said observations in intraoperative notes (See 'Extension Doctrine')
- ✓ Draw neat and proper diagram wherever necessary.
- ✓ Record procedures, especially endoscopic and microsurgical, and store digitally, if possible.
- ✓ Take and preserve photographs of the patient taken before and after the procedure in plastic and cosmetic surgery.
- ✓ Specifically record in sterilization operations whether you have observed any signs of earlier sterilization (cash incentive by the government is the temptation for second attempt).
- ✓ Specifically record even unrelated observations that may have bearing on the future management of the patient.
- ✓ Record estimated blood loss.
- ✓ If the surgery/procedure is taking unusually long time,
 - send someone from inside the OT to explain the delay to the patient's attendants and
 - specifically record the reasons for the delay in operation notes.
- ✓ Follow standard protocols during intervention, especially the ones that are meant to minimize incidents of leaving foreign body in the patient.
- ✓ Ensure before closing that there are no instruments, gauzes or foreign bodies left inside the patient's body.
- × Don't exceed the procedure that has been agreed/advised/consented even if there may be a temptation to do so on the operation table except in unforeseen emergencies.
- × Don't explore further in cases where the surgery/incision is predetermined as per x-ray/CT/MRI findings and if the abnormality is perchance not found at the predetermined area. Instead, after

repeating investigations to confirm the location of the diseased area, a fresh surgery may be scheduled.

4.4. Post-surgery/Post-procedure

- ✓ Sit for at least a few minute and carefully see if everything has been recorded properly after completing a procedure/surgery.
- ✓ Count swabs, gauzes, needles, mops, sutures, instruments, etc., after every procedure/surgery.
- ✓ Leave the patient only after he/she has clinically stabilized.
- ✓ Make all the necessary arrangements before leaving the patient.
- ✓ In case any organ/cyst/tumor/aspirated fluid, especially a healthy organ, is removed from the patient's body,
 - show the same to the patient,
 - take acknowledgment,
 - send the same for histopathological examination, and
 - preserve this acknowledgment as well as the pathological report in the patient's medical records.
- ✓ Take prompt action at the first sign of infection or to correct post-procedure complaints/complications.
- ✓ Transfer the patient promptly in case of —
 - complications which can be treated more appropriately by another hospital or
 - a request from the patient or his/her attendant/relative.
- ✓ Make and preserve postoperative notes.
- ✓ Take requisite steps for ascertaining the result of surgery/procedure wherever possible.
- ✓ In case any foreign body is left inside the patient's body, immediately inform the patient and make efforts to remove the foreign body at the earliest.
- ✓ Specifically and properly advice postoperative care and precautions and monitor regularly.
- ✓ Record failure of the patient to follow post-discharge advice and precautions.
- × Don't leave the OT immediately after surgery without the patient stabilizing.
- × Don't delay in attending to post-surgery complications.
- × Don't delay in referring the patient to appropriate facility, if indicated, in case of post-procedure complications.
- × Don't certify or give an impression or announce that a particular surgery/procedure has been successful until and unless you are 100% sure.
- × Don't have a casual approach during postoperative care.

4.5. Anesthesia

- ✓ Visit the patient a day or at least a few hours before the surgery/procedure and physically examine the patient for any abnormality rather than merely discussing with the consulting surgeon and/or referring to the case papers.
- ✓ Take history of patient for allergies and whether the patient had undergone any procedure with anesthesia.

- ✓ Take specific and separate consent for epidural/general/local/spinal anesthesia.
- ✓ Follow standard routine for pre-anesthetic evaluations.
- ✓ Conduct preoperative test to ascertain whether the patient can bear anesthesia.
- ✓ Perform sensitivity test before giving anesthesia.
- ✓ Ensure that all standard monitoring devices are present and in working condition before the patient is anesthetized.
- ✓ Approach induction of anesthesia keeping in mind the possibility that the patient will be unexpectedly difficult to intubate and with a clear plan of action.
- ✓ Record distinctly and accurately pre-, post- and intra-anesthesia notes.
- ✓ Record the names of drugs as well as their doses and time of administration to the patient.
- ✓ Visit the patient in early post-operation period and once after complete recovery.
- × Do not proceed with anesthesia if even in the OT any abnormality is found in the patient for which requisite arrangements are not present.
- × Do not proceed with anesthesia until everything is in place.

4.6. Blood transfusion

- ✓ Take separate and specific consent for transfusion of blood, if anticipated.
- ✓ Take consent for transfusion of blood for all surgeries/procedures along with the consent for the surgeries/procedures, rather than not taking it.
- ✓ Procure blood from blood banks run by qualified persons and having the requisite license.
- ✓ If there is probability that patient may require blood transfusion —
 - request for blood in advance,
 - send patients blood for grouping and cross matching,
 - procure enough blood before starting procedure/surgery.
- ✓ Preserve copies of certificates certifying that the mandatory testing of blood has been done by the blood bank in the medical records of the patient.
- ✓ Check expiry date before administration.
- ✓ Transfusion must be done by a qualified, experienced doctor.
- ✓ You can rely upon certificates of blood banks.
- × Don't transfuse blood in patients who have given advance directives prohibiting blood transfusion.

5. Precautions - Hospitals

5.1 Hospitals — general precautions

- ✓ Have valid and subsisting requisite licenses from statutory authorities.
- ✓ Obtain valid consent from, and provide proper counseling to, the patient before admission.
- ✓ Maintain confidentiality.
- ✓ Ensure that accidents/errors are immediately reported.
- ✓ Preserve copies of certificates certifying that the mandatory testing of blood has been done by the blood bank in medical records

- ✓ Procure drugs and consumables of standard quality and from reputed vendor/company
- ✓ Make all the requisite arrangements in terms of medicines, doctors, nurses, etc., in transferring a patient
- ✓ Lifesaving drugs must always be present in OT
- ✓ Inform police in suspicious cases.
- ✓ Store poisonous drugs under lock — release only when prescribed in writing by the attending doctor.
- ✓ Obtain and preserve in the records name, permanent address, contact number, etc., of all the members of medical, paramedical and nursing staff, especially those present during a medical mishap so that they can be produced in court as your witness in legal proceedings.
- ✓ Register, if applicable, under statutes like Medical Termination of Pregnancy Act, Transplantation of Human Organs Act, etc.
- ✓ Try to have a functional in-house 'Patients Grievance Redressal Cell'.
- × Don't admit or treat any patient without requisite infrastructure, expertise and staff.
- × Don't give any assurance to a patient that he/she would receive treatment exclusively from a particular doctor if it is not possible to fulfill the same.
- × Don't refuse requests of patients for opinion/visit/consultation of another doctor.
- × Don't take the name of the patient whenever emergency announcement is being made on a public announcement system calling doctors for help.

5.2. Admitting patients

- ✓ Admit a patient only if there are emergency arrangements and management options in place, as also equipments and doctors, to meet any complications that may arise during the course of treatment.
- ✓ Anticipate all future complications before admitting a patient. Ensure that necessary equipments, expertise and doctors necessary are readily available.
- ✓ Specifically record the fact that the patient insists on being admitted though not advised.
- ✓ Always record the full name of the patient, especially if the name is common, like Raju, Suresh, Rani, etc., so that the chances of a mix-up are minimized.
- ✓ Specifically mention in the admission form —
 - the arrangements with consultants, and
 - that round-the-clock observation and treatment will be provided by junior doctors/RMOs.
- ✓ Arrange for suitable specialists for consultations at the earliest after admission.
- ✓ In giving packages/estimates/quotations for specific procedures/surgeries,
 - it is advisable to execute a separate written, well-defined agreement with the patient;
 - all the contingencies and exigencies must be taken into consideration;
 - both inclusions and non-inclusions must be clearly specified;
 - specifically state that in case of complications, longer stay or other unforeseen circumstances, extra charges will be payable and the same are not computed in the package/estimate/quotation;

- specifically state the period for which the package/estimate/quotation will be valid; it is advisable to have this period as short as possible.

