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Original Article

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Blunt Trauma Injuries of Cervico-Thoraco-Abdominal Region among the Victim around Costal Area of Odisha

Monaj Kumar Jena*, Sudhansu Sekhar Sethi**

Abstract

Objective: The present study aims to highlight the distribution of cervico-thoraco-abdominal injuries sustained to the victims of blunt force trauma. *Material & Methods:* This is an autopsy-based observation of cervico-thoraco-abdominal injuries to victims during the period of May 2014 to May 2015 at central morgue SCB Medical College Cuttack. All the deaths from cervico-thoraco-abdominal injuries were included in the study. The autopsy case files and information furnished by the police in inquest were studied in detail. *Results:* Among the 246 cervico-thoraco-abdominal injury related deaths, the thoracic injury accounted for most. Male predominance was observed and the age group most vulnerable were 21 to 40 years. Lungs and Solid organs of the abdomen were most commonly involved organ in thoracic and abdominal region respectively. Many of the victims are hospitalized and treated. Accidental manner predominant, followed by rare homicidal cases. No cases of suicidal manner were reported. Many of such cases remain undiagnosed during hospital stay due to inadequate initial assessment and management. *Conclusion:* This study not only help in the pattern of injury sustained but also help in its prevention.

Keywords: Cervico-Thoraco-Abdominal Injuries; Blunt Force Trauma; Fatality.

Introduction

In the field of forensic medicine several types of wounds are differentiated according to their origin like blunt force, sharp force, gunshot injury and injury due to cold, heat, etc. Furthermore, the wound morphology should be compared with the history to confirm the injury consistent with events.

The blunt force trauma, the term itself suggests physical damage due to mechanical force applied either by the object to the body or the movement of the body against a hard surface. Among all the injuries the human beings are invariably suffered by the most common form of blunt injuries in all spheres of life. Blunt trauma to the different region of the body, i.e. cervical area , chest and abdomen end into a complex fatality by different manners irrespective of biomechanics of its production. The cervico-thoracic-abdominal region containing vital organs of the body is the major site of impact. The study deals with the pattern of cervico-thoracic-abdominal injuries sustained along with its application in the prevention of fatal outcomes[1, 6].

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Material and Methods

This study is an autopsy based observation of cervico-thoraco-abdominal injuries in victims during the period from May 2014 to May 2015. All the deaths from cervico-thoraco-abdominal injuries were included in the study. The autopsy case files and information furnished by the police in inquest were studied in detail. A detailed Victimiologic profile was made. The data were compiled with a focus to analyzing injuries to the cervico-thoraco-abdominal region with special reference to the nature of the wounds and organs most commonly affected. The cases were analysed in accordance with parameters like age, sex, manner of production, duration of survival, associated injuries etc. Injuries to the head and extremities are excluded from the study.

Observation

Out of 2107 autopsy cases during the study period, the blunt trauma to the cervical, thoracic and abdominal areas comprising of 246 cases (11.67%). Among which the cervical trauma were 42, thoracic region 104 and abdominal region consisting 100 cases (Fig-1). The incidence of upper cervical injury, i.e from C1 to C4 is less in comparison to the lower cervical injury 1:9.5. The male sex almost outnumbered the female sex and highest incidences were in the age group of 21 to 40 (Fig-2). Victims of blunt trauma cervical injury attended the medical treatment in a ratio of 2.5:1 (Fig-3), so also maximum number of deaths are delayed instead of early and immediate i.e 4:3:3.5 (Fig-4). The manner like fall and accident is greatly prevalent in contrast to suicidal and homicidal manner (Fig-5). The association of blunt trauma abdomen twice in comparison to the thorax.

The blunt trauma to the thorax comprising 104 autopsies revealed more frequent involvement of the lungs, followed by heart and great vessels. The males are dominating the females in a ratio of 16.3:1. The incidence is more in age group of 21 to 40 years. All the deaths are due to accidental in nature. The victims in the ratio of 1.4:1 were rendered medical treatment and the incidence victim of immediate death followed by early and late. The incidence of the blunt trauma abdomen is very frequent.

