

View Point

Blunders/Mistakes in Postmortem Examination and Suggested Remedies

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ABSTRACT

Word blunders and mistakes have different meanings. Blunder means clumsy or foolish mistakes, while mistake means an error of judgment. There is no scope of blunders/mistakes in forensic medicine. A medical practitioner must remember that his responsibility as a medical jurist is very great, for very often his is the only reliable evidence on which the liberty of life of an individual depends. How often do autopsy blunders/mistakes occur? None knows because there are no data collection centres at national as well as state level. We discuss three examples of such blunders/mistakes. In one case, uterus was reported ruptured but it was found intact, in second case the finding of hanging was described but cause of death was opined as strangulation and in third case the opinion was pressure over the neck. We can suggest many remedial measures but root cause of such blunders/mistakes is teaching, which is not practically oriented.

Keywords: Blunders, Mistakes, Autopsy, Postmortem

INTRODUCTION

Word blunder and mistake have different meanings. Blunder means clumsy or foolish mistakes, while mistake means an error of judgement¹. There is no scope of blunders/mistakes in forensic medicine. A medical practitioner must remember that his responsibility as a medical jurist is very great, for very often he is the only reliable evidence on which the liberty or life of an individual depends². How often do autopsy blunders/mistakes occurs² None knows because there are no data collection centres at national as well as state level.

The blunders in postmortem are done usually by medical officers, working in periphery at primary health centre, community health centre and district hospitals. Medical officer working at periphery as medicolegal expert commit blunders/mistakes due to lack of knowledge of this subject of forensic medicine. They consider medicolegal work as burden but have to carry out as per rules. Usually, they try to avoid the medicolegal work and even take casual leaves especially for postmortems. The other causes of

blunders include pressure by news in media, politicians, mob, police, rumors and fear of registration of FIR. Medical professionals harbour apprehension that they will be a witness and may have to face the police interrogation. It may need going to police station repeatedly and waiting and also to be a witness in a court of law. They fear that they may have to go to the court on number of days and may have to wait for long time and may have to face sometimes long unnecessary cross examination, which sometimes may be humiliating for a man in medical profession².

AIMS AND OBJECTIVES

1. To establish data collection centres for such blunders/mistakes at national or state level.
2. To find out causes for these blunders/mistakes.
3. To suggest remedial measures in such cases.
4. To bring blunders/mistakes in the knowledge of our colleagues.

OBSERVATION

Case No. 1: A female patient was admitted in a private hospital for delivery with h/o LSCS on 14 September 2008 at 5.30 AM. The patient was kept for normal delivery up to 11.15 AM but there was no progress of labour. The lady doctor decided to go for LSCS but the husband and relatives did not give consent, despite of repeated request. At 2.45 PM, IUD of fetus occurred but even then the relatives not consented for LSCS. Then the doctor asked them to consent for delivery by outlet forceps and also warn them that scar of previous LSCS may rupture. The relatives finally agreed for this procedure. At 4.30 PM, a male stillborn child was delivered. At 9.30 PM, the patient c/o difficulty in respiration and developed respiratory arrest and declared dead at 10 PM on 14 September 2008. The relatives were informed. They became agitated; mob collected and started throwing stones on hospital. Then police controlled the situation and body was shifted to mortuary. The government doctor's medical board conducted postmortem examination (PMR No 146, date 15 September 2008) and observed a tear of size 5 inches x 3 inches x cavity deep in uterus, transversely placed and opined that cause of death is 'hemorrhagic shock due to rupture of lower uterine segment'. However, viscera's were preserved for chemical and histopathological examination. The lady doctor requested police to take expert opinion from expert of medical college but police did not bother and ultimately she requested to honorable Rajasthan High Court for this. On order of honorable Rajasthan High Court, the opinion was obtained from medical board of our institution, in which it was found that the uterus was intact (Report No. Path/593/dated 10 November 2008) and there was no negligence on the part of the treating doctor. The innocent lady doctor was forced to remain in jail for 3 months.

Case No. 2: The medical board conducted a postmortem examination of an alleged case of hanging of female at periphery (PMR Dispatch No-10496 date 29 June 2010). The doctors mentioned in PMR that the tissues underneath the ligature mark are a vascular, dry, white and glistening but opined that the cause of death is strangulation. The accused were arrested. The medical board constituted on request of higher authorities of police, reviewed the

PMR and opined that the cause of death is hanging. The innocent accused was bailed out by court on our report.

Case No. 3: In this case, a postmortem was conducted by medical board of an alleged case of hanging at periphery and opined that the cause of death is pressure over neck. They also mentioned in PMR (PMR NO- 8/12) that the underlying fascia and muscles of neck are normal. The medical board of our institution constituted by order of honorable high court, gave the opinion that cause of death is hanging.

DISCUSSION

In case No. 1, the members of medical board, in which a senior specialist of gynaecology and obstetrics was also a member did not bothered to see the uterus, which was found intact by histopathologist. They wrote a tear in uterus. The reason for it is best known to them. However, it appears that they were standing away from the body and ordered the sweeper to carry out the postmortem. They even did not bother to see the alleged organ uterus. The other reason could be the pressure of mob, news in print media. At least the alleged part should be dissected by doctor, if whole of the postmortem is not conducted by their hands.

Second, as per BHT the patient expired after about 6 h of procedure. In case, size mentioned by the board of tear in uterus, the patient should die immediately after rupture. This finding is also not consistent with PMR and goes against the theory of rupture.

In the second case, members of board were confused between hanging and strangulation and opined strangulation in place of hanging. If someone is not sure, at least he can consult a textbook of the forensic medicine before giving opinion.

In the third case the opinion was incomplete. The honorable Rajasthan High Court was very sore on this. We always teach the student that the opinion should be very clear.

We can suggest many remedial measures but root cause of such blunders is teaching which is not practically oriented. Till we do not stress on practical teaching, such blunders/mistakes shall occur in future also.

Second, in present scenario, we see that there are junior specialist/senior specialist of various subjects like medicine, surgery, etc. at PHCs, CHCs and district hospitals, but we do not find the junior specialist of forensic medicine even at the district level. The medical officer who have done diploma in forensic medicine should be promoted to junior specialist/senior specialist till the MD forensic medicine people are available.

It has been stressed that the medicolegal expert is not a detective⁴. If a medical officer working as forensic expert is wrong in one case, how he can be right in all other cases.

It may be hard to criticise a fellow practitioner, but it would be wrong to ignore the public interest and to conceal that which one knows to be true or to suppress which one honestly believes to be true. This is usually done under

the misguided notion that by doing so, they would be doing disservice to the profession. On the contrary, such persons who ignore the public interest, brings the profession to disrepute. The golden rule 'Do unto others as you would wish that they should do unto you' should be strictly observed on these occasions.

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