× Do not admit patients who require treatment from a particular specialist who may not be available during the relevant period.

5.3. Discharging patients

✓ Attending/authorized doctor must issue and sign all discharge orders.

✓ Release minors/incompetents —

- only to parents or authorized guardian, and
- take proper acknowledgment in writing.

✓ Advise proper follow-up care.

× Do not discharge any patient prematurely.

× Do not delay discharge of a patient for nonpayment of charges.

× Do not discharge patient with notified communicable diseases.

5.4. Discharge against medical advice

✓ Consider any such request only if it is made by the patient in writing. Duly preserve this request in medical records.

✓ Explain specifically to the patient the consequences that may ensue after discharge or in transit, and duly record the same.

✓ Record specifically and elaborately 'discharge against medical advice' whenever the patient is being discharged because of his/her insistence for being discharged.

✓ Make the patient sign a 'discharge against medical advice' form.

✓ Make appropriate entries in the medical records.

5.5. Patients care

✓ Ensure that —

- medical care is provided to each patient under a competent doctor;

- patients are seen and physically checked by the attending doctor on a regular basis;

- during each visit, the attending doctor reviews each patient's total care, including medications and treatments;

- all new symptoms are forthwith brought to the notice of the attending doctor;

- indicated time is strictly followed in giving medicines and injections, charting, surgical dressing, giving hot/cold applications, conducting investigations;

- drains/catheters/Ryles tubes/tractions/I.V. lines are removed only after receiving written directions from the attending doctor and that the doctor/nurse after removing the aforesaid duly and promptly record the same in the patients' case papers;

- old, unconscious, diabetic, anesthetized or high-risk patients are provided utmost care and are monitored continuously and their vitals are recorded at recommended intervals;

✓ Manage with utmost care old, unconscious, semiconscious, diabetic and anesthetized patients.

- ✓ Keep patients with suicidal tendency at a place where they can be easily observed.
- ✓ Protect children and unconscious persons from injury or fall.
- ✓ Examine the patient at short intervals while giving hot water bag.
- ✓ Take care of patients' valuables.
- ✓ Provide necessary information regularly to relatives.
- ✓ Ensure that intolerable behavior of patients is duly reported.
- ✓ Keep personal rapport and healthy communication with patients.

5.6. Nursing home regulations

- ✓ Follow diligently nursing home regulations prescribed by the state government, local municipalities, village *panchayats* and town planning authorities.
- ✓ Make efforts to know and follow other rules and regulations that are applicable.

5.7. RMOs/doctors/consultants

- ✓ Clearly define and document *inter se* relationships between hospital and consultants in the form of a valid, legal, binding and enforceable written agreement.
- ✓ Before consulting or professionally engaging doctors working in government hospitals, ensure that their service conditions permit them to undertake private professional engagements.
- ✓ Ensure that there is rapport and healthy communication amongst all health care professionals.
- ✓ Ensure that duly qualified, competent and experienced doctors, surgeons and anesthetists are at work.
- ✓ Prepare and regularly update a comprehensive list of specialists with their contact numbers, time and days of availability or non-availability, whose presence may be required in case of emergencies and complications, depending upon the type of procedures/surgeries that are undertaken.
- ✓ Avoid using the services of overworked doctors, paramedical staff, especially in surgeries/procedures.

5.8. Nursing

- ✓ Nurses must have the requisite qualifications and proper training.
- ✓ Devise protocols to minimize negligent acts of nurses, especially the common ones like —
 - Failure to note or act on an order of change
 - Medication without prescription
 - Failure to administer medication
 - Failure to discontinue medication
 - Wrong medication
 - Wrong dosage
 - Medication to the wrong patient
 - Wrong route of medication
 - Negligence in giving injection
 - Using unsterilized needle

- Using unhygienic equipments
- No proper response to allergic reactions
- Not accompanying weak patients/old patients/children to bathrooms and toilets

5.9. Staff

- ✓ Promote practice of different paramedics.
- ✓ Paramedical staff, assistants, subordinates, locums, nurses must have the requisite qualifications, competence and proper training.
- ✓ Check original certificates of qualifications and keep an attested copy in your records, especially in cases where the requisite qualification is legally prescribed.
- ✓ Be careful in selection.
- ✓ Be thoughtful in giving responsibilities.
- ✓ Avoid overworked staff, especially in OT/ICU.
- ✓ Ensure that their communication skill is good and put to proper use, especially in interactions with patients.
- ✓ Ensure that their behavior towards patients is good and compassionate.
- ✓ Keep constant vigil over staff and associates.
- ✓ Conduct surprise checks.

5.10. Infrastructure and equipments

- ✓ Keep equipments in proper and working condition.
- ✓ Keep equipments sterilized.
- ✓ Ensure that there are no inflammable substances and corrosives.
- ✓ Ensure adequate lighting.
- ✓ Ensure that bathrooms and toilets do not have slippery floors.
- ✓ For emergency department equipments,
 - have effective and proper preventive maintenance program in place;
 - conduct regular dry runs; and
 - have sufficient numbers as well as extra sets or standby arrangements in case of failure or repairs, especially for life-saving equipments like oxygen cylinder, suction machine, insulator, ventilator, defibrillator, cardiac monitor, etc.
- ✓ All cots must have railings and they must be raised in case of children and unconscious/serious/psychiatric patients to prevent them from falling.
- ✓ Avoid complicated or major elective surgeries/procedures if requisite facilities are absent.
- ✓ Synchronize all watches/clocks (wrist, table or wall) that are used for recording time in a hospital/nursing home. Instruct medical, paramedical and nursing staff to note and record the time from only such watches/clocks that are synchronized.

5.11. Operation Theater/Room

Ensure that

- ✓ 'Aseptic techniques' are followed
- ✓ Proper and regular disinfection and sterilization (decontamination) is done
- ✓ Fumigation/fogging is done at prescribed interval
- ✓ Swab test is performed at recommended intervals
- ✓ Instruments and equipments are sterilized regularly
- ✓ Laproscopes and arthroscopes are sterilized between patients, ideally
- ✓ Sterilizers are kept in clean rooms
- ✓ Sterile objects are wrapped, stored, transported and handled properly
- ✓ Cleaning and mopping is done at recommended intervals
- ✓ No brooming is permitted under any circumstances
- ✓ Surgical team performs surgical scrub, wears appropriate surgical apparels, double-gloving is followed in patients infected with blood-borne pathogens
- ✓ Patient transport vehicle is cleaned properly
- ✓ Bedpans, blood pressure cuffs, stethoscopes, linen, furniture, floors, etc are disinfected regularly and properly
- ✓ Water treatment facility are proper and working
- ✓ Room is designed scientifically with the recommended air management design and equipments
- ✓ Regular pest control treatment is done
- ✓ Proper and regular surveillance is in place

5.12. Intensive Care Units

Ensure that —

- shifting the patient from normal bed/ward to ICU/ICCU and vice versa is done solely in the patient's interest;
- the number and qualifications of doctors attending to the patients in ICU/ICCU are in accordance with the relevant rules and regulations of that state;
- the condition of the patient in ICU/ICCU is properly and continuously monitored by qualified and experienced doctors and nurses only;
- senior doctors attend to patients regularly and at shorter intervals and are available during emergencies;
- under no condition are the patients monitored by non-allopaths;
- only duly qualified and experienced paramedical staff is employed;
- beds are attached with central console/monitor where the nursing staff as well as the doctor on duty are positioned;
- proper protocols are in place to ensure that RMOs do not leave without another taking charge, especially during changes in shift;
- ICU/ICCU is adequately stocked with emergency and life-saving drugs;
- appropriate backup is available in case of electricity failure;
- instructions like intubations, etc., are executed immediately.

