Ethical & Legal Aspects of Medical Practice

Guidelines for Medical Practitioners

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The book provides guidelines for various ethical and legal issues in everyday medical practice. It is designed for medical practitioners and students and outlines practical solutions with relevant references without going into lengthy theoretical discussions of legal principles.

Relevant advances and updates in the medicolegal system are included after consulting with experts in various medical and legal fields.

We welcome critical remarks for improving subsequent editions. Do write to us at info@legalmedicine.in.

Dr. Labanya Mukhopadhyay
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Section A

Ethical & Legal Aspect of Medical Practice
ETHICS ASPECTS OF MEDICAL PRACTICE
Medical ethics are regulated by National Medical Council in India. Legal aspects are guided by the laws of the country. Both deals with the following:

i. Doctor-patient relationship
ii. Doctor-doctor relationship
iii. Doctor-state relationship

Medical ethics are the moral values as applied to medical practice. These explains the moral principles for the members of medical profession. These are self-imposed code of conduct assumed voluntarily by medical professionals.

Medical etiquette are the conventional laws of courtesy observed between the members of medical profession.

Bioethics is concerned with the ethical questions that arise in practice. Medical practice is considered "ethical" if it respects principles of bioethics.

BIOETHICS

Bioethics is the study of the ethical issues emerging from advances in medicine. Bioethics governs moral judgement in medical practice and policy. Bioethicists analyze the ethical questions that arise in medical practice.

Medical ethics are moral values applied to medical practice. Medical practice is considered "ethical" if it respects the principles of bioethics. These principles guide ethical decision-making in medical practice, such as organ donation, organ transplant, euthanasia, right to life and health, surrogate pregnancy, genetic engineering in human health etc.

Basic Principles of Medical Bioethics

There are four basic principles of medical bioethics:

i. Autonomy
ii. Beneficence
iii. Nonmaleficence

Autonomy

Autonomy is the right to self-determination, i.e., the right to make own healthcare decisions without any interference. For this, patient’s decision-making process must be free of coercion.

Two concepts explain the process of autonomy:
i. Informed decision: Patient must have adequate knowledge about their medical condition and should be able to examine and explore all available treatment options before coming to a decision.

Patients are usually unaware of the details of their medical condition and depend on medical professionals for requisite information and explanation. This may lead to *paternalistic attitude* from the treating physician, who informs the patient about their illness and the treatment they deem right, without explaining the consequences of the proposed treatment or other available treatment options.

ii. Patients in an impaired state may be unable to take a rational decision. Decision making capacity of the patient may be affected by several factors such as physical or emotional trauma, pain, grief, denial etc. It is the responsibility of the physician to help their patients reach an informed decision in such situations.

**Extent of Autonomy**

Autonomy does not grant a patient exclusive control over their decisions. The patient’s education, knowledge, and their capacity to understand the issue affect their decisions. Autonomy is not an absolute principle but rather an extent to which the patient's decision may be applied.

Extent of autonomy is limited in certain situations:

a) If autonomy harms the patient or other individuals, the physician can override such decisions.

b) If the patient’s decision violates the conscience of the physician, they should explain the facts to the patient. However, if the difference still persists, the case should be discussed with other physicians or referred to an Ethics committee.

Issues of autonomy can be usually resolved by assessment of a patient’s capacity, an empathetic attitude from the physician, and through clear physician-patient communication.

**Beneficence**

Medical decisions should be taken with the intent to benefit patients.

It requires:

I. The physician knows/follows the concept of due care

II. The physician maintains and updates their knowledge and skill

III. The physician considers the circumstances of individual patients while taking their decision.

**Nonmaleficence**
Nonmaleficence implies that a medical procedure or treatment should not harm the patient or the society.

**Justice**

Justice implies that there should be equal distribution of healthcare resources among patients. Similarly, benefits and burdens of biomedical research must also be distributed equally among different groups in society.

To ensure justice in patient care, medical professionals must consider the following:

I. Competing needs of the patients
II. Fair distribution of limited resources
III. Rights and obligations of a medical professional
IV. Respecting laws and regulation.

The four above-mentioned principles of Bioethics help resolve all ethical issues in medical practice. These principles are not hierarchical, and they should be well-balanced in order to resolve conflicts.

The patient’s wellbeing is the most important aspect, and is considered as the sum of autonomy, beneficence and nonmaleficence. Autonomy takes precedence over beneficence and nonmaleficence. However, the wellbeing of the society outweighs an individual patient’s autonomy.

Nonmaleficence supersedes beneficence if the benefits and harms of a procedure are similar.
MEDICAL ETHICS

Concern with moral principles for the members of medical profession. These are self-imposed code of conduct assumed voluntarily by medical professionals.

Medical Council of India

It is a statutory body having responsibilities of establishing and maintaining uniform standards of medical education and recognition of medical qualifications.

Indian Medical Council (IMC) Act 1956

MCI was established in 1934 under IMC Act 1933. The act was repealed in 1956, and further modified in 1964, 1993, 2001 and 2010.

The act has following particulars

i. To give recognition for representation of license medical practitioner
ii. Provide registration of foreign medical qualification
iii. To maintain an All-India Medical Register.

Schedules

There are three schedules of the Indian Medical Council Act 1956.

i. First Schedule contains recognized medical qualifications granted by universities in India.
ii. Second Schedule contains recognized medical qualifications granted outside India.
iii. Third Schedule: It has two parts
   • Part 1 - contains qualifications granted by medical institutions not included in 1st schedule.
   • Part 2 - contains qualification granted outside India not included in 2nd schedule.

Functions of MCI

i. Recognition of medical qualification
ii. Recognition of foreign medical qualification
iii. Maintenance of register
iv. Regulation of standard of undergraduate and postgraduate medical education
v. Disciplinary control
vi. Derecognition of medical qualification
vii. Prescribe Code of Ethics
viii. Appellate Tribunal--- MCI act as appellate tribunal. Medical practitioner can appeal to central govt for any action against him by SMC. Central govt consults MCI and MCI gives it recommendation to the govt. These recommendations are binding in the appealing person.
During the COVID-19 pandemic in March 2020, the Medical Council of India issued guidelines for the telemedicine in India, to help patients to consult their doctors without the need to visit the hospital.
National Medical Commission

NMC regulates medical education and medical professionals in India. It replaced the Medical Council of India on 25 September 2020.

Functions of NMC are:
1. Grant recognition of medical qualifications
2. Accreditation to medical schools
3. Registration to medical practitioners
4. Monitors medical practice
5. Assesses the medical infrastructure in India.

The commission consists of four autonomous boards:
   i. Under-Graduate Medical Education Board (UGMEB)
   ii. Post-Graduate Medical Education Board (PGMEB)
   iii. Medical Assessment and Rating Board
   iv. Ethics and Medical Registration Board
Ethics

Medical ethics deals with moral principles, values, and guidelines that govern the conduct and relationship of doctor with patients, fellow doctors, and state.

Ethical regulations were enforced on medical practitioners by MCI and now by National Medical Commission (NMC).

Violation of code of conduct may result into charges of professional misconduct, and may result into disciplinary action.

Unethical acts

Indian Medical Council (Professional conduct, Etiquette and Ethics) Regulations, 2002, Sec-6, gives details of the unethical acts by medical practitioner.

6.1 Advertising:

6.1.1 Soliciting of patients directly or indirectly, by a physician, by a group of physicians or by institutions or organisations is unethical. A physician shall not make use of him / her (or his / her name) as subject of any form or manner of advertising or publicity through any mode either alone or in conjunction with others which is of such a character as to invite attention to him or to his professional position, skill, qualification, achievements, attainments, specialities, appointments, associations, affiliations or honours and/or of such character as would ordinarily result in his self aggrandizement. A physician shall not give to any person, whether for compensation or otherwise, any approval, recommendation, endorsement, certificate, report or statement with respect of any drug, medicine, nostrum remedy, surgical, or therapeutic article, apparatus or appliance or any commercial product or article with respect of any property, quality or use thereof or any test, demonstration or trial thereof, for use in connection with his name, signature, or photograph in any form or manner of advertising through any mode nor shall he boast of cases, operations, cures or remedies or permit the publication of report thereof through any mode. A medical practitioner is however permitted to make a formal announcement in press regarding the following:

1) On starting practice.
2) On change of type of practice.
3) On changing address.
4) On temporary absence from duty.
5) On resumption of another practice.
6) On succeeding to another practice.
7) Public declaration of charges.
6.1.2 Printing of self photograph, or any such material of publicity in the letter head or on sign board of the consulting room or any such clinical establishment shall be regarded as acts of self advertisement and unethical conduct on the part of the physician. However, printing of sketches, diagrams, picture of human system shall not be treated as unethical.

6.2 **Patent and Copy rights**: A physician may patent surgical instruments, appliances and medicine or Copyright applications, methods and procedures. However, it shall be unethical if the benefits of such patents or copyrights are not made available in situations where the interest of large population is involved.

6.3 **Running an open shop (Dispensing of Drugs and Appliances by Physicians)**: A physician should not run an open shop for sale of medicine for dispensing prescriptions prescribed by doctors other than himself or for sale of medical or surgical appliances. It is not unethical for a physician to prescribe or supply drugs, remedies or appliances as long as there is no exploitation of the patient. Drugs prescribed by a physician or brought from the market for a patient should explicitly state the proprietary formulae as well as generic name of the drug.

6.4 **Rebates and Commission**:

6.4.1 A physician shall not give, solicit, or receive nor shall he offer to give solicit or receive, any gift, gratuity, commission or bonus in consideration of or return for the referring, recommending or procuring of any patient for medical, surgical or other treatment. A physician shall not directly or indirectly, participate in or be a party to act of division, transference, assignment, subordination, rebating, splitting or refunding of any fee for medical, surgical or other treatment.

6.5 **Secret Remedies**: The prescribing or dispensing by a physician of secret remedial agents of which he does not know the composition, or the manufacture or promotion of their use is unethical and as such prohibited. All the drugs prescribed by a physician should always carry a proprietary formula and clear name.

6.6 **Human Rights**: The physician shall not aid or abet torture, nor shall he be a party to either infliction of mental or physical trauma or concealment of torture inflicted by some other person or agency in clear violation of human rights.

6.7 **Euthanasia**: Practicing euthanasia shall constitute unethical conduct. However, on specific occasion, the question of withdrawing supporting devices to sustain cardio-pulmonary function even after brain death, shall be decided only by a team of doctors and not merely by the treating physician alone. A team of doctors shall declare withdrawal of support system. Such team shall consist of the doctor in charge of the
patient, Chief Medical Officer / Medical Officer in charge of the hospital and a doctor nominated by the in-charge of the hospital from the hospital staff or in accordance with the provisions of the Transplantation of Human Organ Act, 1994.

6.8 Code of conduct for doctors and professional association of doctors in their relationship with pharmaceutical and allied health sector industry.

6.8.1 In dealing with Pharmaceutical and allied health sector industry, a medical practitioner shall follow and adhere to the stipulations given below:

a) **Gifts**: A medical practitioner shall not receive any gift from any pharmaceutical or allied health care industry and their salespeople or representatives.

b) **Travel facilities**: A medical practitioner shall not accept any travel facility inside the country or outside, including rail, air, ship, cruise tickets, paid vacations etc. from any pharmaceutical or allied healthcare industry or their representatives for self and family members for vacation or for attending conferences, seminars, workshops, CME programme etc. as a delegate.

c) **Hospitality**: A medical practitioner shall not accept individually any hospitality like hotel accommodation for self and family members under any pretext.

d) **Cash or monetary grants**: A medical practitioner shall not receive any cash or monetary grants from any pharmaceutical and allied healthcare industry for individual purpose in individual capacity under any pretext. Funding for medical research, study etc. can only be received through approved institutions by modalities laid down by law / rules / guidelines adopted by such approved institutions, in a transparent manner. It shall always be fully disclosed.

e) **Medical Research**: A medical practitioner may carry out, participate in, work in research projects funded by pharmaceutical and allied healthcare industries. A medical practitioner is obliged to know that the fulfillment of the following items (i) to (vii) will be an imperative for undertaking any research assignment / project funded by industry – for being proper and ethical. Thus, in accepting such a position a medical practitioner shall:

   i. Ensure that the particular research proposal(s) has the due permission from the competent concerned authorities.

   ii. Ensure that such a research project(s) has the clearance of national/ state / institutional ethics committees / bodies.

   iii. Ensure that it fulfils all the legal requirements prescribed for medical research.
iv. Ensure that the source and amount of funding is publicly disclosed at the beginning itself. Ensure that proper care and facilities are provided to human volunteers if they are necessary for the research project(s).

v. Ensure that undue animal experimentations are not done and when these are necessary they are done in a scientific and a humane way.

vi. Ensure that while accepting such an assignment a medical practitioner shall have the freedom to publish the results of the research in the greater interest of the society by inserting such a clause in the MoU or any other document / agreement for any such assignment.

f) Maintaining Professional Autonomy: In dealing with pharmaceutical and allied healthcare industry a medical practitioner shall always ensure that there shall never be any compromise either with his / her own professional autonomy and / or with the autonomy and freedom of the medical institution.
PROFESSIONAL SECRECY/MEDICAL CONFIDENTIALITY

Medical practitioners must maintain secrecy that they come to know about the patient. 

*Disclosure of patient’s secrets is considered as failure of trust and confidence, and doctors can be sued by the patient for damages or face disciplinary action by medical council.*

**Conditions for Professional Secrecy**

- The healthcare professional who receives the information has a duty to respect the client’s confidentiality.
- The information is shared as part of the professional’s job.
- The information is private.

The *only exception is for disclosure to ‘professional assistants’,* which usually includes nurses or other employees, but not external service providers.

It constitutes criminal liability if the secret is disclosed to third-party service providers, such as health insurance, hospital billing and IT companies for data processing. However, laws are now being amended in certain countries for information to passed to other service providers.

**Requirements for third party service providers:**

- The service provider must be chosen carefully.
- Detailed instructions must be issued to the service provider for confidentiality.
- The service provider must be informed of the criminal consequences of a breach of confidentiality.
- The contract with the service provider must be entered into in written form.
- It must be specified to the service provider whether he or she is authorised to deploy other persons to perform the contract.

*Privacy of the patients in India is protected by the code of ethics of the Indian Medical Council (Professional Conduct, Etiquette and Ethics) Regulations, 2002. There are no specific laws.*

Health Ministry has proposed a Digital Information Security in Healthcare Act (DISHA) in 2018 which has not been implemented yet.
PRIVILEGED COMMUNICATION

It is exception to professional secrecy. The physician is authorized to divulge secrets of a patient under following conditions.

- **Waiver of privilege by a competent adult patient** or his/her legal guardian, i.e., by consent of the patient for disclosure.
- When required by the court of law.
- Court-ordered examinations.
- Mandatory reporting statutes, such as:
  - notifiable diseases
  - Suspected crime
  - Births, deaths, epidemic diseases
- **Self interest**: Negligence proceedings against the physician by the patient, civil or criminal suits by the patient against the physician.
- **Patients own interest** when the patient has suicidal tendencies or other self harming disorders.

For the communication to be privileged, **it must be made to the person or authority, who has a duty towards it.** Medical practitioner can discuss the case with other doctors and paramedical staff, to provide better service to the patient.

**Guidelines for disclosure**

i. Notifiable disease can be notified to the statutory body in the interest of public/society. If the patient is minor or insane, parents or guardian should also be informed.

ii. In case of minor or insane, information should be disclosed to parents or guardians.

iii. In case of husband and wife, information should not be disclosed to spouse without consent.

iv. Even if the patient is treated free as in government hospitals, physicians should not disclose the facts.

v. No information can be disclosed to any third party, even if they are paying for medical expenses.

vi. Under **trials prisoners also have right to privacy**, however convicted prisoners have no such right and the information can be provided to the authorities.

vii. Information gathered during **medical examination for employment or insurance purposes can be revealed**. Consent of patient in such cases is implied.

viii. Confidentiality ethically survives a patient's death unless disclosures are required by statute or case law.
PROFESSIONAL MISCONDUCT (INFAMOUS CONDUCT)

Any unethical act, described in Section-6 of IMC regulation, and the following acts of commission or omission on the part of a physician shall constitute professional misconduct rendering him/her liable for disciplinary action, under IMC Regulations, 2002, Sec-7. However, the list of unethical offences is not complete, and situation may arise out of these categories.

**Indian Medical Council (Professional conduct, Etiquette and Ethics) Regulations, 2002, Sec-7**

7.1 **Violation of the Regulations**: If he/she commits any violation of these Regulations.

7.2 If he/she **does not maintain the medical records** of his/her indoor patients for a period of three years and refuses to provide the same within 72 hours when the patient or his/her authorised representative makes a request for it.

7.3 If he/she **does not display the registration number** accorded to him/her by the State Medical Council or the Medical Council of India in his clinic, prescriptions and certificates etc. issued by him.

7.4 **Adultery or Improper Conduct**: Abuse of professional position by committing adultery or improper conduct with a patient or by maintaining an improper association with a patient will render a Physician liable for disciplinary action as provided under the Indian Medical Council Act, 1956 or the concerned State Medical Council Act.

7.5 **Conviction by Court of Law**: Conviction by a Court of Law for offences involving moral turpitude / Criminal acts.

7.6 **Sex Determination Tests**: On no account sex determination test shall be undertaken with the intent to terminate the life of a female foetus developing in her mother’s womb, unless there are other absolute indications for termination of pregnancy as specified in the Medical Termination of Pregnancy Act, 1971. Any act of termination of pregnancy of normal female foetus amounting to female foeticide shall be regarded as professional misconduct on the part of the physician leading to penal erasure besides rendering him liable to criminal proceedings as per the provisions of this Act.

7.7 **Signing Professional Certificates, Reports, and other Documents**: Registered medical practitioners are in certain cases bound by law to give, or may from time to time be called upon or requested to give certificates, notification, reports, and other documents of similar character signed by them in their professional capacity for subsequent use in the courts or for administrative purposes etc. Any registered practitioner who is shown to have signed or given under his name and authority any such certificate, notification, report, or document of a similar character which is untrue, misleading or improper, is liable to have his name deleted from the Register.
7.8 A registered medical practitioner shall not contravene the provisions of the Drugs and Cosmetics Act and regulations made thereunder. Accordingly,
   a) Prescribing steroids/psychotropic drugs when there is no absolute medical indication.
   b) Selling Schedule „H“ & „L“ drugs and poisons to the public except to his patient; in contravention of the above provisions shall constitute gross professional misconduct on the part of the physician.

7.9 Performing or enabling unqualified person to perform an abortion or any illegal operation for which there is no medical, surgical, or psychological indication.

7.10 A registered medical practitioner shall not issue certificates of efficiency in modern medicine to unqualified or non-medical person.

7.11 A physician should not contribute to the lay press articles and give interviews regarding diseases and treatments which may have the effect of advertising himself or soliciting practices; but is open to write to the lay press under his own name on matters of public health, hygienic living or to deliver public lectures, give talks on the radio/TV/internet chat for the same purpose and send announcement of the same to lay press.

7.12 An institution run by a physician for a particular purpose such as a maternity home, nursing home, private hospital, rehabilitation centre or any type of training institution etc. may be advertised in the lay press, but such advertisements should not contain anything more than the name of the institution, type of patients admitted, type of training and other facilities offered and the fees.

7.13 It is improper for a physician to use an unusually large sign board and write on it anything other than his name, qualifications obtained from a university or a statutory body, titles and name of his speciality, registration number including the name of the State Medical Council under which registered. The same should be the contents of his prescription papers. It is improper to affix a sign-board on a chemist’s shop or in places where he does not reside or work.

7.14 The registered medical practitioner shall not disclose the secrets of a patient that have been learnt in the exercise of his/her profession except:
   i. in a court of law under orders of the Presiding Judge.
   ii. in circumstances where there is a serious and identified risk to a specific person and/or community.
   iii. notifiable diseases.

In case of communicable/notifiable diseases, concerned public health authorities should be informed immediately.
7.15 The registered medical practitioner shall not refuse on religious grounds alone to give assistance in or conduct of sterility, birth control, circumcision, and medical termination of pregnancy when there is medical indication, unless the medical practitioner feels himself/herself incompetent to do so.

7.16 Before performing an operation, the physician should obtain in writing the consent from the husband or wife, parent, or guardian in the case of minor, or the patient himself as the case may be. In an operation which may result in sterility the consent of both husband and wife is needed.

7.17 A registered medical practitioner shall not publish photographs or case reports of his/her patients without their permission, in any medical or other journal in a manner by which their identity could be made out. If the identity is not to be disclosed, the consent is not needed.

7.18 In the case of running of a nursing home by a physician and employing assistants to help him/her, the ultimate responsibility rests on the physician.

7.19 A physician shall not use touts or agents for procuring patients.

7.20 A physician shall not claim to be specialist unless he has a special qualification in that branch.

7.21 No act of invitro fertilization or artificial insemination shall be undertaken without the informed consent of the female patient and her spouse as well as the donor. Such consent shall be obtained in writing only after the patient is provided, at her own level of comprehension, with sufficient information about the purpose, methods, risks, inconveniences, disappointments of the procedure and possible risks and hazards.

7.22 Research: Clinical drug trials or other research involving patients or volunteers as per the guidelines of ICMR can be undertaken, provided ethical considerations are borne in mind. Violation of existing ICMR guidelines in this regard shall constitute misconduct. Consent taken from the patient for trial of drug or therapy which is not as per the guidelines shall also be construed as misconduct.

Violation of code of conduct may result into charges of professional misconduct, and either of the following disciplinary action:

i. Warning Notice

ii. Penal erasure: It can be temporary or permanent.
**Erasure of name:** Name of the medical practitioner may be removed from the medical council register under following situations:

ix. Where the medical practitioner is not traceable at his/her given address.

x. After the death of medical practitioner.

xi. After professional misconduct, practitioner name can be erased. Permanent erasure of name from medical register is termed as *professional death sentence.*
CONCEPTS OF MEDICAL PRACTICE AND NEGLIGENCE

Doctor – patient relationship

Doctor-patient relationship is formed when a physician takes an affirmative action in rendering services to the patient's care.

