CLINICAL MANAGEMENT IN MEDICO-LEGAL PRACTICE

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Medico-legal Report

I. (a) GUIDE LINES FOR M/R WRITING

- Must be written so that it could be acceptable as evidence in a Court of Law
- Must be written by a medical officer who had examined the case
- Should be written as soon as possible after the exam:
- Should be in simple and clear terms for the information of Law Court
- Should be brief and concise
- Avoid inaccurate terms (about, nearly)

- Avoid the use of highly medical or technical terms
- Record the negative findings as well as the positive ones
- Any correction made on the report must be initialed or signed fully and dated by the M/O who did the correction. Care must be taken to avoid mistakes.
- Must be given based on
    - the facts observed by himself.
    - the aggregate of findings
    - not on hear say evidence

I. (b) REGISTER OF MEDICO-LEGAL CASES (MEDICAL 29)

- The findings must be immediately entered in the RPC after exam: of the case and after noting down the findings in the medico-legal report.
- The same words and number as that noted in the M/R must be written down.
- Two I/D of the person examined must be noted down
- At the end of the description, the examining M/O must write full signature, date, name in **block letter**, sama number, designation, hospital

I. (c) DUTIES OF M/O REGARDING M/R

1. Must be kept in a safe place by the M/O
2. Care must be taken not to make mistakes in the report.

   The correction must be initialed, signed fully and dated
3. Must be send to the corresponding police station on the same day ***or*** the day after ***or*** as soon as the report is complete (Preferably within 7 days)

Medico-legal report consists of

1. Preamble
2. Body/ Findings
3. Opinions, Inferences, Conclusion

1. PREAMBLE

(a) Report number, yearly number and serial number (reference number)
(b) Date and time of examination.
(c) I/D of Police
- Name, Rank, Serial number, Police station of the police officer who brought the case to the hospital.
(d) I/D of the person
- Name, age, sex, father’s name of the person to be examined, full address.
(e) I/D marks
- unknown bodies, rape cases and age determination
(f) Brief h/o of the case (e.g. h/o of assault)

2. FINDINGS

In Hurt cases

(a) Record both external and internal findings

(b) External injury must be completely described

Nature, Number, Site, Size, Shape, Margins and Ends.

Direction, Lie, Foreign bodies.

(c) Internal findings based on investigations must be recorded

CXR – pneumothorax, haemothorax, haemopneumothorax,

SXR – fracture or dislocation of a bone or a tooth

CT scan (head) – ICH

X-ray should be mentioned type, Reg; number, Date, findings and Radiologist's opinion

(d) Types of medical treatment and surgical operation must be fully noted down

(e) Opinion

Must be given based on the facts found on exam: and

results of investigation done.

1. simple or grievous hurt (သာမန်/ပြင်းထန်)

2. nature of the weapon used (တုံး/ချွန်/ထက်)

3. treated as an in-patient or out-patient (တွင်း/ပြင်ပ)

Note: လူနာအား (   ) ဆေးရုံကြီးသို့ (   )နေ့တွင် လွှဲပြောင်း ကုသမှုခံယူရန် ညွှန်ကြားထားသဖြင့် ရဲမှုခင်းဆေးစာနှင့် အပြီးသတ်ထင်မြင်ချက်အား သက်ဆိုင်ရာဆေးရုံကြီးမှ တောင်းခံနိုင်ပါရန်။

M.P.C. Section 320 – GRIEVOUS HURT.

The following kinds of hurt only are designated as " grievous hurt ".

1. Emasculation
2. Permanent privation of the sight of either eye
3. Permanent privation of the hearing of either ear
4. Privation of any member or joint
5. Destruction or permanent impairment of the power of any member or joint
6. Permanent disfiguration of the head or face
7. Fracture or dislocation of a bone or tooth
8. Any hurt which endangers life, or which causes the sufferer to be, during the space of twenty days, in severe bodily pain, or unable to follow his ordinary pursuits.

In case of rape and age determination,

1. General built
2. Height
3. Weight
4. Dentition
5. (a) Voice changes
   (b) Moustache (in male)
6. Breast changes
7. Axillary hair
8. Pubic hair
9. External genital development
10. Menstrual history
11. Investigation result (X-ray, vaginal swab for spermatozoa, etc.)

In case of age determination

- The physical and X-ray findings are consistent with a Myanmar girl/boy of age between ( ) and ( )years.

ကိုယ်ကာယစစ်ဆေးတွေ့ရှိချက်များနှင့် ဓါတ်မှန်တွေ့ရှိချက်များအရ ဤမိန်းကလေး/ယောက်ျားလေးသည် အသက် ( ) နှင့် ( ) အတွင်းရှိ သာမန်ဖွံ့ဖြိုးသူ မြန်မာ အမျိုးသမီး/အမျိုးသား တစ်ဦးနှင့် တူညီသည်။

In case of rape

1. Sign of recent sexual intercourse present.

လတ်တလော ကာမစပ်ယှက်ထားသည့်လက္ခဏာတွေ့ရသည်။

2. Sign of recent physical penetration present.

လတ်တလော ထိုးသွင်းထားသည့်လက္ခဏာတွေ့ရသည်။

3. No definite medical opinion can be given regarding recent sexual intercourse.

ကာမစပ်ယှက်ထားသည့် လက္ခဏာရှိ/မရှိ ဆေးပညာအရ တိကျသော ထင်မြင်ချက်မပေးနိုင်ပါ။

Opnions on Sexual Assault

၁။ ခန္ဓာကိုယ်ပြင်ပတွင် ဒဏ်ရာများမတွေ့ရှိပါ။ (သို့) တွေ့ရှိပါက ဖော်ပြရန်။

၂။ မှန်ပြားအမှတ် ( ) တွင် သုတ်ပိုး စမ်းသပ်တွေ့ရှိသည်။ (သို့) မတွေ့ရှိပါ။ (CEပြန်စာကိုးကားရန်)

၃။ အပျိုမြှေး ပကတိ အတိုင်းရှိသည်။ (သို့) အပျိုမြှေး စုတ်ပြဲနေသောဒဏ်ဟောင်း နာရီလက်တံအနေအထားအရ ( ) နေရာများတွင် တွေ့ရသည်။ (သို့) အပျိုမြှေး လတ်တလောစုတ်ပြဲနေသော ဒဏ်ရာ နာရီလက်တံ အနေအထားအရ ( ) နေရာများတွင် တွေ့ရသည်။

၄။ အထက်ဖော်ပြပါ ထင်မြင်ချက်(၃)ခုမှ တွေ့ရှိချက် စမ်းသပ်နှင့် ကိုက်ညီသောထင်မြင်ချက်တခုခု

၅။ အသက်စစ်ဆေးခြင်း

၆။ အရက်/မူးယစ်ဆေးဝါးနှင့်စိတ်ကိုပြောင်းလဲစေတတ်သောပစ္စည်း သုံးစွဲထားခြင်းရှိ/မရှိ။

မူးယစ်ဆေးဝါးနှင့်စိတ်ကိုပြောင်းလဲစေတတ်သောပစ္စည်းများသုံးစွဲထားခြင်းရှိမရှိ

1/ rl,pfaq;twGufrSwfykHwifxm;jcif; &Sdr&Sd (rxb eHygwf pmtrSwf)

2/ rl,pfaq;aomufoHk;rIrSwfwrf;0if &Sdr&Sd (pmtrSwf)

