Contemporary Issue

Common Medicolegal Problems Faced by Medical Officers of Armed Forces Medical Services

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Abstract

Many a times medical officers of Armed Forces Medical Services face problems concerning policy as well as policy matters in connection with their medico-legal duties and responsibilities. This is particularly so with hospital administrators, pathologists and surgeons. Over and above, the lack of Army Orders and DG Memoranda on this topic makes one feel at a loss. The consequences of mistakes committed while performing medicolegal duties may include strictures from the courts. This article tries to list the common medicolegal problems encountered by medical officers of Armed Forces Medical Services working at different levels and in different capacities, and provides solutions for the same.

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Introduction

Forensic Medicine including Medical Jurisprudence, which is a subject in MBBS curriculum of II year, familiarizes and addresses the medico-legal (ML) aspects of medical practice. This knowledge is essential for both private practitioners as well as for the doctors employed in institutions both private and government, as the laws are equally applicable to both categories of doctors. Unfortunately, the institutional doctors tend to be complacent and ignorant of the laws under the presumption that it is the employer / hospital administrator who is supposed to address any legal problem. This is especially so in our set-up, as military doctors are not asked to perform ML work and as a consequence are ignorant of basic ML procedures and formalities. Usually, the problem gets compounded in a peripheral hospital, as even the senior medical administrators can not provide guidance and solution to the ML problems, albeit occasionally. In spite of ML problems cropping up from time to time, there is no clear cut Army Order (AO)/Special Army Order (SAO) or DG Memorandum about the ML responsibilities of service medical officers which leads to doubts and at times confusion, depending upon the situation. There is a tendency on the part of military medical officers (MOs) to avoid ML duties which he cannot and should not, being a registered medical practitioner. For example, duties under Criminal Procedure Code (Cr.PC) section 539, Cr. PC section 175, section 202 of Indian Penal Code (IPC) etc. This reluctance is basically due to lack of knowledge and information. This article is being writ-

ten with the intention of providing answers to the usual ML problems, which arise in our peripheral hospitals and Medical Inspection (MI) rooms and is being made available to all MOs of Armed Forces Medical Services. The list of questions and problems addressed is not exhaustive. It has been compiled based on the service experience of the authors and the usual questions and doubts raised by the MOs attending various refresher courses at Armed Forces Medical College, Pune.

Problems faced by Regimental Medical Officers (RMOs):-

Attending patients :-

RMOs are the authorised medical attendants (AMA) [1], for the troops as well as their families placed under their care. Legally, it means the contract of doctor patient relationship is in force. Hence, the RMO is duty bound to attend all the calls made by these persons. It goes without saying that in case of emergencies the patient has to be attended wherever he is, even at his home. The usual reluctance of a young MO to attend to someone either in his office or at his home may put him in trouble if the situation is one of an emergency and non-attendance or insistence of attending to the patient only in the MI room, leads to bodily damage to the patient. The doctor can be sued for medical negligence. MOs should use their medical knowledge to decide whether it is an emergency or not and act accordingly.

Although all MOs are ethically duty bound to attend to any ailing person, even if he is the enemy

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soldier, legally a registered medical practitioner (RMP) is at liberty not to accept a patient without giving any reasons [2]. However, the usual reasons given for not accepting a particular case are lack of experience, lack of facilities, busy schedule etc. But the RMO has no such choice in case of troops and families for whom he is the AMA. But he is at liberty not to attend to a person for whom he is not the AMA. The situation is somewhat similar to the MOs of National Health Scheme of England.

When a doctor attends to a patient only during an emergency, the doctor patient relationship does not get established. Hence, the possibility of the doctor getting blamed for medical negligence subsequently, should a mishap occur with the patient, does not arise [2]. Existence of doctor patient relationship is essential for medical negligence to occur. The doubt comes up when a civilian who has sustained injuries is brought to the MI room for emergency care. The MO in charge (MOIC) MI room can go ahead with emergency treatment without any hesitation, rather ethically he is duty bound to attend to all emergencies.

Death Certificate

If the RMO has examined the person either just before death or within previous 7 days prior to death and is sure of the cause of death and has no doubt about the death being natural, he is duty bound to issue the death certificate (AFMSF - 93, Part I) immediately. Otherwise he will declare the person dead and inform the police, making it a ML case [3]. A RMP is authorised to issue death certificate only for natural deaths. Hence, all cases of unnatural (suicidal, accidental and homicidal) deaths and deaths where there is room for suspicion about the death being natural, are to be reported to police for further investigations as ML cases. The RMO is duty bound to examine and declare a person dead at the place of death, for whom he is the AMA. He should not insist that the 'dead' person should be brought to the MI room for declaration of death.