It implies a duty of care towards patient, which must be applied with expected standards. To prove a case of medical negligence, a breach in the duty of care and/or the standard of care must be proved.

Duty of care

A duty of care arises whenever there is a relationship between a patient and health care provider. The duty of care must conform to the standard reasonably expected of a competent doctor.

The duty of care may exist even in the absence of any contract between patient and doctor and the doctor-patient relation may not be so obvious. For example, when a doctor attends an unconscious patient, or when doctor reviews the patient’s radiological or blood reports, but never actually meets the patient, the duty of care is established.

Under the relationship, the physician owes a duty to patient to either:

- continue to treat the patient or
- properly terminate the relationship.

A withdrawal from relationship is permitted after a sufficient notice period to procure other medical attention.

Special Circumstances

There are situations, when establishing the doctor-patient relationship and thus the duty of care is questionable.

xii. Third party: If a patient poses a danger of violence or spreading communicable disease to others, the physician bears a duty to exercise reasonable care to protect the foreseeable victim (third party).

xiii. At the scene of accident: When medical professionals provide emergency assistance voluntarily to a person at the scene of an accident, they are protected by legally protected from liability, unless their action was grossly negligent.

xiv. Medical examination for third party: During medical examination for insurance, employment or personal injury cases, physician have limited duty of care towards patients. Primary duty of the physician is owed to the plaintiff’s employer and the duty owed to the plaintiff is not to harm him while conducting the examination.
xv. **On-call physicians**: A doctor-patient relationship is established when a physician assumes the obligation to provide services to a hospital patient with whom he/she had no direct or indirect contact.

xvi. **Unborn child**: Medical practitioners owe a duty of care of not doing any harm to the unborn child. If the child is not born alive (as in abortion), no duty of care arises. If the child is born alive with injuries due to prenatal or perinatal care, a duty to the child exists.

**Standard of care**

Medical practitioners must discharge their duty with accepted medical standards. For medical negligence compensation, plaintiff must show that

i. There was breach of duty (either act of commission or omission),

ii. Breach caused harm,

iii. The risk created or the harm caused was foreseeable.

Practitioners are also not held negligent for their inability to treat a patient successfully.

**Bolam test**

The accepted medical standards were defined in "Bolam v Friern Hospital Management Committee" judgement. It states that: “if a doctor acts in accordance with a responsible body of medical opinion, he or she will not be negligent.”

Thus, a medical practitioner must demonstrate that at least one other medical professional with an ordinary level of skill would have acted in the same way in delivering an ordinary level of care.

The **Bolitho Test**, was an amendment to the Bolam Test.

The Bolam Test states that no doctor can be found guilty of negligence if they are deemed to have acted "in accordance with a responsible body of medical opinion."

However, in case of "Bolitho v City and Hackney HA", experts disagreed on the course of treatment. It was held that the final arbiter to decide on clinical negligence is the court and not the medical profession. It is for the court to decide whether there is a requisite logical basis for a defendant’s expert medical opinion.

The Bolitho Test explains the “responsible body,” as the one whose opinion had a “logical basis.” Combining the two tests, standard of care can be explained as… "a doctor is not negligent if he or she acts in accordance with a responsible body of medical opinion, provided that the Court finds such an opinion to be logical".
MEDICAL NEGLIGENCE / PROFESSIONAL NEGLIGENCE

Negligence is the breach of a legal duty to care. Medical negligence is the bodily injury or death of a patient, caused either by lack of reasonable care and skill or by wilful negligence, by medical professionals.

Medical negligence can result either from act of commission or omission. For medical negligence, one must prove that harm has occurred as a direct result of an act or a failure to act. The medical negligence is proved if all the four following components are established.

i. **Duty of care**: It exists once the physician-patient relationship is established.

ii. **Expected standard of care, and breach of the established duty of care**.

   Standard of care is what a competent physician in the same field would do in the same situation, with the same resources.

   Duty to care is the reasonable care to avoid foreseeable injury to the patient.

iii. **Causation (damage)**: The defendant (patient) suffered from the damage. Without damage, there can be no liability.

iv. **Correlation between negligent act and damages**: It involves establishing the responsibility for a specific harm to be imposed on negligent party. Factual causation is proved by establishing whether the harm would have occurred without the negligent act ("but for" test).

Negligence is not simply a bad result as physician can not insure or guarantee health. Medical practitioners only to meet the standard of skill possessed generally by others practicing in the same field under similar circumstances.

**Determination of severity of legal liability involves**:

i. Assessment of the magnitude of liability.

ii. Reasonable foreseeability.

iii. Correlation of harm with the negligent act.

iv. Intervening events.
Medical negligence acts may result in a

i. Civil action by the injured party (claimant) or
ii. Criminal prosecution by the state.

Negligence is established on the balance of probabilities (civil cases) or beyond reasonable doubt (criminal prosecution).

Civil negligence

It must be established that physician owed a duty of care to the patient, the duty of care was breached, and harm was the direct result of the breach of duty.

Successful civil actions result in monetary compensation to the injured party or dependents, without any legal punishment to defendant (Physician).

Criminal negligence

In criminal negligence, there is serious harm to the patient or death from the incompetency or grossly negligent acts of the practitioner. It results into legal punishment to medical practitioner.

Incidences of Medical negligence

Deviation from accepted medical standards or negligent acts of a physician, is considered as medical negligence. If such negligence causes harm to the patient, it may result into liability on practitioner/hospital.

Common categories of medical negligence are:

- Wrong diagnosis
- Lack of proper investigation
- Wrong treatment
- Errors or negligence during surgical procedures
- Negligence during administration of anaesthesia
- Lack of post-operative care
- Negligence during childbirth and labor

Burden of Proof

Law assumes physician to be innocent until proven guilty. The burden of proof in medical negligence lies with the complainant. A higher standard of evidence to support an allegation of negligence is required against physician.
Res ipsa loquitur (Thing speaks for itself)
In a medical negligence case, complainant has the burden to prove the liability of medical practitioner. However, **there are instances, where the act itself implies medical negligence**. In such cases, the doctrine of “res ipsa loquitur” applies.

The negligence act of the defendant (physician) is evident and **does not require any proof or medical evidence**. Under this doctrine, the patient must present certain circumstantial evidence/ facts and does not need to prove the negligent act. The physician must prove that the act done by him/ her was not negligence.

**Res ipsa loquitur is not a cause of action but a rule of evidence.** Unaided laymen must be able to determine that negligence have occurred without the aid of an expert.

For application of doctrine of res ipa loquitur, following conditions must be satisfied:

i. Injury would not have occurred under ordinary situations, in the absence of negligence.

ii. Treatment or instrument causing injury was under the control of the defendant at the time the negligence.

ii. Injury was not due to the voluntary act or the contributory negligence of the patient.

**Explanation**
Common examples are leaving surgical instrument in the body, or the wrong limb is operated. However, in complex cases, such as misuse of surgical instruments or injury to surrounding organs during surgery, common knowledge may not be sufficient to determine whether the harm ordinarily would not have happened. If such cases require expert evidence to prove negligence, and doctrine of res ipa loquitur may not apply.

When a team of surgeons, physicians, nurses, anesthetists, and technicians are present during a surgical procedure, or in the care of a patient, one physician may not be held liable.

**Doctrine of common knowledge**
It is a **variant of Res ipsa loquitur**. In “common knowledge” exception relating to a malpractice case, **no expert witness is required to prove negligent act or the standard of care**. This exception involves case of obvious or extreme error.

To apply the doctrine of “res ipa loquitur”, circumstantial evidence is required that the physician was engaged in negligent act and such negligence caused the injuries to the plaintiff.

The “common knowledge” doctrine applies in cases when there is direct evidence that physician breached customary practice.

**Assumption of risk Doctrine**
Assumption of risk is a legal doctrine, which is raised by the medical practitioner. When a patient willingly exposes him or herself to the risks involved with proposed treatment or
procedure, the medical practitioner is not be liable for damages. Consent of the patient is usually the defence used by the treating physician.
For this doctrine, harm or injury should be of type that may occur even after reasonable care has been taken.
To prove the assumption of risk defense, the defendant (Medical practitioner) must demonstrate the following:
• The plaintiff (patient) had actual knowledge of the risk involved; and
• The plaintiff (patient) voluntarily accepted the risk, either expressly through agreement or implied by their words or conduct
The defendant bears the burden of proof.

Contributory negligence
It is the unreasonable conduct or absence of ordinary care on the part of the patient or his personal attendant which combined with the doctors’ negligence contributed to the injury.
As the contributory negligence breaks the causal connection between doctor’s negligence and patient’s injury or loss, patient may not recover any damages. In some countries, law permits apportionment of the fault. The plaintiff may be entitled to partly reduced compensation.
Common examples are failure to take suggested treatment, Failure to give proper history or leaving hospital against medical advice. Burden of proof lies with the defendant by preponderance of evidence.

last clear chance doctrine
The last clear chance doctrine is applied in negligence cases where both plaintiff and defendant are responsible for injury. When defendant (Physician) applies for contributory negligence of patient, the negligent plaintiff (Patient) can still recover damages if he/she can show that the defendant had the last clear chance to avoid the injury.
The burden of proof is on the plaintiff (Patient) to prove that the defendant (Physician) had the last clear chance to avoid injury.

Comparative Negligence
Under this doctrine, the defendant (Physician) is held partly responsible and is not relieved completely of responsibility simply because the patient also failed to exercise due care.
Comparative negligence allows a negligent plaintiff (patient) to recover some damages for their injuries. It allows patient to recover damages based on the percentage of fault.
Avoidable Consequence Rule

Patient harmed by the negligent action of a medical practitioner, must take reasonable steps to avoid aggravating the injuries. Patient has a duty to minimize damages and cannot recover damages for what could have been avoided by reasonable acts.

Avoidable consequences only limit a plaintiff from recovering for his or her enhanced harm rather than losing the whole claim.

Medical maloccurrence

Medical maloccurrence is a less-than-ideal outcome of medical care, which may or may not be related to the reasonable quality of care provided. Medical maloccurrence is always present in cases of malpractice, but the converse is not true.

These are unavoidable complications which arise from unpredictably of the patient. In maloccurrence, applicable standard of care is not violated as compared to malpractice.

It includes:

i. Medical and surgical complications, that can be anticipated and represent unavoidable risks.

ii. Complications that arise unpredictably and are unavoidable.

Examples include idiosyncratic response to drugs, amniotic fluid embolism following Caesarean section etc.

Therapeutic misadventure

Therapeutic misadventure is an injury, or an adverse event caused by medical management rather than by an underlying disease. A physician has no control over an incident of misadventure. It differs from medical negligence, which includes acts of commission or omission. A therapeutic misadventure incident can be defended in a court of law by the medical practitioner.

It can be either diagnostic, therapeutic or experimental.

Examples includes adverse drug reaction, medication errors in writing prescriptions, dispensing, administering, and monitoring effects of drugs.
Vicarious liability / Respondent superior

It is the liability imposed on one person for the wrongful actions of another person, which arises because of some legal relationship exists between the two.

**Essential ingredients**

i. To constitute vicarious liability, there must be a relationship such as: Master-Servant, Principal-Agent, or Independent Contractors.

ii. The act must be committed within the scope of employment.

**Explanation**

A servant who is controlled and supervised by his employer works according to the master thus the employer is liable for the negligent actions of the servant. The employer derives profit from servant's work, so is also responsible for the losses caused by the activity of the servant which occur within the scope of employment.

**Scope of Employment**

The act of the employees related to the terms of the employment are considered as within the scope of employment. Situations where a worker is not working under the scope of employment are:

- Independent Contractor.
- Illegal Acts of the employee.

Employer is responsible for the negligent action of servants because servants work under the contract of services unlike independent contractors. The negligent act of the servant is considered as the act of the employer, but the work of an independent contractor can not be controlled by the employer.

**Vicarious Liability in healthcare institutions**

The hospital is vicariously liable for the negligent actions of the employees, which includes doctors, nurses, technicians, lab assistants, administrative staff. A doctor is held liable for employees working under his/her supervision.

Hospital or institution is not liable for the acts of independent consultants, but hospital is responsible to ascertain proper qualifications and credentials of the employees and independent consultants.

**Vicarious Liability of Doctors**

Doctors also have vicarious liability for other healthcare professionals who were working under their supervision such as assistant physicians, nurse, technicians, or medical students. When doctors are working in partnership, each is liable for the negligent act of the other. During surgery, a surgeon may not be responsible for the anaesthetist as both work as independent consultant.
Exceptions

The usual defence of hospital is that they provide only infrastructural facilities and services of staff and technicians and cannot themselves perform or recommend any surgery or procedure. However, several judgments have held hospitals vicariously liable for damages caused to the patients by negligent acts of their consultants for the following reasons:

- The patients go to a hospital and not for specific consultant for medical services and pay to the hospital the necessary cost. Consultants doctor fees includes the commission of the hospital.
- The terms under which the hospital employs consultants are between them. Thus, hospital cannot escape the liability, so far as third-party patients are concerned.
Borrowed servant doctrine

Under this rule, a servant may have two masters at the same time. To determine the liability of such a person, it must be determined, which master he/she was under control at the time of negligent act. For example, in healthcare facility, a hospital employee may assist an independent consultant, and is considered as borrowed servant. The consultant is liable for the negligent acts of the borrowed hospital employee.

Cases of borrowed servant doctrine are divided into two categories:

i. **Operative situation**: The surgeon is in absolute control over the assisting employees during operation and is considered as "Captain of the ship". This makes the surgeon vicariously liable for the hospital employees.

ii. **Non-operative situation**: The consultant is not always responsible for the hospital employees, as the control over the employee act is not absolute. The liability in such situation is based on the facts:

   • Who had the control over the employee at the time of negligent act.
   • Whether the act comes under hospital duties.

**Examples**: A surgeon is responsible for assisting employees in operating room, including resident anaesthetic doctors. However, surgeon is not liable for qualified anaesthesia consultants. Here, the resident becomes his borrowed servant during the surgery. The hospital is responsible for the resident doctor in the absence of surgeon.
Corporate Negligence

Under corporate negligence, health-care facility, owes a direct duty towards patients, to ensures their safety and well-being. Hospital's standard of care is non-delegable to other staff or consultants. Hospitals are responsible for the following areas:

i. duty to use reasonable care in the maintenance of facility and equipment.
ii. Duty to select and retain only competent consultants and employees.
iii. Formulate appropriate rules, policies, guidelines, and procedures to ensure standard of care.

Product liability

It arises when a person is injured from a defective medical product or drug, without adequate warning about the product’s potential defects or dangerous side effects. Medical product liability claim is a lawsuit against a manufacturer. Medical professional or hospital is not liable for defective product if they use the product correctly.

Manufacturers are responsible for design, manufacture, quality control, adequate warnings and safety concerns involving their products.

Duty of doctors is to install the product carefully and inform patients about alternatives treatment and side effects.

Examples of medical products associated with liability are hip and knee replacement parts, stents, IUDS, breast implants, dialysis filters, drugs etc.

Novus actus interveniens - new intervening act

It is an independent, intervening act which breaks the causation of events between a negligent act and the ultimate harm. Such a new act helps the wrongdoer to escape or limit the liability arising from the final outcome.

The new act can either be an act of the injured person himself, or of a third party, but not an act of the original wrongdoer himself.

A negligent act of a doctor, following the initial injury, will constitute the new intervening act, as it breaks the chain of events between the original injury and the harm.

To establish medical liability, the defendant (original wrongdoer) must show that:

i. Subsequent treatment was “grossly negligent”, and
ii. Ultimate harm was not a reasonably foreseeable consequence of the original injury.
Legal defences in medical negligence

i. **Section 80 IPC** (Accident in doing a lawful act)
   Any harm done, without any criminal intention or knowledge in the doing of a lawful act in a lawful manner by lawful means and with proper care and caution is not an offense.

ii. **Section 81 IPC** (Act likely to cause harm)
    Any harm done, without any intention to cause harm and in good faith in order to avoid other damages to a person or his property is not an offense.

iii. **Section 88 IPC** (Act not intended to cause death)
    It is not an offense if the act is done in good faith for the good of other people and does not intend to cause harm even if there is a risk involved and the patient has given the consent explicitly or implicitly.

iv. **Res Judicata**
    When a case has already been decided by a court, the plaintiff (patient) cannot bring another legal suit against the negligent doctor, as the matter has already been judged.

v. **Law of limitation**
    There is a limitation period in law, during which a patient can file negligence case against the doctor. The period is 2 years from the date of alleged negligent act or 2 years from the appearance of sign and symptoms of negligence.
CONSENT

According to Indian contract act 1872, Section 13, "two or more persons are said to be in consent when they agree upon the same thing in the same sense."

Medical examination, treatment, any diagnostic or therapeutic procedure, without consent is considered as an assault or battery as per law, even if the act is done in good faith or for the benefit of the patient. Medical practitioner is liable under both tort and criminal law if he / she attempts to examine or treat a person without valid consent.

Consent should be free and fulfilling the following criteria.

1. Legally consent should be without:
   - **Coercion**: Coercion is any act which includes threat, unlawful detention or causing a threat of detaining property of the other party with the view of obtaining his consent.
   - **Undue Influence**: When the party is at the position to dominate the will of other party and make an undue advantage over the other party.
   - **Fraud**: When a party to consent, try to the conceal the actual fact or provides information which is not true.
   - **Misrepresentation**: When the party entered into the contract with the intent to deceive or caused the mistake without having intention, it amounts to misrepresentation.
   - **Mistake**: These are the mistakes of the facts, which can be unilateral or bilateral.

2. **Capacity**: Patient must have the capacity to understand his/her illness and able to make rational decision about the proposed medical treatment.

Types of consent

Patient can give consent in following ways:

- **Implied consent**: This is the most common in doctor-patient relationship, where conduct of the patient implies his/her consent.
- **Express consent**: The patient expresses his/her consent either verbally or in writing. Although both, verbal and written have equal importance but written consent has more evidential value.
- **Tacit consent**: Tacit consent is given by actions (or conduct) that imply consent. It is understood or implied without being openly said or by not interposing an objection.
- **Surrogate consent**: This consent is given by relatives or guardians of the patient.
- **Advance consent**: It is the consent given by patient in advance.
- **Proxy consent** is given by an authorized person.
Informed consent

The patient is informed or educated about his illness before taking the consent. Doctor-patient relationship is fiduciary, which involves faith, trust, confidence, and honesty. Patients are usually not aware of medical knowledge and technical terms. They depend on the physician for such information, which helps them to make “informed decision”. Thus, doctor-patient relationship with patient must be based on truthfulness to provide complete and appropriate information.

The following elements are required to be documented for informed consent:

i. Nature of illness
ii. Proposed treatment or management
iii. Risks and benefits and the procedure
iv. Alternative options available to patient
v. Risks and benefits of alternative options
vi. Outcome in the absence of any treatment

Following standards are to be considered for the adequacy of an informed consent.

a. Reasonable patient standard: What would the average patient need to know for an informed decision?

b. Reasonable physician standard: How much physician should disclose about the illness and proposed treatment?

The standard applied are those of a ‘reasonable physician’ dealing with a ‘reasonable patient’.

c. Subjective standard: What patient needs to know to make an informed decision? There are no clear parameters regarding the quantum of information to be given. This varies with every patient and must be decided by the treating physician.

Exceptions to informed consent

There are several exceptions to the doctrine of informed consent:

1. Incapacity of the patient: Patient is unable to make clear decision. In such cases an evaluation by a psychiatrist to determine Capacity may be required.

2. Emergency situations with inadequate time to obtain consent: In such situations, surrogate decision maker may be required, according to state laws.

In the absence of consent, medical treatment and procedure can be performed in good faith. In instances, if there is any harm to the patient, medical practitioner can not be sued for negligence as the act was done in good faith.
According to Section 52 IPC, any harm caused to a person in *good faith*, even without consent is not an offence. If circumstances are such that it is impossible to signify consent.

Essentials of good faith are: Logic and a reason, a good intention, due or reasonable care and with expertise or a skill.

3. **Minor and informed consent**: Minor patients under the age of 18, cannot give informed consent. In such cases, parents or guardians permits treatments or interventions and is termed as informed permission.

4. **Examination of arrested accused person**: Examination of an arrested person, can be undertaken, without his/her consent, if there are reasonable grounds for believing that an examination of his person will afford evidence as to the commission of an offence.

5. **Therapeutic waiver** (Voluntarily waived consent): A competent person may give up his right of informed consent by waiving it.

6. Psychiatric examination and treatment under court orders.

**Guidelines for consent**

*In Clinical practice*

i. In routine practice, an oral consent is sufficient, however written consent has more evidential value in court.

ii. Written consent should also be signed by a witness.

iii. Disclosure to third party cannot be made without consent of the patient.

iv. There should not be a blanket consent at the time of admission. Consent is an ongoing process and should be taken for every procedure.

v. A person can give valid consent to suffer any harm which may result from an act not intended or not known to cause death, done in good faith and for his benefit (Sec 88 IPC).

vi. Emergency situations: Treatment and procedures can be performed without consent, if the circumstances are such that it is impossible to obtain consent from patient and no lawful guardian is available.

vii. An insane or intoxicated person cannot give valid consent (Sec 90 IPC).

viii. For organ donation, will of the deceased is sufficient. However, consent of a person is not binding on his/her spouse or lawful dependants.

**Medico-legal Cases**

i. In medicolegal cases, accused has the right to refuse to medical examination and treatment. However, an accused can be examined without consent as per Section 53 CrPC.
ii. Consent from relatives is required for pathological autopsy.

iii. No consent is required for medico-legal autopsy.

Reproductive age group

i. In medicolegal cases involving rape, pregnancy, abortion or delivery, females cannot be examined without consent.

ii. Consent for treatment from spouse is not required.

iii. For contraceptive, sterilization and artificial insemination, consent of each spouse is necessary.

iv. For illegal acts like abortion, consent is invalid.