3/ ukd,fum,pdwfoyÜHpfaq;awGUcsuf &Sdr&Sd

wdkufaq;jywfvufrSwfm

4/ aq;xkwfty&m &Sdr&Sd

5/ qD;ppfaq;awGUcsuf (TLC) &Sdr&Sd ("gwfcGJ"0e&Sdyefpm)

pdwfoyÜH0if rl,pfaq;oHk;pGJonfhtajctaerawGU

pdwfoyÜH0if rl,pfaq;oHk;pGJonfhtajctaeawGUonf/

Opinion for examination of drunken person

1. Had not taken alcohol

   (အရက်သောက်မထားပါ)

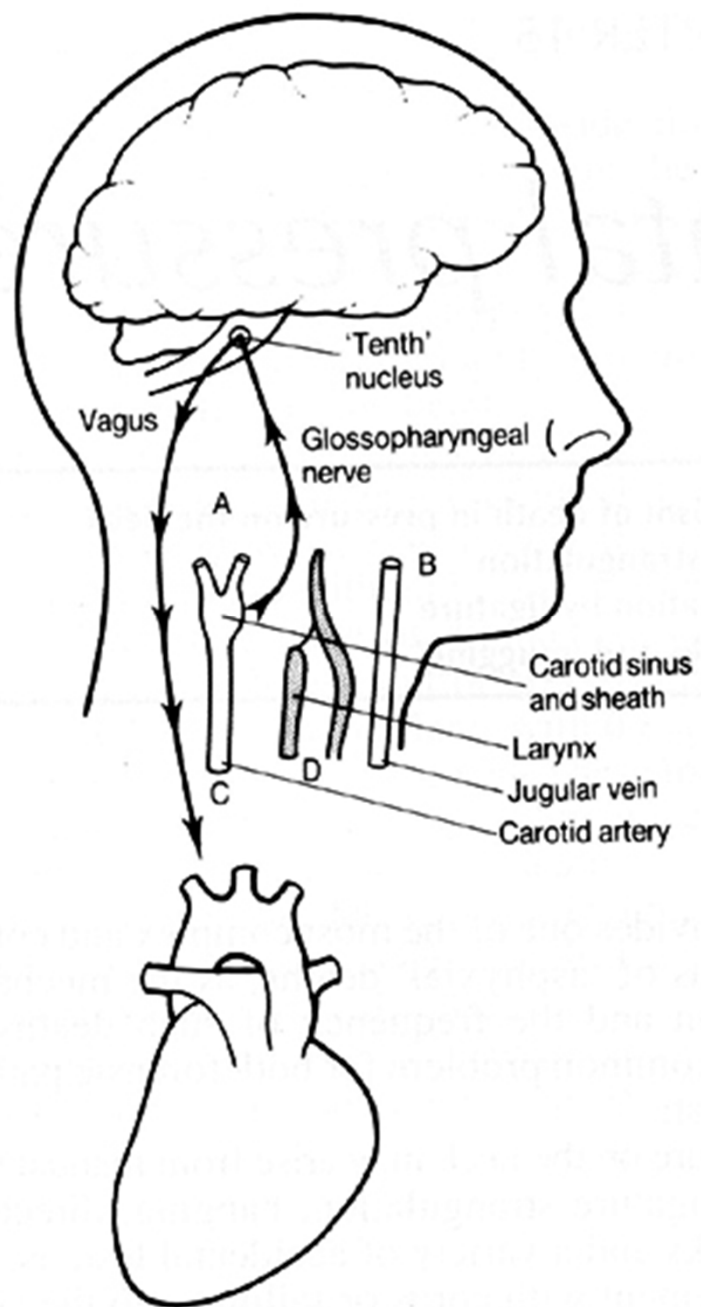
2. Had taken alcohol, but not under the influence of alcohol.

   (အရက်သောက်ထားသည် ။ သို့သော်မမူးပါ)

3. Had taken alcohol, and under the influence of alcohol.

   (အရက်သောက်ထားသည် ။ မူးနေသည်)

- **Definition**
- Hanging is a form of asphyxial death where the body is wholly or partially suspended by a ligature around the neck, " the constriction force " being the weight of the body or that of the head or upper trunk.
- **Causes of death**
- 1. Cerebral congestion
- 2. Cerebral anoxia
- 3. True asphyxia
- 4. Comato- asphyxia
- 5. Vagal inhibition
- 6. Fracture or dislocation of the cervical vertebra


'Tenth'
nucleus
Vagus
Glossopharyngeal
nerve
A
B
Carotid sinus
and sheath
Larynx
D
C
Jugular vein
Carotid artery

JUDICIAL HANGING

- A sudden drop of 5 to 7 feet according to the weight of the condemned person and the fall has been arrested by a sudden jerk of the ligature produces a fracture dislocation of the upper cervical vertebrae. The spinal cord is compressed or lacerated, resulting in instantaneous death. Usually, the C_2 and C_3 are injured but C_4, C_1 and C_2 may be found fractured or dislocated in a few cases.

Post-mortem features

External findings

ligature mark around the neck is the only specific sign

The appearance of ligature mark depends on:

1. Nature of the ligature used
2. Types of knot (*Fixed Knot or running noose)*
3. Point of suspension
4. Duration of suspension
5. The constriction force
6. Texture of the ligature used
7. Diameter of the ligature used

Description of the ligature mark

2. Breadth of ligature (i.e. diameter)
3. Site - in relation to Adam's apple:
4. Shape and pattern
5. Colour –
6. Edges -
7. Whether ligature mark is continuous /interrupted?
8. Consistency – parchmentized or not
9. Other associated injuries e.g. finger nail scratches
10. Site of most prominent part of ligature mark

Typical ligature mark

- - usually a single ligature mark
- - situated above the thyroid cartilage (Adam's apple)
- - the size and shape varies with the material used
- - Individual imprint patterns m/b impressed on the neck
- - also vary with the period of suspension.
- - also vary with texture of ligature used

- also vary with running noose or fixed knot

- most prominent at a point opposite the point of suspension

- As the body sinks downwards,

- site of ligature - 80%, 15%, 5%, rare cases,

Other features of hanging

- Head
- Face
- Tip of tongue
- Dribbling of saliva
- vital reaction because (ligature presses on the submandibular salivary gland, it stimulates saliva secretion.
- Eyes
- Penis
- Nail

Examination of the Scene of Death of Hanging

- **A. Place of hanging**
- outdoors / indoor, order of furniture, farewell letters, disturbance of dust, cobwebs
- **B. Body**
- clothed / naked / female attire, complete or partial hanging, hypostasis, rigor mortis, position of limbs, saliva trickling, fluid at tip of penis, any dust on finger pads, any material detached from ligature or other sources underneath the finger nails, any injuries, defence wounds
- **C. The ligature**
- Type, point of suspension, type of knot etc.

Traumatic asphyxia

- provides the most extreme demonstration of the classic signs of asphyxia.

1. - chest and us.ly abdomen are compressed by an unyielding substance or object, ~ chest expansion and diaphragmatic lowering are prevented.

e.g. 1. - buried in earth, 2. - buried in grain, sand and coal, 3. - pinned under an over-turned vehicle, 4. - by the toppling of a tractor, 5. - by falling timber or masonry, 6. - crushing in crowds. ~ foot-ball ground tragedies, ~ underground train station, ~ trapping between a vehicle and wall

7. - during sexual intercourse (rare) –esp.ly when incapacitated by drink or drugs.