Fig.1: Total no. of autopsy in different injury cases

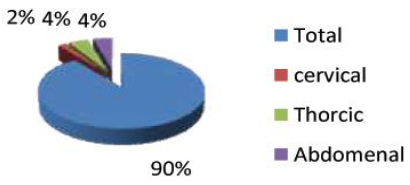
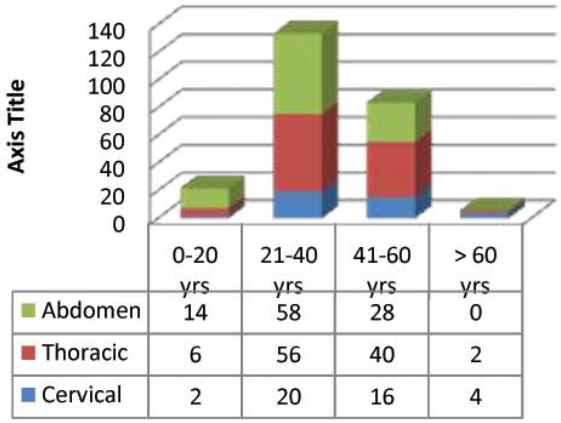


Fig. 2: Relationship between Age and Location



	0-20 yrs	21-40 yrs	41-60 yrs	> 60 yrs
Abdomen	14	58	28	0
Thoracic	6	56	40	2
Cervical	2	20	16	4

Fig. 3: Hospitalisation of injury cases

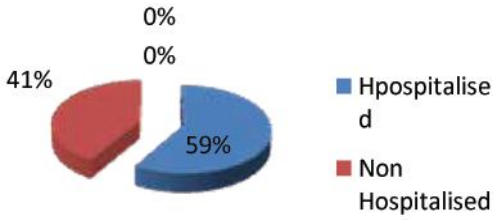


Fig. 4: Survival duration in different region

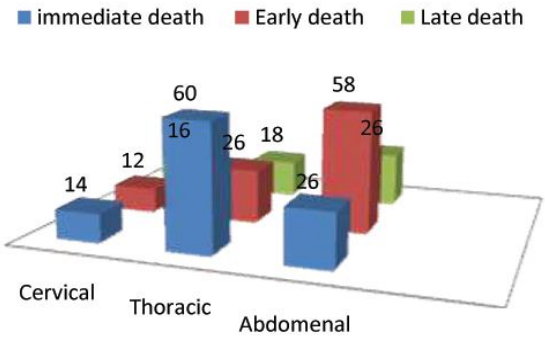
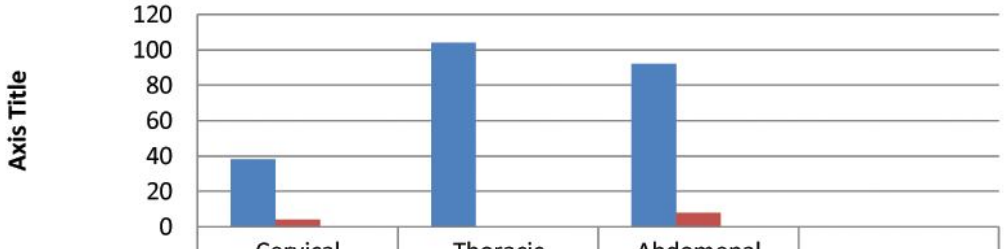
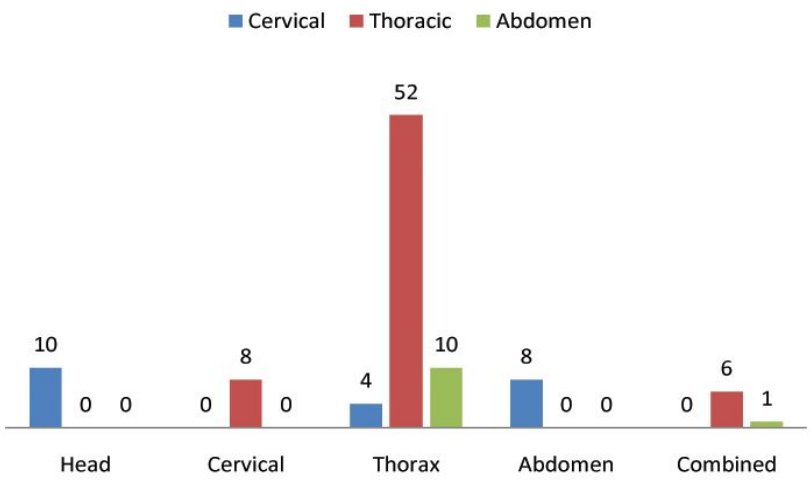