Minor and adolescents

i. A child below 12 yrs. and insane person can not give valid consent to any act done in good faith for its benefit. In such cases, consent of parents / guardian is required. (Sec 89 IPC).

ii. Person above 18 yrs. can give valid consent to suffer any harm which may result from an act not intended to cause death / grievous hurt (Sec 87 IPC).

iii. Consent is required only from either of the parents or the legal guardian. It is preferable to involve both parents, especially if the treatment is invasive. If the parents disagree, the physician should consider the child’s best interest.

iv. **Loco Parentis**: In absence of parents / guardian, consent is taken from person in-charge.

v. In planned and non-therapeutic procedures, consent of both persons should be taken.
Section B

General Guidelines
Chapter 3 - Record Keeping

RECORD KEEPING

The Medical Council of India guidelines insist on preserving the inpatient records for three years from the commencement of treatment. Medico-legal case records should be maintained until the final disposal of the case even though only a complaint or notice is received.

**According to Medical Council of India Regulations 2002 guidelines**

1. Maintain indoor records in a standard proforma for 3 years from commencement of treatment.
2. Request for medical records by patient or authorized attendant should be acknowledged and documents issued within 72 hours.
3. Maintain a register of certificates with the full details of medical certificates issued with at least one identification mark of the patient and his signature.
4. Efforts should be made to computerize medical records for quick retrieval.

**Responsibility for records**

Medical records are the property of the hospitals, and it is the responsibility of the hospitals to maintain and produce patient records on demand by the patient or appropriate judicial bodies. It is the duty of the treating doctor to write and sign the documents. An unsigned medical record has no legal validity.

Treating doctors have duty to write and sign documents.
Hospital records are property and responsibility of Hospital.
CONFIDENTIALITY
Medical records are confidential and should not be released without the consent of the patient except in some specific situations.

i. During referral,

ii. When demanded by the court or by the police on a written requisition,

iii. When demanded by insurance companies under the Insurance Act and when the patient has relinquished his rights of confidentiality on taking the insurance,

iv. When required for specific provisions of Workmen’s Compensation cases, Consumer Protection cases, or for Income tax authorities.

v. Research teams can access and use medical records for research purpose, without patient consent and without revealing the identity of the patient.

Confidentiality after death of patient
Duty of confidentiality to a patient remains even after death. Relevant information about the patient’s death is disclosed in following situations:

- On death certificate.
- In the court of law.
- To relevant legal authorities in Medico-legal cases.
- To the parents about the circumstances and causes of a child’s death.
- To any other person who has a right of access to records.

Records are confidential and can be released only by consent of patient. Information can be revealed only by patient’s consent and in Notifiable diseases.
TELEMEDICINE GUIDELINES

Telemedicine guidelines are meant for RMPs under the IMC Act 1956. The guidelines cover norms and standards of the RMP to consult patients via telemedicine.

Exclusions:
The guidelines specifically explicitly exclude the following:

i. Specifications for hardware or software, infrastructure building & maintenance.
ii. Data management systems involved, standards and interoperability.
iii. Use of digital technology to conduct surgical or invasive procedures remotely.
iv. Other aspects of telehealth such as research and evaluation and continuing education of healthcare workers.
v. Does not provide for consultations outside the jurisdiction of India.

Mode of Communication

i. Video (Telemedicine facility, Apps, Video on chat platforms, Skype/Facetime)
ii. Audio (Phone, VOIP, Apps etc.)
iii. Text Based:
   • chat based applications (specialized telemedicine smartphone Apps, Websites, other internet-based systems etc.)
   • General messaging/ text/ chat platforms (WhatsApp, Google Hangouts, Facebook Messenger etc.)
   • Asynchronous (email/ Fax etc.)

Context

- The Registered Medical Practitioners should exercise their professional judgment to decide whether a telemedicine consultation is appropriate in a given situation or an in-person consultation is needed in the interest of the patient.
- The RMP shall uphold the same standard of care as in an in-person consultation but within the intrinsic limits of telemedicine.

Identification of RMP and Patient

- Patient’s identity - An RMP should verify and confirm patient’s identity by name, age, address, email ID, phone number, registered ID or any other identification as may be deemed to be appropriate.
- RMP’s Identity - The RMP should ensure that there is a mechanism for a patient to verify the credentials and contact details of the RMP. They should display the registration number accorded by the State Medical Council/National Medical
Commission, on prescriptions, website, electronic communication (WhatsApp/ email etc.) and receipts etc. given to the patients.

- Check age when prescribing medication – through proof. If minor they should be accompanied by an adult and proof of both should be available including relationship.

**Consent**

Patient consent is necessary for any telemedicine consultation. The consent can be Implied or explicit depending on the following situations. If the patient initiates the telemedicine consultation, then the consent is implied.

Explicit Consent: If a Health worker, RMP or a Caregiver initiates a Telemedicine consultation, explicit consent is required, which can be recorded in any form. Patient can send an email, text or audio/video message. Patient can state his/her intent on phone/video to the RMP (e.g. “Yes, I consent to avail consultation via telemedicine” or any such communication in simple words). The RMP must record this in his patient records.

**Types of Consultation**

There are two types of patient consultations:

First Consult
- the patient is consulting with the RMP for the first time; or
- the patient has consulted with the RMP earlier, but more than 6 months have lapsed since the previous consultation; or
- the patient has consulted with the RMP earlier, but for a different health condition or if new symptoms appear or
- the RMP cannot recall earlier consult.

Follow-Up Consult(s)

The patient is consulting with the same RMP within 6 months of his/her previous in person consultation and this is for the continuation of care of the same health condition.

**Patient Management**

If the condition can be appropriately managed via telemedicine, then the RMP may proceed with professional judgment to:
- Provide Health Education as appropriate in the case; and/or
- Provide Counselling related to specific clinical condition; and/or
- Prescribe Medicines

**Prescribing Medicines**

Prescribing medicines without an appropriate diagnosis/provisional diagnosis will amount to a professional misconduct.

The categories of medicines that can be prescribed are listed below:
• **List O**: It will comprise those medicines which are safe to be prescribed through any mode of tele-consultation. In essence they would comprise of ‘over the counter’ medications. For instance, these medicines would include, paracetamol, ORS solutions, cough lozenges etc.

• **List A**: These medications are those which can be prescribed during the first consult which is a video consultation and is being re-prescribed for re-fill, in case of follow-up. This would be an inclusion list, containing relatively safe medicines with low potential for abuse Is a list of medication which RMP can prescribe in a patient who is undergoing follow-up consult, as a refill.

• **List B**: Is a list of medication which RMP can prescribe in a patient who is undergoing follow-up consultation in addition to those which have been prescribed during in-person consult for the same medical condition.

• **Prohibited List**: An RMP providing consultation via telemedicine cannot prescribe medicines in this list as these medicines have a high potential of abuse and could harm the patient or the society at large if used improperly. These include medicines listed in Schedule X of Drug and Cosmetic Act and Rules or any Narcotic and Psychotropic substance listed in the Narcotic Drugs and Psychotropic Substances, Act, 1985

**Issue a Prescription and Transmit**

- RMP shall provide photo, scan, digital copy of a signed prescription or e-Prescription to the patient via email or any messaging platform.
- In case the RMP is transmitting the prescription directly to a pharmacy, he/ she must ensure explicit consent of the patient that entitles him/her to get the medicines dispensed from any pharmacy of his/ her choice.

**Digital record keeping**

1. Log or record of Telemedicine interaction (e.g. Phone logs, email records, chat/ text record, video interaction logs etc.).
2. Patient records, reports, documents, images, diagnostics, data etc. (Digital or non-Digital) utilized in the telemedicine consultation should be retained by the RMP.
3. Specifically, in case a prescription is shared with the patient, the RMP is required to maintain the prescription records as required for in-person consultations.

**Telemedicine guidelines have prohibited list of medicines for prescription.**

**Electronic records of patients should be kept.**
Section C

Legal and Ethical guidelines
THERAPEUTIC PRIVILEGE

Doctor-patient relationship is fiduciary, which involves faith, trust, confidence, and honesty. Patients are usually not aware of medical knowledge and technical terms. They depend on physician for such information, which helps them to make “informed decision”. Thus, doctor relationship with patient must be based on truthfulness to provide complete and appropriate information.

There are certain exceptions where information is withheld from the patients. Therapeutic privilege is one such exception to full disclosure. It involves withholding of information by medical professional during the informed consent process. This doctrine of therapeutic privilege is based on the belief that disclosure of information may lead to harm or suffering of the patient.

There are precedents of the legal judgments, which recognize therapeutic privilege for patient’s benefits. However, withholding information from a competent patient requires greater justification than patient benefit alone.

Arguments

There are several judgements in which courts have rules against therapeutic privilege, as it goes against the doctrine of informed consent.

There are judgments both in favour and against the therapeutic privilege and disclosure of information. Chances that the patient would reject the treatment, cannot justify therapeutic privilege. Patient's right to informed decision takes precedence over doctors' discretion. In common law society, autonomy is fundamental right of the patient.

Patients may be denied full disclosure of all the relevant information in emergency situations, where the patient is minor or incompetent.
COMPETENCY AND CAPACITY

Competency is a legal term. It is presumed to be present in all persons unless proved otherwise. Competence of a person is his mental ability and cognitive capabilities to act rationally. Incompetence of a person is a legal decision given by the courts. Competence is usually determined for a specific task or act. For example, a person may be incompetent to make will but may be competent to make healthcare decision. General incompetence may be considered in persistent vegetative state, severe dementia, mental retardation, or other psychotic disorders.

Capacity of a person is determined by a physician and is task specific. A patient may not have the capacity to make a decision for surgery but may have capacity for some minor treatment. Capacity of a person is his/her psychological abilities to form rational decisions. The cases in which physician is uncertain, are referred to psychiatrist for further evaluation.

In clinical practice, capacity can be determined by assessing the following components.

1. **Communication**
   Patient should be able to communicate about his/her illness and express the choice of treatment. Frequent changing of decision by patient may question his capacity.

2. **Understanding**
   Patient should have understanding about his illness and its link with treatment and possible outcome. Any problem with intelligence, attention can affect the understanding and thus the capacity.

3. **Appreciation**
   Patient should be able to correlate the illness with the treatment options and their likely outcome. A lack of appreciation may result from the lack of capability to understand or emotions or some delusions.

4. **Rationalization**
   The patient should be able to weigh the risk and benefits of available treatment options. This reasoning may be affected in depression, dementia, and psychosis.
CONSENT

Guidelines for consent in Clinical practice

ix. In routine practice, an oral consent is sufficient, however written consent has more evidential value in court.

x. Written consent should also be signed by a witness.

xi. Disclosure to third party cannot be made without consent of the patient.

xii. There should not be a blanket consent at the time of admission. Consent is an ongoing process and should be taken for every procedure.

xiii. A person can give valid consent to suffer any harm which may result from an act not intended or not known to cause death, done in good faith and for his benefit (Sec 88 IPC).

xiv. Emergency situations: Treatment and procedures can be performed without consent, if the circumstances are such that it is impossible to obtain consent from patient and no lawful guardian is available (Sec 92 IPC).

xv. An insane or intoxicated person cannot give valid consent (Sec 90 IPC).

xvi. For organ donation, will of the deceased is sufficient. However, consent of a person is not binding on his/her spouse or lawful dependants.

**Emergency situations**

Treatment and procedures can be performed without consent, if the circumstances are such that it is impossible to obtain consent from patient and no lawful guardian is available. (Sec 92 IPC)

Patient’s autonomy supersedes beneficence and non-maleficence.
EMERGENCY TREATMENT

Right to Emergency Medical Care

- As per Supreme Court, all hospitals both in the government and in the private sector are duty bound to provide basic emergency medical care, and injured persons have the right to get emergency medical care.
- Such care must be initiated without demanding payment/advance, and basic care should be provided to the patient irrespective of paying capacity.

Refusal by patient for emergency treatment

Steps to be followed when patient refuses treatment:
Establish whether the patient has the mental capacity to make the decision for refusal of treatment. Capacity of a person is his/her psychological abilities to form rational decisions. It is determined by a physician and is task specific.
Capacity assessment is a two-stage test:
First stage: Establish whether the patient has an impairment of or disturbance in the functioning of their mind or brain. This may be temporary or permanent.
Second stage: If the impairment is sufficient to affect the patient capacity to make decision.
The patient must be able to do all the following:
   i. Understand the information relevant to the decision (including the reasonably foreseeable consequences of whatever decision is made or of failing to make a decision).
   ii. Retain that information in making the decision.
   iii. Use or weigh the information available, and
   iv. Communicate the decision by any means, including speech, sign language, or simple muscle movement.

If the patient lacks the capacity, treatment should be initiated, even against the consent of the patient. If the patient has the capacity to make the decision about their treatment, wishes of the patient should be followed.
Children and autonomy: Emancipation Laws in India

According to the Majority Act of 1875, a child is a minor until he/she attains the age of 18 years. Moreover, certain other limitations are also there which includes:

i. **Minors cannot enter a contract, and**

ii. **They cannot legally separate from their parents.**

Only after attaining the age of majority that they can live their life as per their wishes. The rationale behind categorising children below the age of 18 as minors is based upon the opinion that they have not reached a certain level of maturity until the age of 18 and hence, incapable of decision-making.

However, there are cases in family law where parents go through a rough separation. In such cases, the emancipation of minors is undertaken by a court process where they are recognised as independent adults capable of decision making provided they prove themselves worthy and competent to live and support themselves before being given such permission to emancipate.

The Indian Council of Medical Research's (ICMR) in its ethical guidelines for medical research continues to give primacy to the parents’ consent. However, they have also carved out provisions to consider the child’s perspective. Depending on the age and cognitive development of the child, assent must be obtained before conducting any medical research.
CONSENT

**Sec 89 IPC**: A child below 12 yrs. and insane person can not give valid consent to any act done in good faith for its benefit.

In such cases, consent of parents / guardian is required.

**Loco Parentis**: In absence of parents / guardian, consent is taken from person in-charge such as schoolteacher.

**Sec 87 IPC**: Person above 18 yrs. can give valid consent to suffer any harm which may result from an act not intended to cause death / grievous hurt.

Consent is required only from either of the parents or the legal guardian. It is preferable to involve both parents, especially if the treatment is invasive.

If the parents disagree, the physician should consider the child’s best interest.

*In planned and non-therapeutic procedures*, such as male circumcision and immunizations, consent of both persons of parental responsibility should be taken.

**Consent in emergency situations**

**Sec 52 IPC**: Any harm caused to a person in good faith, even without consent is not an offence, if circumstances are such that it is impossible to signify consent.

**Good Faith**: With due care and attention. E.g.: amputation in traffic accident, treatment of coma patient.

In emergency where parents or guardian are not available, emergency treatment which is in the child’s best interests may be given.

**Non-therapeutic procedure**

In cases of non-therapeutic procedures, such as cosmetic surgery, advantages and disadvantages of the procedure should be considered in deciding whether it is in child best interest. Procedures, as cosmetic surgery, may have emotional benefits but should be weighed against the risk involved and effectiveness. Physicians cannot be compelled to perform a procedure, which is not in the best interest of the child.

**Parental refusal of treatment against medical advice**

Where parents refuse for the treatment of the minor, urgency of the treatment and medical condition of the minor should be considered. In non-emergency situations, cases should be referred to court or ethics committee for decision making.

Parent’s decision can be overruled if the child is at risk of significant harm.

**Refusal for treatment by minors**

The wishes of a competent minor are important but are not decisive and his welfare precedes his autonomy. An individual who has reached the age of majority is free to do with his life what he wishes, but every step must be taken to ensure that children survive to attain that age.
Withholding information from a child

Telling the truth is the fundamental duty of a doctor. Doctor-patient relationship is based on that trust. However, young persons cannot be given access to information that would cause them harm.

Withholding information from a minor patient has its own risks. The information may be revealed unintentionally by some family member or other medical staff, and this would undermine the doctor-patient relationship. Not knowing about the diagnosis, may cause more distress to the patient and more anxiety.

Underage contraception

There are no laws that prohibit contraceptive advice to minors. Competency in a person is assumed on achieving the age of majority, which is 18 years in most of the situations. There are specific laws or criteria for emancipated minors.

In UK, physician can provide contraceptive services to a minor of under 16 years of age, under the Fraser Guidelines as follows:

1. He/she has sufficient maturity and intelligence to understand the nature and implications of the proposed treatment
2. He/she cannot be persuaded to tell her parents or to allow the doctor to tell them
3. He/she is very likely to begin or continue having sexual intercourse with or without contraceptive treatment
4. His/her physical or mental health is likely to suffer unless he/she received the advice or treatment
5. The advice or treatment is in the young person’s best interests.

Fraser guidelines are also applied to decisions about treatment for sexually transmitted infections and termination of pregnancy.

Capacity determination in minor patients

Legally, adults above 18 are assumed to have capacity to make their own decisions, and children under-18s are generally legally assumed to lack it, on the basis that they do not have the cognitive abilities to make decisions. There are no laws or any precedence in India so far.

In UK, Gillick competence is relied upon to determine the capacity and whether under-16s can themselves consent to treatment.
MTP procedure for minors

There is no lower age limit mentioned in MTP act, below which MTP cannot be done. Thus, MTP procedure can be performed on minors. However, written consent of parents or guardian is required for MTP procedure like any other medical services.

Guardian: The MTP Act defines guardian as a person "having the care" of the minor person. This includes anyone who has the care of a minor girl. Thus, an adult over 18 years, accompanying a minor girl to a clinic could be a de facto guardian and could consent to an abortion on the girl's behalf.

Legal duty: Protection of Children from Sexual Offences (POCSO) Act, 2012 was enacted to prevent and address child sexual abuse. Under POCSO Act medical providers are required to report sexual abuse among minors. Therefore, a pregnant minor girl married/unmarried is considered a victim of sexual assault, and a medical provider is required to report the pregnancy to the appropriate authorities, even if the girl has not expressed a desire to take legal action.

According to POCSO act, anyone who knowingly fails to make this report can be punished with up to six months in prison and a fine.

Medico-legal procedure before performing the abortion

a. Rule 5(3) of the POCSO Rules states that "no medical practitioner, hospital or other medical facility centre rendering emergency medical care to a child shall demand any legal or magisterial requisition or other documentation as a pre-requisite to rendering such care."

b. 2013 Ministry of Health and Family Welfare Guidelines and Protocols: Medico-Legal Care for Survivors / Victims of Sexual Violence state, “Providing treatment and necessary medical investigations is the prime responsibility of the examining doctor” and that “admission, evidence collection or filing a police complaint is not mandatory for providing treatment.”

This means that providers can inform the authorities about the pregnant minor after performing the abortion.

Preserving the evidence: Product of conception

The products of conception serve as an evidence of an offence that should be preserved by the medical practitioner under Section 201 (IPC) if possible.

Under 12 years: Cannot give consent.
Under 18 years: Cannot give consent for any invasive procedure, general anaesthesia, and surgical operations.
Autonomy of minor patient is not decisive.
Sex determination of unborn fetus

Pre-Conception and Pre-Natal Diagnostic Techniques (PCPNDT) Act, 1994 was enacted to stop female foeticides and capture the declining sex ratio in India.

Conditions in which the act allows pre-natal diagnostic techniques

Exceptions where pre-natal diagnostic techniques can be conducted for detection of the following abnormalities:

- chromosomal abnormalities
- genetic metabolic diseases
- Family history of diseases
- sex-linked genetic diseases
- congenital anomalies
- any other abnormalities or diseases as may be specified by the Central supervisory board

Pre-natal diagnostic techniques shall be used or conducted by the qualified person on satisfying the following conditions:

- age of the pregnant woman is above thirty-five years
- the pregnant woman has undergone two or more spontaneous abortions or fetal loss
- the pregnant woman had been exposed to potentially teratogenic agents such as drugs, radiation, infection, or chemicals
- the pregnant woman has a family history of mental retardation or physical deformities such as spasticity or any other genetic disease
- any other condition as may be specified by the Central Supervisory Board
- no person, being a relative or the husband of the pregnant woman shall seek or encourage the conduct of any pre-natal diagnostic techniques on her except for the purpose specified in Section 5(2) of the PC-PNDT Act.
MEDICAL TERMINATION OF PREGNANCY ACT, 2021

An Act to provide for the termination of certain pregnancies by registered Medical Practitioners. It provides criteria by the govt. of India about doctors who are eligible to do medical abortions and where such an abortion can be legally allowed to be carried out, whether medically (with pills) or surgically.

It permits termination only up to 24 weeks of pregnancy under the following circumstances:

- When continuation of pregnancy is a risk to the life of a pregnant woman or could cause grave injury to her physical or mental health.
- When there is substantial risk that the child, if born or dead would be seriously handicapped due to physical or mental abnormalities,
- When pregnancy is caused due to rape (presumed to cause grave injury to the mental health of the woman).
- When pregnancy is caused due to failure of contraceptives used by a woman or her partner (presumed to constitute grave injury to mental health of the woman).

Permissible age limit of pregnancy

The decision of MTP between 20-24 weeks however needs consent from 2 registered medical practitioners.

There is no upper limit to the gestation/ pregnancy age for termination if the unborn baby is found to have a substantial abnormality according to a medical board.

The Medical Board

It shall consist of the following,

a) a Gynaecologist
b) a Paediatrician
c) a Radiologist or Sonologist; and
d) such other number of members as may be notified in the Official Gazette by the State Government or Union territory, as the case may be."

Confidentiality

Confidentiality of the woman must be maintained and respected, intending to undergo an abortion within legal boundaries. Her name and other particulars will not be revealed to anyone except the person authorised "in any law for the time being in force."

Consent

Consent of husband or partner is not required.

Involvement of a parent or a legal guardian is a must for any abortion in a woman less than 18 years of age.

Place where pregnancy may be terminated

a) A hospital established or maintained by Government, or
b) A place for the time being approved for the purpose of this Act by Government.
Approval of a place

The following facilities must be provided:
   a. An operation table and instruments for performing abdominal or gynaecological surgery
   b. unaesthetic equipment, resuscitation equipment and sterilisation equipment
   c. drugs and parenteral fluids for emergency use.