Features of traumatic asphyxia

Classic signs of asphyxia- very marked and prominent

- Face, neck, shoulders down to the thoracic inlet are grossly discoloured (red-purple) &can extend lower than clavicles, may reach down to level of third rib.
- Conjunctivae – grossly congested and hae'agic. M/b so engorged with bld that hae'agic t/s actually bulges out thro' the lids
- Face, lips, scalp – swollen, congested with petechiae and ecchymoses
- Copious blding from ears and nostrils
- may be local bruises and abrasions fr. Wt. of vehicle or beam, injuries to chest wall
- Lungs – dark & heavy & sub- pleural petechial hae'age

Postural asphyxia

Closely allied to traumatic asphyxia

When a person remains in a certain position for an extended time, either due to being trapped, or being in a drunken or drugged state, there may be mechanical impediment to adequate respiratory movements. In addition, the normal venous return to the heart may be impaired.

Such positions usually entail inversion, either of the whole body or of the upper half. Persons who have been trapped upside down or even only in a jack-knife position, with the upper half of their body bent acutely downwards from the waist may have such impairment of their respiratory movement that they become hypoxic.

A person may in a state of drunkenness or other disability, slip out of bed, so that the head and shoulders are on the floor, with the leg and pelvis still at a higher level on the bed. There may also suffer the same disturbance of respiratory movements, which when prolonged may lead to death.

Inversion may occur during torture; crucifixion has the element of postural asphyxia. In inverted crucifixion, postural hypoxia is the major factor; inspiration would be impeded by the weight of abdominal viscera upon the diaphragm.

DROWNING (SUBMERSION)

Many corpses are recovered from water, but not all have drowned.

Of those that have drowned, pathological proof is often difficult or even impossible to obtain.

The autopsy diagnosis of drowning presents one of the major problems in forensic medicine, especially when there is delay in recovering the victim.

Bodies retrieved from water may have:

a. Died from natural d/s before falling into the water
b. Died from natural d/s while already in the water
c. Died from injury before being thrown into the water
d. Died from injury while in the water
e. Died from effects of immersion other than drowning
f. Died from drowning

All the above may show signs of immersion on examination, but this is rarely helpful, other than confirming that they had indeed been in water. It does not assist in differentiating the mode of death.

Death from drowning

Defination

It is a form of asphyxial death where the entry of air is prevented from entering the lungs by water or any fluid or any pultaceous matter into which the head has fallen and remained.

Possible causes of death

1. ***Asphyxia –***
2. ***Laryngeal spasm***
3. ***Cardiac inhibition (Reflex death / Immersion syndrome / Hydrocution)***
4. ***Electrolyte imbalance.***
5. ***Other causes*****: Exhaustion, fright, fear, and injuries.**
6. ***Secondary drowning***

Conditions where the lungs are relatively DRY at Post-mortem

- even though the person has died of drowning are:

1. **Soft H_2O drowning**
2. **Reflex death**
3. **Laryngo-spasm**
4. **Drowning in infants because due to respiratory enfeeblement**
5. **Drowning in elderly end emaciated people**
6. **Alcoholics**
7. **Poisoning with barbiturates / sedatives**
8. **Drowning with head injury**
9. **Drowning with other factors. e.g. electric shock, epilepsy, cardiac diseases**

Post-mortem features of drowning

External signs - **presumptive**

- **specific**

Presumptive signs

- **Whole body including clothing are wet**
- **Mud, sand, seaweeds, found on the body, in between layers of clothing, ears, nostrils.**
- **Cyanosis – not very marked**
- **Eyes – serene looking, congested, half-open**

- **Washerwoman's hands – Blanching and sodden appearance of the skin of the palms and soles. This only shows that the person has been submerged for a sufficient length of time. It does not indicate that the cause of death is drowning.**

- **Cutis anserina (goose-skin) – due to contraction of erectores pilorum muscles which are connected to hair follicles. It only indicates that molecular life of erectores pilorum muscle is still present during the time of submersion. It is not a conclusive sign of drowning.**

- **Retraction of scrotum and penis. Due to contraction of dartos muscle which brought the testes closer to the trunk.**

Specific signs

1. Fine white, tenacious, lathery froth or foam like soap-suds, sometimes tinged with blood, mushrooming from the mouth and nostrils. If such a froth is removed by undertaker during transit, it can be reproduced by exerting pressure on the chest.

   Amount of froth and degree of ballooning of the lungs will depend on the amount and duration of struggle to breathe before death.

2. Cadaveric Spasm

   Firm clasping or grasping in the hands of objects found in water such as grass, weeds, prawns, fish, and cybals. Sometimes mother and child may be found clasping each other in cadaveric spasm.

Internal Signs

1. **Fine white tenacious froth in air passages down to terminal bronchioles**

2. **Water logging and ballooning of lungs**

   On cutting the costal cartilage and as the sternum is lifted up, both lungs are found to bulge as if they are under tension. The anterior edges of both lungs came into juxtaposition to each other. There is over-lapping of the cardiac area; the edges are no longer sharp but appear to be more or less rounded, and both lungs are under tension. They press not only outwards but also on the diaphragm, pushing it downwards.

Both lungs are larger in size and heavier in weight. They are definitely voluminous. Patchy discoloration of the surface of both lungs , i.e. reddish areas alternating with pale areas, are present. (Pale areas are filled with air ; red areas filed with blood). On careful examination, there will be parallel rib impression marks on the surfaces of both lungs. They are doughy to feel and subcrepitant and pit on pressure. Cut sections show copious flow of bloodstained frothy watery fluid. In fact, the lungs are soggy and waterlogged with ballooning of both lungs.

Unusual fluid (muddy water, sewage water) in the stomach - not very conclusive.

In addition, there may be some of the general non-specific signs of asphyxia, but petechial haemorrhages are uncommon in drowning because the vascular bed in the lungs is so compressed by air and water and few become distended enough to rupture.

2. *Was drowning due to accident, suicide or homicide?*

The following factors are to be considered:

(a) Age infants and young children – never suicidal, mostly accidental

(b) Sex females – preponderance in drowning and mostly suicidal in nature (less incidence of death by hanging in female)

(c) Motives

- inter personal conflicts
- unrequited love affairs, unwanted pregnancy
- examination failures
- physical illness – chronic debilitation diseases
- psychiatric illnesses – depression
- high responsibilities
- unknown – genetic?

(d) Ligatures on the body

method of ligature? – very important.

(e) Weighted body.

(f) Clothing - naked, fully clothed, swim suits?

(g) Injuries

- **defense wounds**
- **signs of struggle**
- **ante-mortem or post-mortem injuries?**

(h) Farewell letters

(i) Other circumstantial evidences

- **narcotics, sedatives and hypnotics, poisons in stomach**
- **pregnancy**
- **eye witnesses**

MEDICO-LEGAL INVESTIGATION OF UNKNOWN DECOMPOSED BODY RECOVERED FROM WATER

Note: Advanced decomposed bodies, bodies recovered from water

COD I. (a) Unascertained due to advanced decomposition

(no injuries, no bony fractures, no natural diseases and no sign of poisoning)

အလောင်းမှာ အလွန်အမင်း ပုပ်ပွနေသောသောကြောင့် သေဆုံးသည့် အကြောင်းအရင်းကို တိကျသောထင်မြင်ချက် မပေးနိုင်ပါ။

သိုသော် သေဆုံးသူတွင်

၁။ ခန္ဓာကိုယ်ပြင်ပတွင် သေစေနိုင်သော ဒဏ်ရာများမတွေ့ရှိပါ။

၂။ ခန္ဓာကိုယ်ရှိ အရိုးများ မကျိုးပါ။

၃။ ကိုယ်တွင်းခေါင်းများအတွင်း သွေးယိုခြင်း မရှိပါ။

၄။ သေစေနိုင်လောက်သည့် သဘာဝရောဂါများ မတွေ့ရှိပါ။

၅။ အဆိပ်သင့်လက္ခဏာများ မတွေ့ရှိပါ။

များသောအားဖြင့် ဖြစ်နိုင်သည်မှာ ရေနစ်သေဆုံးခြင်း ဖြစ်ဖို့များပါသည်။

Type of deaths in which Forensic autopsy should be done;

