FORENSIC MEDICINE FACE TO FACE WITH MEDICAL NEGLIGENCE

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Abstract

While conducting autopsies, a doctor often comes across a case, which shows a chance evidence of obvious gross medical negligence. But due to systemic restrictions, he cannot take an initiative to report such cases in a manner where in the affected families can get due compensations. His dilemma is further enhanced by the fact that the lay people and the law enforcement agencies are not in a position to take cognizance in such cases. While highlighting three such case reports, the paper has made an attempt to discuss such problems. The obvious remedies involve a positive role to be played by the subject of Forensic Medicine, which will also help to enhance the standards of patient care and reducing the incidents of medical negligence.

Introduction

Medical negligence is professional negligence on the part of the doctor, and can be either due to absence of reasonable care and skill, or due to willful negligence (2,8,10). The term "Reasonable Care" of course goes proportionately with the known inability of the patient to take care of himself, as well as the level of competence expected out of the doctor. Medical negligence can be due to acts of commission (doing something that should not have been done), or acts of omission (not doing something that should have been done).

The question of alleged negligence can be brought up in both Civil as well as Criminal Courts.

Forensic Medicine faces the topic primarily under three conditions:

1. While teaching the subject to medical students.

2. Conducting autopsies or reviewing medical records in cases of death due to alleged negligence.

3. Chance discoveries during routine medico legal autopsies in cases that were under medical treatment.

It is under the third category that the following case reports are being discussed.

The autopsies were conducted in the Department of Forensic Medicine of University College of Medical Sciences and Guru Teg Bahadur Hospital, Delhi, as routine medico legal autopsies.

CASES DESCRIPTION

Case1:

A 45 years old male was driving his scooter when it slipped in the rain. In the emergency room, he was disoriented, with slurred speech, relatively stable vitals, and his breath smelling of alcohol. There were no externally visible injuries.

He died in the hospital four days later, being unconscious throughout, and all the while being managed conservatively as a case of acute alcoholism. Hospital death certificate mentioned the cause of death as Acute Alcohol Intoxication.

An autopsy was conducted the next day. It revealed a large hematoma in right temporo-parietal area of scalp, a fissured fracture of right squamous temporal bone, and an extradural hematoma pressing upon the edematous brain in right parieto-temporal area.

Evidence of cerebellar herniation was present.

Autopsy report gave the cause of death as Head Injury.

Case 2:

A 24-year-old male, a known case of Depressive Mental Illness, cut his throat with a kitchen knife. In the emergency room, he was stable and maintaining his vitals. His neck wound was repaired surgically. He died on the second day at the hospital, and the hospital death certificate mentioned the cause of death as Cut Throat Wound. An autopsy was conducted the next day. There was congestion of face and eyes. The cut throat wound on the left side of neck had cut the skin and some underlying muscles, but had spared the airways and other deeper vital neck structures. The laryngeal apparatus was found to be grossly edematous, and vocal cords were almost completely blocking the airway. Lower airways were found patent. The organs were all congested. No gross edema was found in other body structures. No tracheostomy wound was found. Autopsy report gave the cause of death as Sharp Weapon Injury to Neck, causing inflammatory edema and blockage of airways.

Case 3:

A 20-year-old male pedestrian was hit by a TSR during winters.

In the emergency room, he was unconscious, but with relatively stable vitals.

Externally, a bleeding laceration was present over the forehead. He died one day later in the hospital, all the while being unconscious and being managed conservatively as a case of concussion (post CT scan). Hospital death certificate mentioned the cause of death as Head Injury.

An autopsy was conducted the same day. There was a laceration measuring 3.5 X 1.0 X 0.2 cm on the right side of forehead, with some bruising of underlying scalp tissues. Internally, the brain was found to be pale, with no gross structural pathology or edema. The lungs were contused near their hila. The right lobe of liver was found lacerated, with 1500 ml of blood in the peritoneal cavity. The organs were all pale. Autopsy report gave the cause of death as Blunt Trauma Injuries to Abdomen resulting in hemorrhagic shock.

DISCUSSION

While studying the Case 1, it is obvious that the medical team fell into the trap of the Grey Zone that envelops the head injury and alcoholism. Absence of external injuries further added to the hasty presumption, and the patient was not suspected of having a possible head injury. Just a CT scan would have saved the day (2,5,8,9,10).