Fig. 5: Manner of injury in different parts



	Cervical	Thoracic	Abdomenal	
Fall/ Accident	38	104	92	
Homicidal	4	0	8	
Suicidal	0	0	0	

Fig. 6: Associated injury to different region



The 100 victims of blunt trauma abdomen revealed the involvement of mostly solid visceral injuries followed by hollow and vessels (2:1.1:0.9). The accidental manner of death in a higher frequency followed by homicidal. With a ratio of 2.5:1, the victims attended the medical treatment and most of them in the age group of 21 to 40 years having male sex dominance. Early death found to be in 52% of cases and next is late death followed by immediate. The blunt trauma abdomen has greater associated with thoracic trauma.

Discussion

A total no. of 2107 autopsies were conducted during the study period of May 2014 to May 2015, of which 246 cases of cervico-thoracic-abdominal injury related death. Accident alone to the caused majority of injury related death followed by homicidal (29:1). Our findings coincide to the finding of Sharma B.R.et al (2004) , Husaini N et al (2009), Meera Th et al (2005) [2,5,7]. In the present study injury involve thoracic and abodominal region in majority of cases. This can be correlated with the cause as mostly in this study due to accident. This can also correlated with anatomical correlation with anatomical correlation of this region that can makes it easily susceptible to impact in any form [1] .

Males were more commonly involved in comparison to female due to the social structure of the Indian society where male dominating family exits and poor awareness of traffic rules and regulation. Another association could be assumed between the lack of adequate body fats and hence lesser Cushing effect from blunt trauma in case of males and compared to female. Our as in the findings are accordance with the studies of Singh and Dhatterwal et al [1].

The highest incidence of fatalities in the age group 21 to 41 years, as this age group is the tender age to be involved in activities of all works as a mean of earning livelihood and it is at par with the studies of other researcher like Husaini N et al, Wong Z.H et al, Kaul A et al [2,3,9]. With modernization of equipments as well as emergency medical facilities, the victims are immediately shifted to such care leading delay in death agrees to study like Meera T H et al [5].

Conclusion

The cervico-thoraco-abdominal injuries require a multi-discipininary approached in the management. The postmortem study describes the injury pattern and nature of injury to highlight the trends in this coastal region. In this study thoracic injuries are more common than cervical and abdominal. A meticulous autopsy helps to determine the actual anatomical site of primary impact which helps in preventing fatal consequences in undiagnosed cases. A trivial trauma in this region (cervico-thoracic-abdominal) without any external manifestation can end into disastrous consequences by involving the internal organ. Hence a thorough examination also always mandatory for evaluation and treatment. The study depicts and highlights towards prevention of not only medical negligence on parts of medical officers, but also in reference to prompt meticulous observation to such victims of cervico-thoracic-abdominal injury.

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Review Article

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Legal Culpability of Dereliction of Privileged Communication

P. C. Sahoo*, Ashim Mishra**

Abstract

The recent plane crash by a German-wings co-pilot has shocked the whole world. Moreover the revelation by the doctors about his health condition, questions the fundamental basis of confidentiality clause in the Medical ethics. The rash act of the pilot resulted in loss of many lives. There had been many debates on this issue of owing of duty to warn. This is an attempt by the authors to rationally study the legal culpability of the doctors by reviewing the literature and substantiate the boundaries between the medical confidentiality and privileged communication.

Keywords: Professional Secrecy; Privileged Communication; Legal Culpability**.**

Introduction

The confidential nature of communication between physician and patient is a well-recognized concept in medical ethics. It ensures the need of a patient to be free in his entire communication process with his physician in order to avail effective and sound treatment. The communication follows the Principle of Confidentiality of Medical ethics. They are not expected to divulge the secrets confided to them during the course of medical practice except in few conditions that come under Privileged Communication. But an important issue still remains cryptic in this entire process. The legal culpability of the doctors where the confidentiality causes harm to the society and sometimes results in mass disasters is not typically discussed in literature reviews.The recent crash of German airlines raises very important questions [1].

What we need at this very hour is to ask ourselves several simple but important questions.