Hospital Manual,May 1997,

Chapter 14, Paragraph 9

1. When death was due to accident, suicide and homicide
2. Infanticides
3. When death was due to criminal abortion
4. When any female of child bearing age collapsed and died suddenly
5. Deaths from all types of poisoning
6. Sudden and unexpected deaths
7. All deaths that occur within 24 hours after admission to hospital

8. Found dead or brought dead cases
9. All deaths where no doctor will come forward and certify the cause of death
10. Deaths due to natural catastrophes
11. Deaths due to iatrogenic causes or therapeutic mishaps
12. Deaths occurring on the operation table
13. Deaths before full recovery from full anesthesia
14. When the deceased is life-insured

15. Whenever death occurs in such places and under such circumstances as to be suspicious
    - death in custody
    - death in home for the aged
    - death in adopted children's home
    - death of servant's or maids
    - when an inmate of the mental hospital dies
16. When death was due to neglect
17. When death was due to narcotic drugs
18. When death occurs due to illegal operations, e.g. vasectomy, sterilization without approval of the board
19. Death of armed force person

In Medico-legal autopsy cases

Cause of Death – must be recorded in correct sequence

I. (a) Immediate cause

(b) Antecedent cause

(c) Underlying cause

II. Contributory cause

Common Causes of Sudden Death

1. Cardiac causes

- Coronary insufficiency
- Hypertensive heart disease
- Valvular heart diseases
- Congenital heart disease
- Cardiomyopathies
- Cardiac tamponade
- Pulmonary thrombo-embolism

2. Respiratory causes

- Acute infection – acute bronchitis, bronchopneumonia, lobar pneumonia, laryngitis, viral haemorrhagic pneumonitis,
- Pulmonary embolism with or without infarction, originating from silent venous thrombus in lower extremities
- Acute severe asthma
- Pneumothorax – caused by rupture of emphysematous blebs/ TB
- Chronic lesion – TB, Ca lungs, lungs abscess, bronchiectasis
- Sudden airway obstruction – laryngeal edema from infection, haemorrhage from TB or tumour, prolapsed tumor mass
- Cor pulmonale

3. Disease of the CNS

- Subarachnoid haemorrhage due to rupture of Berry's aneurysm
- Spontaneous intracerebral haemorrhage associated with atherosclerosis and hypertension
- Pontine haemorrhage
- Cerebellar haemorrhage
- Haemorrhage in a brain tumour or abscess
- Meningitis
- Meningococaemia
- Acute encephalitis
- Cerebral artery thrombosis or embolism with or without infarction
- Carotid artery thrombosis
- Status epilepticus

4. Diseases of G. I. T.

- Peptic ulcer, duodenal ulcer, gastric ulcer bleeding, haemorrhage and shock
- Rupture of viscera, strangulated hernia
- Mesenteric thrombosis with infraction of bowel
- Acute pancreatitis (sometimes haemorrhagic)
- Severe fatty metamorphosis of liver
- Spontaneous rupture of spleen in malaria
- Haemorrhage from oesophageal varices (cirrhosis of liver)
- Acute peritonitis due to rupture of viscera, PU, DU, GU perforation
- Intestinal obstruction
- Diseases of Urogenital system
- Rupture of ectopic pregnancy
- Uremia with chronic renal disease

5. Miscellaneous

- Diabetes mellitus – hypoglycaemia, diabetic coma
- Sickle cell anaemia
- Addison's disease
- Hyperthyroidism
- Blood dyscrasia

CATEGORIES OF SEVERITY OF BODILY INJURY RESULTING IN DEATH

(1)A wound which is "necessarily fatal" (ကောန်မုချ သေရမည့် ဒဏ်ရာ)

- So severe that it will surely cause death.
- No amount of treatment could save the person's life.

Eg- Gross injury to vital organs such as gunshot wound through the heart; crush injury of the brain; incised wound of the neck totally decapitating the head.

(2)A wound which is "sufficient in the ordinary course of nature to cause death" (ဖြစ်တတ်သော သဘောအရ သေတန်ရာသော ဒဏ်ရာ)

- Cause immediate danger to life
- Amenable to surgical treatment
- Death is certain without treatment
- But the person may survive (or die) with treatment

Eg- An epidural haemorrhage resulting from a blow to the head will endanger life by causing cerebral compression. A timely craniotomy with removal of the blood clot may save the life of the patient.

– stab wound of the stomach, intestine or liver; stab wound of the chest penetrating into the lungs

(3) A wound which is "likely to cause death" (သေစေခြင်း ဖြစ်နိုင်သော ဒဏ်ရာ)

- Less severe type of injury
- Death may occur with or without treatment.
- Without treatment, he may survive or die.

Eg: injury to the femoral vein, some cases of stab wound to the lungs or intestines.

(4) A wound which is "not likely to cause death but might possibly cause death" (ပုံမှန်အားဖြင့်မသေနိုင်။ အခန့်မသင့်လျှင်သေနိုင်သည်။)

- Minor type of injury
- usually would not cause death
- death may result from a remote complication

Eg: a small lacerated wound of the finger would not commonly lead to death, but fatal complication may occur if tetanus sets in.

INVESTIGATIONAL PROCEDURE IN ALL MEDICOLEGAL DEATHS

1. history

From the police, relatives, neighbours, local authority
Any eye-witness
History of agony, past history of medical diseases, operations and hospital admissions
Social and family history(alcohol and narcotics)

2. Scene of crime investigation

self
photographs from police

3. Personal Identification

Basic and absolute characteristic

4. Postmortem examination

External and internal examination

5. Further investigation

Histology
Toxicology and etc

6. Discussion with the police

Further information from the police on subsequent police investigations

7. Review of the case and giving the final opinion

Principles and Guide lines for management of Medico-legal cases

- Medical officers in Myanmar, especially those working as TMOs, THOs and As in the emergency departments of various hospitals throughout the country, have the duties and responsibilities of handling **criminal cases** correctly and efficiently.
- The clinical, administrative, public health and social duties of a medical officer are many, and in some cases more than what should be expected from a person of his status. But in respect to handling of police cases, the general public still expects him to perform perfectly without any flaws or mistakes.