Dilemmas Encountered in a Hospital Setup :

MO IC MI Room / Duty Medical Officer (DMO):-

All medical and ML certificates and reports issued from a hospital are issued by the administrative authority of the hospital i.e. Commandant/Senior Registrar/Registrar or Administrative Officer. Accordingly, all letters and requisitions for certificates by individuals / police stations are to be addressed and delivered to the administrative authority of the hospital. MI rooms and Out Patient Departments (OPD) are not

to issue any certificate directly to any individual or police. The same restrictions apply to the DMOs also, except the issue of death certificate. MO IC MI room / DMO is responsible to inform all cases of accident, suicide and homicide to the police, as required under Section 39 of Cr PC. The discretion of not informing attempted suicides to police, available to RMP (private) [1], is not available to doctors working in government health set up. It is the duty of the first MO who attends to the case, to inform the civil police.

Stomach Wash Fluid in Poisoning Cases

MO IC MI room / DMO / Specialist who orders the stomach wash is responsible for safe custody of the fluid obtained till it is handed over to the police. Same is the case with other substances like vomitus, stools, container of poison etc. (section 201 IPC). Hospital administrators are responsible to provide such facility for safe custody to avoid tampering with valuable evidence.

After having collected the fluid, appropriate preservative is added to it, the bottle is labelled and the lid sealed with a specific seal, either the hospital seal or the personal seal of the doctor. The impression on the seal applied should be legible. The requisition form for investigation to be carried out is also to be filled properly. The police officer in charge of the case, investigating officer (IO), is informed of the collection of the specimen and asked to collect it for further submission to forensic science laboratory. The specimen is handed over either to the IO or his authorised representative and receipt for the same is obtained by the MO and preserved. Maintaining this "chain of custody" is important, as this evidence of handing over of the specimen may have to be produced in the court. Many a times, it so happens, that the IO does not arrange for collection of the sample. Even in such a situation, the specimen cannot be destroyed without the permission of IO. However, in practice, to avoid unnecessary accumulation of such samples, the IO is requested to collect the samples within a specified time limit (three weeks) and informed that failing to do so, it will be presumed that the sample is not needed for investigations and will be destroyed. The procedure is practised with the concurrence of police authorities.

If a sample collected is lost or destroyed by MO who collected it without permission of IO, he can be punished by the court for causing loss/destruction of evidence under section 201 of IPC.

Case of alleged rape at MI Room /Gynae OPD:

Rape being a serious criminal offence, the alleged

victim of rape should be directed to the nearest police station for lodging a complaint first, unless she is in need of urgent medical treatment. Once she lodges a complaint in the police station, she will be referred to the hospital by the officer in charge of the police station through a letter and along with a police constable. Then only the doctor should proceed to examine her. However, if she is in need of urgent treatment, she should be admitted, emergency care provided and the nearest police station informed immediately. The hospital administrator must ensure that the case is registered in the police station.

Hospital Administrators :

The commonest problem faced by the hospital administrators is obtaining the autopsy report of ML postmortems conducted in civil hospitals. All prosecutors are bound to make the autopsy report ready either immediately after finishing the post-mortem (PM) or within a day or two. The administrative head of the civil hospital may not agree to provide the same to the military hospital directly. He is supposed to reveal the findings only to the police authorities, who ordered the PM. Hence the civil hospital usually asks the military hospital to obtain the copy from the concerned police station.

In case of autopsies where organs have been sent for chemical analysis, final cause of death will not be decided by the prosecutor till the chemical analysis report of the samples sent to the State Forensic Science Laboratory (FSL) is received. The FSL usually takes 6 months to 1 year to give the report due to heavy workload. Personal liaison with the FSL can hasten the process. Once it is explained to the FSL authorities that family pension of the deceased soldier is not finalised till the final cause of death is declared, they oblige and provide the report at an early date.

Chemical analysis of the specimen preserved :

As brought out earlier, the preserved specimens have to be handed over to the IO, along with a requisition form for analysis, for onward submission to the FSL. However, in some cases the IO does not collect the specimen. Under such exceptional circumstances as well as for arriving at a definitive diagnosis in non-ML cases, there is a provision to get the required analysis done at FSL on payment. This provision helps in arriving at a final diagnosis and finalising the fatal case documents.

The medical documents of all ML cases including cases of family members should be preserved in the medical record section of the hospital, indefinitely. In our set up, the fatal case documents of soldiers dying

in service are available with DDG Pensions. These documents have to be produced in original in the court, during the court proceedings. They are also essential for the summoned MO to refresh his memory before attending the court.

Confidentiality of documents - AIDS/HIV positive cases :

Ethical and legal requirement of maintaining professional secrecy in connection with all medical documents need not be reiterated. But special attention to this aspect is to be given in AIDS/HIV positive cases. Methods to conceal the HIV positivity of any patient like marking the documents with a code sign / number rather than writing "HIV Positive" is to be adopted. Access to such medical records is to be limited to only those individuals with a justifiable medical need or right to see them [4].