As regards the Case 2, for the reasons best known to him, the surgeon omitted a tracheostomy, although prescribed by the standard textbooks in such cases where repair is carried out on a cutthroat wound. Absence of injuries to the deeper neck structures probably added to his confidence. But inflammatory edema, secondary to healing and repair, is bound to develop, and can even compromise on intact airways (1)

In the Case 3, the profusely bleeding scalp wound in an unconscious patient attracted all the attention and concern. No other external injuries were present as the patient must have been clad in heavy woolens. Possibility of polytrauma was not suspected, and the patient actually died from slowly hemorrhaging ruptured liver, which was very much amenable to surgical intervention (2,5,8,9,10)

In all the above three cases, there could have been no possibility of contributory negligence on part of the patient. The treating physicians were in full control of the situation, and should have reasonably foreseen and avoided the negligent acts. As such, there is nothing to suggest as a defense against gross negligence (2,4,8,10).

Autopsy reports, like other medico legal documents, are not to be disclosed unless handed over to the police. Therefore, the doctor who conducts an autopsy in such cases cannot discuss the incriminating findings with the relatives of the deceased (7,8,10).

Lay people have little insight into these technical matters, unless specifically told and explained. And so is the case with the police and the judiciary.

Negligence being a legal issue, to be decided upon by a Court of Law, the doctor cannot specifically mention so in the autopsy report, unless asked to do so by the authority requesting the autopsy. As negligence is not the primary issue in these cases, such questions are never asked from the doctor (8,10).

Although all the facts are stated in the autopsy report, they generally do little to alter the course of proceedings. As in here, the first two cases would never have reached the Court of Law, while in the third case the guilt of the accused stayed the same, no matter as to which body part of the victim was affected. Cognizance of the issue of medical negligence thus becomes difficult.

Thus, although the helpless families of the victim are legally entitled to be paid suitable damages, they are actually denied of it, just because legal cognizance cannot be affected.

In such cases, how wise, or how much practically possible it would be for the doctor conducting the autopsy, to personally volunteer such information to appropriate statutory boards like the Medical Council, is a question split wide open for debate. Although the hospital authorities concerned can be informed, and the matter taken up in 'Death Meetings' and 'Medical Audits', the prime issue of justice to the families of the victims would still hang in mid air.

The subject of Forensic Medicine obviously faces this dilemma. The question arises, as to whom a duty is owed (7,8,10).

The Court of Law - Yes, it is statutory, but the complete facts are already in black and white in the autopsy report!

Medical Profession - Yes, as ethically bound. The matter can be brought to the notice of hospital authorities and even medical councils, but what about the justice to the aggrieved families!

Hospital authorities - When the doctor is conducting autopsy under employment of the hospital where negligent treatment was given, how much practical it would be to blow the whistle!

The victim / his family - There is no therapeutic relationship!

Considering all, the above, there seems to be a pressing need for revaluation of the sense of duty of such a doctor who is conducting the autopsy. As a doctor, his foremost duty is towards humanity, and it should not be defeated(8).

Even from the point of view of benefit to the medical profession, the issue is important, especially in Indian context. India is still in the incipient stages of emergence into an era where people will become more aware of their rights and the judicial remedies, and the number of cases in the courts for claiming damages in medical negligence will become plentiful. In the developed countries, this situation has already arrived. It is therefore imperative that the medical professionals in India adopt healthy preventive practices before hand.

SUGGESTIONS

Such unfortunate cases should be notifiable to a central independent tribunal, comprised of both medical and legal representatives. The tribunal should have statutory powers to take cognizance on itself and initiate proceedings towards suitably compensating the families of such victims and payment of damages, after contacting and apprising them of the facts.

The present day Consumer Redressal Forums are not suited for the purpose, as they cannot penalize the majority of culprits which are actually the state owned hospitals, and who are giving treatment free of cost. Moreover, cognizance can be taken only when the families report the case first (8).

Prevention is of course better than cure. The following measures can be implemented:

a) The subject of Forensic Medicine should receive more attention in the medical institutes and their curricula. It should be also realized that this is the only subject that can provide the final window through which the clinicians can assess their own understanding and management of patients. They should regularly interact with the doctors who are conducting autopsies on such victims. Rate of pathological autopsies, as we all know, is unfortunately very low in India.

b) The Medical Audits and the Hospital Death Meets should be enforced in a more productive and meaningful manner with active inputs from Forensic Medicine specialists.

c) 'Emergency Room Medicine' should be developed as a full-fledged specialty subject, so that, instead of acting merely as screening room, resuscitation room or a traffic control room, the emergency room is actively managed by trained specialists who can ensure that the patient care is not restricted to the myopic attention of a single specialty (3).

CONCLUSION

There is a pressing need for the development of a system, wherein the cases of medical negligence which otherwise would have gone unreported, can be taken notice of and the affected families suitably compensated.

The subject of Forensic Medicine can play a pivotal role and the specialists of this field should strive towards a common goal. The medical institutes and other appropriate authorities should realize the significance of this role. This would benefit not only the patients, but also the medical profession itself.

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