- The public, and in some cases the law court and the police regard the medical officer as an "**expert**" who is supposed to know every thing about the medical field. This is not a totally correct assumption and when doctors do not perform to their expectation, some of the member of the public has very *little hesitation* to ***write a complaint letter*** to the authorities at the cost of an envelope and a postage stamp.
- So a medical officer must not only be honest, unbiased, correct and efficient in the field of Forensic Medicine, but also be conversant with the areas *where complaints are most common*, and also know the *means and the methods to prevent such unwanted complaints*

COMMON MEDICO-LEGAL PROBLEMS

1. Complaints to the Ministry of Health regarding reports on

(a) Wound descriptions

(b) Opinions on nature of the weapon used

(c) Opinions on simple hurt and grievous hurt and the use of the term 'simple so far'

(d) Medical negligence

(e) Opinions given in cases of alcoholic intoxication

(f) Opinions given in case of sexual assaults

2. *Inability or failure* to perform a competent medicolegal autopsy

2.1 *Certifying death without* performing a required forensic *autopsy*

2.2 *Not fully conversant with the objectives* of a forensic autopsy

2.3 *Deficient skill and knowledge* in performing a forensic autopsy

3. Lack of knowledge regarding pathology of sudden deaths

4. Lack of knowledge and skill on death investigations, and the death certificate
5. Problems in Exhumation
6. Lack of knowledge in writing an informative medico-legal report
7. Lack of knowledge and experience in giving evidence in trial courts
8. Very few forensic specialists in the country for proper effective referral

COMMUNICATING WITH THE MEDICO-LEGAL PATIENTS AND THEIR RELATIVES

- medico- legal reports and registers are confidential in nature
- But ptient or relative has the full right to know the extent and severity of his injuries
- Disclosure of information to the concerned part, will dispel any doubt or mistrust

INFORMATIVE MEDICO-LEGAL REPORT

- the history of the incident should contain relevant information . (e.g. "assaulted by three using sticks and dah two days ago", rather than "history of assault").
- In wound description- a sketch or a diagram is more informative than words
- The **reason(s)** for giving the particular medico-legal opinion should be written in the report when *necessary*
- If the patient failed to return to the medical officers as instructed, this should also be *noted in* the report
- Instructions to the public, when necessary, should also be noted in the report

CO-OPERATION AND CO-ORDINATION WITH THE POLICE

- Having a good working relationship with the police is essential for gathering of relevant information and investigation of criminal cases
- The police officer can provide pertinent information of the scene investigation conducted by him and photographs of the scene, which is extremely important in forming the opinion as to the manner of death. (e.g. hanging)

CO-OPERATION AND CO-ORDINATION WITH THE CHEMICAL EXAMINER'S OFFICE

- Chemical Examiner's Office in Yangon & Mandalay has to report on the analysis of samples sent from all over the country, the toxicological analysis is still being done in Yangon

COMMUNICATION WITH THE HEALTH AUTHORITIES AND OTHER RELATED AUTHORITIES

- Prompt communication and providing written information when necessary is one form of expressing that the medical officer is aware of the problem

FORMING A MEDICAL BOARD TO GIVE MEDICO-LEGAL OPINION ON A "*DIFFICULT*" CASE

- general rules in management of medico-legal cases is the use of a "Two doctors" system
- A report written and signed by two doctors relayed the message that this is done in a proper and unbiased manner
- In a very difficult case the medical officer may even have to request the senior officer such as the medical superintendent to form a medical board
- The opinion of the medical board will protect the medical officer against unwanted accusations

INTUITION TO SPOT AND PREVENT POTENTIAL PROBLEM CASES

- The intuition comes from experience and careful studying and critical analysis of cases experienced by oneself as well as by others
- One has to remember that even a bad experience is beneficial, if it serves to point to a weak area in the work system, which one can improve or modify

CONCLUSION

- The principles in the management of ML cases although very similar to that of clinical cases, have some distinct differences. Human behavior in the Myanmar culture is such that although people may readily forgive and forget obvious medical negligence act by a doctor in the care of a patient, a little mistake or flaw in the ML management tends to be viewed with suspicious eyes.
- In other fields of medicine, the **clinical history** provides a very important aspect of the medical investigation, whereas, regarding **criminal cases**, the history given could not be assumed to be correct and true all the time.

- This is compounded by the fact that although Forensic Medicine is a specialized subject, the assistant surgeons are unrealistically expected to be an expert in this field of medicine with the academic knowledge gained in the *undergraduate class.*
- Steps are now being taken to remedy these defects and inclusion of this topic in the *undergraduate* as well as the *post graduate courses* is one of the means to generate **problem-solving skills** in the management of ML cases

Exhumation

(Disinterment)

-The retrieval of previously buried body for PM exam;

-Usually followed by a first autopsy or a re-autopsy following new information

-the removal of body buried in a legitimate fashion in a cemetery or graveyard (inhumation)

-rather than the recovery of an un-coffined, clandestinely buried victim of suspicious death(SOC)

Reasons

1. When all or part of a graveyard has to be moved for some development of the ground. Often no special exam; of each body is made unless there is some historical or anthropological interest

2. Where some civil legal matter needs to be investigated such as personal injuries for insurance or civil litigation for negligence- usu; after a RTA

3. Where new information or substantiated allegations arise to suggest that a death was due to criminal action either from injury or poison

4. In ancient or historical circumstances to investigate either the individual or a series of individuals for academic interest

Legal Procedure

-Warrant for exhumation(chairman of the Township Judicial Committee

-Team work

1. A representative of the judicial committee
2. IO not below the rank of inspector of police
3. Next of kin(relatives) to identify the grave
4. Superintendant of cemetery
5. Grave diggers
6. A doctor
7. A representative for the accused (if there is any)
8. Photographer

-Strict safeguard to identify the grave and the coffin(no mistake can be made)

-grave must be positively ID by the cemetery authorities(plans and records)

-An official must personally point out the grave to be opened

-Carried out at dawn to be avoid spectators and publicity

-The grave to be dug down to just above coffin level

-To see the final exposure of the coffin

-To identify the coffin by name plate(funeral director)

-Lift the coffin to the graveside and loosen a lift to allow foul gas to escape into the open air

-Transport to the mortuary for PM exam;

-Use a rigid base(a trestle or extra large coffin or fibreglass shell)

-Remove the excess earth and mud to avoid excessive fouling of the PM room

-Take a full photographic record of every stage

-Identify the coffin and the contents again at PM room (coffin plate, internal coffin fittings, features of the corpse from personal knowledge)

-If poisoning is suspected, samples of earth from the surface of the grave, from other parts of the cemetery, from immediately above the coffin and from the sides and beneath the coffin should be taken

-Samples of the shroud, coffin trimming and any loose materials should be retained

-Perform a full autopsy

Is exhumation worth carrying out?

-It can’t be as satisfactory as the exam; of a freshly dead body

-Because of doubts about the usefulness of the result

-The balance bet; the potential advantage must be weighed against the cost, publicity and distress to relatives

Value

-Valuable information can be gained even a surprisingly long time after burial

-Even negative information gained may be of considerable legal value
Eg; the absence of alleged or suspected fractures

-Positive information such as
(1)Heavy metals may persist for many years and be detectable
(2)Some organic materials may survive for a long time
(3)Barbiturates have been found after 7 years in a buried body
(4) Various types of fractures

Notes

Ample samples are taken from the grave and its surroundings to avoid the later accusation that any abnormal substances found were environmental artefacts or were unassociated with the corpse.