Experience or training

Registered medical practitioner shall have one or more of the following experience or training in gynaecology and obstetrics, namely:-
   a) In the case of a medical practitioner who was registered in a State Medical Register immediately before the commencement of the Act, experience in the practice of gynaecology and obstetrics for a period of not less than three years.
   b) in case of a medical practitioner who was registered in a State Medical Register on or after the date of commencement of the Act,-
      i. if he has completed six months of house surgery in gynaecology and obstetrics; or
      ii. unless the following facilities are provided therein, if he had experience at any hospital for a period of not less than one year in the practice of obstetrics and gynaecology; or
      iii. if he has assisted a registered medical practitioner in the performance of twenty-five cases of medical termination of pregnancy in a hospital established or maintained, or a training institute approved for this purpose, by the Government.
   c) In the case of medical practitioner who has been registered in a State Medical Register and who holds a post-graduate degree or diploma in gynaecology and obstetrics, the experience or training gained during the course of such degree or diploma.

Protection of Medical practitioner for action taken in good faith

No suit or legal proceedings shall lie against any registered medical practitioner for any damage caused or likely to be caused by anything, which is in good faith done or intended to be done under this Act.
MTP PROCEDURE FOR MINORS

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*Therefore, a pregnant minor girl married/unmarried is considered a victim of sexual assault, and a medical provider is required to report the pregnancy to the appropriate authorities, even if the girl has not expressed a desire to take legal action.*

According to POCSO act, anyone who knowingly fails to make this report can be punished with up to six months in prison and a fine.
REFUSAL BY PATIENT FOR EMERGENCY CAESAREAN

- Capacity assessment should be done, however capacity may be fluctuating. Effort should be made to enhance the patient’s capacity.
- Previous statements made by the patient should be considered to respect patient autonomy.
- A competent woman can refuse obstetric intervention even if that results in the death or serious disability of the child to be born.
- In an emergency situation, and where it is not possible to find out a patient’s wishes, treatment can be given without consent provided that it is immediately necessary to save her life or to prevent a serious deterioration in her condition.
ASSISTED REPRODUCTIVE TECHNOLOGY

In India there are no specific law to regulate ART and the doctor has to follow general principal of law and the guidelines of Indian Council of Medical Research.

To make a specific law relating to ART, the Central Government approved the “Assisted Reproductive Technology (Regulation) Act 2021”.

Informed Consent
An informed written consent is required from the couple and the donor of oocyte / semen. The procedure is performed after the consent of the husband. AID without the husband’s consent can be ground for divorce or judicial separation.

Legitimacy of the child born through ART
A child born through ART shall be presumed to be the legitimate child of the couple, born within wedlock and shall have all the rights of support, parentage, and inheritance.

Donors shall have no parental right or duties in relation to the child and their anonymity shall be protected.

Adultery in case of ART
The procedure is performed after the consent of the husband and there is no sexual intercourse involved, thus it does not amount to adultery on part of the wife or the donor.

AID without the husband’s consent can be ground for divorce or judicial separation.

Consummation of marriage and AID
As there is no sexual intercourse, marriage is not considered to be consummated by AID.

Right of an unmarried woman to AID
There is no restriction for an unmarried woman going for AID. A child born to a single woman through AID is deemed to be legitimate. However, it is recommended to be performed only on married women and with the written consent of husband.

Anonymity of donors
Anonymity of donors must be protected as they have no parental right or duties in relation to the child.

Concerns
The ART Act permits only married heterosexual couple and a woman above the age of marriage. It excludes single men, cohabiting heterosexual couples and LGBTQ individuals and couples from accessing ARTs.

ART Act does little to protect the egg donor. Egg donor’s written consent is required but there is no provision for her counselling or the ability to withdraw her consent before or during the procedure.
She receives no compensation or reimbursement of expenses for loss of salary, time and effort, and constitutes unfree labour. Children born from ART do not have the right to know their parentage.
SURROGACY

The Surrogacy (Regulation) Act, 2021 defines the eligibility criteria for surrogate mother, appropriate authority, registration of surrogacy clinics, National and State Surrogacy Boards.

Purpose of the Surrogacy bill
i. For intending couples who suffer from proven infertility
ii. Only for altruistic purpose. Commercial surrogacy was banned.
iii. Not for commercial purposes
iv. Not for producing children for sale, prostitution or other forms of exploitation

Parentage of surrogate child
A child born out of a surrogacy procedure will be deemed to be the biological child of the intending couple.

Abortion of surrogate child
Written consent of the surrogate mother and the authorisation of the appropriate authority is required. This authorisation must be compliant with the Medical Termination of Pregnancy Act, 1971.

Withdrawal from surrogacy contract
The surrogate mother will have an option to withdraw from surrogacy before the embryo is implanted in her womb.
STERILIZATION

Guidelines: Family Planning Division, Ministry of Health and Family Welfare 2014

Common methods used in the country are:

i. Mini laparotomy
ii. Laparotomy with tubal ligation
iii. Laparoscopy

Introduction

- Clients must be provided informed choice.
- Written consent should be taken prior to surgery.
- Doctors and staff should be trained and skilled in the female sterilization techniques, use of appropriate anaesthesia and managing emergencies.
- All instruments and equipment must be in optimum working condition.
- The facility must be equipped with drugs and equipment to handle emergencies as appropriate.
- Standard infection prevention practices must be adhered.
- Clients must be screened for medical eligibility for female sterilization.

Eligibility of Providers to Perform Sterilization Procedure

Female Sterilization

A. Minilap Sterilization
   1. DGO, MD/MS in Obs/Gyn
   2. Trained in Minilap Sterilization
      - Specialist in other surgical fields
      - MBBS

B. Laparoscopic sterilization
   1. DGO, MD/MS in Obs/Gyn
   2. Trained in Laparoscopic Sterilization
      - Specialist in other surgical fields
      - MBBS
Male Sterilization

Conventional Vasectomy: MBBS and above (trained in Conventional vasectomy)
No-scalpel vasectomy (NSV): MBBS and above (trained in No Scalpel vasectomy)

- District-wise list of doctors are empanelled for performing sterilization operations.
- Only those doctors whose names appear on the panel are entitled to carry out sterilization operations.

Counselling

Counselling should be done for all the clients seeking for family planning services. The purpose is to provide informed choice regarding the type of contraceptive method to be used.

Informed choice and Informed consent

Ensure that all clients choose the best option/s for their health care needs after getting full information about all available options.

The consent of the partner is not required for sterilization.
However the partner should be encouraged to come for counseling.

Eligibility Criteria for Clients Undergoing Female Sterilization

(Self-declaration by the client will be the basis for compiling this information.)

- Clients should be ever married.
- Female clients should be above the age of 22 years and below the age of 49 years.
- The couple should have at least one child, whose age is above one year, unless the sterilization is medically indicated.
- Clients or their spouses/partners must not have undergone sterilization in the past (not applicable in cases of failure of previous sterilization).
- Clients must be in a sound state of mind, so as to understand the full implications of sterilization.
- Mentally ill clients must be certified by a psychiatrist and a statement should be given by the legal guardian/spouse regarding the soundness of the client's state of mind.
- A relevant medical history, physical examination and laboratory investigations need to be completed to ascertain eligibility for surgery.
LEGAL AND ETHICAL GUIDELINES - TERMINALLY ILL PATIENTS

Surrogacy in decision making

Treatment decision making becomes difficult in patients who have lost the capacity either temporarily or permanently. While still competent, a patient may appoint a family member or friend as a surrogate decision maker, in anticipation of future incompetence. The aim of physician in such cases should be to restore the decision-making capacity of the patient.

Surrogate decision making creates some ethical issues. Physician mostly relies on next of kin or financial provider to make such decisions.

Some states have enacted surrogate making laws, which establishes the hierarchy to designate the surrogate. This is helpful when there is disagreement between family members. Ethically appropriate surrogate should be the one who knows the patient, their wishes, and values. The surrogate should make the decision as the patient would make it for himself / herself. Surrogate should not do something that the patient would not want to do to self. This also relieves the surrogate from the burden of making life and death decision.

Physicians can always override the decision of a surrogate, if their decision is not in the best interest of the patient.

In situations of difference of opinion between surrogate and the physician, the case may be referred to hospital ethics committee.
Legal, ethical, and social aspects of ‘Do not resuscitate’

“Do not resuscitate” (DNR) may be a written document or an oral statement. It is considered as a legal order made by the patient, indicating that in case their heart stops beating, they do not want to receive cardiopulmonary resuscitation. With DNR, patient prevents the medical interventions to their body.

Advance directives and living wills are the written documents by the patient themselves, stating their wishes for treatment during terminal illness.

Advance directives (AD) require certain actions to be taken or not taken. Advance directive requires one of the following courses of action to be taken.

i. The AD asks for life-prolonging measures.
ii. The AD asks for life support to be withheld or withdrawn.
iii. The AD opts for “do not resuscitate (DNR)”.

Legal status

Legal status of DNR, advance directives or living wills varies in different countries. Patient autonomy alone is not considered enough in such cases. The order of DNR is placed and implemented by the physician. In deciding a case as DNR, the order (by physician) depends on both medical judgement and patient’s wishes and values.

An advance directive is legally valid and enforceable in USA, Canada, Australia and in some countries in Europe. It is also endorsed by the United Nations Convention on the Rights of Persons with Disabilities.

In India, concept of advance directives was legally accepted in “Mental Healthcare Act, 2017” for the first time. The law allows the person with mental illness to give an ‘advance directive’ for how they should be treated in case of a mental health situation.

Ethical issues

Indian laws do not allow withholding or withdrawal of life-sustaining treatments or euthanasia. Any discussion on advance directive (Ads) leads to a discussion on euthanasia. Therefore, it is important to examine the legal and ethical status of euthanasia.

In India there is no formal process of discussion and documentation of DNR. Patient autonomy is a weak concept and surrogate decision making by the next of kin or the financial provider usually overrides patient wishes.

Circumstances for withholding life-sustaining treatment

Decisions to DNR are made in two different situations.

- Treatment is withheld from an actively dying person where cardiopulmonary resuscitation (CPR) is unlikely to be successful or may result in quality of life that would not be in best interests of patient to sustain.
• The decision of withholding of treatment is made in advance (Ads), in a situation where a life-threatening condition may arise.

The decision of DNR depends upon the physician’s professional judgement of the chances of successfully restoring cardiopulmonary status of the patient versus the probable futility of a resuscitative attempt.

However, ethical, legal and sometimes financial implications are also considered.

The issue of DNR raises ethical issues about autonomy (patient’s wishes and choices), beneficence (appropriate decision making), non-maleficence (harm avoidance) and justice (allocation of limited resources).

**Medico-legal aspects of DNR**

ML aspect deals with following issues:

i. Competency of an individual in decision-making

ii. Standards and processes of decision-making

iii. DNR in an incompetent individual.
Euthanasia

Since March 2018, passive euthanasia is legal in India. Patients must consent through a living will and must be either terminally ill or in a vegetative state.

Living wills for passive euthanasia are allowed for patients suffering from a terminal illness or is in a vegetative state.

Present guidelines for passive euthanasia:

i. A decision has to be taken to discontinue life support either by the parents or the spouse or other close relatives, or in the absence of any of them, such a decision can be taken even by a person or a body of persons acting as a next friend. It can also be taken by the doctors attending the patient. However, the decision should be taken bona fide in the best interest of the patient.

ii. Even if a decision is taken by the near relatives or doctors or next friend to withdraw life support, such a decision requires presence of two witness and countersigned by first class judicial magistrate and should also be approved by a medical board set up by the hospital.

Criteria for Diagnosis of Brain-stem Death in India

- Patient should be deeply comatose (due to irreversible brain damage of known etiology); exclude reversible causes of coma.
- Absence of spontaneous respiration.
- Neuromuscular blocking agents to be excluded as a cause of respiratory failure.
- Reversible causes of coma should be excluded.
- Brain-stem reflexes should be absent:
  - Pupillary light reflex - Pupils are dilated, fixed and do not react to light
  - Doll's head eye movements (oculocephalic reflex) (absence of conjugate deviation of eyes when head is fully rotated to one side. Performed only when there is no fracture or instability of the cervical spine
  - Corneal reflex is absent
  - No motor response to stimulation within any cranial nerve distribution (e.g. no response to the supraorbital pressure)
  - No Gag (Pharyngeal) reflex (to stimulation of pharynx)
  - No Cough reflex (to suction catheter in the trachea)
  - Vestibulo-ocular reflex (oculovestibular reflex/caloric testing) is absent (No eye movements after installation of 50 ml of ice cold water into each external acoustic meatus for 1 min)
• Apnea test (absence of respiratory movements after disconnection from the ventilator for sufficient duration to have pCO$_2$ rise above threshold (>50-60 mmHg) for stimulating respiration)

*Tests are required to be repeated, after an interval of 6 hours.*
Legal and ethical guidelines – Psychiatric Patients

Provisions under MHCA 2017

1. Rights of a person with mental illness:
   a. Right to access mental health care services
   b. Protection of Persons with Mental Illness (PMI) from inhuman treatment
   c. To have free access to their medical records
   d. Right to complain about deficiencies in health care services

2. Advanced Directive: PMI can make Advance Directive for the way they want to be treated for their illness and nominate a representative.

3. Mental health establishments: Under this, Central and State mental health authorities to be established in every state. Every mental health institute is to be registered with this authority.

4. Admissions of PMI: The procedures for admission, treatment and discharge of PMI have been outlined.

5. Decriminalizes suicide attempt by mentally ill person

6. Electroconvulsive therapy (ECT) procedures not to be performed without administration of muscle relaxants and anaesthesia. ECT should not be performed on minors.

Advance Directive (AD)

It is a legal document by a person explaining his / her wishes about medical treatment if that person becomes incompetent or unable to communicate. It is of two types—

a) Living will: In this, the person indicates their choice of medical treatment.

b) Healthcare proxy: In this, a person nominates another individual to take medical decision on their behalf.

A mentally ill person can revoke, modify or cancel an Advance Directive at any time.
Involuntary admission for addiction treatment

Section 89 of the MHCA allows for the involuntary admission and treatment of a person with mental illness, if he has "……tried or threatening to harm himself or has behaved violently or is causing another person to fear bodily harm from the person with mental illness or has shown/is showing inability to care for himself to a degree that places the individual at risk of harm to himself". This will, however, require permission from a nominated representative. Persons with ‘dependence syndrome’ continue using psychoactive substances despite harm to themselves, which is a criterion of ‘dependence syndrome’ itself. Considering this 'use despite harm' as per ICD-10, it is possible to admit a person with dependence syndrome without his consent at his family’s insistence, keeping in line with Section 89 of the MHCA.

Capacity determination of patients is important before admission.
EThical Issues

Ethical issues for sports physician arise because of his/her role to return the athlete to competition as soon as possible. Duty of the physician is conflicting and is divided among various stakeholders in professional sports.

1. Physician have a duty towards the athlete for his well being.
2. Physician has duty towards administrators which includes coaches, team owners, management, and other stakeholders. Other stakeholders are sports agents, athlete families, media, and fans.

Physician have a fiduciary responsibility to care for the athlete while maintaining the confidentiality and privacy. However, such duty is compromised by the desire of both the athlete and management to return an athlete to sport with minimal recovery time. This often results in:

- Use of analgesics and other medications to allow injured player to continue.
- Inadequate assessment on the field due to time pressure.

Ethical issues also arises when the physician considers themselves as part of the team or when they want to please the management to continue with their position as team doctor.

Confidentiality and privacy: Confidentiality is major concern in sports medicine. The issue of maintaining confidentiality arises from the duty of physician towards the athlete as patient but physicians are hired by the team management. Team management have the right to know about the athlete's fitness to compete and includes both the past medical history and current status.

Guidelines

i. Physicians are bound by the code of ethics to maintain confidentiality, except under conditions in which withholding the information may result in harm to the patient or someone else.

ii. Physician should not disclose athlete’s personal history that has no bearing on his or her ability to perform as athlete.

iii. Physician is not under the obligation of confidentiality if, an athlete discloses is illegally taking performance-enhancing drugs.

iv. Physicians hired by the management, should clarify with the athlete that they are not the patient’s private health care professional and confidentiality is not guaranteed.
Doping in sports

World anti-doping agency code 2021 is the international framework governing doping in sports. It defines doping as "Occurrence of one or more anti-doping rules violation set forth in Art. 2.1 through 2.11 of the code".

In India, doping is not criminalized. Anti-doping program follows the guidelines of World anti-doping agency (WADA) and National Anti-doping agency (NADA). WADA provides information on the performance enhancing drugs prohibited for use by athletes. It includes any substance and methods that satisfies any two of the following three criteria

i. It has the potential to enhance sports performance
ii. It represents an actual or potential health risk to the athlete
iii. It violates the spirit of sports.

Art. 4.2.2 further divides the list of prohibited substances in three categories

a. Substances and methods prohibited at all times.

b. Substance and methods prohibited in competition.

c. Substances prohibited in particular sports.

Substances or methods which mask the effect or detection of prohibited substances are also prohibited.

The purpose of this subclassification of specified or non-specified is to recognize that it is possible for substance to enter into athlete's body unintentionally. Specific substances are found in certain food items and medicines which are available commonly and have a higher risk of accidental consumption.

Civil penalties for athletes for using prohibited drugs is exclusion from all results including medals privileges and awards.

Prohibited drugs list as provided by WADA can be accessed at [https://www.wada-ama.org/en/prohibited-list](https://www.wada-ama.org/en/prohibited-list).
Section D

Public Health
TESTING FOR HIV

Standard Operating Procedures for HIV & Syphilis - Ministry of Health and family Welfare

HIV patients have the right to confidentiality. Confidential information cannot be revealed without the consent of the patient. However, Courts have permitted disclosure in the following situations:

1. Required by law (statutory requirement)
2. Administration of justice
3. In the best interest of the patient (disclosure to a medical team if necessary for the treatment of the patient)
4. To protect another person (partner notification)
5. Necessary for public interest

Guidelines according to Human Immunodeficiency Virus and Acquired Immune Deficiency Syndrome (Prevention and Control) Act, 2017 are as follows:

Informed Consent for HIV Testing

Informed consent for testing and disclosure must be in writing. Counselling and Testing Centre require a patient’s informed consent.

Nature of the HIV disease, proposed test, implications of a positive and a negative test result, and the consequences of treatment must be disclosed to the patient before taking consent.

Disclosure of HIV status

As per the act, no person shall be compelled to disclose HIV status except by an order of the court that the disclosure of such information is necessary. Also, no person shall disclose or be compelled to disclose the HIV status, or any other private information of other person imparted in confidence.

The act also includes areas where informed consent for disclosure is not required:

- By a healthcare provider to another healthcare provider who is involved in the care of such person, when such disclosure is necessary to provide care or treatment to that person.
- By an order of a court that the disclosure of such information is necessary in the interest of justice.
- In suits or legal proceedings between persons, where the disclosure of such information is necessary.
- If it relates to statistical or other information of a person that could not reasonably be expected to lead to the identification of that person; and
- to the officers of the Central Government or the State Government or State AIDS Control Society of the concerned State Government for the purposes of monitoring, evaluation, or supervision.

**Disclosure of HIV positive status to partner**

The act states that No healthcare provider, except a physician or a counsellor, shall disclose the HIV-positive status of a person to his or her partner. Disclosure can happen only after completion of four probabilities:

a) reasonably believes that the partner is at the significant risk of transmission of HIV from such person; and
b) such HIV-positive person has been counselled to inform such partner; and
c) is satisfied that the HIV-positive person will not inform such partner; and
d) has informed the HIV-positive person of the intention to disclose the HIV-positive status to such partner:

The act also provides that disclosure to the partner shall be made in person after counselling and that a healthcare provider shall have no obligation to identify or locate the partner of an HIV-positive person.

With respect to partner notification of woman, the act takes an exception and provides that a healthcare provider shall not inform the partner of a woman where there is a reasonable apprehension that such information may result in violence, abandonment or actions which may have a severe negative effect on the physical or mental health or safety of such woman, her children, her relatives or someone who is close to her.
NOTIFIABLE DISEASES

The WHO International Health Regulations, 1969 has made disease reporting mandatory. This will help WHO in its global surveillance and advisory role. Occurrence of "Notifiable diseases" has to be reported to the Government by law.

The doctors must report the occurrence of notifiable diseases to the Chief Medical Officer of the district. It helps authorities to collect information of the spread of the disease, monitor and control the disease.

Various laws significant to infectious diseases, which must be notified to the government are:

- i. Food Safety and Standards Act, 2006
- ii. The Lepers Act, 1898
- iii. National AIDS control and prevention policy, 2002
- iv. The Epidemic Diseases Act, 1897

Integrated Disease Surveillance Programme (IHIP) is responsible for collecting data of notifiable diseases. Notifiable diseases are listed as **Presumptive** and **Laboratory confirmed**. Notification can be submitted by filling the Form P (Presumptive) or Form L (Laboratory confirmed) or through the IHIP portal. ([https://ihip.nhp.gov.in/idsp/#/login](https://ihip.nhp.gov.in/idsp/#/login))

**List of diseases**

**Diseases under Surveillance: Presumptive (P Form)**

1. Acute Diarrhoeal Disease (including acute gastroenteritis)
2. Bacillary Dysentery
3. Viral Hepatitis
4. Enteric Fever
5. Malaria
6. Dengue / DHF / DSS
7. Chikungunya
8. Acute Encephalitis Syndrome
9. Meningitis
10. Measles
11. Diphtheria
12. Pertussis
13. Chicken Pox
14. Fever of Unknown Origin (PUO)
15. Acute Respiratory Infection (ARI) / Influenza Like Illness (ILI)
16. Pneumonia
17. Leptospirosis
18. Acute Flaccid Paralysis < 15 Years of Age
19. Dog bite
20. Snake bite
21. Any other State Specific Disease (Specify)
22. Unusual Syndromes NOT Captured above (Specify clinical diagnosis)

**Diseases under Surveillance: Laboratory Confirmed (L Form)**

1. Dengue / DHF / DSS
2. Chikungunya
3. JE
4. Meningococcal Meningitis
5. Typhoid Fever
6. Diphtheria
7. Cholera
8. Shigella Dysentery
9. Viral Hepatitis A
10. Viral Hepatitis E
11. Leptospirosis
12. Malaria
   - PV:
   - PF:

With the Covid-19 situation, the Government implemented the **Epidemic diseases (Amendment) Ordinance 2020**, to prevent the spread of the disease. It amends the Epidemic Act and provide protection and powers to the Central Government to control from spreading of the COVID-19.
Notifiable diseases under Factories Act 1948

According to Section 89 of the act:

Medical practitioner attending an employee of a factory, who is suffering from any disease specified in the 43[Third Schedule], should inform the office of the Chief Inspector stating:

i. the name and full postal address of the patient,

ii. the disease from which he believes the patient to be suffering, and

iii. the name and address of the factory in which the patient is, or was last, employed.
Section E

Forensic Medicine & Toxicology
MLC REPORT - GUIDELINES

An injury report commonly known as MLC, is a type of medico-legal document. It is prepared by a medical doctor in medico-legal cases. Any medical document, even the routine reports and examination documents can be considered to fall under medico-legal case, if those documents are required by law.