1. Whether it is a responsibility that we inform the status of a patient engaged in high risk activity / profession?
2. Is it appropriate to rely only on patient's versionduring history taking?
3. Is verifying and mentioning the status of a patient engaged in a high risk profession to his employer our moral duty?
4. Does violation of the duty or failure to warn brings onus of culpability on the treating physicians.

Background

The oath of Hippocrates clearly points the principle of confidentiality.

"And whatsoever I shall see or hear in the course of my profession, as well as outside my profession in my intercourse with men, if it be what should not be published abroad I will never divulge, holding such things to be holy secrets" [2].

Professional secrets are the ones, which a doctor comes to know about his patient in his professional capacity as a physician. Thus every doctor should be cautious to reveal statements confided in him by his patients [3]. How far it is ethical that the component of secrecy outweighs the dangers of the outcome? There is no need stick to conservatism or randomly follow whatever action determines better consequences.

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New York was the first state to enact a physician patient privilege statute in 1828 [4].

For the physician-patient privilege to be applicable in a proceeding, three requisites' must be satisfied: (1) The physician-patient relationship must have been established; (2) the communication under inquiry must have been an outcome of that relationship and not merely an outgrowth of a social encounter; and (3) the communication must have been made under confidential circumstances [5].

Privileged communication is the bonafide information given to a concerned person or authority, by a doctor, by virtue of his duty to protect the interest of the society. To be bonafide the information should be given only to the concerned person or authority [6].

The privilege belongs to the patient, not the doctor. This privilege will only cover information given to a doctor for the purposes of obtaining treatment or diagnosis. However, even when an individual's mental or physical condition is in issue, courts generally will construe the waiver.

Patient Litigant exception: When the medical condition is at issue, the physician patient privilege is waived [4].

Public Safety exception: If a physician believes that a patient may be dangerous to others, several state statutes allow him to disregard the patient's privilege and warn the authorities, as well as the victim(s) [4].

Disclosure of information compelled in legal proceedings wherein the patient's criminal behavior is an issue. In controversies arising from the physician-patient relationship such as suits for malpractice or actions for the fee, the privilege does not apply. Where a patient's mental capacity to execute a deed or a will is an issue, the privilege does not apply, and disclosure by the physician may be compelled. There is also no physician-patient privilege in a disciplinary proceeding such as to revoke or suspend a physician's license.

Discussion

We must know the rationale behind professional secrecy is to develop confidence in a patient to consult and trust the medical professionals. Confidentiality relates to matters of professional ethics, privileged communication refers to legal rights, and privacy is a more general term for some of the individual's rights [7]. We know that medical confidentiality is based on ethics rather than law.Then carefully reviewing facts that the treating psychiatrist completely relied on the patients statement that he was not on flying duty raises some issues to debate. The treating doctor's statement carefully shifts the onus of culpability from as they stated "Had the airlines told doctors he was still flying, they might have felt the need to break their vow of patient confidentiality and inform his employers because he might be a danger to others''. Medical records showed that pilot was taking medicine for depression, anxiety disorders and panic attacks and had informed the flight school about an episode of severe depression [1].

Many times the state's need for patient information conflicts with the patient's right of privacy [8]. In Tarasoff V Regents of University of California presented a new theory on liability imposed several questions [9].

Was a duty owed if the threats of dangers were not aimed at anyone at particular?

What steps did a psychiatrist or therapist have to take to discharge the duty?

Was a duty to warn still owed if the potential victim was already aware of patient's threat or dangerous propensities? How was the therapist's determination of dangerousness to be judged if the profession itself disclaimed the ability to accurately predict future behavior?

Specific threat to specific victim rule as in Brady decision and foreseeable violence created a duty to protect others regardless of the victim was identified or specified as in Lipari decision contradicts each other, thereby leaving scope for unambiguity [9, 10, 11].

Even the GMC strictly advises that if, as a member of a board or similar body, you are concerned that a decision would put patients or the health of the wider community at risk of serious harm, you should raise the matter promptly with the chair [12]. These issues need to be debated among professionals and thereby put rational guidelines for determining the scope of Privileged Communication. Whether the treating doctor has any right to entirely rely on the patient provided information or has a duty to enquire the background from the employer if he suspects some harm may be done by the patient during the scope of his employment. Privileged communication is deemed necessary where the treating doctor feels it could be hazardous to lives of people and society at large. The victims need not be identified and specified.