အလောင်းပြန်လည်တူးဖော်ခြင်းမှတ်တမ်း (**PME - /**)

ရည်ညွှန်းချက်။ ။ ( ) အေးချမ်းသာယာရေးဖွံ့ဖြိုးရေးကောင်စီ၏ ( ) ရက်စွဲပါစာအမှတ် ( )

၁။ ဖြစ်စဉ်အကျဉ်း

၂။ သို့ဖြစ်ပါ၍ အဆိုပါ မှုခင်းဖြစ်ပွားမှုအတွက် စစ်ဆေးနိုင်ရန် ( ) အေးချမ်းသာယာရေးဖွံ့ဖြိုးရေးကောင်စီ၏ ( ) ရက်စွဲပါစာအမှတ် ( )အရ၊ အလောင်းအား ပြန်လည်တူးဖော်စစ်ဆေးခွင့်နှင့် ( )မြို့နယ် အေးချမ်းသာယာရေး ဖွံ့ဖြိုးရေးကောင်စီ၏ ( )ရက်စွဲပါစာအမှတ် ( )အရ အလောင်းအား ပြန်လည် တူးဖော်စစ်ဆေးခွင့်ပြုခဲ့ပါသည်။

၃။ အလောင်းအား ပြန်လည်တူးဖော်စစ်ဆေးနိုင်ရန်အတွက် ( )ဆေးရုံကြီးမှ ဒေါက်တာ ( )၊ ဒေါက်တာ ( ) နှင့် ရင်ခွဲရုံတာဝန်ခံ ( )တို့ပါဝင်သော အဖွဲ့သည် ( ) ရဲစခန်းမှ ( ) နှင့်အတူ ( ) ရဲစခန်း ( ) မြို့နယ် တရားရုံးမှ တာဝန်ရှိ ပုဂ္ဂိုလ်များ ပါဝင်လျှက် ( )ရက်နေ့ နံနက် ( )နာရီအချိန်တွင် ( ) ပြည်သူဆေးရုံကြီးမှ ထွက်ခွါခဲ့ရာ ( )ကျေးရွာသို့ ညနေ ( ) နာရီအချိန်တွင် ရောက်ရှိခဲ့ပါသည်။

၄။ အလောင်းအား ပြန်လည်တူးဖော်စစ်ဆေးခြင်းတွင် ပါဝင်သော အဖွဲ့ဝင် များမှာ
(၁) ဦး ( ) တွံ့ဘက်မြို့နယ်တရားသူကြီး ( )မြို့
(၂) ဒေါက်တာဦး( )ပထမ လ/ထမှုခင်းဆရာဝန်၊ ( ) ပြည်သူ့ဆေးရုံကြီး
(၃) ဒေါက်တာဦး( )လ/ထ ဆရာဝန်၊ ( ) ပြည်သူ့ဆေးရုံကြီး
(၄) ဦး ( ) ရင်ခွဲရုံတာဝန်ခံ၊ ( ) ပြည်သူ့ဆေးရုံကြီး
(၅) ရဲအုပ် ( ) လ ( ) အမှုစစ်အရာရှိ ( ) ရဲစခန်း ( ) မြို့
(၆) ဒုရဲအုပ် ( ) လ ( ) ( ) ရဲစခန်း ( ) မြို့
(၇) တကက ( ) လ ( ) ( ) ရဲစခန်း ( ) မြို့
(၈) တက ( ) လ ( ) ( ) ရဲစခန်း ( ) မြို့
(၉) ရဲတပ်သား ( ) လ ( ) ( ) ရဲစခန်း ( ) မြို့
(၁၀)ဦး ( ) ဥက္ကဋ္ဌ၊ ရပ်ကွက်အေးချမ်းသာယာရေးနှင့်ဖွံ့ဖြိုးရေးကောင်စီ ( )ကျေးရွာ
(၁၁)ဦး ( ) အတွင်းရေးမှူး၊ ရပ်ကွက်အေးချမ်းသာယာရေးနှင့်ဖွံ့ဖြိုးရေးကောင်စီ ( )ကျေးရွာ
(၁၂)ဦး ( ) သေဆုံးသူ၏ ခင်ပွန်း။
(၁၃)ဦး ( ) သေဆုံးသူ၏ အကို။
(၁၄)ဦး ( ) အလောင်းတူးဖော်သူ။
(၁၅)ဦး ( ) အလောင်းတူးဖော်သူ။
(၁၆)ဦး ( ) ဓါတ်ပုံဆရာ။ ( ) ဓါတ်ပုံတိုက်။ ( ) မြို့

၅။ သေဆုံးသူ၏ ဆွေမျိုး ( )အား သေဆုံးသူ၏ ရာဇဝင်နှင့်ပတ်သက်၍ တွေ့ဆုံမေးမြန်းခြင်းမှတ်တမ်း

၆။ အလောင်းပြန်လည်တူးဖော်ခြင်းမှတ်တမ်း

(က) အလောင်းမြှုပ်ထားသော ( )ရွာ သင်္ချိုင်းမြေနေရာပြ မြေပုံကြမ်း

(ခ) ရာသီဥတုအခြေအနေ

(ဂ) မြေအနေအထား

(ဃ) အလောင်းမြှုပ်ထားသည့်နေရာ ညွှန်ပြသူများ

(၁) ဦး ( )

(၂) ဦး ( )

(င) အလောင်းတူးဖော်သူများ

(၁) ဦး ( )

(၂) ဦး ( )

(စ) အလောင်းတူးဖော်ခြင်းစတင်ချိန် (   )နာရီ ( ) ရက်

မြေအနက် (၁ပေခွဲအထိ)ပေါက်တူးဖြင့် တူးဖေါ်ပြီး ၄င်းနောက် ဂေါ်ပြားဖြင့် ဖြေးညှင်းစွာ ဆက်လက်တူးဖေါ်ပါသည်။မြေအနက်(၃)ပေတွင် (၁၆း၂၀)နာရီအချိန်တွင် အခေါင်း အပေါ်ပိုင်းပေါ်လာပြီးနောက်လက်ဖြင့်ယက်၍ ဆက်တူးပါသည်။ ခေါင်းပေါ်ပြီးနောက် အခေါင်းပေါ်မှ မြေကြီးနမူနာအနည်းငယ်ယူထားပါသည်။ တွင်းအနက်(၄)ပေ တွင် အခေါင်းတခုလုံးပေါ်ပြီး၊ ၄င်းအောက်မှမြေကြီးနမူနာအနည်းငယ် ယူထားပါသည်။ (၁၇း၀၀)နာရီအချိန်တွင် အခေါင်းတူးဖေါ်ခြင်းပြီးဆုံးပါသည်။ အခေါင်း မြေပြင်ပေါ်သို့ ရောက်ပြီးနောက် အခေါင်းကိုဖွင့်၍ မြေမြှုပ်စဉ်က ဝတ်ဆင်ဖုံးအုပ်ပေးခဲ့သော အဝတ်အစား အသုံး အဆောင်များကို သက်သေများနှင့် စစ်ဆေးခဲ့ရာမှန်ကန်မှု ရှိကြောင်းအတည်ပြု၍၊ ခေါင်းကိုပြန်လည် ဖုံးအုပ်ပါသည်။ စတင်မတူးဖေါ်မီမြေနေရာညွှန်ပြခြင်း၊ စတင်တူးဖေါ်ခြင်း၊ တူးဖေါ်နေစဉ်နှင့် အခေါင်းမျက်နှာပြင်စပေါ်ခြင်း၊ ပြီးဆုံးခြင်း၊ စစ်ဆေးခြင်း အချိန်တိုင်းတွင် မှတ်တမ်းဓါတ်ပုံများရိုက်ပါသည်။ တွင်းထဲမှ မြေကြီးနမူနာနှင့် သင်္ချိုင်းအခြားနေရာမှ မြေကြီးနမူနာ (ဘေစူန) အနည်းငယ်ယူပြီး၊ ချိပ်ပိတ်ကာ အမှုစစ်အရာရှိမှယူဆောင်ခဲ့ပါသည်။ အခေါင်းကို ပြန်လည်ဖုံးအုပ်ချည်နှောင်ပြီးနောက် ------ ဆေးရုံကြီးသို့ ယူဆောင်စေခဲ့ပါသည်။

တူးဖေါ်စစ်ဆေးခြင်းကိစ္စများ အလုံးစုံပြီးဆုံးပြီးနောက် (၁၇း၅၀)နာရီအချိန်တွင် ပြန်လည်ထွက်ခွါခဲ့ရာ ( )အချိန်တွင် ---------- ဆေးရုံကြီးသို့ ပြန်လည်ရောက်ရှိခဲ့ပါသည်။

MEDICAL ETHICS FOR GENERAL PRACTITIONERS

DEFINITION OF ETHICS

- Ethicos (Greek) – characters, manners or morals
- Ethics may be defined as philosophic inquiry into the nature and ground of morality.
- Medical Ethics may be defined as the application of ethical theory and moral practice to medicine.