MLC vs Non-MLC case

Without any specific guidelines, it is up to the medical practitioner to decide, whether a case is MLC or not. On attending a case of either injury, poisoning or any other condition, if the medical practitioner thinks that some investigation is required by legal authorities, either police or magistrate, he/ she labels the case as MLC.

Medico-legal register

Hospitals

In government hospitals and most of the major private hospitals, medico-legal register is maintained. Personal details, identification marks, fingerprints of the individual are recorded. Details of person accompanying the patient are also be noted.

Private practice

In private practitioners’ clinic, where such registers are not maintained, details of the case can be recorded on letterhead or plain paper with stamp and signature of the physician. Medicolegal case documents are prepared in duplicate. Overwriting and correction made are to be authenticated with the signature and stamp of the medical officer. Use of abbreviations should be avoided.

Medicolegal documents are confidential records and should be stored in safe custody to avoid tampering. The records should be thorough and complete. MLC documents including case sheets, X-rays and investigation reports must be preserved properly in the medical record section indefinitely.

All evidence collected should be mentioned in medico-legal documents to establish the chain of custody in a court of law subsequently.

These documents are to be produced to the concerned authorities (Police Investigating Officer/ Court / Court of Inquiry) as and when required.

A case may be registered as an MLC even if it is brought several days after the incident. No backdate MLC should be made.

Examples of ML cases

The following are some of the examples of ML cases. The list is not complete and only serves as example. Medical officers should use their judgement to label cases as medico-legal case.

i. Assault and battery, including domestic violence and child abuse
ii. Road Traffic Accidents (RTA), industrial accidents etc.
iii. Any cases of trauma with suspicion of foul play
iv. Electrical injuries, Burns and Scalds
v. Poisoning, Alcohol and other Intoxication
vi. Drug overdose and Drug abuse
vii. Undiagnosed coma
viii. Chemical injuries
ix. Sexual Offences, Criminal abortions,

xi. Cases of asphyxia as a result of hanging, strangulation, drowning, suffocation etc.

xii. Custodial deaths
xiii. Death in the operation theatre
xiv. Death due to Snake Bite or Animal Bite
xv. Firearm injuries

Doubtful cases
If physician is not sure of any illegal activity or injury, it is his/her discretion to decide. However, it is suggested, that whenever in doubt, it is safe to inform the legal authorities (police). This also avoids unnecessary allegation against the practitioner in future.

Only informing the police does not make the case as MLC. The case documents must be labeled as ML and details must be entered in MLC register, for future reference. If at the time of examination, case is not registered as MLC and on investigation some illegal activity is found, case can still be labeled as MLC at later date or time. However, such delays may result in loss of evidence. Thus, any doubtful case must be registered as MLC and police must be informed at the earliest.

MLC registered elsewhere
If MLC is registered in other hospital and patient is referred, it should be treated as MLC case.
No new MLC number should be issued. Treatment should continue in old MLC number. Information to police is not required.

Delays in MLC
If the case is brought to hospital several days after the incident, it still should be reported, and present findings of patient are recorded.

In doubtful cases, register a case as MLC.
Patient's refusal for MLC

It is common for the patient or relatives to request not to register a case as MLC. Such request should not be entertained, and the attending physician must decide according to the findings. Consent from the patient is not necessary to register a case as MLC.

If on patient’s insistence, physician does not register MLC, then it is like hiding the crime and not giving evidence to police. In such cases, physician may be sued under section 201 IPC, which is causing disappearance of evidence of an offence.

Patient's refusal for MLC and treatment

To avoid registration of MLC case, a patient may refuse for treatment also. Physician cannot compel a person for treatment and MLC. When a person refuses for treatment (and MLC) and physician has not collected any evidence, there is no doctor-patient relationship established.

In such cases, physician should perform his duty as a member of general public, and act according to section 39 CrPC and may not inform the police.

Treatment in MLC

Priority must be given to treatment of a person over the MLC registration. In emergency situations, patient must be treated first, and MLC can be registered after he/she is stabilized.

Referral of ML case

MLC can be referred to another hospital for further management. However, emergency treatment must be provided and only after patient is stabilized, they should be transported to another facility.

In situations where ML cases are referred to another hospital, the second doctor (at referred hospital) should register a fresh MLC and record their own findings. Although registration of second MLC is not mandatory, but it helps the physician in court to explain his/her own findings.

Death of Non-ML case in hospital

If an admitted non-medico-legal patient dies in hospital, MLC is not registered. Patient's relatives may raise their concern about illegal activity before death or medical negligence during treatment, as cause of death. In such cases, police are informed, who sends the body for post-mortem examination.

MLC in private practice

Private hospitals, nursing homes and practitioners can register medico-legal cases. If MLC register is not maintained by private practitioner, findings can be recorded on letterhead or plain paper. All such documents are numbered, stamped and signed by the physician.

Usually in private practice, MLC patients are referred to government hospitals to avoid documentation and subsequent appearance in court. In such situations, if the patient is serious
and does on way to hospital or his medical condition aggravates, physician can be sued under section 304A, IPC or for negligence.

Police must be informed by the attending physician by phone or other means. Daily diary number from police should be recorded on the MLC document.

**Information to police**

The police should be informed. Under Section 39 CrPC, the medical officer is legally bound to inform the police about the arrival of a ML case. Failure to report such cases may result in prosecution under Sections 176 and/ or202 IPC.

In case of discharge /transfer /death of such a case in the hospital, the police should be informed.

**Making MLC in admitted patients in wards**

Sometimes patients are admitted straight to emergency room for medical attention. In such cases MLC is not registered in casualty. Often call is sent to forensic or casualty physician to attend such cases for MLC registration.

Other situations where MLC registration wards is required are violence inside hospital, attempted suicide by patients or suspicion of violence of poisoning raised by relatives after patient is admitted in wards.

In all such cases police must be informed. Casualty physician or forensic expert should visit the patient, record findings and collect evidence.

Hospital duty nurses or resident doctors can sign as witness. The procedure for taking consent remains the same as for any other case.

In absence of MLC register, findings can be recorded on official hospital papers.

All such sheets used to record MLC findings are signed and total number of pages used are mentioned in the report.

The report should be made in duplicate, with original report attached to the hospital case sheet. Duplicate copy is kept in department for further reference during court appearance.

**Death of an MLC patient**

In situations where an MLC patient admitted for treatment, dies in the hospital, police must be informed. In such cases, death certificate is not issued. The body is handed over to police for further investigation and post-mortem examination.

**Brought dead cases**

Cases, which are declared “death on arrival/brought dead” to hospital, are not registered as MLC. The time at which the person was brought must be recorded. Alleged history and name of the accompanying person should be noted. Bodies of such person should not be handed
over to relatives. Police must be informed, and the body should be sent for post-mortem examination. It is the job of Chief Medical officer to inform the police. It is mandatory. Any suspected materials, articles of food, excreta, gastric lavage samples, etc., should be preserved and sent for further examination. Death certificate is also not issued to the relatives.

**Leave against Medical advice by MLC patients**

If attendants are taking patient away forcibly and against medical advice, it should be recorded on file and police should be informed.

**Inspection of record by lawyers, insurance company or other investigating agencies**

Professional secrecy should be maintained. The records of the case should never be disclosed to any unauthorized third party. If lawyer or other investigating agencies need to inspect the documents, they must get a court order in this regard. Such instances should be referred to the Medical Superintendent or MO in-charge for guidance as the court orders cannot be defied.

**Information under the "Right to Information Act" (RTI)**

Hospital / medical officer can claim exemption u/s 8(1) (e) of the RTI Act if information pertaining to a victim/patient is sought by a third party.

Doctor- patient relationship falls under the category of fiduciary relationship and u/s 8(1) (e) of the RTI Act.

**Section 8(1)(e) RTI act:**

"information available to a person in his fiduciary relationship, unless the competent authority is satisfied that the larger public interest warrants the disclosure of such information"......

If FIR has been registered and the investigation is in progress, the hospital authorities / Medical officer can claim exemption 8(1) (h) of the RTI Act on the ground that providing copy of medico-legal records would impede the investigation and/or apprehension or prosecution of offenders.

**Section 8(1)(h) RTI act:**

"information which would impede the process of investigation or apprehension or prosecution of offenders;"......

If the disclosure of information may endanger the life and safety of any person (potential witnesses, victim etc), exemption can be claimed under Section 8(1) (g) of RTI act.

"information, the disclosure of which would endanger the life or physical safety of any person or identify the source of information or assistance given in confidence for law enforcement or security purposes;"......
Filling-up of MLC register

Consent

Attending physician is responsible for taking consent of the person. Even if such documentary work is delegated to the nursing staff, physician must verify that procedures are being followed.

To register a case as MLC, consent of the patient is not required. Even if the patient is victim of violence and does not want police case, MLC should be registered. However, for examination of a patient of medico-legal case, consent is required, unless the person is under arrest by police.

Medical examination under Sec 53, Cr PC.

a. Under Section 53 (1) of Cr P.C., a person can be examined at request of the police by use of force.

b. Section 53 (2) lays down that whenever a female is to be examined, it shall be done only by or under the supervision of a female doctor.

As far as possible, consent must be obtained from the patient, when he/ she is competent to give it.

In situations where the patient is minor, unconscious or mentally unsound, consent should be taken from legal guardian.

In case of an unconscious patient, consent to emergency treatment is implied.

Identification marks

Two identification marks must be recorded for future identification.

Identification marks should be on exposed and accessible parts of the body, where they can easily be displayed in court, without causing any embarrassment to the patient.

Fingerprints are also taken on the MLC form for identification.
**Injury examination**
All the injuries present are recorded. Minor or apparently insignificant injuries should also be recorded. Old injuries present are also recorded.
Legally, only the injuries recorded are considered to be present. Whatever, injuries are not recorded, are not considered to be present at the time of examination. Therefore, it is important to note small insignificant and old injuries also.
If necessary, photographs of the injuries are taken for future reference.

**Nature of each injury**
Opinion about nature of injury is given against each injury separately. In case of multiple injuries, different weapons may have been used to inflict different injuries.
Either of the following three opinion are given:

a. Simple  
b. Grievous  
c. Dangerous to life

Sometimes a patient is kept under observation as in head injury or requires lab and radiological reports. In such cases, where an immediate opinion can not be given, opinion is stated as “pending further investigation” or “under observation”. In these cases, a “subsequent opinion” is given after receiving the reports. Subsequent opinion can be given on a separate sheet of paper or on the forms provided by the hospitals. These opinions should be made in duplicate and must correlate to the serial number and injury of the original report.

A dangerous weapon like firearm can cause “Simple injury”.

**Type of weapon used**
Weapons used for inflicting injuries can be either sharp, blunt or firearm. Sharp weapon can be either single edged or double edged. Weapons can be sharp penetrating objects or firearms. Opinion regarding the type of weapon used is given against each injury, separately.

**Salient features of ML Cases**
- **Certifying fitness**: Whenever the investigating officer requests the doctor for certifying fitness of the patient to make a statement, the examining doctor will certify the fitness status on the original MLC sheet. He/she will mention date and time clearly with signature, name in full of designation below the certification.
- **Confidentiality**: Doctors should maintain confidentiality in all MLC cases.
- **MLC reports and documents**: All reports and documents of a medico legal case are labeled as MLC with the number assigned.
• Providing details to IO: If the I.O. gives requisition for any clarification regarding certain points mentioned in the report given, answer is given in writing.

• Copy to IO: If the I.O. demands an original document/photocopy of the MLC, copy is given, and a receipt obtained.

• Documents to court: If the court demands X-Ray films, P.M. report etc. they are deposited in the court and a receipt obtained.

**Admission and Discharge of MLC**

i. Whenever a medico-legal case is admitted the same is documented in admission papers and hospital records.

ii. When MLC patient is discharged, it must be informed to the police authorities of the hospital.

iii. Police is informed if MLC patient takes discharge against medical advice.

**Compos Mentis**

In a medico-legal case, if the police want a statement from the patient, the attending physician must certify that patient is fit for statement, i.e. patient is compos mentis. Certification by physician must be signed and dated with the time of examination mentioned.
**Examination of weapon**

Before examination of weapons by medical professionals, they must by examined for presence of fingerprints and for blood or other stains by serologist. Before accepting weapon for examination, doctors should make sure that weapons have been examined by forensic experts for fingerprints and serologists.

**Opinion**

After describing the weapon, opinion is given whether it could have been the weapon of offence for the injuries described in MLC. If the opinion is given on a separate form, reference to the MLC number and date must be mentioned on the opinion form.

In cases, where multiple injuries are present on the victim, there is a possibility of using different weapon for inflicting those injuries. In such cases, opinion must mention and correlate weapon to individual injury.

If the suspected weapon is ruled out as weapon of offence, opinion is given in negatively. However, if the weapon is suspected weapon of offence, opinion is usually given in double negative form.

**Example**

- Exhibit examined is not the weapon of offence for injury number ___ ___ ___.
- Exhibit can not be ruled out as a weapon of offence for injury number ___ ___.

Opinion should also be given, whether the weapon examined is dangerous weapon or not. Dangerous weapons are defined under section 324 and section 326 IPC.
Record keeping of Medico legal cases

1. Three copies of medic-legal report are prepared. Original is given to police after getting proper receipt. One copy is kept as hospital record and one copy is kept in medical superintendent office.

2. If medico-legal report has been issued, then duplicate report should not be issued unless requested by police in writing or by order of court.

3. MLC documents should be kept as confidential. There is no time limit for safe keeping the MLC records. Records are kept until judgement by the court of law has been issued.
EXAMINATION OF SEXUAL ASSAULT VICTIM -- GUIDELINES

*Purpose of forensic medical examination* is to form an opinion on the following:

I. Whether a sexual act has been attempted or completed.

II. Whether such a sexual act is recent, and whether any harm has been caused to the survivor’s body.

III. The age of the survivor needs to be verified in the case of adolescent girls/boys.

IV. Whether alcohol or drugs have been administered to the survivor needs to be ascertained.

A *female nurse or attendant should be present* while examining victim.

**Responsibilities of Physician**

i. Treatment the patient and provide support

ii. Examine the victim and collect material evidences to facilitate and aid the justice.

**Consent**

Written informed consent of a victim is a must for medical examination.

A victim of age 12 years and above can give consent. If she is child under 12 years of age or of unsound mind, then consent of parent or guardian should be taken.

**Samples to be collected from victim**

1. Clothes and undergarments
2. Foreign evidentiary material – like hair, fiber, button etc.
3. Fingernail scrapings
4. Scrapings from suspected stain marks from body surface
5. Scalp hairs – for comparison with scalp hairs found over body/clothes of alleged accused
6. Swab from teeth bite mark
7. Combing of pubic hairs
8. Hair clipping of victim
9. Vaginal swab/smears, cervical smears
10. Washings of posterior fornix of vagina for
   - Detection of spermatozoa
   - Presence of sexually transmitted disease
12. Urine: Pregnancy test, detection of alcohol,
13. Condom if found at scene of crime – laboratory examination for presence of blood/vaginal epithelial cells and semen, pubic hairs, DNA profiling of semen.
Opinion

Rape is a legal term and not a medical diagnosis.

Provisional clinical opinion
After examination of the victim, a provisional opinion of the medical examiner is provided to the inquest officer. It should be based on history of the incident, signs of physical violence, signs of sexual violence on genitals and other parts of body.
At the time of examination, samples are preserved for analysis, which are sent to forensic laboratory. It takes some time to receive report of samples analysis. Provisional opinion helps authorities in investigation.

Final opinion
After receiving the lab reports, a final opinion is provided. This is provided after corelating the clinical history, signs of violence, provisional opinion with sample analysis.
Normal or negative lab analysis findings does not refute or confirm the forceful sexual intercourse.
Absence of injuries or negative laboratory may also result under following circumstances:
   a. Use of intoxication or threats making victim unable to resist.
   b. Victim's activities such as washing, bathing, changing clothes, urinating or douching resulting into loss of evidence.
   c. Delay in reporting or examination.
Such reasoning must be considered and mentioned while providing the final opinion.
### Provisional clinical opinion

<table>
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<th>Genital injuries</th>
<th>Physical injuries</th>
<th>Opinion</th>
<th>Rationale why forced penetrative sex cannot be ruled out</th>
<th>What can FSL detect</th>
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<tr>
<td>Present</td>
<td>Present</td>
<td>There are signs suggestive of recent use of force/forceful penetration of vagina/anus. Sexual violence cannot be ruled out.</td>
<td>Evidence for semen and spermatozoa are yet to be tested by laboratory examinations in case of penile penetration.</td>
<td>Evidence of semen except when condom was used</td>
</tr>
<tr>
<td>Present</td>
<td>Absent</td>
<td>There are signs suggestive of recent forceful penetration of vagina/anus.</td>
<td>Evidence for semen and spermatozoa are yet to be tested in case of penile penetration. The lack of physical injuries could be because of the survivor being unconscious, under the effect of alcohol/drugs, overpowered or threatened. It could be because, there was fingering or penetration by object with or without use of lubricant- which is an offence under Sec 375 IPC.</td>
<td>Evidence of semen or lubricant except when condom was used</td>
</tr>
<tr>
<td>Absent</td>
<td>Present</td>
<td>There are signs of use of force, however vaginal or anal or oral penetration cannot be ruled out.</td>
<td>The lack of injuries could be because of the survivor being unconscious, under the effect of alcohol /drugs, overpowered or threatened or use of lubricant.</td>
<td>Evidence of semen or lubricant</td>
</tr>
<tr>
<td>Absent</td>
<td>Absent</td>
<td>There are no signs of use of force; however final opinion is reserved pending availability of FSL reports. Sexual violence cannot be ruled out.</td>
<td>The lack of genital injuries could be because of use of lubricant. The lack of physical injuries could be because of the survivor being unconscious, under the effect of alcohol/drugs, overpowered or threatened. It could also be because, there was fingering or penetration by object with use of lubricant- which is an offence under Sec 375 IPC</td>
<td>Evidence of semen, lubricant and drug/alcohol</td>
</tr>
</tbody>
</table>
**Final opinion - For penile penetration**

To be formulated after receiving reports from the FSL.

<table>
<thead>
<tr>
<th>S. No.</th>
<th>Genital injuries/diseases</th>
<th>Physical injuries/diseases</th>
<th>FSL report</th>
<th>Final opinion</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Present</td>
<td>Present</td>
<td>Positive for presence of semen</td>
<td>There are signs suggestive of forceful vaginal/anal intercourse.</td>
</tr>
<tr>
<td>2.</td>
<td>Present</td>
<td>Absent</td>
<td>Positive for presence of semen</td>
<td>There are signs suggestive of forceful vaginal/anal intercourse.</td>
</tr>
<tr>
<td>3.</td>
<td>Absent</td>
<td>Present</td>
<td>Positive for presence of semen</td>
<td>There are signs suggestive of forceful vagina/anal intercourse.</td>
</tr>
<tr>
<td>4.</td>
<td>Absent</td>
<td>Absent</td>
<td>Positive for presence of semen</td>
<td>There are signs suggestive of vagina/anal intercourse.</td>
</tr>
<tr>
<td>5.</td>
<td>Absent</td>
<td>Absent</td>
<td>Positive for drugs/alcohol and semen</td>
<td>There are signs suggestive of vagina/anal intercourse under the influence of drugs/alcohol.</td>
</tr>
</tbody>
</table>
### Final opinion – For non-penile penetration

To be formulated after receiving reports from the FSL

#### For non-penile penetration

<table>
<thead>
<tr>
<th>S. No.</th>
<th>Genital injuries/ diseases</th>
<th>Physical injuries/ diseases</th>
<th>FSL report</th>
<th>Final opinion</th>
</tr>
</thead>
<tbody>
<tr>
<td>6.</td>
<td>Present</td>
<td>Present</td>
<td>FSL report is negative for presence of semen/ alcohol/ drugs/lubricant</td>
<td>There are no signs suggestive of vagina/anal intercourse, but there is evidence of physical and genital assault.</td>
</tr>
<tr>
<td>7.</td>
<td>Present</td>
<td>Absent</td>
<td>FSL report is negative for presence of semen/ alcohol/ drugs/lubricant</td>
<td>There are no signs suggestive of vagina/anal intercourse, but there is evidence of genital assault.</td>
</tr>
<tr>
<td>8.</td>
<td>Absent</td>
<td>Present</td>
<td>FSL report is negative for presence of semen/ alcohol/ drugs/lubricant</td>
<td>There are no signs suggestive of vagina/anal intercourse, but there is evidence of physical assault.</td>
</tr>
<tr>
<td>9.</td>
<td>Absent</td>
<td>Absent</td>
<td>FSL report is negative for presence of semen/ alcohol/ drugs/lubricant</td>
<td>There are no signs suggestive of penetration of vagina/anal.</td>
</tr>
<tr>
<td>10.</td>
<td>Absent</td>
<td>Absent</td>
<td>FSL report is positive for presence of lubricant only</td>
<td>There is a possibility of vaginal/anal penetration by lubricated object.</td>
</tr>
</tbody>
</table>
## Final opinion for non-penetrative assault

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Bite marks present and /or FSL detects salivary stains</td>
<td>There are signs suggestive of evidence of bite mark/s on ______ site (time the injury)</td>
</tr>
<tr>
<td>2.</td>
<td>Sucking marks (discoid, subcutaneous extravasation of blood, with or without bite marks) present and /or FSL detects salivary stains</td>
<td>There are signs suggestive of sucking mark/s on ______ site (time the injury).</td>
</tr>
<tr>
<td>3.</td>
<td>Forceful fondling, with presence of bruises or contusions with or without fingernail marks</td>
<td>There are signs suggestive of forceful physical injuries on ______ site (time the injury) (which may be due to fondling)</td>
</tr>
<tr>
<td>4.</td>
<td>Only forceful kissing and FSL detects salivary stains</td>
<td>There are signs suggestive of salivary contact (which may be due to kissing)</td>
</tr>
<tr>
<td>5.</td>
<td>If the history suggests forced masturbation of the assailant by the survivor and if there is evidence of seminal stains detected on the hands</td>
<td>There are signs suggestive of the survivor of seminal fluid contact (which may be due to masturbation)</td>
</tr>
<tr>
<td>6.</td>
<td>In case there are no signs of sucking, licking... detected, but the history suggests some such form of assault</td>
<td>It is still important to document a good history because the survivor may have had a bath or washed him/herself.</td>
</tr>
</tbody>
</table>
ALCOHOL INTOXICATION - EXAMINATION

Drunkenness

Condition produced in a person, by consuming alcohol in sufficient quantity, to cause him to lose control of his faculties to such an extent that he is unable to safely execute the occupation in which he/she is engaged at that particular time.