AO 54/75 [5], which deals with Courts of Inquest and Courts of Inquiry in cases of un-natural deaths of serving soldiers makes provision for holding inquest by military authorities in operational areas. It also states that a service pathologist should be made available to the civil authorities to carry out the postmortem if a suitable MO is not available with them.

Computers in Medicine

With the fast growing popularity and availability of computers, military hospitals too are using them to store medical records of patients. The futuristic approach includes provision of networking of military hospitals. Although this will greatly facilitate patient management and documentation, such on-lining of medical records is likely to endanger confidentiality of the medical records. The resolution adopted by World Medical Association (WMA) in 1973 on Medical Secrecy and Computers in Medicine:

- Re-affirms the vital importance of maintaining medical secrecy not as a privilege for the doctor, but to protect the privacy of the individual as the basis for the confidential relation between the patient and his doctor;
- Asks the United Nations, representing the people of the world, "to give to the medical profession the needed help and to show ways for securing this fundamental right for the individual human being."
- Request all national medical associations to take all possible steps in their countries to assure that medical secrecy, for the sake of the patient, will be guaranteed to the same degree in the future as in the past.

- Requests member countries of WMA to reject all attempts having as a goal legislation authorising any procedures to electronic data processing which could endanger or undermine the right of the patient for medical secrecy.
- Express the strong opinion that medical data banks should be available only to the medical profession and should not, therefore, be linked to other central data banks.

Pathologists and ML Autopsy

Authority to carry out ML post-mortem in military hospital [6]:-

Military MOs are not empowered by the state home ministry to carry out ML autopsies. The administrative set up of the state government authorises only the MOs functioning in state health services for such work, for administrative convenience. On similar principle, MOs working in railway hospitals, private hospitals and private medical colleges are also not empowered to carry out ML autopsies, unless the institution has obtained a specific government permission from the state home department. Usually such sanction is given to private medical colleges/hospitals to facilitate teaching. Another problem faced by the pathologist / OIC military hospital is that, at times the individual's unit obtains police clearance for carrying out the ML autopsy by military MO, usually in a case of Sudden Death or Unattended Death. Invariably the police clearance is worded as follows:-

"The undersigned has no objection to the military MO carrying out the PM on the dead body of It is requested that a copy of the PM report may be provided to the undersigned for our records".

Such a letter is not acceptable as clearance. The police should specifically state that they are not suspecting foul play and the case should be deemed closed as ML case by them and consequently they can not ask for a copy of the PM report. The IO is empowered to come to such a decision after the "Panchanama" and can dispose off the body if he decides that the cause of death is natural and no foul play is suspected. Office of DGMS (Army) has clarified this issue in 1987 (Army HQ/DGMS-5(A) letter No.31303/Policy/DGMS-5A Dtd.06 Jul 87) and the format of the clearance certificate to be obtained as per that letter is reproduced as Appx 'A' to this article.

Clinical Autopsies :

One more issue for the benefit of hospital administrators and pathologists needs clarification; that is

about the mandatory requirement of clinical PM on any serving soldier dying in service, except during war to establish the cause of death. The usual understanding of all hospital administrators is that a PM diagnosis is a must for all such cases. That is NOT the requirement of PCDA Pensions, Allahabad. What is essential for them is a conclusive unequivocal diagnosis of cause of death. If that has been established by procedures like biopsy, ECG, microbiological studies etc. before death, then autopsy is not mandatory [7].

Pre-requisites for conducting ML autopsy :

Despite all that has been written above, in some situations a service pathologist or surgeon may have to carry out ML autopsy, especially in remote areas or as a result of political decisions. Under such circumstances he must ensure that the following documents are submitted to him by the police authorities prior to the beginning of the autopsy :

- a. Requisition by police officer in charge of the case (IO) to carry out autopsy addressed to the military hospital.
- b. A copy of 'Panchanama'
- c. Dead body challan-copy enclosed as Appx 'B'

It should be noted that consent from relatives is not required for ML autopsies, unlike clinical autopsies. After completing the ML autopsy the body is handed over to the police authorities (NOT to the relatives of the deceased) and a receipt obtained for the same. Police authorities will hand over the body to the relatives. As an alternative the body may be handed over to the relatives directly by the military hospital after obtaining written permission from the police authorities.