PRINCIPLES OF MEDICAL ETHICS

- AUTONOMY
- BENEFECIENCE
- NON-MALEFICIENCE
- JUSTICE (EQUITY, FAIRNESS)

AUTONOMY

- Respect and protect the rights and dignity of persons
- Respect for autonomy
- Protection of persons with impaired or diminished autonomy (vulnerable or dependant)

- INFORMED CONSENT is essential

BENEFECIENCE

- Should be beneficial
- Should make a positive contribution towards the welfare of the patient

NON-MALEFICIENCE

- DO NO HARM to the patients
- If damage – Civil Negligence
- If Gross damage – Criminal Negligence

- PATIENT SAFETY is essential

JUSTICE (EQUITY, FAIRNESS)

- Ethical obligation to treat each person in accordance with what is morally right and proper to give each person what is due to him or her
- Difficult to obey

ETHICAL THEORIES

- UTILITARIANISM

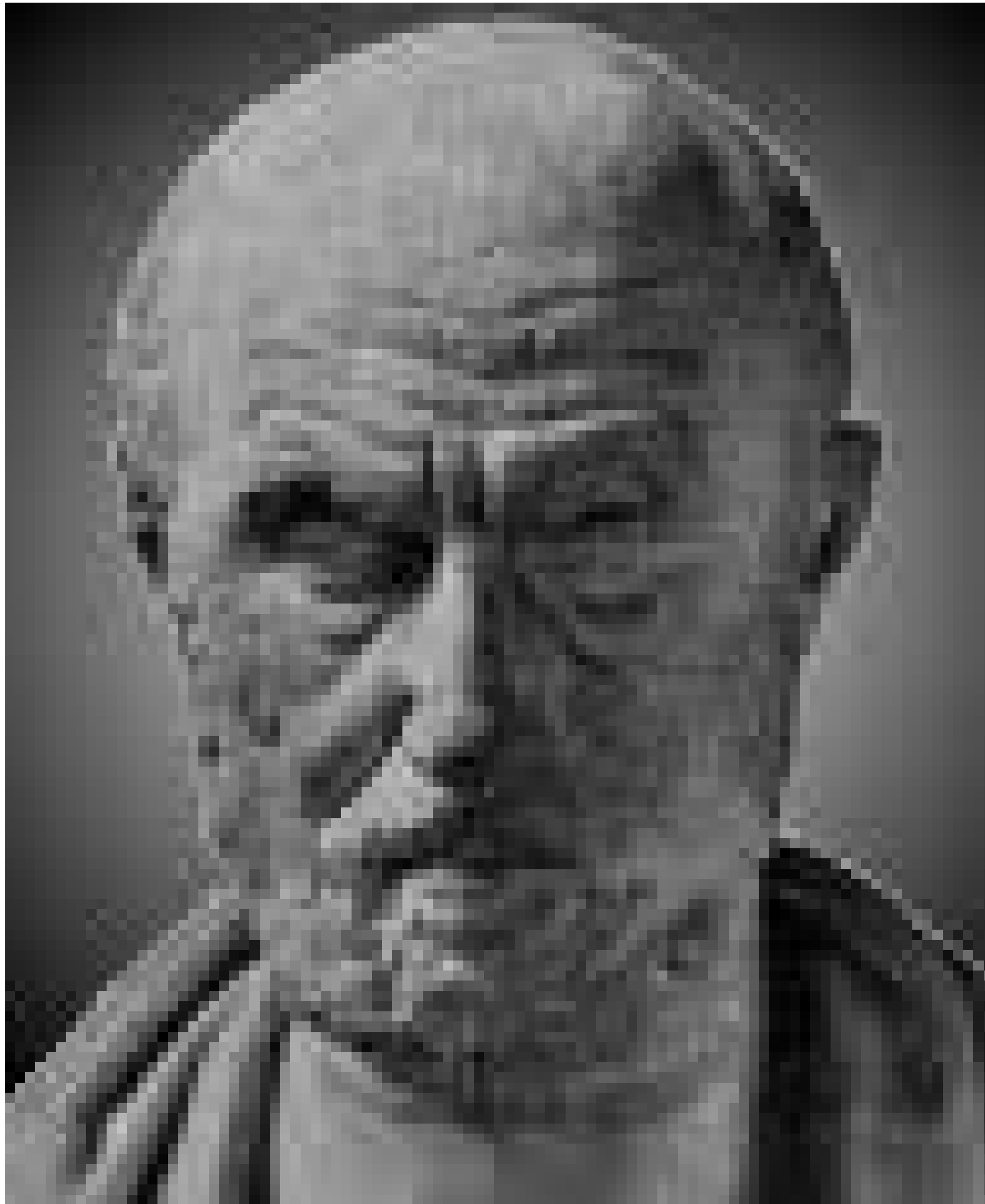
- KANT THEORY

UTILITARIANISM

- John Stuart Mill (1806-1873)
- The greatest happiness theory
- Maximum utility for the majority of people
- Like a calculator, has a cold brain, no warmth, no feelings and no mercy

KANT THEORY

- Does no depend on the result of happiness for the majority
- Good intension is an action to perform your duty
- Living by morality and duty, not by happiness or feelings
- Strict principle – telling the truth is right and if you lie, it is wrong



GENEVA DECLARATION

- At the time of being admitted as a member of the medical profession:
- I solemnly pledge to consecrate my life to the service of humanity;
- I will give to my teachers the respect and gratitude that is their due;
- I will practice my profession with conscience and dignity;
- The health of my patient will be my first consideration;

- I will respect the secrets that are confided in me, even after the patient has died;
- I will maintain by all the means in my power, the honor and the noble traditions of the medical profession;
- My colleagues will be my sisters and brothers;
- I will not permit considerations of age, disease or disability, creed, ethnic origin, gender, nationality, political affiliation, race, sexual orientation, social standing or any other factor to intervene between my duty and my patient;

- I will maintain the utmost respect for human life;
- I will not use my medical knowledge to violate human rights and civil liberties, even under threat;
- I make these promises solemnly, freely and upon my honor.

DECLARTION OF LISBON (Right of the Patient)

- It reads the follows:
- The patient has the right to choose his physician freely
- The patient has the right to be cared for by a physician who is free to make clinical and ethical judgments without any outside interference
- The patient has the right to accept or to refuse treatment after receiving adequate information

- The patient has the right to expect that his physician will respect the confidential nature of his medical and personal details
- The patient has the right to die in dignity
- The patient has the right to receive or to decline spiritual and moral comfort, including the help of a minister of an appropriate religion

PROFESSIONALISM

- Professionalism is the basic of medicine's contract with the society
- The principles and responsibilities must be clearly understood by both the profession and society
- At present, medical profession is confronted by an explosion of technology, changing in health care delivery, bioterrorism and globalization

DEFINITION

- Profession derives from Profess which means ‘to proclaim something publicly’

- Current meaning of Professionalism denotes that ‘ to balance the medical value with reciprocal set of right and privileges between medicine and society’

- Practicing it requires formal education
- Its member enjoys control over their own training standards
- Its members have their own displinary mechanisms
- There is a scholar journal devoted to its standards
- The practitioners enjoy relatively high social status
- Its practitioners have secured protection from state regulation as well as from market pressures

FUNDAMENTAL PRINCIPLE

- Principle of primacy of patient welfare
- Principle of patient autonomy
- Principle of social justice

Physicians profess two things

- To be competent to help the patient
- To have the patients' best interest in mind

- Such commitment invites trust from their patients

Physicians profess two ways

- The first is the public act of Oath taking during medical graduation ceremonies
- The second way of professing is implicit in the doctor-patient relationship

- Such tacit commitment occurs in everyday between a physician and a patient; if not, the patient would never willingly consult a patient.