Conclusion

The plane crash took many valuable lives and the

offending pilot was also killed in the incident. The incident may explain the intent of the pilot involved establishing his mens rea or he may have the knowledge of the consequences of his action which can fix his culpability. The truth only emerges after resolution of conflicts regarding the facts and the law. There must be uniform standards to delimit the scope of medical secrecy. There must be parameters for determining the legal culpability of violation of clauses of privileged communication.

Suggestion

This is novice attempt to delineate the facts and more debate is required by the medical and legal experts to arrive at a rational view.

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Review Article

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Legal Stand of Medical Practitioner

Nishat Ahmed Sheikh

Abstract

Every Medical Practioner equally must have sufficient knowledge of law in order not to conflict with it during the practice of his profession. He stands in the Witness box, when he deals with a Medico-legal case or when he prepares and issues a Document or when charges of Medical Negligence are framed against him. Medico-legal case is the property of Law, and the Registered Medical Practitioner is only the custodian for time being. 174 Cr. P. C. empowers the police to enquire and report on suicide, etc. It can also include deaths arising out of investigative and therapeutic procedures performed by qualified medical practitioners of all recognized medical systems. It does not preclude the right of aggrieved relatives of a deceased patient to prosecute the doctor for criminal liabilities under Section 304-A of the IPC, it prevents doctors from being arrested immediately after the unfortunate death of a patient. It also offers doctors an opportunity for being assessed by their peers for any alleged professional lapses. There is a need to emphasize the importance of proper communication skill and vigilantly dealing of the medico legal cases. "Ideal" medical records should be kept in every case. Doctor should use the reasonable degree of skill, care, knowledge prudence in treatment of his patient.

Keywords: Mens Rea; MLC; 174 Cr. P. C; Criminal Law.

Introduction

A Registered medical Practioner is the medical man after having medical degree and registering with provincial medical council entitled to practice of allopathic modern system of medicine [1]. The Medical doctor not only relieves suffering of patients, he also guides and educates the society about the diseases and their preventions. He is a master in his field of medicine i.e. in dealing with the patients and his sufferings. Medical doctors have highest level of social responsibility, professional integrity, professional excellence and help in the administration of justice [2]. Every Medical Practioner equally must have sufficient knowledge of law in order not to conflict with it during the practice of his profession. The legal system is like mire to medical Practioner, for this he has to be familiar with various .acts and rules & regulations that are in force, know his responsibilities about medico-legal cases, law of the state and country or otherwise he may find himself inadvertently contravening these and courting trouble and also amounts to professional misconduct attracting disciplinary action by State Medical Council [3].

As such with the professional qualification and capacity, a Registered Medical Practitioner enters the Court of Law into two areas. They are the Witness box and Accused box. He is made to stand in the Witness box, when he deals with a Medico-legal case (M.L.C.), or when he prepares and issues a Document. When charges of Medical Negligence are framed against him, he enters the accused box [4].

Medico-legal case

Medico legal case is a case of injury or illness resulting out of sexual assault, poisoning or any suspicious circumstances, where the attending doctor, after eliciting history of the patient and on medical examination, decides that an investigation by law enforcement agencies is essential to understand establish and fix the criminal responsibility for the case in accordance with the law of the land in the

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interest of truth and justice of victim / patient and state. But as such no act in the law defined it so far [5]. It is implied that, any case in which a Medical examination or treatment is done, where the Law is expected to interfere, at any time. Medical practitioners many times identify the cases as Medico-legal cases, and the Law never interferes in them. Sometimes in some trivial cases, he may not regard it as a Medico-legal case, but the Law may ask about the details. However, it is always advisable, to label the case as Medico-legal case, even a little of suspicion arises [6].

How a Medico-legal case differs from Medical case

Medico-legal case is the property of Law, and the Registered Medical Practitioner is only the custodian for time being. Hence any Medico-legal case is examined or treated; intimation must be made to the nearest Police Station, voluntarily by the Hospital authority. Casualty area must have an accident register to enter the cases with serial number for further reference and all details about the case must be entered in to it. All those things must be preserved, which act as Material Evidence about the case, or which need further examination or analysis. They must be sealed and handed over to the I.O. under receipt. Necessary Requisition is to be issued to the I.O. in case an analysis of the preserved material is needed, which includes the exact nature of examination required. Intimation must be made to the nearest Police Station regarding the Discharge / Death / Missing of such patient. Necessary arrangements are to be made for conducting the Post-mortem examination, in case of Death. A copy of the case sheet may be given to the I.O. on requisition [6].