Conclusion

Like all RMPs, military MOs also have obligatory ML duties. It is hoped that the information provided in this article will provide answers to the ML questions faced by officers of Armed Forces Medical Services. As stated in the introduction, newer problems can crop up. In an effort to create a data bank of ML cases encountered in military hospitals, the Department of Forensic Medicine, Armed Forces Medical College, has taken up an AFMRC Project (2203/98) and has established a Nodal Centre for ML case study. Protocol for reporting cases to the nodal centre was distributed to all military hospitals along-with a directive from respective DGsMS. However, the response from the hospitals has not been encouraging. Very few hospitals have reported cases. The form to be used for reporting cases to the nodal centre is enclosed

as Appx 'C'. Contribution to such a data bank will also help the peripheral hospitals as a source for ready reference when any ML problem is encountered. It is hoped that all MOs of Armed Forces will be sensitised to this aspect through this article and report all ML cases encountered by them.

References

1. Regulations for the Medical services of the Armed Forces - 1983; para 287.
2. Subramanyam BV, editor. Modi's Medical Jurisprudence and Toxicology, 1999. New Delhi
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4. Kotabagi RB, Pathak PR, apte VV. AIDS - medicolegal aspects. MJAFI 1999;52-2:145-7.
5. Army Order 54/75 - Courts of inquest and courts of enquiry in cases of un-natural deaths.
6. Regulations for medical services of the Armed Forces. 1983; Para 58.
7. Personal communication from Lt Col GU Deshpande (Retd). Ex-JDAFMS pensions (Path), CDA (P), Allahabad.

Appx 'A' to Army HQ/DGMS-5(a)

letter 31303/Pol/DGMS-5A dt 06 Jul 87

POLICE CLEARANCE (VIDE CrPC SEC 174)

1. On receipt of the information of death of _____ from _____ the case has been investigated by the police and found that there is no reasonable suspicion of foul play involved in the death.
2. Police authorities do not intend sending the dead body for postmortem and have decided not to hold an inquest. The police have no further interest in the case
3. There is no objection from the police authorities to carry on the enquiry/postmortem examination and further disposal of the dead body by the Military Authorities, as may be considered necessary by them.

Station :

Dated :

Office Seal

Signature _____

(To be Signed by SHO, Police Station)

Name

(In block capital letters)

Designation:

Dead body Challan used for sending a dead body for post mortem examination

1. Name of deceased
2. Age
3. Married, Single, Widow or Widower
4. Date and Hour of death
5. Describe condition of body when found, position surroundings and any mark of violence, blood stains or vomited matter which may have existed.
6. Day and hour on which the body was seen by the officer making report
 - a. Beginning of the report
 - b. Completion of the report
7. Was the body cold or warm when found?
8. Had the deceased suffered from recent illness? If so what? State duration and describe the illness as far as known.
9. Had deceased suffered from accident, injury or violence of any kind? If so describe it.
10. If clothes, weapons, vomited matter or other articles are forwarded, state why this is done and what relation they bear to the case? Describe them.
11. Is death supposed to have been due to natural causes, accident, suicide or homicide? State briefly and plainly any suspicions that may exist and why.
12. Is there suspicion of poisoning? If so, is any particular poison supposed to have been employed? Mention any symptoms of poisoning which are reported to have existed during life and appearances pointing to poisoning observed after death.
13. In the case of woman, is she supposed to be pregnant or had been recently delivered?
14. Is abortion or attempted abortion known or suspected? And if the former, has the foetus been found?
15. State the finding of the jury (if any) and mention any reasons they may have been given for their finding.
16. Remarks - under this head the police officer should give any information not included in the above questions which he may consider likely to assist the civil surgeon in framing the opinion of the cause of death, or request by police officer for collecting the sample (if any) required for investigation.

Date :

Signature of Investigating Officer.

MEDICOLEGAL CASE PROTOCOL

_____ HOSPITAL

MLC NO _____ A&D NO. _____ DATE OF ADM _____

ARMY NO _____ RANK _____ NAME _____

AGE _____ SEX _____ RELIGION _____ UNIT _____

DATE & TIME OF DISCHARGE / DEATH _____

DATE & TIME OF POSTMORTEM _____

PLACE OF POSTMORTEM _____

BRIEF CLINICAL HISTORY / PANCHANAMA (Including Injuries) :-

CLINICAL EXAMINATION FINDINGS :

CLINICAL DIAGNOSIS :

COURSE OF EVENTS DURING HOSPITAL STAY & OUTCOME :

BRIEF POSTMORTEM FINDINGS :

AUTOPSY DIAGNOSIS (GROSS) :-

POSTMORTEM INVESTIGATIONS :-

FINAL DIAGNOSIS :-

ADMINISTRATIVE PROBLEMS ENCOUNTERED AND HOW SOLVED :-

PROFESSIONAL PROBLEMS ENCOUNTERED AND HOW SOLVED :-

DISPOSAL OF THE CASE BY LEGAL AUTHORITIES (POLICE / COURT):-

DATE OF COMPLETION & SUBMISSION OF FATAL DOCUMENTS :

Date :

O/C STATS SECTION/REGISTRAR