6. Precautions – Pathology Laboratories/Imaging Centres

6.1. Pathology Laboratories/Imaging Centres — general precautions

- ✓ Ensure that investigations are carried out promptly.
- ✓ Take consent rather than not taking one.
- ✓ Staff must be duly qualified.
- ✓ Develop and follow proper protocols to avoid wrong labeling.
- ✓ Reporting on sensitive parameters must be done after repeating the test or performing confirmatory tests.
- ✓ Rule out pregnancy before carrying x-rays of uterus in women.
- ✓ In case of HIV tests, irrespective of the results of enzyme immune assay (EIA),
 - advice to correlate the results clinically by western blot technique (WBT) and
 - write this advice prominently on the same report.
- ✓ Compare previous reports before reporting in case of follow up investigations.
- ✓ Notify results promptly.
- ✓ Ensure that the procedure/investigation has been performed and reported correctly before signing reports.
- ✓ Specifically state in reports the accuracy of the procedure undertaken.
- ✓ Insert a suitable disclaimer and an indemnity clause in case of sensitive or new techniques/procedures.
- ✓ Specifically state if the investigations are preliminary in nature. Add further, 'subject to confirmatory tests'.
- ✓ Give separate reports for both preliminary tests and final tests.
- ✓ Write if indicated — 'further clinical correlation suggested'.
- ✓ Inform the referring doctor on phone in case of emergency.
- ✓ Inform the patient and the referring doctor of any abnormal finding that needs immediate attention.
- ✓ Record the full name of the patient, especially if the name is common, like Raju, Suresh, Rani, etc., so that the chances of a mix-up are minimized.
- ✓ Keep all the reports out of patients' reach. The usual practice of keeping reports ready for delivery at reception must be avoided.
- ✓ Give reports to the patient on proper identification.
- ✓ In case of mixing up of reports, send a letter by registered post A/d informing the patient of the mix-up and calling to return the report. Preserve a copy of this letter and its postal acknowledgment for at least 3 years.
- ✓ While handing over scans/films/x-ray plates to the patient,
 - check whether reports have been duly recorded in the patient's medical records,
 - take a proper receipt from the recipient, and
 - duly record the date of giving (and/or receiving back in case these are being taken back).
- × Don't delay in carrying out the necessary tests, especially in emergency patients.
- × Don't falsely publicize as '24 hours open.'

7. Precautions – Blood banks

7.1. Blood banks — general precautions

- ✓ Blood donation must be voluntary and not under greed, fear or coercion.
- ✓ Take consent of the donor in writing.
- ✓ Use properly sterilized instruments.
- ✓ Properly disinfect blood donation area.
- ✓ Take proper history of donor for jaundice, HIV, hepatitis, etc.
- ✓ Perform rigorous tests for communicable diseases.
- ✓ Check blood strictly and certify accordingly.
- ✓ Cross-matching and certifying compatibility of blood must be done only by a qualified blood bank technician.
- ✓ Ensure anonymity between the donor and the recipient.
- ✓ Ensure that frequency of donation and total volume of blood donated are in accordance with age, weight and general health of the donor.
- ✓ Keep medical records of donors confidential.
- ✓ Regularly check the following:
 - Proficiency of staff
 - Adequacy of equipments and premises
 - Quality of methods and reagents, source material and finished product

8. Precautions – Maternity hospitals/wards

8.1. Maternity hospitals/wards — general precautions

- ✓ Ensure presence of a qualified gynecologist during delivery. If the gynecologist under whose care the patient is admitted is unable to attend, at least another duly qualified gynecologist must be present and must attend the patient during delivery.
- ✓ Use separate files/folders or at least separate sheets for both the infant and the mother.
- ✓ Keep constant vigilance as baby snatching/changing incidents are increasing.
- ✓ Maintain a register of record of every woman who delivers or undergoes MTP.
- ✓ Immediately after delivery,
 - Record birthmarks of the newly born,
 - Record weight and other features, and
 - Put something around the infant for identification.
- × Gynecologist must not leave the patient immediately after delivery.
- × Don't allow unknown persons in or around the place where the infant and the mother are housed.

9. Precautions – Documentation and Medical Records

9.1. Documentation by doctors

● Every doctor is required to author, record and preserve five types of documents, in the course of discharging his/her professional duties:

- Medical records (IPD & OPD)
- Medical certificates
- Medicolegal reports
- Dying declarations/depositions
- Intimations to police

9.2. Stationery

✓ Medical records must be written on printed stationery having proper name, address and registration number accorded by a medical council of the doctor/hospital/nursing home, as well as qualifications (in case of a doctor's stationery); or at least, a rubber stamp of the same must be put on each and every sheet.

✓ Every sheet added to medical records must have the name of the patient and must be numbered serially.

✓ Ensure that separate files/folders or at least separate sheets are used for both the infant and the mother (maternity wards/homes).

9.3. Writing

✓ Write date and time on each and every piece of medical record.

✓ Write in continuity, and 'timing' of entries must be in proper sequence.

✓ Use standard medical terms and abbreviations.

✓ Duly record the time when the patient is first checked. Thereafter, make entries serially and at stipulated intervals.

✓ Make a specific endorsement 'I agree with . . .' in case you agree with the entries of clinical examination/diagnosis made by juniors, consultants or colleagues.

✓ Attending doctors/consultants must sign at appropriate places.

✓ Encircle the portion having mistakes and then write correctly outside the circle.

× Don't —

- erase,
- put white ink,
- overwrite, or
- make any entry in the margin.

× Don't write medical records in a hurry in case of a medical mishap/accident or where a medicolegal problem is apprehended.

× Don't write anything in codes or unknown/uncommon short forms/abbreviations.

9.4. Medical records

9.4.1. Medical records — general precautions

- ✓ Entries should be legible, clear and meaningful and sufficiently complete to allow those not treating a patient to review the record and assume continuing care when necessary.
- ✓ Record facts. Don't interpret the events.
- ✓ Record timely, fully, factually, accurately and promptly.
- ✓ Maintain discipline in recording exact time except in emergencies.
- ✓ Record carefully and accurately childbirth, CT, etc.
- ✓ Record time in 24 hour format rather than a.m./p.m.
- ✓ Record all births/deaths.
- ✓ Witnesses in a consent form must be from both the side i.e. one from the doctors side and the other from the patients side.
- ✓ Ask the patient to fill a form about his or her medical history.
- ✓ Avoid the practice of recording abnormal findings only. Vitals, even if they are normal, must be recorded accurately and regularly.
- ✓ Take consent to dispose off the removed organs, cysts, etc according to your protocol.
- ✓ Record blood transfusion.
- ✓ Record weight of the baby in pediatric consultations.
- ✓ Record history of drug reaction/allergy, if any.
- ✓ Maintain separate medical records of HIV/AIDS patients and keep them confidential.
- ✓ Maintain medical records of IPD patients in the standard format laid down by MCI.
- ✓ Send medical records or an abstract thereof with the patient who is being transferred or referred.
- ✓ Preserve a copy of transfer/discharge summary, referral note, etc. given to the patient.
- ✓ Prepare 2 copies of OPD records – one for the patient and one for the doctor.
- × Don't manipulate records.
- × Don't indulge in falsification of records.
- × Don't write long, defensive or derogatory notes. Stick to the facts.
- × Don't write criticism, complaints, emotional comments and extraneous remarks.
- × Don't ignore the entries made by others, especially paramedical staff. Remember, a medical record has many authors.