When to inform the Magistrate / Police in Medico Legal Case

The Law gives no time limit regarding the intimation of M.L.C. No concept of Late MLC there is no stipulated time period beyond which an MLC cannot be registered. Request of the patient, relatives or friends regarding non registration of an MLC, should not be entertained. Generally, an intimation is to be made immediately after the examination / admission, or before closer of General Diary (G.D.) of that day in Police Station. Usually with in 24 hours of admission / examination is accepted.

In case of recording the Dying Declaration, an immediate intimation should be sent to the Magistrate, with a copy to the nearest Police Station. In case of Death / Discharge / Missing of Patient, no time lapse is to be made in intimating the Police.

Failure to inform police in such cases may result in penal consequences.

Is it necessary to register a case as M.L.C? Is it necessary to inform the Police in all M.L.C. s?

Yes, as we are not the representatives of the Law, we are not the investigating authority to decide on the case, we are not going to follow up the case after its Discharge / Death and we are not taking any legal opinion about the case.

Is it necessary to inform in cases of Suicidal Deaths

Yes, as it is an unnatural Death and we do not know the mens rea or Guilty mind: The criminal mind that made a person to commit the offence, behind the act.

Is it necessary to inform in Suicidal attempts

Yes, as we do not know the mens rea, it may be necessary to record the Dying Declaration. The case may become serious and die, where a Post mortem examination may become mandatory, as it is an un-natural death.

Sec. 309 IPC: Attempt to commit suicide: Describes that "Whoever attempts to commit suicide and does any act towards the commission of such offence, shall be punished with simple imprisonment for a term which may extend to 1 year or with fine or both". an attempt for committing suicide is an offence, but the Medical practitioner can take little risk in withholding the information for a while, at least till the patient becomes serious, as the patient and attendants do not want to take the trouble created by the so called Law protectors [7].

Sec. 306 IPC: Abetment to commit suicide: Describes that "If any person commit suicide, whoever abets the commission of such suicide shall be punished with imprisonment of either description for a term which may extend to 10 years, and shall also be liable to fine" [7].

Some important things to be remembered in M.L.C.s

Any Registered Medical Practitioner can treat M.L.C.s, provided proper procedures are followed. Earlier permission from District Authorities was needed, to treat M.L.C.s. All instructions given to Duty Doctors / Para-Medical staff must be in writing only. No oral instructions are to be followed / given. Do not discuss about the case with un-authorized persons. No certificate is to be issued to the patient or attendant without informing Police, and without proper Requisition. All Documents must be prepared

in Duplicate. Always keep a copy for the record. In case of receiving M.L.C. from other Hospital, always insist for the referral letter. Check whether it is already made M.L.C. Other wise make it now and intimate the Police. In case of referring the M.L.C. to other centre, always send a Referral letter, which bears the details of M.L.C, prepared in duplicate and issued under receipt.

Our role as Medical Practioner is not just limited to activating the police machinery and a false belief that determining nature of injury accidental or suicidal is the role of police and not ours. In spite of the fact that health system has been identified as a key sector in identifying reasons for a certain health complaint as well as documenting good quality evidence in cases where medico legal overtones are involved [5].

In current scenario, the nursing cadre plays insignificant role in handling the medico legal cases. Though they play a crucial role in caring for the patient, they have no powers in medical hierarchy in handling medico legal cases. A growing concept of Forensic Nursing in western countries where Nurses being trained to collect any trace evidence, keep records properly and in lock and key, label and seal materials properly, keep all materials in safe custody till handing over to police and handing over materials to police after proper receipt.

What is a *Document? :* According to **Sec. 29** of **I.P.C.,** any matter, this is written or otherwise, taken as evidence in the Court of Law is a Document [8,9].

A Registered Medical Practitioner prepares three types of Documents. They are Reports, Opinions, and Certificates.

Report is a filled in proforma of enlisted findings made on a fact by a person having specialized knowledge in that field.

Opinion is interpretation of the findings to come to a conclusion, based on the knowledge, experience, and belief.

Second Opinion: Always does the basic examination and observes the findings before interpreting them.

Expert Opinion: Interprets on the available findings, may not do another examination.