Examination

Most of the cases brought for examination are driving or causing disturbances under effect of alcohol.

Examination can be conducted either with consent or without consent under sec 53 CrPc of an arrested person.

Diagnosis

Diagnosis is based on clinical examination and test of blood and urine.

Clinical diagnosis

It includes:

1. **Smell** of alcohol in breath
2. **General examination**: Manners and behaviour, speech, self control and mental alertness.
3. **Specific examination** of alcohol intoxication:
   A. Eye examination- Pupil size and reaction to light, Nystagmus
   B. Impairment test - Romberg’s test
   C. Muscle co-ordination tests
   D. Test for reaction time

A. **Eye examination**

1. Pupil dilates and constricts at a much slower rate.
2. Positive McEwan’s sign: In case of alcohol intoxication, pupils are contracted, but on external painful stimulation of the person, e.g. pinching skin of face or neck would cause transient dilation of the pupils, followed by slow constriction again.
3. Positional Alcohol Nystagmus (PAN): There are to types of PAN.
   i. **PAN I** is characterized by nystagmus to the left when the left side of the head is down, and to the right when the right side of the head is down. It normally occurs during rising and peak BAC levels starting around 40mg/dl.
   ii. **PAN II** normally appears between 5 to 10 hours after drinking. In this the nystagmus appears in the opposite directions seen in PAN I. It occurs during the alcohol elimination phase.
B. Impairment tests: Romberg test

*Procedure: Romberg's Balance Test*

Instructions (The doctor should instruct the examinee with demonstrations).

- Stand up straight with feet together with the arms down by the sides of the body.
- Tilt his head slightly backwards and then close the eyes.
- Keep the head in chin up position with eyes closed and estimate up to 30 seconds in mind.
- Bring down the head to initial position when 30 seconds have gone by.
- Open the eyes and say “finish”.

Romberg test is positive if the person has loss balance with eyes closed, during the test. Loss of balance is increased swaying of the body or foot movement in the direction of a fall or falling.

Romberg test is negative if the person is able to remain stable during the test and have minimal swaying.

C. Muscle co-ordination tests

Various test to observe muscle co-ordination are:

- Walk and turn test
- One leg stand test
- Rapidly alternating movement evaluation
- Finger and nose test
- Point-to-Point Movement Evaluation

D. Test of reaction time

- Ruler drop test

Collection of Blood Sample

The alcohol concentration varies in blood samples collected from various parts of the body. Usually, blood from the femoral or subclavian vessels is collected in a living person. The following precautions must be taken while collecting blood samples:

i. Take two samples of blood, 10-15 ml. each. Preserve each sample with 100 mg. of sodium fluoride.

ii. Disinfect the skin before taking the sample with non-alcoholic disinfectant, such as mercury chloride solution.

iii. Dispatch the blood at the earliest, observing legal formalities.

iv. Store the collected blood in a refrigerator, if it has to be stored.

Use blood alcohol kits for the collection of the sample. The kit consists of:

i. Sterile disposable syringe.

ii. Blood collection tubes.
Examination of Alcohol Intoxication

iii. Preservative. Usual one is sodium fluoride.
iv. Mercury salts.
v. Anti-coagulants like fluoride, citrate, and oxalate.

Opinion for Drunkenness

- Person has not consumed alcohol
- Person has consumed alcohol but is not under the influence of alcohol.
- Person has consumed alcohol and is under the influence of alcohol.

Breath levels of alcohol

It is estimated that a breath alcohol concentration of 35 µg / 100 ml corresponds to a blood alcohol concentration of 80 mg/ 100 ml. However, blood-breath ratio (BBR) shows person-to-person variation across different population groups. The BBR may range from 1300:1 to 3100:1. Because of this wide range of values, the breathalyzer test for alcohol is not a reliable testing method. Still, a breath analyzer test is an easy, non-invasive procedure and breath levels of alcohol between 35 and 50 µg / 100 ml is accepted by most countries.

Urine levels of alcohol

Ratio of urine alcohol level and blood alcohol level is usually taken as 1.3 : 1 in equilibrium. The urine secreted during or after alcohol intake will be diluted by the urine already present in the bladder. With an empty bladder, the urine alcohol level reflects the blood alcohol level. 2 urine samples should be collected at an interval of 30 minutes to ascertain whether the person is in absorptive or metabolic phase. The value obtained using the Widmark formula has to be multiplied by 0.75 to obtain the blood alcohol level.

**BACK CALCULATION OF ALCOHOL CONCENTRATION**

This is done to extrapolate the blood alcohol concentration at an earlier time than when the sample is collected for testing.

**Circumstances of back calculation**

1. To find out if there was a possibility of the person committing the crime while his blood alcohol level was in excess of the permissible limits of alcohol.
2. To establish the systemic alcohol concentration of the person when the crime took place.

Back calculation of blood alcohol concentration is valid only in the post-absorptive stage (approximately 2 hours after the last drink taken) when the alcohol is being eliminated from the body at a steady rate.
The rate of elimination is taken as 15 mg/100ml/hour for occasional drinkers and 19 mg/100ml/hour for heavy drinkers.

**Validity of back calculation**

1. It has to be ensured that the person’s blood alcohol concentration has not dropped down to zero at any time during the investigation.
2. Back calculation should be done only in the metabolic phase and not while absorption is still ongoing. Two blood samples at an interval of 30-60 mins should be collected and tested to find out if the person is in absorptive stage or metabolic stage.
3. For a valid back calculation, the blood alcohol level should be more than 20 mg%
4. Back calculation will not be valid if the blood alcohol levels are due to consumption of alcohol post incident.

**Defence against high blood alcohol levels obtained from back calculation**

1. **Post incident drinking (‘Hip flask’ defence):** When alcohol is consumed after the incident but before the sample has been collected, thus necessitating taking into account the contribution of this additional alcohol intake.
2. **‘Laced drinks’ defence:** When alcohol has been consumed unwittingly (when drinks were laced with alcohol), and calculations are required to account for this extra alcohol level.
DEATH CERTIFICATE – GUIDELINES

Death certificate is issued under the provisions of the Registration of Birth & Deaths Act (RBD), 1969.

Purpose of Death Certificate

The data on death certificate serve many purposes:

i. Help in assessing the effectiveness of public health programmes.
ii. Provide a feedback for future policy and implementation.
iii. Essential for better health planning/management and for deciding priorities of health and medical research programmes.

Regulations

State Government regulations require that, in the event of the death of any person, the death certificate must be issued.

i. By the physician, who attended the person during his / her last illness, without charging any fee.
ii. To the concerned person, stating “the cause of death” to the best of his knowledge and belief.
iii. The certificate shall be received and delivered by such person to the Registrar.

The doctor must have attended the deceased in the last seven days preceding death.

MCCD should not be issued, and dead body should not be released if:

i. The injured is brought dead.
ii. A crime has already been registered by the police.
iii. The police have already been informed about the case.
iv. The cause of death is not known.

In case it is an Unnatural death, body should be handed over to the police, who holds an inquest and sends the body for Post-mortem examination. However, the doctor is responsible to inform the registrar about the occurrence of death. The registrar can note the event of occurrence of death and mention in the column of Cause of Death that –The Inquest report is awaited.

Medical practitioners are instructed not to fill and submit form - 4/ 4A for still births. For stillbirths, separate Form-3 is made available.
Medical death certificate – Form 4 & 4A
The certificate is issued in Form No-4 for institutional deaths and 4A for non-institutional deaths.
The format of the certificate proper (medical part) conforms to the standard prescribed by the World Health Organization (WHO).
The form has two parts:
   a. **Medical part** – stating the underlying cause of death.
   b. A detachable portion separated by perforation mark containing **information on fact of death**.
Causes of death are classified, coded and grouped according to the Tenth revision of the International Classification of Diseases (ICD-10) recommended by WHO.

**Medico-legal Cases**
If suicide or homicide is ruled out, how the fatal injury occurred should be explained, briefly indicating the circumstances or cause of the accident.

**In Medico-legal cases, detachable portion of MCCD is NOT given to relatives.**

In medico-legal cases, the certificate has to be given by the police authorities.
In medicolegal cases **Pending Investigations** should be mentioned. However, the Registrar should be informed of such cases, by the hospital.

**Female death**
Information on pregnancy and delivery is needed in case of death of women in the child-bearing age (15 to 49 years) even though the pregnancy may have had nothing to do with the death.

**Old age or senility**

**Old age (or senility) should be not given as a cause of death if a more specific cause is known.**

If old age was a contributory factor; it should be entered in Part II. Example (a) Chronic bronchitis, of old age.
ANNEXURE 1

<table>
<thead>
<tr>
<th>S. No.</th>
<th>Forms</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Medical Sickness &amp; Fitness Certificate</td>
</tr>
<tr>
<td>2</td>
<td>Consent for surgical operation</td>
</tr>
<tr>
<td>3</td>
<td>Form-4, MCCD</td>
</tr>
<tr>
<td>4</td>
<td>Form-4A, MCCD</td>
</tr>
<tr>
<td>5</td>
<td>Perinatal death</td>
</tr>
<tr>
<td>6</td>
<td>Dying declaration</td>
</tr>
<tr>
<td>7</td>
<td>Drunkenness</td>
</tr>
<tr>
<td>8</td>
<td>MLC register</td>
</tr>
<tr>
<td>9</td>
<td>Weapon examination certificate</td>
</tr>
<tr>
<td>10</td>
<td>Treatment &amp; Discharge of ML Case</td>
</tr>
<tr>
<td>11</td>
<td>Information regarding a Medico-legal case</td>
</tr>
<tr>
<td>12</td>
<td>Information of death in Medico-legal case</td>
</tr>
<tr>
<td>13</td>
<td>MTP consent forms</td>
</tr>
<tr>
<td>14</td>
<td>MTP admission register</td>
</tr>
<tr>
<td>15</td>
<td>Age estimation certificate</td>
</tr>
<tr>
<td>16</td>
<td>Recent delivery</td>
</tr>
<tr>
<td>17</td>
<td>Drug intoxication</td>
</tr>
<tr>
<td>18</td>
<td>Examination of sexual offence</td>
</tr>
<tr>
<td>19</td>
<td>Notifiable diseases- P and L Form</td>
</tr>
<tr>
<td>20</td>
<td>Post-mortem examination</td>
</tr>
</tbody>
</table>
MEDICAL CERTIFICATE

Signature of Applicant .............................................

I, Dr. ................................................................. after careful personal examination of the case hereby certify that Dr./Shri /Smt. /Ms. ............................................. (name & designation of applicant) of the Office of the ......................... whose signature is given above is suffering from ........................................ and, therefore, I consider, that a period of absence from duty from ................. to ................. with effect from ................. is necessary for the restoration of his/her health.

Place: .................................................................
Date: .................................................................
Signature & seal Medical Practitioner Registration No. ______________

FITNESS CERTIFICATE

Signature of Applicant .............................................

I, Dr. ................................................................. do hereby certify that I had carefully examined Dr./Shri/Smt./Ms. ............................................. (name & designation of applicant) of the Office of the ......................... whose signature is given above and find that he/she has recovered from his/her illness and is now fit to resume duties in Government service. I also certify that before arriving at this decision, I have examined the original medical certificate and statement of the case (or certified copies thereof) on which leave was granted or extended and have taken these into consideration in arriving at my decision.

Place: .................................................................
Date: .................................................................
Signature & seal Medical Practitioner Registration No. ______________
Consent for Surgical Operation

I hereby consent myself/my ward ........................................ to undergo the operation of .......................................................... .......................................................... .......................................................... on........................................, under ............................................ anesthesia.

The nature and purpose of surgery ........................................................., its possible risks and complications .................................................. or side effects, and alternative methods of treatment ..........................................................

........................................................................................................................................have been explained to me in detail by Dr................................................................., in the language familiar to me. The approximate period of stay in the hospital and the treatment cost have been mentioned too.

Name of Doctor: .................................. Signature of Doctor: ..................................
Designation: .................................. Date: ..................................
Place: .................................. 

Signature of Patient/Guardian: ..........................................................
Name: ..........................................................
Address: ..........................................................

Witness:
1) Name and Signature................................................
   Address................................................
   ..........................................................

2) Name and Signature................................................
   Address................................................
   ..........................................................
FORM NO.4
(See Rule 7)
MEDICAL CERTIFICATE OF CAUSE OF DEATH
(Hospital in patients. Not to be used for stillbirths)
To be sent to Registrar along with From No.2 (Death Report)

Name of the Hospital: ..............................................................................

I hereby certify that the person whose particulars are given below died in the hospital in
ward No............... on ............... at ............... A.M./P.M

<table>
<thead>
<tr>
<th>NAME OF DECEASED</th>
<th>Age at Death</th>
<th>For use of Statistical Office</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sex</td>
<td>If 1 year or more, age in years</td>
<td>If less than 1 year, age in Months</td>
</tr>
<tr>
<td>1. Male</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Female</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

CAUSE OF DEATH

I. Immediate cause
   State the disease, injury or complication which Caused death, not the mode of dying
   such as Hear failure, asthenia, etc.
   (a) .................. due to (or as consequences of)

Antecedent cause
   Morbid conditions, if any, giving rise to the above Cause, stating underlying conditions
   last
   (b) .................. due to (or as consequences of)
   (c) ..................

II.

Other Significant conditions contributing to the Death but not related to the diseases or conditions
causing it.

Manner of Death
5. Pending Investigation
   If deceased was a female, was pregnancy the death associated with?
   If yes, was there a delivery?  1. Yes  2. No

How did they injury occur?
1. Yes  2. No

Name and Signature of the Medical Attendant certifying the Cause of Death.
Date of Verification:..............................................................................

SEE REVERSE FOR INSTRUCTIONS
(To be detached and handed over to the relative of the deceased)

Certified that Shri/Smt/Kum............................................. S/W/D of Shri.............................................
R/O............................................................... was admitted to this hospital on..................
and expired on ..................................................

Doctor:..........................................
(Medical Supdt.Name of Hospital)
FORM NO.4A
(See Rule 7)
MEDICAL CERTIFICATE OF CAUSE OF DEATH
(For Non-Institutional deaths. Not to be used for stillbirths)
To be sent to Registrar along with Form No.2 (Death Report)

I hereby certify that the deceased Shri/Smt/Kum.................................. son of/wife of/daughter of .................................. resident of .................................. was under my treatment from .................. to ................. and he/she died on .................................. at .......... A.M. / P.M.

<table>
<thead>
<tr>
<th>NAME OF DECEASED</th>
<th>Age at Death</th>
<th>For use of Statistical Office</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Sex</td>
<td>Age in completed years</td>
</tr>
<tr>
<td>3. Male</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Female</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

CAUSE OF DEATH

I. Immediate cause
State the disease, injury or complication which caused death, not the mode of dying such as Heart failure, asthma, etc.

(a) .....................
due to (or as consequences of)

II. Antecedent cause
Morbid conditions, if any, giving rise to the above Cause, stating underlying conditions last

(b) .....................
due to (or as consequences of)

(c) .....................

II. Other Significant conditions contributing to the Death but not related to the diseases or conditions causing it.


If deceased was a female, was pregnancy the death associated with?
If yes, was there a delivery? 1. Yes 2. No

1. Yes 2. No

Name and Signature of the Medical Practitioner certifying the Cause of Death.
Date of Verification: .................................................................

SEE REVERSE FOR INSTRUCTIONS
(To be detached and handed over to the relative of the deceased)

Certified that Shri/Smt/Kum........................................ S/W/D of Shri............................
R/O........................................ was under my treatment from .................. to ................. and he/she expired on .......... at .......... A.M. / P.M.

Doctor: ................................................
(Signature and address of Medical Practitioner/Medical attendant with Registration No.)
CERTIFICATE OF CAUSE OF PERINATAL DEATH

To be completed for still births and live born infants dying within 168 hours (1 week) from birth

Identifying particulars of mother

☐ This child was born live on _____________________________________________ at ____________ hours
And died on _____________________________________________ at ____________ hours

☐ This child was still born on _____________________________________________ at ____________ hours
and died before labour ☐ during labour ☐ not known ☐

Name ..............................................................

This child was born live on _____________________________________________ at ____________ hours

W/D .......................   Rank ..........

Name of .........................................

Identifying particulars of infant

1st day of last menstrual period or, if unknown, estimated duration

Birth weight: ___________________________ grams

Sex:

☐ Boy ☐ Girl ☐ Indeterminate

Pregnancies:

Number of previous of pregnancy (completed weeks)

Live births ☐
Still births ☐
 Abortions ☐

Antenatal care, two or more visits ☐ Yes ☐ No ☐ Not known

Outcome of last previous pregnancy:

☐ Live births:
☐ Still births:
☐ Abortions:

Date: _____________________________

Attendant at birth

Delivery:

☐ Normal spontaneous vertex
☐ Other (specify) _____________________________

Other trained person (specify) _____________________________

Attended at birth

☐ Physician ☐ Trained midwife

Other relevant circumstances

☑ The certified cause of death has been confirmed by autopsy

I certify: _____________________________

Autopsy information may be made available later

Autopsy not being held

Signature and qualification _____________________________

Causes of death

a. Main disease or condition in fetus or infant

b. Other diseases or conditions in fetus or infant

c. Main maternal disease or condition affecting fetus or infant

d. Other maternal disease or condition affecting fetus or infant

e. Other relevant circumstances
PROFORMA FOR RECORDING DYING DECLARATION BY A MEDICAL PRACTITIONER

I, Dr. ..................................................................................................Son/Daughter of ..............................................,
working as ...........................................................................................................,
residing at ...........................................................................................................
in presence of witnesses (1) ......................................................................Son/Daughter of ..............................................,
residing at ...........................................................................................................
and (2) ................................................................................................................Son/Daughter of ..............................................,
residing at ...........................................................................................................
shall record the dying declaration of ..............................................................
male/female aged .......... years, S/o ................................................................residing at ..............................................................
..........................................................................................................................
at ........................................................... am/pm, on..........................................................
in the word by word order as narrated by the declarant.

Before recording this dying declaration, I have examined the declarant and found that his/her condition is
critical and he/she may die any time hereafter, in spite of the life saving treatment being given to him/her. I
have also thoroughly examined his/her level of consciousness, orientation of time and space, memory and
other mental faculties and I hereby certify that the declarant is in possession of a sound mind to deliver his
dying declaration. The words of the declarant as said by him are ..........................................................
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In order to clarify the points as revealed by the answers to the questions recorded in continuation to this, I
asked the following questions to which the declarant gave the answers, which are recorded in that sequence

Question: ............................................................................................................................
Answer: ..............................................................................................................................
........................................................................................................................................
........................................................................................................................................
........................................................................................................................................
........................................................................................................................................
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I Dr. ..................................................................................................Son/Daughter of ..............................................,
certify that the above declaration was recorded by me and I
also certify that the declarant ..............................................................maintained his/her sound state of mind
throughout the dictation of his/her declaration. The recording ended at ............................................am/pm on ..........

Signature:

Name & address of the Medical Practitioner:

Read over to me and found to be correct

(Should be translated into declarant’s mother tongue)

Signature:

Name & address of the declarant:

Recorded and signed in my presence.

Signature,
Name & address of First witness:

Signature,
Name & address of First witness:
CERTIFICATE OF DRUNKENNESS

Requisition received from the ............................................................ police station, dated ..........................................
for the examination and certification of drunkenness of ............................................................ ...... aged........ years and accompanied by HC / PC No. ..............

Name : .............................................................. Age : ........years. Sex : Male / Female.
Address : .................................................................................................................................

Consent : .................................................................................................................................

Whether under arrest or not (to be specified in requisition) : Yes / No
Date & time of arrest (as specified in the requisition): .................................................................
Date & time of examination: .................................................................
Identification marks:
(1) ........................................................................................................................................
(2) ........................................................................................................................................
History :
(a) relevant to consumption of alcohol : .................................................................
(b) relevant to illness if any : ...............................................................................................