9.4.2. Specifically record (in both the internal records and records given to the patient)

- ✓ Each and every treatment given to the patient, each and every step, even the ones which have been attempted but have failed
- ✓ Previous treatment taken, diagnosis, name of the doctors/hospitals visited by the patient, especially if the patient has been treated by an unqualified medical practitioner
- ✓ Medications, if any, taken regularly by the patient, especially for chronic diseases
- ✓ History of drug reaction/allergies, if any.
- ✓ Wound, abnormality or disfigurement found on clinical examination
- ✓ Findings like diabetes, smoking and drinking habits (occasional, regular or heavy) of the patient that may have any bearing on diagnosis, treatment or prognosis

- ✓ All incidents (like the 'fainting of the patient's relative on hearing of the decision to amputate') that may even remotely have a bearing on medical decisions
- ✓ Blood transfusion.
- ✓ Weight of the baby in pediatric consultations.
- ✓ Second opinion or opinion on reference
- ✓ Reference letters given for consultations/second opinion
- ✓ Requisite preoperative exercise
- ✓ Reports of pre-surgery investigations
- ✓ Discharge against medical advice
- ✓ Symptoms and diagnosis, if any, in case an unknown/unexplained complication arises during or after the treatment
- ✓ Adverse reaction of a drug and remedial measures taken
- ✓ Any abnormality or deterioration in the patient's condition, observed during examination or follow-ups
- ✓ Postoperative care and precautions advised
- ✓ The fact that the emergency patient was outside the scope of your specialization and expertise and yet necessary treatment was given before transferring to an appropriate facility
- ✓ The fact that the requisite test dose or sensitivity test has been done and that there has been no adverse reaction even after lapse of the prescribed period
- ✓ The fact that the patient has —
 - refused admission in spite of medical advice
 - refused to comply with medical advice or conduct investigations
 - not kept appointments or has delayed treatment
 - insisted for a procedure/surgery for cosmetic purpose
 - insisted to be referred or transferred to another hospital/doctor
 - sought further time to consider an option
 - delayed reporting, or has not reported, for follow-ups as advised
 - failed to take postoperative care and precautions and the resulting symptoms or problems, if any
- ✓ The reason/s for —
 - revising a diagnosis
 - deferring any procedure
 - giving preference to one procedure over another
 - changing the course of treatment, either midway or after provisional diagnosis
 - not starting a procedure or not giving a medicine at the ideal or indicated time
 - performing surgery/procedure in haste
 - inability to provide postoperative care
 - a surgery taking unusually long time
 - delay in attending a patient, especially in an emergency
- ✓ The fact that the patient was duly informed —

- at the earliest about unfavorable results of treatment
- the date and time of procedure/surgery
- about drug reaction and the appropriate remedial steps taken
- about side effects of the prescribed drugs, especially in case of sensitive drugs or drugs having serious side effects
- the time for starting a treatment or performing a surgery/procedure
- about all the hospitals that have the requisite infrastructure and that the final choice was left to the patient

9.4.3. OPD patients

✓ Specifically record the following:

- Complaint
- Display of pain and discomfort
- General condition
- History
- Clinical examination
- Symptoms
- Summary of investigation reports
- Diagnosis
- Treatment
- Consent for various procedures (including refusals, if any)
- Second opinions (if any)
- Allergies reported
- Sensitivity test reports relating to drugs to be given to the patient
- Response to medication, especially if it is not on expected lines
- Sequence of events in chronological order
- Instructions about diet, rest, exercise, drugs, investigations, etc.
- Noncompliance with any medical advice

9.4.4. IPD patients

✓ First part must include the following data about the patient:

- Age
- Address
- Marital status
- Religion

✓ Second part must include records of daily care and treatment:

- Medical history
- Physical examination, including provisional or working diagnosis and plan for definitive diagnosis and/or treatment
- Symptoms or condition being addressed

- Diagnostic and therapeutic orders, including all medication, treatments, diet and restorative and special medical procedures required for the safety and well-being of the patient
 - Progress records describing significant changes in a patient's condition, written at the time of each visit
 - Operative reports
 - Preoperative and postoperative treatment
 - Delivery reports
 - Anesthesia records
 - Nurses' notes containing observations made by them
 - Medication and treatment records
 - Charts of vital signs
 - Dental reports
 - Occupational/activity/physical therapy notes and related reports
 - Dietary notes and related reports
 - Investigations advised on the basis of reports
 - Fluid intake and output charts
 - Treatment rendered
 - Patient's response
 - Patient's status at the time treatment is discontinued
 - Discharge summary
- ✓ Record daily care and treatment.
 - ✓ Ensure that all orders are signed by doctors.
 - ✓ Progress notes must be updated daily, even if there is little or no new information to add.
 - ✓ Ensure that only those doctors and nurses who are duly authorized and fully conversant with the patient's case make entries in medical records.
 - ✓ Record both names of the specialists who have been consulted and their respective advice.
 - ✓ Monitor regularly and duly record blood sugar as well as dose of insulin and time of administering it, especially in cases of diabetic IPD patients.
 - ✓ Closely and continuously monitor and record vitals at recommended intervals, especially in high-risk patients.
 - ✓ Mention the following in the admission form:
 - Arrangements between consultants and the hospital
 - The fact that round-the-clock observation and treatment will be provided by junior doctors/RMOs

9.4.5. Brought-dead/death-before-diagnosis cases

- ✓ If a patient is brought dead or dies before the diagnoses could be made,
 - report to police,
 - make the report in duplicate,
 - take acknowledgment from the police, and
 - retain your copy for records.

- ✓ In reporting to police, record the following:
 - Name (if known) of the patient
 - At least two identification marks over exposed parts
 - Address (if known) of the patient
 - Name of the person accompanying the patient (in case of police, write name, number, rank and police station)
 - From where the patient is brought
 - Cause of injury as stated by the patient or the accompanying person
 - Injury status (nature, extent, location)
 - Consciousness status when brought
 - Vital signs
 - Time and date
- × Don't prepare medical records in such cases.