PROFESSIONAL RESPONSIBILITIES

- Professional competence
- Honesty with the patient
- Patient confidentiality
- Maintaining appropriate relations with the patients
- Improving quality of care

PROFESSIONAL RESPONSIBILITIES (cont)

- Improving access to care
- Just distribution of finite resources
- Scientific knowledge
- Maintaining trust by managing conflicts of interest
- Professional responsibilities

CHARACTERISTICS OF PROFESSIONALISM

- Body of knowledge
- Trustee
- Professional training
- Professional independence
- Legal aspect of profession
- Autonomy
- Professional regulation and Ethics
- Service

CRITERIA TO PROFESSIONALISM

- Training
- Intellectualism
- Autonomy
- Judgment
- Independence
- Service
- Dedication
- Pride

INFAMOUS CONDUCT
(SERIOUS PROFESSIONAL MISCONDUCT)

- "If it is shown that a medical man, in the pursuit of his profession, has done something, with regard to which it would be reasonably regarded as disgraceful or dishonorable, by his professional brethren of good repute and competence, then it would be open to the Council to say that he has been guilty of infamous conduct in a professional respect."

- Professional misconduct is a legal term in health care as it is closely related to a bigger crime known as medical malpractice
- When a health care provider such as doctors, nurse, physician, etc, shows behavior outside the bounds of what is considered acceptable or worthy of its membership by the health care regulatory bodies and standards of profession

- “Serious professional misconduct” which may lead to erasure or suspension from the register arose mostly from “Six A s”.
- 1. Abortion
- 2. Adultery
- 3. Alcohol
- 4. Addiction
- 5. Association
- 6. Advertising/ Self promotion

- **Others**
- False Certification -
- Fee splitting -
- Failure to attend -
- Fraud and Financial Falsification -
- Force -
- Indecent behavior –

LAW AND ETHICS

- Set of governing rules
- To protect the public
- Minimal standards – promotes smooth functioning of society

- Principles, standards, guide to conduct
- To elevate the standard of competence
- Builds values and ideals

- Civil or criminal liability
- Upon conviction-fine, imprisonment, revocation of license, or other penalty as determined by courts

- Suspension or eviction from medical society membership, as decided by peers

- An illegal act by a health care practitioner is always unethical but an unethical act is no necessarily illegal

UNETHICAL PRACTICE IN MYANMAR

- Referral ethics
- Medical care ethics
- Disclosure of information
- Management of dying cases and certification of death
- Ethics relating to pregnancy and abortion
- Medico-legal
- Miscellaneous

REFERRAL ETHICS

- Referral fees
- Insulting and degrading manners of some specialists, and some emergency medical officers of some government hospitals towards the general practitioners when a case is referred.
- Purposive late referral to hospital or specialist
- Specialists do not refer back the patient to GP even after completing Rx

MEDICAL CARE ETHICS

- Refusal of treatment
- Unnecessary repetition and over investigation
- Over specialization by some specialist
- Hasty diagnosis and treatment without proper clinical examination
- Using drugs of questionable potency
- Neglecting patient under anesthesia-

DISCLOSURE OF INFORMATION

- Concealing the true diagnosis and telling white lies (eg.cancer)
- Confidentiality versus community interest (HIV)
- Conceal the information that the disease or injuries are related to police cases
- Disclosure of medical information about sensitive issues (preg in unmarried woman to her brother)

MANAGEMENT OF DYING CASES AND CERTIFICATION OF DEATH

- Is it ethical to charge fees for certifying death
- Should a doctor certify death just because he was the only doctor who last saw the patient alive
- Should a doctor certify death when he does not know the immediate and underlying cause of death

- Asked to treat a moribund case
- Is it ethical not to treat the case and refer it to the hospital
- If the patient died during treatment, how does he protect himself against unwanted accusation of medical negligence

ETHICS RELATING TO PREGNANCY AND ABORTION

- Unwanted pregnancies and illegal abortions
- Guidelines for prevention of induced abortions
- About a known abortionist

MEDICO-LEGAL

- General practitioner in the management of criminal abortions
- What to do about a known abortionist
- Should a doctor certify death when the immediate and underlying cause of death are not known
- When to report a case of a drug addict who would not follow the doctor’s advice to stop using the drug

MISCELLANEOUS

- Quack doctors
- Lack of quality control and standardization of private laboratories and medicine.
- Drug shops prescribing wrong drugs
- Escalating cost of health care system in private hospitals
- Permitting HA to do GP in a GP's name
- Switching off hand phones at nights to escape phone on call

PATIENT SAFETY

- Adverse medical incidents results from a range of causes including faulty medical devices, medication errors, communication errors, unsafe blood or blood product transfusions, infections acquired in the course of care and surgical procedures, anesthesia and obstetric trauma.

- Current concept of patient safety place the prime responsibility for the most adverse incidents on deficiencies in health care system design, organization and operation.
- System deficiencies may include the absence of protocols, faulty equipment, missing patient information or inadequate supervision

- While adverse events cannot be eliminated, they can be dramatically reduced.
- Lawyers of defenses in health systems can be established to prevent mishaps or at least prevent minor mishaps from turning into major failures that can result in patient harm and something death.

- These defenses include procedures such as the use of standardized practical guidelines, special handling and dispensing of potentially harmful medicines when they are delivered to the clinical area, pertinent information such as the information on a patient’s drug allergies, and decisions such as clinical judgment on patients

- While the great majority of adverse incidents are known to result from system failures, they are also caused by unqualified, incompetent or poorly performing individuals.
- Safe patient care requires competent, conscientious and safety-conscious individuals at the front line.

- It is therefore vital that best practice standards and guidelines be adhered to by the medical profession and that patient safety be a key component of medical education curricula and training.
- Preventable or avoidable harm is different from negligent harm.
- Adverse incidents, malpractice lawsuits, medical liability insurance, the practice of defensive medicine and the rising of costs of health care is a vicious cycle.

- At the country level, improving patient safety will require a concerted and sustained effort by a wide range of actors including the ministries of health, licensing and regulatory bodies, hospital and professional associations, consumer groups and civil society organizations

WHEN HARM DOES OCCURS

- There should be a system in place whereby the event can be reported and investigated with due respect to confidentiality
- Patient and their families should be fully informed and supported
- Providers involved in unintentional harm should also receive support
- Corrective actions should be taken to prevent future harm and widely share lessons learned
- There should be a mechanism to fairly compensate the patient and their family

THE KEY RECOMMENDATIONS

- Restoring trust and reducing the risk of malpractice litigation
- Empowering consumers and patients to become more engaged in their own care
- Encouraging doctors to raise concerns about patient safety
- Strengthening accountability mechanisms to better ensure the competencies of physicians

- Improving the clinical and educational experience of pre-registration house officers and encouraging adherence to clinical guidelines to improve quality and reduce liability risk
- Integrating patient safety concepts and practices into medical education and training

- Wishing all of you to become
- Competent,
- Ethical,
- Non-negligent,
- Safe (both doctor and patient)
- Professional
- To build our Medical Profession in the future.

Thanks for Your Attention