Smell of alcohol in breath: Present / Absent.
General appearance & behavior.
(a) Clothing : Decently dressed / Disordered / Soiled / Torn.
(b) General disposition : Calm / Talkative / Abusive / Aggressive.
(c) Speech : Normal / Thick and slurred / Incoherent.

Higher functions
(a) Self control: Normal / Impaired. (b) Memory : Normal / impaired.
(c) Orientation of time & space: Normal / impaired. (d) Reaction time: Normal / Delayed.
Muscular co-ordination
(a) Gait: Normal / Unsteady / Unable to stand upright.
(b) Finger nose test: Positive / Negative.

Systemic examination findings:
Romberg’s sign: Positive / Negative.
Any other findings / Injuries on the body: ..........................................................................................

Smell of alcohol in breath: Persisting / Not persisting.

Special examination (Blood & Urine): Preserved / Not preserved.
Opinion:
1) There is nothing on examination to suggest that the person has consumed alcohol.
2) The person examined has consumed alcohol, but is not under the influence of alcohol.
3) The person examined has consumed alcohol and is under the influence of alcohol.

Date:          Signature:
Place:         Name:
Name of Institution:  Designation:
(strike off which is not applicable)

Received the certificate : ........................................... (Signature & P.C.No )

Ref. No. ML/MASO.....................Date : ..........................
# Medico-Legal Register

<table>
<thead>
<tr>
<th>S. No.</th>
<th>Name</th>
<th>Age</th>
<th>Sex</th>
<th>Religion</th>
<th>Occupation</th>
</tr>
</thead>
<tbody>
<tr>
<td>C/O</td>
<td>Brought By</td>
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<tr>
<td><strong>MLC No.</strong></td>
<td>Address</td>
<td>Place, Date &amp; Time of Examination</td>
<td></td>
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</tr>
<tr>
<td>Date &amp; Time of Arrival</td>
<td>History</td>
<td></td>
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<tr>
<td>Police Station</td>
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<tr>
<td>Police Officer</td>
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<tr>
<td>Date of Admission</td>
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<td>Date of Discharge</td>
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<tr>
<td>Date &amp; Time report submitted</td>
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<tr>
<td>Consent</td>
<td>Marks of Identification</td>
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<tr>
<td>General Physical Examination</td>
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</tr>
</tbody>
</table>

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**MLC - 1**
### Particulars of Injury / Symptoms (In case of Poisoning)

<table>
<thead>
<tr>
<th>S. No</th>
<th>Type of Injury</th>
<th>Location</th>
<th>Size</th>
<th>Age of Injury</th>
<th>Remarks</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<td>Investigation Advised</td>
</tr>
</tbody>
</table>

Symptoms (In case of Poisoning)

<table>
<thead>
<tr>
<th>S. No.</th>
<th>Nature of Injury</th>
<th>Type of Weapon used / Poison suspected</th>
<th>Sample preserved</th>
<th>Signature</th>
<th>Name of Medical Officer</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>
Weapon examination certificate

Investigating Officer ______________________
Police Station ____________________________

Received the package sealed/unsealed, with reference number_________ Dated ______________ Case file number ____________, from police station ________________.

Contents of the package

Identification of alleged weapon of offence ____________________________________________

Diagrammatic representation -- (Not to scale)

Size, shape and measurements

Presence of any stains/foreign material:

Opinion

1. With reference to MLC/postmortem number ____________, dated __________, the exhibit number __________, identified as ______________ cannot be ruled out as a weapon of offence for the injury numbers ________________.

2. With reference to MLC number ____________, dated __________, the exhibit number ____________, identified as ______________ is not the weapon of offence.

Name and signature

Designation and official seal
TREATMENT / DISCHARGE CERTIFICATE
(Issued In Continuation To The Accident Register-Cum-Wound Certificate)

1. Serial No., Date & Name of Institution of the Wound Certificate

2. Name ................................................................. Age : ......years. Sex : male/female

3. Address .................................................................

4. IP No. ............... Date of admission ....................... Date of discharge ......................

5. Name of the doctor who treated the patient* .................................................................

6. Condition at admission .................................................................

7. Results of clinical investigations if any .................................................................

8. Injuries diagnosed other than those noted in the Wound Certificate, if any .................................................................

9. Details of treatment given, including those of surgical and other procedures if any .................................................................

10. Condition at discharge .................................................................

11. Advise given at the time of discharge regarding further treatment if necessary .................................................................

12. Remarks if any : .................................................................

Date: ................................................................. Signature:

Place: ................................................................. Name:

Name of Institution: ................................................................. Designation:

* The name in both these columns should be same.

** Strike off which is not applicable.

Issued to ................................................................. as per his request No. ............. dated .............

Date ................................................................. Signature of the issuing officer :
To,

The Sub — Inspector of the police

(Subject: Information regarding a Medico-legal case)

Sir/Madam,

This is to inform you that patient by name.................................................................

male/female, aged ........ years, son/daughter/wife of ....................................................resident of

................................................ has been brought into the Emergency Department / OPD/ Ward

at......am/pm......alleged to have been .................................................................

................................................

................................................

................................................

................................................

.................

(State brief history and condition of the patient)

Date and time of incident

at......am/pm, dated ...................... at (place) .................................................................

Attending Doctor’s Name and Designation.................................................................

Reg No ..............................................................................

Signature of Doctor: ..................................................................................

Date and Time :.................................

He/She is being treated as out/in-patient in Ward No/ OPD/Ward/Emergency

..........................................................................................................................

This information was already given on telephone to........................................... (Name of

Police Officer) of police station................................................... on......... at......am/pm.

Please do the needful.

Yours faithfully

Name (Security personnel) .................................................................

Signature: ..............................................................................

Dated: ......................... Time: ....................................................


To,

The Sub — Inspector of the police

Police Station …………………………….

(Subject: Information of death in Medico-legal case)

Sir,

This is to inform you that patient by name………………………………………………………………………………

male/female, aged ........ years, son/daughter/wife of ............................................................resident of

……………………………………………………………………………………………….. who was admitted in this hospital in Ward / OPD/

Emergency .......................... On ........................... at........am/pm......as a medico-legal case

has expired on ............ at .........................

OR

Is brought dead to this Hospital on ........................... at ..............................

This information of Medico-legal registration was already sent on ..........................................................
at .............................

Please do the needful.

Yours faithfully

Signature of Doctor: .................................................. Date and Time : .................................

Name of Doctor: ..................................................

Designation: ....................................................
Consent form (Form C)

I .. daugther/wife of ......................... aged about .......................... Years of ...........................(here state the permanent address) at present residing at ............................................ do hereby give my consent to be termination of my pregnancy at ..........................................

(State the name of place where the pregnancy is to be terminated).

Place:

Date:

(To be filled in by guardian where the woman is a lunatic or minor)

I ................................................. son/daughter/wife of ........................................ aged about ......................................... Years of ............................................. at present residing at ................................................................. (permanent address)........................................ do hereby give my consent to the termination of my pregnancy of my ward ................................. who is a minor/lunatic at ........................................

(Place of termination of pregnancy)

Place:

Date:

Signature
FORM I

(Name and qualifications of the Registered Medical Practitioner in block letters)

(Full address of the Registered Medical Practitioner in block letters)

(Name and qualifications of the Registered Medical Practitioner in block letters)

(Full address of the Registered Medical Practitioner in block letters)

(Name and qualifications of the Registered Medical Practitioner in block letters)

(Full address of the Registered Medical Practitioner in block letters)

(Full address of the Registered Medical Practitioner in block letters)

(Full address of the Registered Medical Practitioner)

hereby certify that *I/We/am/are of opinion, formed in good faith, that it is necessary to terminate the pregnancy of ............................................... (Full name of pregnant woman in block letters) resident of ................................................................... (Full address of woman in block letters) for the reasons given below**.

I/We hereby give intimation that *I/We terminated the pregnancy of the woman referred to above who bears the serial No. ......................... in the Admission Register of the Hospital/approved place.

Place :

Date :

Signature of Registered Medical Practitioner

Signatures of Registered Medical Practitioners

*Strike out whichever is not applicable.

** of the reasons specified items (i) to (v) write the one which is appropriate:-

(i) In order to save the life of the pregnant woman.
(ii) In order to prevent grave injury to the physical or mental health of the pregnant woman.
(iii) In view of the substantial risk that if the child was born it would suffer from such physical or mental abnormalities as to be seriously handicapped.
(iv) As the pregnancy is alleged by pregnant woman to have been caused by rape.
(v) As the pregnancy has occurred as a result of failure of any contraceptive device or methods used by married woman or her husband for the purpose of limiting the number of children.

Note:- Account may be taken of the pregnant woman’s actual or reasonably foreseeable environment in determining whether the Continuance of a pregnancy would involve a grave injury to her physical or mental health.

Place :

Date :

Signature of the Registered Medical Practitioner

Signatures of the Registered Medical Practitioners
FORM II

1. Name of the State .................................................................

2. Name of Hospital/approved place .............................................

3. Duration of pregnancy (give total No. only)
   a) Upto 12 weeks ..............................................................
   b) Between 12-20 weeks .....................................................

4. Religions of women :
   a) Hindu
   b) Muslim
   c) Christian
   d) Others
   e) Total

5. Termination with acceptance of contraception:
   a) Sterilisation
   b) I.U.D.

6. Reasons for termination: (Give total number under each sub-head):
   a) Danger to life of the pregnant woman.
   b) Grave injury to the physical health of the pregnant woman.
   c) Grave injury to the mental health of the pregnant woman.
   d) Pregnancy caused by rape.
   e) Substantial risk that if the child was born, it would suffer from such physical or mental abnormalities as to be seriously handicapped.
   f) Failure of any contraceptive device or method.

Signature of the Officer In-charge with date
# Form III

**MTP Admission Register**

(To be destroyed on the expiry of five years from the date of the last entry in the register)

<table>
<thead>
<tr>
<th>S.No (1)</th>
<th>Date (2)</th>
<th>Name of Pt. (3)</th>
<th>Wife/Daughter (4)</th>
<th>Age (5)</th>
<th>Relation (6)</th>
<th>Address (7)</th>
<th>Duration of Pregnancy (8)</th>
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<thead>
<tr>
<th>Reasons on which Pregnancy is terminated (9)</th>
<th>Date of termination of Pregnancy (10)</th>
<th>Date of discharge of patient (11)</th>
<th>Result &amp; Remarks (12)</th>
<th>Name of Registered Medical Practitioner(s) by whom the opinion is formed (13)</th>
<th>Name of Registered Medical Practitioner by whom Pregnancy is terminated (14)</th>
</tr>
</thead>
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</table>
REPORT OF EXAMINATION FOR ESTIMATION OF AGE

Requisition received from the ……………………………………………………………………….
Dated……………..for the examination and certification of age of ……………………………………..
…………………………………………………………………………………………………………….. male/female, involved in Crime No. ……….. of 
…………………………………………………………………………………………………………….. police station and accompanied by……………….
1. Name of the subject: ……………………………………………………………………………..
2. Address: …………………………………………………………………………………………..
3. Age: ……….yrs.(…………………………………………….years) as stated by the subject.
4. Consent: ……………………………………………………………………………………………
5. Date and time of examination: …………………………………………………………………
6. Identification marks
   (1)………………………………………………………………………………………………….
   (2)………………………………….………………………………………………………………
7. Physical examination:
   Height………….cm.  Weight………kg.  General build: Poor / Moderate / Good.
   Voice: Masculine / Feminine.  Adam’s apple: Prominent / Not prominent.
   Hair: Moustache : ………………………………….  Pubic:……….…………………………
   Axillary: …………………………………….  Chest: …….…………………
   Breasts: ………………………………………………………………………….……………...
   External genitalia:………………………………………………………………………………
   Menarchy / Ejaculation:…………………………………………………………………………
   Date of last menstrual period (for females ): …………………………………………………..
8. Dental examination:
   Total number  of teeth: ………….…    Temporary:…………..  Permanent: ….….……….
   Details:…………………………………………………………………………………………..
9. Radiological examination:
   Regions          Findings
   a. Shoulder: ……………………………………………………………………………………
   b. Elbow: ………………………………………………………………………………………
   c. Wrist: ………………………………………………………………………………………
   d. Pelvis: ………………………………………………………………………………………
   e. Skull & jaw :…………………………………………………………………………………

   Opinion: Based on physical, dental and radiological findings, I am of the opinion that the subject
   is aged above …(………………………..) years and below …(………………………..) years of age.

   Date: Signature: 
   Place: Name: 
   Name of Institution: Designation: 

Forwarded to:

P.M. No………………. Date …………………..
REPORT OF EXAMINATION FOR EVIDENCE OF RECENT DELIVERY

Requisition received from the………………………………………………………………………. for
the examination of a female,
named……………………………………………………………………………...aged………years, to look for signs of
recent delivery, vide Crime No. ……………… o f…………………………………… Police station
dated …………………….. and accompanied by WHC/WPC No. ……………………………

Name & Address of the subject: ……………………………………………………………………………
………………………………………………………………..………………………………………………
………………………………………………………………………………………………………………..
Age………. years.  Marital status: Married / Unmarried.  Occupation: …………………………………….
Consent: ……………………………………………………………………………………………
…………..…………………………………………………………………………………………………….
Date, time & place of examination…………………………………………………………………..
Identification marks:
(1) ……………………..………………..……………………………………………………………………...
(2)…………………………...………………………………………………………………………………

History related to gestation (as stated by the subject): Menarche :…………………………………………
Date of last Menstrual period:………………    ………………….… Antenatal checkup: Taken / Not taken
Any other details:……………………...………………………………………………………………………
………………………………………………………………………………………………………………

Physical examination
a) General:  (1) Height…………cm. (2) Weight……….kg.        (3) Build : Good / Moderate / Poor.
(4) Conjunctival pallor: Present / Not present.
(5) Breasts: Engorged / Tender / Visibly full / Patulous.
(6) Areola of nipple: Dark and prominent with Montgomery’s tubercles / pale and non-prominent
(7) Nipple: Colostrum or milk could be expressed / Could not be expressed.
(8) Abdomen: Pendulous with wrinkled skin / Non-pendulous with smooth skin.
(9) Striae gravidarum: Present and reddish in color / Present as healed scars / Absent.
b) Uterus: Palpable per abdomen / Not palpable per abdomen. If palpable per abdomen, details regarding
size, tenderness etc ………………………………………………………………………………………….
……………………………………………………………………………………………………………….
c) Vagina:
(1) Labia: Swollen / Not swollen  (2) Labial tenderness : Present / Absent
(3) Injuries to labia: Present / Absent. If present, describe…………………………………………….
……………………………………………………………………………………………………………….
If present, describe …………………………………………………………………………
……………………………………………………………………………………………………………….
d) Cervix:
(1) Cervical lips : Soft and swollen / Firm.       (2) Cervical mucus plug: Present / Absent
(3) External Os : Closed / Open / Admits one finger / Admits two fingers.
(4) Injuries: Present / Absent. If present, describe ……………………………………………………….
……………………………………………………………………………………………………………….
(5) Lochia discharge at Os : Present / Not present. If present : Lochia rubra / Lochia serosa / Lochis
alba e) Systemic examination findings : …………………………………………………………………………
………………………………………………………………………………………………………………
 f) Laboratory examinations:
 i.  Urine for pregnancy test: Positive / Negative
 ii.  USG Abdomen (Optional): …………………………………………………………………………
 iii. Any other: ……………………………………………………………………………………………
OPINION

- There is evidence / no evidence suggestive of a recent vaginal delivery / abortion.
- Approximate period since the date of delivery could be ............

Date: Signature:
Place: Name:
Name of Institution: Designation:

(strike off which is not applicable)

Received the certificate: ........................................... (Signature & P.C.No.)

Ref.ML. No.......................... Date.............................
Report of examination of a victim alleged to have been drugged

Requisition received from the …………………………………………………….. police station, dated ………………………
for the examination and certification of …………………………………………………………………………..
aged……….years, alleged to have been drugged and accompanied by HC / PC No. ………………………………..

Name: …………………………………………………………… Age: ……years.  Sex: Male / Female.
Address: ……………………………………………………………………………………………………………………………
Consent: ……………………………………………………………………………………………………………………………
Date & time of examination: …………………………………………………………………………
Identification marks:
(1) ………………………………………………………………………………………………………………………………………
(2) ………………………………………………………………………………………………………………………………………

History:
……………………………………………………………………………………………………………………
……………………………………………………………………………………………………………………
……………………………………………………………………………………………………………………
(a) Date & time of the alleged incident : ……………………………………………..……..……………..
(b) Regarding mode of administration: …..……………………………….………………………………
(c) Loss of consciousness: Yes / No / Can’t remember. If Yes, period of unconsciousness:……………..
(d) Whether able to remember what has happened from the point of administration to recovery: Yes / No.
(e) If Yes, was he/she able to respond to what was happening during that period: Yes / No.
(f) Any sequel that he/she is able to make out:……………………………………………………

General Examination:
1. Clothing: In proper order/Disordered. 2. Level of consciousness: Conscious/Semiconscious/Unconscious
Physical Examination:
Height:…………..cm.         Weight:…………kg.           Build and nourishment: Good / Moderate / Poor.
Nostrils and nasal mucosa:……………………………………………………………………………………………
Lips, oral cavity and circum-oral regions:………………………………………………………………………..
Marks of injection on the skin:……………………………………………………………………………………….
Systemic examination findings: Pulse : ………./min. B.P.: ………………………….mm of Hg.
Injuries on the body:……………………………………………………………………………………………………
……………………………………………………………………………………………………………………
Any other finding :……………………………………………………………………………………………………

Laboratory examination:
Nasal swabs: Preserved / Not applicable. Stomach Aspirat : Preserved / Not applicable.
Vomitus: Preserved /Not applicable. Blood: Preserved / Not applicable. Urine: Preserved / Not applicable.
Opinion:

1) Reserved pending results of laboratory examinations.
2) Findings of physical and laboratory examinations are consistent with / not inconsistent with / not consistent with the alleged history of having been drugged.

(strike off which is not applicable)

Date: Signature:
Place: Name:
Name of Institution: Designation:

Received the certificate: ……………………………………….. (Signature & P.C.No.)
Report to be forwarded with material objects sent for chemical analysis

<table>
<thead>
<tr>
<th>Ref. MLC. No./</th>
<th>Dated:</th>
<th>Name of the subject:</th>
<th>Age: years.</th>
</tr>
</thead>
<tbody>
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</table>

Address: 

Crime No. of Police station.

Medico-legal examination conducted:

<table>
<thead>
<tr>
<th>Material Objects preserved</th>
<th>Preservative used (if any)</th>
</tr>
</thead>
<tbody>
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</table>

Mode of packing: Collected in glass bottles / wrapped with paper, tied, and sealed.

Copy of labels affixed to bottles / packages: Attached.

Impression seal affixed to the bottles:

History of the case:

Findings of examination:

Examination required:

Signature:

Name: __________________________

Designation: ____________________

To

The Regional Chemical Examiner __________________________

Sir,

I am forwarding the above mentioned material objects through Sri. __________________________

PC. No. for chemical examination and certificate. I request that three copies of your certificate may be sent to me at an early date.

Yours faithfully,

(Office Seal) __________________________

Name: __________________________

Designation: ____________________

Date: __________________________
Examination of Sexual Offence victim

1. Name of Hospital ...........................................OPD No .................Inpatient No..........................
2. Name ...........................................................D/O or S/O..........................................................
3. Address..............................................................................................................................................
4. Age (as reported) ............................................ Date of Birth ..........................................................
5. Sex (M/F/Others) .................................................................................................................................
6. Date & time of arrival in hospital ........................................................................................................
7. Date & Time of Examination ................................................................................................................
8. Brought by ............................................................ (Name & signature)
9. MLC No .......................................................... Police Station ..........................................................
10. Whether conscious, oriented to time, place & person ........................................................................
11. Any physical/intellectual/psychosocial disability ................................................................................

12. Informed Consent/Refusal: I .................................................................................................................. hereby give consent for:

   Medical examination for treatment  □ Yes  □ No
   Medico-legal examination  □ Yes  □ No
   Sample collection for clinical and forensic examination  □ Yes  □ No

   I also understand that as per law, the hospital is required to inform the police, and this has been explained to me.

   I want the information to be revealed to the police.  □ Yes  □ No

Signature / Thumb impression ....................................................................................................................

Consent By .............................................................. Relation .................................................................

Female attendant at time of Examination ...................................................................................................

13. Identification Marks
   (1) .................................................................................................................................
   (2) .................................................................................................................................

   Left Thumb Impression
14. Relevant Medical / Surgical history

Onset of menarche (in case of girls) Yes No Age of onset

Menstrual history – Cycle length and duration Last menstrual period

Menstruation at the time of incident - Yes/ No,

Menstruation at the time of examination - Yes/ No

Pregnant at time of incident - Yes/No, If yes duration of pregnancy weeks

Contraception use: Yes/No If yes – method used:

Vaccination status: Tetanus (vaccinated/not vaccinated),

Hepatitis B (vaccinated/not/vaccinated)

15 A. History of Sexual Violence

(i) Date of incident/s being reported (ii) Time of incident/s (iii) Location/s

(iv) Estimated duration: 1-7 days 1 week to 2 months 2-6 months >6 months

Episode: One Multiple Chronic (>6 months) Unknown

(v) Number of Assailant(s) and name/s

(vi) Sex of assailant(s)

Approx. Age of assailant(s)

If known to the survivor – relationship with the survivor

(vii) Description of incident in the words of the narrator:

Narrator of the incident: survivor/informant (specify name and relation to survivor)
15 B. **Type of physical violence used if any (Describe):**

Hit with (Hand, fist, blunt object, sharp object) Burned with

<table>
<thead>
<tr>
<th>Physical Violence</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Biting</td>
<td>Kicking</td>
</tr>
<tr>
<td>Pinching</td>
<td>Pulling Hair</td>
</tr>
<tr>
<td>Violent shaking</td>
<td>Banging head</td>
</tr>
<tr>
<td>Dragging</td>
<td>Any Other</td>
</tr>
</tbody>
</table>

15 C.

i. Emotional abuse or violence if any (insulting, cursing, belittling, terrorizing)

ii. Use of restraints if any:

iii. Used or threatened the use of weapon(s) or objects if any:

iv. Verbal threats (for example, threats of killing or hurting survivor or any other person in whom the survivor is interested; use of photographs for blackmailing, etc.) if any:

v. Luring (sweets, chocolates, money, job) if any:

vi. Any other:

15 D.

i. Any H/O drug/alcohol intoxication:

ii. Whether sleeping or unconscious at the time of the incident:

15 E. If survivor has left any marks of injury on assailant/s, enter details:

15 F. **Details regarding sexual violence:**

Was penetration by penis, fingers or object or other body parts

(Write Y=Yes, N=No, DNK=Don't know).