9.4.6. Injury cases

- ✓ Record the following in your case papers:
 - Name (if known) of the patient
 - At least two identification marks over exposed parts
 - Address (if known) of the patient
 - Name of the person accompanying the patient (in case of police, write name, number, rank and police station)
 - From where the patient is brought
 - Cause of injury as stated by the patient or the accompanying person
 - Level of consciousness
 - Vital signs
 - Accurate description of the patient's clinical condition
 - Details of injury: nature, extent, dimensions, location in relation to a fixed bony landmark, age of the wound, seriousness of the wound
 - Prognosis
 - Time and date

9.4.7. Bed-head ticket

- ✓ Maintain properly — from time of admission till discharge/death.
- ✓ First note history of the patient in details.
- ✓ Next record the following:
 - Symptoms
 - Provisional diagnosis
 - Provisional treatment advised
 - Investigations suggested
 - Final diagnosis

- Final treatment advised
- ✓ Entries must be made everyday, both in the morning and evening.
- ✓ RMO/visiting physician/visiting surgeon must —
 - record time of attending the patient and
 - make entries in his/her own handwriting or at least sign below 'case seen by Mr.'
- ✓ Condition of the patient, whether improving/deteriorating, should be noted.
- ✓ Note all investigation reports serially, dated in chronological order.

9.4.8. Discharge card

- ✓ Briefly record the following:
 - History
 - Condition at discharge
 - Diagnosis
 - Treatment given and advised
 - Reasons for discharge
 - Postoperative care
 - Warnings
 - Precautions regarding food, medicines, etc.
 - Follow-up schedule
- ✓ Write proper note to family or referring physician, in appropriate cases.
- ✓ In case of a complication, mistake or mishap during the course of treatment, record —
 - the reasons for choosing and implementing that particular course of treatment,
 - the resulting complication(s),
 - post-complication treatment, and
 - the reasons for transfer/discharge.
- ✓ It is not necessary to record full details of surgery.
- ✓ Record the reasons for premature discharge in both discharge card/certificate and your medical records.
- ✓ Specifically and elaborately record 'discharge against medical advice' whenever the patient is being discharged because of his/her insistence for being discharged. Insist on a written request from the patient for premature discharge. Duly preserve this letter of request.
- ✓ Prepare discharge summary/ticket in duplicate. Acknowledgment of receipt must be taken from the patient or his/her relative/friend/attendant on the duplicate before issuing the original to them.
- ✓ Issue discharge card even after death of the patient.

9.4.9. Preserve, provide and produce

- ✓ Devise and follow proper protocols in preparing and preserving medical records.
- ✓ Preserve medical records of IPD patients for at least 3 years from the date of commencement of treatment.
- ✓ Proper systems must be in place to retrieve medical records at short notice.

- ✓ In case of a request made for medical records either by the patient/authorized attendant of the patient/medical council/legal authorities, duly acknowledge and issue documents within 72 hours.
- ✓ Provide medical records in the following conditions to the patient or to a third party on the basis of written authorization from the patient:
 - Only when a demand for copies is made in writing
 - Patient is referred/transferred
 - In acknowledgement, take the patient's/authorized person's signature with date.
- ✓ You can charge the patient for photocopying.
- ✓ Retain originals — give photocopies to the patient.
- ✓ In cases of minors if threat of legal action is present, preserve medical records for 21 years — 18 years to become major and 3 years thereafter.
- ✓ Give public notice before destroying medical records.

9.4.10. Computerized medical records

- ✓ Make efforts to computerize medical records.
- ✓ Take special precautions to —
 - provide for data security;
 - prevent unauthorized disclosure of information, i.e., maintaining confidentiality;
 - prevent questionable accuracy of data because of data being not precisely entered by computer operators;
 - prevent equipment failure; develop a disaster recovery plan (e.g., provisions for backup files and electrical shutdowns).

9.4.11. Access and ownership

- Following are the persons having right of access to health records:
 - Patient
 - Person(s) authorized in writing by the patient
 - Parents of a minor patient
 - Guardian of an incompetent patient
 - Patient's heirs and legal representatives or executors/beneficiaries of his/her will after the patient's death
 - Police and statutory authorities
- Access to medical records cannot be denied to a patient even if it is detrimental to the patient.
- Ownership of medical records rests with the hospital; the patient only has a limited right of access.
- Ownership and parting of medical records are contentious issues.
- The question of right to access medical records during treatment remains unsettled.
- ✓ A third party can be given access to medical records only after receiving written consent of the patient.
- ✓ Even in free medical camps, furnish medical records.

9.5. Medical certificates

9.5.1. Medical certificates — general precautions

- You are bound to give certificates in your professional capacity for the following:
 - Subsequent use in the courts of law
 - Administrative purposes
- ✓ Certificates can be given —
 - for reports relating to birth, death, disposal of the dead body, injury or age;
 - under statute relating to lunacy and mental deficiency — Mental Health Act, 1987;
 - under Vaccination Act;
 - under Factory Act;
 - under Education Act;
 - under Public Health Act;
 - under Workmen's Compensation Act;
 - under statutes relating to notification of infectious diseases;
 - under Employees State Insurance Act;
 - under Merchant Shipping Act;
 - for procuring and issuing passport;
 - for procuring and issuing driving license;
 - in connection with sick benefit insurance and friendly societies;
 - for seeking exemptions from appearing in courts or from reporting for duty in public offices, public services or in ordinary employment; or
 - in connection with rural or military matters. Must be issued by the doctor clinically responsible for the patients treatment.
- ✓ Must be issued by the doctor clinically responsible for the patients treatment.
- ✓ Prepare medical certificates in the standard format prescribed by regulations.
- ✓ Give authenticity to the certificate — issue it on a letterhead (though it can also be issued on plain paper) having name, address, qualification, registration number and name of the state medical council that has issued the registration number.
- ✓ Certificates must have the following:
 - Your name, address, qualifications, registration number along with the name of the state medical council that has issued the registration number
 - Name and address of the patient
 - Exact nature of illness
 - Thumb impression or signature of the person to whom it refers
 - Identification marks of the person to whom it refers
 - Date of issuing
 - Legible signature
- ✓ Take specific consent for disclosing illness in medical certificate (unfortunately not at all followed in India).

- ✓ Keep a duplicate copy of each and every certificate issued.
- ✓ Maintain a 'register of medical certificates,' with full details of the certificates issued.
- ✓ Affix legible signature.
- ✓ Give Permanent Disability Certificate only when improvement in the patients condition stops or the limb is amputated.
- ✓ State only those facts that are within your personal knowledge.
- ✓ Limit the certificate to the period during which the patient was actually under your observation.
- × Don't charge fees for giving Certificates.
- × Don't issue a certificate for inadequate or extraneous reasons or based on history of illness supplied by some other person.
- × Don't give false medical certificates.
- × Don't issue certificates of competency in modern medicine to unqualified or non-medical persons.

9.5.2. Death certificate

- ✓ It is obligatory to issue a death certificate if you have last attended the deceased person.
- ✓ It is your responsibility to forward it to the registering authority.
- ✓ Mention the underlying pathological cause and not only symptoms or mode of death.
- ✓ Countersigning on death certificates by civil surgeons — sign only after inspecting the body.
- ✓ Death certificates in allopathic hospitals/nursing homes must be issued by allopathic doctors only.
- × Don't charge any fees for preparing and issuing a death certificate.
- × Don't delay or refuse to give a death certificate because of not having received professional fees.
- × Don't issue a death certificate in the following circumstances/conditions/cases:
 - If not sure about cause of death
 - In case of sudden death
 - Brought-dead cases or death-before-diagnosis cases
 - If you have even the least suspicion of foul play
 - Death is supposedly the result of any violence or unnatural cause; or of drug, medicine or poison
 - You suspect starvation, exposure or neglect
 - If you have not attended to the deceased at least once during the 7 days preceding death
 - Crime has been registered by police or police investigation is in progress

9.5.3. Certificate for leave/absence in office/absence in court

- ✓ State approximate number of days for which absence is likely.

9.5.4. 'Mentally unfit' certificate (under Mental Health Act, 1987)

- ✓ Certificate by two doctors is required to declare a person mentally unfit.
- ✓ Both the doctors must examine the mentally ill person independently of each other.
- ✓ In case you are a relative, partner or assistant of the mentally unfit person, specifically state it in the certificate.

✓ Be extra cautious — on the strength of your certificate, the magistrate may pass reception order under the act, committing a person to psychiatric hospital/nursing home.

9.6. Intimation to police

9.6.1. Intimation to police — general precautions

- ✓ Intimate police in all suspicious cases or if you are not sure of the cause of death.
- ✓ Intimation to police must be —
 - in writing and
 - in duplicate. Obtain police officer's signature as acknowledgment of receipt. Retain and preserve your copy for records.
- ✓ In intimation to police, write the following:
 - Name (if known) of the patient
 - At least two identification marks over exposed parts
 - Address (if known) of the patient
 - Name of the person accompanying the patient (in case of police, write name, number, rank and police station)
 - From where the patient is brought
 - Cause of injury as stated by the patient or the accompanying person
 - Injury status (nature, extent, location)
 - Consciousness and orientation status
 - Vital signs
 - Time and date

9.7. Medicolegal reports

9.7.1. Medicolegal reports — general precautions

- These are 'documents prepared by doctors in obedience to a demand made by an authorized police officer or magistrate'
- Generally in cases relating to assault, rape, murder and poisoning
- This report has three parts:
 - Introduction, i.e., full name, age, address, identity mark and date, place and time of examination
 - Facts observed on examination — to be noted correctly
 - Opinion or inference drawn from such facts — opinion should be expressed briefly and to the point
- ✓ Articles of clothing, weapons, etc., sent for medical examination must be described with full particulars to facilitate their correct identification later in court.
- ✓ Confidentiality must be maintained by taking precautions in the following manner:
 - The report must be transmitted carefully to the authority that has requested for the report.

- The report must be given to other persons only after receiving a clear written direction from the said authority.
- Any request for such report must be directed to the said authority.

9.8. Dying declaration/deposition

9.8.1. Dying declaration — general precautions

- Dying declaration is the 'statement made by a person relating to cause of his/her death or any of the circumstances of the transactions resulting in death.'
- The main role of the doctor is to certify that the patient (declarant) is of *compos mentis*.
- ✓ When the patient expresses his/her wish to make a dying declaration,
 - immediately call an SEO/SEM/Hon. Magistrate to record the dying declaration;
 - even a police officer can be called to record the dying declaration;
 - if short of time, as a last resort, even you can record a dying declaration.
- ✓ If you have to record a dying declaration, record it in the following manner:
 - Record full details.
 - Record in the vernacular.
 - Record actual words and language of the declarant — word by word.
 - Record in the form of questions and answers only to clarify some points.
 - Record in the presence of respectable neutral witnesses.
 - Read over to the declarant, who should be made to affix his/her signature or thumb impression on it, if possible.
 - After conclusion, you must sign it, writing time, date and place; and then witnesses must sign.
 - Forward dying declaration in a sealed envelope to the district magistrate or sub-divisional magistrate of the place where the dying declaration has been recorded.
- ✓ Before recording a dying declaration, certify that the declarant is in a sound state of mind (*compos mentis*) at the time of making the declaration.
- ✓ If the declarant becomes unconscious, the doctor must record whatever has been said and also the fact of declarant becoming unconscious.
- ✓ If possible, police must not be in the vicinity.

9.8.2. Dying deposition — general precautions

- Deposition is the 'evidence taken on oath in the presence of the accused or his/her lawyer, who is allowed to examine the deponent before a magistrate.'
- The main role of the doctor is to certify that the patient (deponent) is of *compos mentis*.
- ✓ Before recording a dying deposition, certify that the deponent is in a sound state of mind (*compos mentis*) at the time of making the deposition.

10. Precautions - Courts and legal proceedings

10.1. Courts and legal proceedings — general precautions

- A patient can approach a consumer court, a civil court, a criminal court and a medical council simultaneously for the same case, and each court/medical council can give judgment contrary to that of the other.
- ✓ Promptly reply to all legal notices, under competent legal advice. Allegations made by the patient must be denied, and specific acts of commission and omission on the part of the patient must be pointed out.
- ✓ Inform the insurance company in writing and also send copies of any legal notice, summons, courts notice, etc. received by you along with copy of your policy. Duly preserve their acknowledgment of receipt.
- ✓ Produce medical records in court to prove your case. Courts acknowledge their correctness in the absence of any evidence to the contrary.
- ✓ Summon doctors and nurses present during a medical mishap as your witnesses in court to prove your case.
- ✓ Avoid blame game in defending in a case where many doctors and hospitals are accused of medical negligence. It hurts everyone.
- ✓ Use authoritative phrases like 'in my opinion' instead of uncertain expressions like 'I feel' or 'I think' whenever called in court as a witness or as an expert.
- ✓ Out of court settlement must be drafted by a proper legal professional and if drafted by the patient, it must be vetted by your advocate.
- ✓ Always give a minimum level of respect even to a patient who may have initiated legal proceedings against you, and maintain decorum while dealing with such patients too.
- × Do not succumb to the temptation of escaping liability by any means.
- × Do not reply impulsively on receiving a legal notice. Take proper advice from peers and legal professionals.

11. Precautions - Doctors giving evidence in witness box (especially in medicolegal cases)

11.1. Doctors giving evidence in witness box (especially in medicolegal cases) — general precautions

- ✓ Make preparations in advance.
- ✓ Be well dressed.
- ✓ Wear apron before you enter the court (not compulsory).
- ✓ Address high court judges as 'My Lord' and subordinate judges as 'Your Honor.' Now, even 'Sir' is permissible.
- ✓ Evidence should be relevant, reliable, clear, honest and impartial.
- ✓ Insist that your statements are properly recorded, especially clarifications.
- ✓ Language must be plain and simple.
- ✓ Answers must be to the point and brief.
- ✓ Be frank.

- ✓ State clearly whenever you —
 - are 'not aware' or
 - cannot 'recollect.'
- × Don't lose temper, though repeated attempts will be made by advocates to get you to do so.
- × Don't use technical terms or language. Remember, everyone in court except you is a non-medical person.

11.2. Leading evidence on your own documents

- ✓ In case you are called to lead evidence on your own documents (certificates, medical records, etc.),
 - ask for the document in question;
 - insist on original copies;
 - if original copies are not provided, ask the judge if permission to lead 'secondary evidence' has been granted;
 - get the said fact recorded;
 - check the document thoroughly;
 - check whether you have authored the document or whether it has been authored under your directions;
 - check your signature on the document;
 - if the document is not authored by you or under your directions or does not bear your signature, say so at the outset and refuse to answer questions on the said document;
 - refresh your memory with your original documents;
 - take time to read and understand your document properly;
 - thereafter, proceed to answer questions;
 - after every question, you are at liberty to read and peruse your document.

11.3. Questions on legal proceedings or textbooks

- ✓ If textbook or any part of legal proceedings is referred to,
 - ask for the same to read;
 - on being shown, read the entire page or even chapter and not only the portion on which your comments are sought; and
 - thereafter, give your answers.

11.4. After giving answer

- ✓ Generally a witness's statement is directly recorded on a typewriter.
- ✓ After giving your answer,
 - listen attentively to what is being recorded, especially your clarifications;
 - insist on your statement being read over;
 - point out mistakes, if any, and get the same rectified.