Mention and describe body part/s and/or object/s used for penetration.
### Penetration

<table>
<thead>
<tr>
<th>Orifice of victim</th>
<th>By penis</th>
<th>By body part</th>
<th>By object</th>
<th>Yes</th>
<th>No</th>
<th>Don’t know</th>
</tr>
</thead>
<tbody>
<tr>
<td>Genitalia (Vagina / Urethra)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anus</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mouth</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Emission of semen

### Oral sex performed by assailant on survivor

Y  N  DNK

### Forced Masturbation of self by survivor

### Masturbation of Assailant by Survivor, Forced Manipulation of genitals of assailant by survivor

### Exhibitionism (perpetrator displaying genitals)

### Ejaculation occur outside body orifice: vagina/anus/mouth /urethra.

If yes, describe where on the body .................................................................

### Kissing, licking or sucking any part of survivor's body

### Touching/Fondling

### Condom used

If yes status of condom

### Lubricant used

If yes, describe kind of lubricant used

If object used, describe object .................................................................

### Any other forms of sexual violence .................................................................

### Post incident has the survivor

<table>
<thead>
<tr>
<th></th>
<th>Yes / No/ Don’t know</th>
<th>Remarks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Changed clothes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Changed undergarments</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cleaned/washed clothes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cleaned/washed undergarments</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bathed</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Douched</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Passed urine</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Passed stools</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rinsing of mouth/Brushing/ Vomiting</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Time since incident

.................................................................................................................................

### H/o vaginal/anal/oral bleeding/discharge prior to the incident of sexual violence

.................................................................................................................................

### H/o vaginal/anal/oral bleeding/discharge since the incident of sexual violence

.................................................................................................................................

### H/o painful urination/ painful defecation/ fissures/ abdominal pain/pain in genitals or any other part since the incident of sexual violence

.................................................................................................................................
16. General Physical Examination
   i. Is this the first examination.................................................................
   ii. Pulse........................ BP..............................................................
   iii. Temp..............................................Resp. Rate..........................
   iv. Pupils ..............................................................................................
   v. Any observation in terms of general physical wellbeing of the survivor..........

17. Examination for injuries on the body if any

<table>
<thead>
<tr>
<th>Scalp examination for areas of tenderness (if hair pulled out/ dragged by hair)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Facial bone injury: orbital blackening, tenderness</td>
<td></td>
</tr>
<tr>
<td>Petechial hemorrhage in eyes and other places</td>
<td></td>
</tr>
<tr>
<td>Lips and Buccal Mucosa / Gums</td>
<td></td>
</tr>
<tr>
<td>Behind the ears</td>
<td></td>
</tr>
<tr>
<td>Ear drum</td>
<td></td>
</tr>
<tr>
<td>Neck, Shoulders and Breast</td>
<td></td>
</tr>
<tr>
<td>Upper limb</td>
<td></td>
</tr>
<tr>
<td>Inner aspect of upper arms</td>
<td></td>
</tr>
<tr>
<td>Inner aspect of thighs</td>
<td></td>
</tr>
<tr>
<td>Lower limb, Buttocks</td>
<td></td>
</tr>
<tr>
<td>Other, specify</td>
<td></td>
</tr>
</tbody>
</table>
18. Local examination of genital parts/other orifices*

A. External Genitalia: Record findings and state NA where not applicable.

<table>
<thead>
<tr>
<th>Body parts to be examined</th>
<th>Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urethral meatus &amp; vestibule</td>
<td></td>
</tr>
<tr>
<td>Labia majora</td>
<td></td>
</tr>
<tr>
<td>Labia minora</td>
<td></td>
</tr>
<tr>
<td>Fourchette &amp; Introitus</td>
<td></td>
</tr>
<tr>
<td>Hymen Perineum</td>
<td></td>
</tr>
<tr>
<td>External Urethral Meatus</td>
<td></td>
</tr>
<tr>
<td>Penis</td>
<td></td>
</tr>
<tr>
<td>Scrotum</td>
<td></td>
</tr>
<tr>
<td>Testes</td>
<td></td>
</tr>
<tr>
<td>Clitoro-penis</td>
<td></td>
</tr>
<tr>
<td>Labio-scrotum</td>
<td></td>
</tr>
<tr>
<td>Any Other</td>
<td></td>
</tr>
</tbody>
</table>
* Per Vaginum /Per-Speculum examination not to be done unless required for detection of injuries or for medical treatment.

P/S findings if performed .................................................................

P/V findings if performed .................................................................

Record reasons if P/V of P/S examination performed ................................

18 B. Anus and Rectum (encircle the relevant)
Bleeding/ tear/ discharge/ edema/ tenderness

18 C. Oral Cavity - (encircle the relevant)
Bleeding/ discharge/ tear/edema/ tenderness

19. Systemic examination
Central Nervous System: .................................................................

Cardio Vascular System: .................................................................

Respiratory System: .................................................................

Chest: .................................................................

Abdomen: .................................................................

20. Sample collection/investigations for hospital laboratory/ Clinical laboratory
i. Blood for HIV, VDRL, HbsAg
ii. Urine test for Pregnancy/
iii. Ultrasound for pregnancy/internal injury
iv. X-ray for Injury

21. Samples Collection for Central/ State Forensic Science Laboratory
i. Debris collection paper
ii. Clothing evidence where available – (pack in separate paper bags after air drying)

List and Details of clothing worn by the survivor at time of sexual violence
iii. **Body evidence samples as appropriate (duly labeled and packed separately)**

<table>
<thead>
<tr>
<th>Evidence Sample</th>
<th>Collected/Not Collected</th>
<th>Reason for not collecting</th>
</tr>
</thead>
<tbody>
<tr>
<td>Swabs from Stains on the body (blood, semen, foreign material, others)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Scalp hair (10-15 strands)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Head hair combing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nail scrapings (both hands separately)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nail clippings (both hands separately)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Oral swab</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Blood for grouping, testing drug/alcohol intoxication (plain vial)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Blood for alcohol levels (Sodium fluoride vial)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Blood for DNA analysis (EDTA vial)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Urine (drug testing)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Any other (tampon/sanitary napkin/condom/object)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
iv. Genital and Anal evidence (Each sample to be packed, sealed, and labeled separately to be placed in a bag)

* Swab sticks for collecting samples should be moistened with distilled water provided.

<table>
<thead>
<tr>
<th>Sample Description</th>
<th>Collected/ Not Collected</th>
<th>Reason for not collecting</th>
</tr>
</thead>
<tbody>
<tr>
<td>Matted pubic hair examination and DNA testing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pubic hair combing (mention if shaved)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cutting of pubic hair (mention if shaved)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Two Vulval swabs (for semen)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Two Vaginal swabs (for semen examination and DNA testing)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Two Anal swabs (for semen examination and DNA testing)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vaginal smear (air-dried) for semen examination</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vaginal washing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Urethral swab</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Swab from glans of penis/clitoro-penis</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Samples to be preserved as directed till handed over to police along with duly attested sample seal.
22. Provisional medical opinion

I have examined (name of survivor)........................................M/F/Other..................aged..................
reporting (type of sexual violence and circumstances)......................, ........days/hours after the incident, after having (bathed/douched etc).......................... My findings are as follows:

- Samples collected (for FSL), awaiting reports
- Samples collected (for hospital laboratory)
- Clinical findings
- Additional observations (if any)

23. Date and time of completion of examination .................................................................

This report contains ................. number of sheets and .............. number of envelopes.

Signature of Examining Doctor

Name of Examining Doctor

Place:

24. Final Opinion (After receiving Lab reports)

Findings in support of the above opinion, taking into account the history, clinical examination findings and Laboratory reports of ...................... bearing identification marks described above, ......................... hours/ days after the incident of sexual violence, I am of the opinion that:

Signature of Examining Doctor

Name of Examining Doctor

Place:
Report of examination of a male accused in sexual offence (including Potency)

Requisition dated……………………. was received at ………………………. on………………………….,
from the………………………………………………………………. for examination including potency of
………………………………….…………..............………………………… aged………. years involved in
crime No.…………………of………………………………….……………………………..Police station. 1.
Name & Address of the subject:…………………………………………………………….…
………………………………………………………………………………………………………………
2. Age:……..years   3. Accompanied by (name & address) ……………………………………………
4. Consent: …………………………………………………………………………………………………
………………………………………………………………………………………………………………
5. Date and time of commencement of examination: ……………………………………………….
6. Marks of identification:
(1) …………………………………………………………………………………
(2) ……………………………………………………………………………………………………………
7. Clinical history: History of any diseases or trauma which may affect potency: Present / Not present.
   If present, details…………………………………………………………………………………………
8. History of sexual development: …………………………………………………………………………..
10. History and alleged cause of injury (if any): …………………………………………………………
11. Physical examination:
    A. General:
    Height:………cm. Weight………..kg. Build: Good/Moderate/Poor. Hair : Normal Adolescent male / Adult
    male type of hair growth on face & body Present / Absent.
    B. Local:
    (a) Penis: Present / Absent. Length ………cm Circumference ……..cm (both flaccid state)
    Disease /Deformity / Injury (if any): Present / Absent. If present, details……………………………………………………………..…………
    Fore skin: Retractable / Non retractable / Circumcised. Smegma deposits on corona: Present / Absent.
    Sensations: Normal / Abnormal. Urethral discharge or tenderness on palpation: Present / Absent.
    Development of testis: Small / Medium / Adult size. Sensations & Reflexes: Normal/Impaired.
    Disease / Deformity / Injury (if any)……………………………………………………………..…………
    C. Systemic examination:
    Pulse…………/min.                                BP………………….mm of Hg.
    Other findings ( CVS, CNS, RS, GIS )……………………………………………….…………………
    D. Injuries on the body if any:
                                                                                           …………………………………………………………………………………………………………………
                                                                                           …………………………………………………………………………………………………………………
                                                                                           …………………………………………………………………………………………………………………
                                                                                           …………………………………………………………………………………………………………………
    The examination concluded at ……………………….…am/pm on…………………………………....

11. Material objects preserved***:
(a) Nail clippings  (b) Scalp Hair (cut) sample  (b) Pubic hair combings (c) Pubic hairs (cut)   (d) Penile
Swabs taken with cotton just wetted in water & shade dried ( to look for vaginal epithelial cells & for DNA
profiling) (e) Penile washings in normal saline
(f) Blood for DNA profiling (g) others if any …………………………………………………………….
OPINION:
* There is nothing to suggest that the above person is incapable of performing the sexual act.
* The above subject may be incapable of performing sexual act.
* **There is evidence / No evidence of Recent Sexual Act (Based on results of Laboratory examinations)**
* Opinion as to cause of injury: Could be as alleged / Could not be as alleged
* Other if any: ………………………………………………………………………………………………………
REASONS FOR CONCLUSIONS ARRIVED AT:
………………………………………………………………………………………………………………………

Date: ___________________ Signature: ___________________
Place: ___________________ Name: ___________________
Name of Institution: _______________ Designation: _______________

Received the certificate: ……………………………………. (Signature, Name & P.C. No.………………)
*Delete whichever is not applicable. **All need not be preserved if examined after 72 hours of alleged incident
## Form P
(Weekly Reporting Format – IDSP)

<table>
<thead>
<tr>
<th>Name of Reporting Institution:</th>
<th>I.D. No.:</th>
</tr>
</thead>
<tbody>
<tr>
<td>State:</td>
<td>District:</td>
</tr>
<tr>
<td>Officer-in-Charge</td>
<td>Name:</td>
</tr>
<tr>
<td>IDSP Reporting Week:-</td>
<td>Start Date:-</td>
</tr>
<tr>
<td></td>
<td>End Date:-</td>
</tr>
<tr>
<td></td>
<td>Date of Reporting:-</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>S.no</th>
<th>Diseases/Syndromes</th>
<th>No. of cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Acute Diarrhoeal Disease (including acute gastroenteritis)</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Bacillary Dysentery</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Viral Hepatitis</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Enteric Fever</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Malaria</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Dengue / DHF / DSS</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>Chikungunya</td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>Acute Encephalitis Syndrome</td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>Meningitis</td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>Measles</td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>Diphtheria</td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>Pertussis</td>
<td></td>
</tr>
<tr>
<td>13</td>
<td>Chicken Pox</td>
<td></td>
</tr>
<tr>
<td>14</td>
<td>Fever of Unknown Origin (PUO)</td>
<td></td>
</tr>
<tr>
<td>15</td>
<td>Acute Respiratory Infection (ARI) / Influenza Like Illness (ILI)</td>
<td></td>
</tr>
<tr>
<td>16</td>
<td>Pneumonia</td>
<td></td>
</tr>
<tr>
<td>17</td>
<td>Leptospirosis</td>
<td></td>
</tr>
<tr>
<td>18</td>
<td>Acute Flaccid Paralysis &lt; 15 Years of Age</td>
<td></td>
</tr>
<tr>
<td>19</td>
<td>Dog bite</td>
<td></td>
</tr>
<tr>
<td>20</td>
<td>Snake bite</td>
<td></td>
</tr>
<tr>
<td>21</td>
<td>Any other State Specific Disease (Specify)</td>
<td></td>
</tr>
<tr>
<td>22</td>
<td>Unusual Syndromes NOT Captured Above (Specify clinical diagnosis)</td>
<td></td>
</tr>
</tbody>
</table>

Total New OPD attendance (Not to be filled up when data collected for indoor cases)

Action taken in brief if unusual increase noticed in cases/deaths for any of the above diseases
# FORM L
(Weekly Reporting Format – IDSP)

<table>
<thead>
<tr>
<th>Name of the Laboratory:</th>
<th>Institution:</th>
</tr>
</thead>
<tbody>
<tr>
<td>State:</td>
<td>District:</td>
</tr>
<tr>
<td>Block/Town/City:</td>
<td>Officer-in-Charge:</td>
</tr>
</tbody>
</table>

**IDSP Reporting Week:**
- **Start Date:**
- **End Date:**
- **Date of Reporting:**

<table>
<thead>
<tr>
<th>Diseases</th>
<th>No. Samples Tested</th>
<th>No. found Positive</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dengue / DHF / DSS</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chikungunya</td>
<td></td>
<td></td>
</tr>
<tr>
<td>JE</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Meningococcal Meningitis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Typhoid Fever</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diphtheria</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cholera</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Shigella Dysentery</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Viral Hepatitis A</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Viral Hepatitis E</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Leptospirosis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Malaria</td>
<td>PV:</td>
<td>PF:</td>
</tr>
<tr>
<td>Other (Specify)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Line List of Positive Cases (Except Malaria cases):**

<table>
<thead>
<tr>
<th>Name</th>
<th>Age (Yrs)</th>
<th>Sex (M/F)</th>
<th>Address: Village/Town</th>
<th>Name of Test Done</th>
<th>Diagnosis (Lab confirmed)</th>
</tr>
</thead>
</table>

- Copy Space:
POST-MORTEM DETAILED NOTES

On the body of a male / female …………………………………………………………………
aged about …….. years sent by ……………………………………………………………
with letter Crime No. …………… dated …… in charge of H.C. / P.C. No………………

Body identified by:
Signature: ……………………………………………………………………………………
Name: ……………………………………………………………………………………..
H.C. / P.C. No: ……………………………………………………………………………

The body was first seen at ………………………… on ……………………………..
Postmortem examination was commenced at………………… on …………………
Post-mortem examination was conducted by: Dr…………………………………………
and was assisted by ……………………………………… and ……………………………

Notes on Scene examination:

Clothes, weapons and other articles sent with the body:
Schedule of observations

A. GENERAL

Body: Entire and intact / Mutilated and in pieces Sex: Male / Female. Ht. ……cm.
Smell: ……………………………………………………Facial appearance: Pale / Normal / Livid.

Eyes: Closed / Half open / Open. …………………………………………………………………
Cornea: Clear / Hazy / Opaque……………………………………………………………………
Pupils: Constricted / Dilated / Regular / Irregular ………………………………………
Conjunctivae: Pale / Normal / Congested ………………………………………………………

Nostrils: ……………………………………………………………………………………………

Tongue: ………………………… Lips: Pale / Blue / ………………………………………

Circum-oral regions…………………… Oral cavity:………………………………

Inner aspects of lips………………………………………………………………………………..

Ears: ……………………………………….. Urethral orifice:………………………………

Anus: ……………………………………………………………………………………………

Rigor mortis ……………………………………………………………………………

Postmortem staining ………………………………………………………………………

Dried salivary dribble mark: …………………………………………………………………

Smears on the body:………………………………………………………………………………

Postmortem ant bite marks:……………………………………………………………………

Postmortem aquatic or other animal bite marks:…………………………………………

Postmortem burns due to exposure to sunlight:…………………………………………

Decomposition changes: ………………………………………………………………………

Any other findings: …………………………………………………………………………………

Body was kept in cold room (If it was kept) at ……………………… on ………………….
INJURIES (Ante-mortem)

External:

Internal:
INTERNAL EXAMINATION

A. **Head and Neck**

Scalp:
Skull:
Meninges and cerebral Vessels:
Brain:

Subcutaneous tissues & muscles of neck:
Mouth and Pharynx:
Cartilages of neck:
Hyoid bone:

B. **Chest**

Ribs and chest wall:
Pleural cavities:
Diaphragm:
Mediastinum and thymus:
Esophagus:
Trachea and bronchi:

**Lungs**

Right:
Left:
Pericardial sac:

**Heart**

General:
Walls:
Valves:
Chambers:
Coronaries:
Aorta:

C. **Abdomen**

Abdominal wall:
Peritoneal cavity:
Liver:
Gall bladder and Billary passages:
Spleen:
Kidneys
   Right: 
   Left:
Pancreas
Adrenal glands
   Right: 
   Left:
Stomach and contents

Intestines and mesentery
Urinary bladder:
Genital Organs:
Spinal Column and Cord:

Additional observations
### Viscera and other Material Objects for Chemical and Other Examinations:

1) Stomach, small intestine and contents  
2) Part of Liver and Kidney  
3) Blood  
4) Urine  
5) Preservative for 1 & 2 (saturated saline)  
6) Preservative for 3 & 4 Sodium fluoride  
7) .  
8) .  
9) .

Post-mortem examination concluded at …………………………….. On ……………………………

**Opinion as to cause of death**

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Received the dead body after postmortem examination along with the articles mentioned .......... 

..............at ................................ on ................................

Signature P.C. No.
POSTMORTEM CERTIFICATE

The requisition for postmortem examination on the body of a male / female by name .......... .............................................................................................................. stated to be aged ........years, involved in Crime No............... of ....................................... police station was received from........................................................................................................ at...............on...............(vide his letter Cr. No................ dated............).

The body was in charge of P.C. No............... who identified the same. The body was first seen by the undersigned and the postmortem examination commenced at.............on ............... and concluded at .............on the same day. The alleged cause of death as per inquest was ........................................................................................................................................................................................................................................

Post-mortem findings
REPORT TO BE FORWARDED WITH THE MATERIAL OBJECTS SENT FOR CHEMICAL ANALYSIS (Preserved during postmortem examination)

1) Postmortem No:………………………………..Dated :………………………………….

2) Name of the deceased:………………………………………………. Age:…years. Sex: M / F.

3) Crime No…………….. of……………………………………………………….. police station.

4) Material objects:
   a) Stomach and part of intestine with contents.
   b) Part of liver and one half of each kidney.
   c) Blood
   d) Urine.
   e) Saturated saline (sample of preservative for 1 & 2).
   f) Sodium fluoride (sample of preservative for 3 & 4)
   g) ……………………………………………………………………………………………
   h) ……………………………………………………………………………………………

5) Mode of packing: Collected in bottles, wrapped with paper, tied and sealed.

6) Impression seal used: X

7) Copy of labels affixed to bottles / packages: Attached.

8) Alleged cause of death as per inquest:

9) Clinical history, treatment, progress etc.:

10) Postmortem findings in brief: ………………………………………………………
               ………………………………………………………
               ………………………………………………………
               ………………………………………………………
               ………………………………………………………

11) Examination required: Quantitative and qualitative analysis for drugs / poisons, detected if any

Signature
Name & Designation

To,
The Regional Chemical Examiner……………………………………

Sir,
I am forwarding the above mentioned material objects through Sri……………………………….. PC.
No…………….. for chemical examination and certificate. I request you that three copies of your certificate may be sent to me at an early date.

Yours faithfully,

Date:  Signature:
Place:  Name:
Name of Institution:  Designation:

PM. No. ……………dated……………………
Final opinion as to cause of death

As per requisition from the ................................................................. of .................................................. Police station dated ................., postmortem examination was conducted on the body of a male/female by name................................................................. stated to be aged about .....years, involved in Crime No. ........of .................................................. police station and the postmortem certificate No........... dated ................. was issued by the undersigned. The opinion as to cause of death was reserved pending results of chemical analysis of viscera and other material objects preserved from the body**.

The Certificate of chemical analysis No..........................dated.................. of the above said viscera and other material objects was received by me on.................. from the Chemical Examiner to Government.

**Laboratory Findings:**

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**Opinion**

Based on the postmortem findings and results of Laboratory examinations, I furnish my Final Opinion as follows:

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Guidelines for Medical Practitioners

The book provides guidelines for various ethical and legal issues in everyday medical practice.

Relevant advances and updates in the medicolegal system are included after consulting with experts in medical and legal fields.