11.5. Supreme Court's directions: Pandit Parmananda Katara's case

- Courts should not summon a doctor to give evidence unless the evidence is necessary.
- Doctors must be given preference in court.
- Doctors must not be asked to wait.
- Unnecessary harassment of doctors by way of requests for adjournments or by cross-examination should be avoided.

12. Emergency care

12.1. Emergency

- Emergency is a situation in which absence of medical attention could result in —
 - placing the health of the individual (including unborn child) in serious jeopardy;
 - serious impairment to bodily functions;
 - serious dysfunction of any bodily organ or part; and
 - a threat to the health or safety of the woman or the unborn child when a pregnant woman is having contractions and there is inadequate time to effect a safe transfer to another hospital before delivery or that transfer may pose a threat to the health or safety of the woman or the unborn child.

12.2. Emergency care — general precautions

- ✓ All doctors are legally bound to attend emergency cases.
- ✓ Contractual doctor-patient relationship is absent.
- ✓ Accept, treat and transfer (if required)
 - each and every patient,
 - courteously and promptly,
 - regardless of his/her ability to pay.
- ✓ All procedural laws stand suspended.
- ✓ Focus only on treatment and not on procedures.
- ✓ Doctors have wider discretion in treatment.
- ✓ Take consent if possible.
- ✓ Record specifically the time of advising a particular surgery/procedure, especially if there is any delay on the part of the patient to give consent.
- ✓ Consult specialists if necessary. Such advice can even be taken on telephone.
- ✓ Involve as many consultants as possible, especially in complicated and serious cases.
- ✓ When operation is a race against time, there is greater allowance for mistakes.
- ✓ In unforeseen emergencies where there is little or no time for planning, the doctor has full liberty to take decisions.
- ✓ Once the patient is stabilized, the doctor is not bound to render further services.
- ✓ Prepare and preserve medical records of all emergency cases.
- × Don't fail or delay in responding to an emergency.

- × Don't wait for consent if it is not forthcoming. Start treatment immediately.
- × Don't wait to confirm a 'suspicion' by appropriate investigations, especially where delay may prove fatal.

12.3. Treatment Plan

- ✓ Examine the patient immediately.
- ✓ Record consent of the patient or the person accompanying the patient if possible.
- ✓ Report to police in cases where you are duty-bound to inform the police or you suspect foul play.
- ✓ Begin treatment as quickly as possible.
- ✓ Restore and maintain vital functions.
- ✓ First, stabilize the patient.
- ✓ Take efforts to minimize scarring and deformity.
- ✓ Specifically note the following in medical records:
 - Name of the patient (if known)
 - At least two identification marks over exposed parts
 - Address (if known) of the patient
 - Name of the person accompanying the patient (in case of police, write name, number, rank and police station)
 - From where the patient is brought (stated by the patient or the accompanying person)
 - Cause of injury/disease (stated by the patient or the accompanying person)
 - Clinical condition
 - Injury status (nature, extent, location)
 - Consciousness and orientation status
 - Vital signs
 - Time and date
- ✓ Transfer the patient to an appropriate facility if indicated.

12.4. Patient's valuables

- ✓ Take hold of valuables of the patient.
- ✓ Prepare a list of the valuables in duplicate, describing the valuables.
- ✓ If the accompanying person is properly known and is a near relative or friend of the patient, hand over valuables under a signed receipt; otherwise, keep valuables in your custody and thereafter hand over to the police under a signed receipt.

12.5. Emergency patient outside the scope of your specialization and expertise

- ✓ Refuse to treat if delay in reaching the appropriate facility may prove costly.
- ✓ Give treatment and conduct investigations that may be necessary to minimize loss.
- ✓ Consult consultants who can deal with such case, even if it is on the telephone.
- ✓ Transfer the patient to the appropriate facility at the first available opportunity.
- ✓ Record in your case papers —

- the fact that the patient was outside the scope of your specialization and expertise,
- the reasons why the patient was outside the scope of your specialization and expertise,
- the fact that treatment was given as it was an emergency, and
- details of clinical findings, provisional diagnosis and treatment given.

12.6. Hospitals and Emergency care

- ✓ All hospitals are bound to attend/admit emergency patients.
- ✓ Hospitals must establish treatment priorities — emergency cases to be treated first, followed by urgent and then less serious cases.
- ✓ All hospitals must necessarily have the following for emergencies:
 - Proper protocols for managing emergencies effectively
 - Adequate equipments and medical personnel
 - Stock of drugs required in emergencies
 - 'On call' specialists who can effectively manage such emergencies
- ✓ In emergencies —
 - investigations advised by consultant(s) must be done at the earliest
 - efforts must be made to procure reports quickly
 - the consultant(s) must be informed about the results of the investigation at once on receiving such reports, and
 - any direction(s) given by consultants must be carried out forthwith
 - if for some reasons the consultant is unable to attend patient within reasonable time, another qualified consultant must be requested to attend emergencies.
- ✓ Hospitals must conduct effective preventive maintenance programs for, and regular dry run of, the equipments usually required in emergencies.
- ✓ Keep extra sets or standby arrangements of life-saving equipments like oxygen cylinders, suction machines, insulators, ventilators, etc.
- × Don't discontinue treatment of accident/serious patients until they are stabilized.
- × Don't delay, refuse or stop treatment for failure to pay charges or deposit money.

13. Emergency situations

13.1. Death of patient under treatment/Death-on-table

- ✓ Inform the police in writing about the death and preserve a copy thereof bearing their acknowledgment.
- ✓ Request the police for postmortem in cases where medicolegal problem is foreseen.
- ✓ Consent of patient's relatives/friends/attendants is not required for conducting postmortem in case of any unnatural death.
- × Don't heed to any request or pressure for not informing police.
- × Don't move the dead body and the equipments, as far as possible, in case of death on table.

13.2. Complications during the course of treatment

- ✓ Record the symptoms and diagnosis, provisional and final, if any.
- ✓ Take proactive remedial measures.
- ✓ Advice appropriate investigations and/or diagnostic procedures/tests.
- ✓ Take second opinion or summon appropriate specialists if indicated, especially in complicated and serious cases, at the earliest.
- ✓ Refer or transfer the patient to a higher facility if indicated.

13.3. Transferring a patient

- ✓ Transfer a patient —
 - when requisite facilities to treat the peculiar condition or complication are absent;
 - for better management and care available elsewhere, especially in difficult cases; or
 - if he/she insists on transfer, and specifically record this fact.
- ✓ Duty of the referring doctor is as follows:
 - He/she should assess the situation and take decision in the best interest of the patient. Transfer should not be an exercise merely to avoid liability.
 - He/she should enumerate all the hospitals that have the requisite infrastructure and leave the final choice to the patient.
 - He/she should take the patient's consent.
 - He/she should give proper referral note and case summary, and a copy thereof signed by the patient must be preserved in the patient's medical record.
 - He/she should pass copies of medical records or investigation reports, and a copy thereof signed by the patient must be preserved in the patient's medical record.
 - He/she should give proper guidance and help in arranging transportation.
 - He/she should ensure that proper care is provided in transit.
 - He/she should give proper instructions to persons involved in the care during transit.
 - He/she or the nurse should accompany the patient if necessary.
 - He/she should advice ambulance service equipped with ICU facility in an emergency requiring critical care.
 - He/she should prepare the patient for transfer.
 - He/she should give all life-saving drugs before departure.
 - He/she should check and record all vitals before departure.
 - He/she should inform in advance the center where the referral/transfer is being made.
 - He/she should record vitals and treatment given in transit.
- ✓ Give medical records, investigation reports, referral notes, case summary, etc., only to the patient or his/her relatives and take proper acknowledgment from the patient/attendant of having received the same.
- × Don't delay in giving transfers when indicated.
- × Don't refrain in giving transfers when indicated.

13.4. Referring a patient

- ✓ Referral note must contain all the necessary details, viz.,
 - history,
 - problems,
 - diagnoses,
 - investigations,
 - treatment.
- ✓ Referring/attending doctor must formulate specific questions for which answers are required.
- ✓ Refer a patient who has suicidal tendency to a psychiatrist. Specifically record this advice.

13.5. Refusal to treat (at the outset)

- ✓ You can refuse to treat at the outset —
 - a non-emergency patient or
 - a patient outside the range of your ability or skill.
- × Don't refuse treatment arbitrarily.
- × Don't refuse treatment on religious grounds, especially in performing procedures relating to sterility, birth control, circumcision and medical termination of pregnancy when there is medical indication.

13.6. Terminating treatment

- ✓ Legally acceptable reasons for termination of treatment are as follows:
 - Patient failing to pay fees
 - Patient failing to show up for appointments
 - Patient refusing to give consent for life-saving procedures
 - Patient not allowing, or interfering in, the implementation of treatment plan
 - Patient refusing to follow instructions
 - Your change of the field of practice
 - Your abandonment of practice
- ✓ You can terminate treatment after giving the patient proper notice and enough time to find another doctor. Take the patient's acknowledgment on such notice.
- × Don't terminate treatment of critical patients where termination may have adverse effect on life or limb of the patient.
- × Don't terminate treatment out of frustration; treatment can be terminated on ethical considerations only.
- × Don't terminate treatment of emergency patients till they stabilize.

13.7. Brought-dead/death-before-diagnosis cases

- ✓ Inform police at the earliest.
- × Don't do anything with the dead body without police permission.
- × Don't prepare medical records.

13.8. Poisoning cases

- ✓ Inform police irrespective of mode of poisoning.
- ✓ Preserve the returning fluid of stomach wash in sealed containers.
- × Don't issue normal death certificate.

13.9. Injury cases

- ✓ Record properly nature, dimension and location of injury.
- ✓ Produce the records before police when demanded.
- ✓ Inform police if there is a reasonable cause for suspicion, especially when history supplied is doubtful or conflicting or when the injury could be a result of criminal act.

13.10. HIV/AIDS patients

- ✓ Isolate the patient.
- ✓ If the hospital is deficient in equipments needed in such cases,
 - refuse to admit the patient;
 - refuse to treat the patient further, i.e., after HIV/AIDS is diagnosed;
 - transfer/refer the patient to a hospital having appropriate facility.
- ✓ Maintain confidentiality.
- × Don't refuse treatment only on the ground that the patient is HIV infected.
- × Don't discriminate an HIV/AIDS patient — it is violation of basic human rights.

13.11. Mentally ill patients

- ✓ Ensure that a third person is not injured by such patients.
- ✓ Take special efforts to keep such patients under control even if there is no consent, but only till the danger exists; thereafter, the restraint must cease.
- × Don't subject mentally ill persons under treatment —
 - to any indignity (physical or mental) or cruelty; or
 - to mechanical restraint, solitary confinement or other harsh measures unless there are compelling reasons, which shall have to be recorded in writing.

13.12. Patients with communicable diseases/notifiable diseases and epidemic diseases

- ✓ Make efforts to inform spouses and family members.
- ✓ Inform authorities in writing, duly acknowledged, wherever statutorily required.
- ✓ Isolate the patient.
- × Don't abandon your duty in fear of contracting disease.

13.13. Duties of the attending doctor — appointment of substitutes/on-call physicians/locums

- ✓ Substitutes or on-call physicians can be called if the attending doctor is —
 - attending to an emergency;
 - in the midst of other professional engagements;

- ill or incapacitated, temporarily or permanently; or
 - on vacations.
- ✓ Specific notice by the attending doctor and consent of the patient are required in case the attending doctor has specifically agreed to attend to the patient or perform a particular procedure.
 - ✓ Select a qualified, experienced and competent doctor.
 - ✓ Provide adequate instructions.
 - ✓ Flag special needs of the patient.

13.14. Duties of substitutes/on-call physicians/locums

- ✓ Attend to calls of substitutes of peers
- ✓ Provide 'reasonable' substitute care.
- ✓ Act with utmost care and consideration.
- ✓ Always keep in mind the interest and reputation of the attending doctor.
- ✓ Return the patient on return of the attending doctor.
- ✓ Avoid passing remarks on the diagnosis made by or treatment given by the attending doctor.

13.15. Engagement of another obstetrician

- ✓ It is permissible only if the attending physician is already engaged on a similar or other serious case.
- ✓ Substitute physician is entitled to professional fees.
- ✓ Substitute physician must withdraw completely on the arrival of the attending doctor.

13.16. Postmortem

- ✓ Promptly inform police of any unnatural death. Police have the power to decide whether to conduct postmortem or not.
- ✓ Inform police in writing of any unnatural death.
- ✓ Specifically request the police to conduct postmortem.
- ✓ Preserve a copy of the intimation bearing police acknowledgment.
- × Don't pay attention to requests or pressure from the patient's relatives not to inform police.

13.17. Euthanasia, brain death

- ✓ Practicing euthanasia is unethical.
- ✓ After brain death, life-supporting devices can be withdrawn in accordance with Transplantation of Human Organ Act, 1994.

13.18. Torture medicine

- ✓ Treat the victim, both physically and psychologically.
- ✓ Document accurately and fearlessly the nature of injuries.
- × Don't aid in or abet torture.
- × Don't be a party to inflict mental or physical trauma.

- × Don't be a party to concealment of torture inflicted.

14. Accidents

14.1 Accidents — general precautions

In case of a medical mishap/accident (or even where a medicolegal problem is apprehended),

- ✓ Collect all medical records and keep them safely.
- ✓ Take appropriate remedial steps to save the patient and minimize loss.
- ✓ Inform the patient and attendants about the accident.
- ✓ Transfer the patient to another facility for appropriate treatment, if indicated
- ✓ Prepare transfer summary or discharge summary carefully, briefly recording the reasons for taking that particular course of treatment, the resulting complication(s), post-complication treatment and reasons for transfer/discharge.
- ✓ Collect all medical records and keep them safely.
- ✓ Avoid writing medical records in a hurry. Take help from peers to complete the records.
- ✓ Make a note for personal reference and use in future enlisting the treatment, mishap, remedial measures, etc.
- ✓ Offer to make good the loss or replace the deficient material/equipment absolutely free or at a discounted rate, if possible — in case of genuine clear-cut deficiency in material/equipment/procedure.
- ✓ Inform the patient and make efforts to remove the foreign body at the earliest — in case you discover that any foreign body has been left inside the body after closing.
- ✓ Obtain and preserve permanent addresses and contact details of the doctors and nurses present during a medical mishap so that they may be summoned as your witnesses in court to prove your case.
- × Don't make efforts to cover up an error, mistake or accident. It is usually counterproductive for both the patient and the doctor.
- × Don't delay in informing police if you sense restlessness in the patient or in his/her relatives.