Certificate is a strengthened statement made on the facts, which is in writing, by a Competent Authority. A Registered Medical Practitioner issues two types of certificates.

Medical Certificate: Voluntarily can be issued by Registered Medical Practitioner.

Medico legal Certificate: Issued by a Registered Medical Practitioner on the Requisition made by a Competent Authority.

A Registered Medical Practitioner enters into Accused Box when a charge of Medical negligence is framed against him. Before going to the details about the medical negligence it is better to have some knowledge about the sections in Criminal Major Acts.

Sections those are helpful to Medical Practitioner [7,10]

Sec. 88 of I.P.C. says that nothing is an offence, which is not intended to cause the death of a person, for whose benefit it is done, in good faith, with his consent.

Sec 52 of I.P.C. defines the Good faith as Nothing is said to be done in good faith, which is done without due care and attention.

Sec. 92 of I.P.C. says that nothing is an offence, which is not intended to cause the death of a person, for whose benefit it is done in good faith, even with out the person's consent, if the circumstances are such that it is impossible for obtaining the consent from him or his guardian.

Sections doing harm to Medical Practitioner [7,10]

Sec.90 of I.P.C. explains that Consent is not valid, if the consent given by a person doing the act knows that; consent was given of such fear or misconception

Sec. 304-A of I.P.C. says whoever causes Death of any person by doing any rash or negligent act not amounting to culpable homicide, shall punished with imprisonment of either description for a term which may extend to two years, or with a fine, or with both.

Sec.304 of I.P.C. says any death resulted by person who has the knowledge of such death and without any intention of such death has caused the culpable homicide not amounting to murder.

Indian Evidence Act in its Sections 101 to 105 says that burden of proof lies on that person whoever desires any Court to give judgment as to any legal right or liability dependent on the existence of facts which he asserts, must prove that those facts exists.

When a person is bound to prove the existence of any fact it is said that the burden of proof lies on that person. Usually it is on Victim.

174 Cr. P. C. empowers the police to enquire and report on suicide, etc. It can also include deaths arising out of investigative and therapeutic procedures performed by qualified medical practitioners of all recognized medical systems. Subsection 1 of Section 174 of the Cr. P. C mentions

the conduct of inquest by the officer-in-charge of the police station. However, in complaints involving medical negligence, the investigating officer should be preferably not below the rank of Deputy Superintendent of Police / Assistant Commissioner of Police.

Further, subsection 3 of Section 174 of the Cr. P. C provides ample powers to an investigating officer when there is any doubt regarding the cause of death; or the police officer for any other reason considers it expedient to conduct an autopsy by a Civil Surgeon[11, 1]. This subsection can be further modified so that autopsies on deaths due to alleged medical negligence should only be performed by a team of doctors, which includes experts from a related specialty under the guidance of a forensic expert. Only if in the opinion of the medical experts there is prima facie evidence of criminality, the investigating officer should proceed further with framing of charges against a qualified doctor under Section 304-A of the IPC[11,1].

The advantages of bringing the investigation of deaths due to alleged medical negligence under Section 174 of the Cr. P. C are that while it does not preclude the right of aggrieved relatives of a deceased patient to prosecute the doctor for criminal liabilities under Section 304-A of the IPC, it prevents doctors from being arrested immediately after the unfortunate death of a patient. It also offers doctors an opportunity for being assessed by their peers for any alleged professional lapses.

Any death of a patient occurred during treatment by a Medical Practitioner, has to be proved by the Victim (Public Prosecutor) beyond all reasonable doubts in the Court of Law that the Doctor was negligent in delivering his duties. As the Doctor is a target figure for many people in the society, some times false allegations are also made, with some motives and interests. Many times, Police people are not considerate to the Medical Profession. Some times, they may worsen the situation for some interests. If it is proved in the Court of Law that the Doctor is not guilty of Medical Negligence after complete trial, damage is already done to his profession by that time. If he wants to claim compensation for such wrong accusation, it is made by serving a Show Cause notice to the person who made a wrong accusation, If the explanation is not satisfactory, a fine of Rs. 500/- is awarded to him and a simple imprisonment for a period of one month. Nothing will get back the reputation of a Doctor. And the Investigating Officer is safe guarded by the law every time as he is doing every thing in a good faith.

In the recent past Honourable Supreme Court of India gave a ruling that, no doctor must be booked directly under *Sec. 304-A* of I.P.C. for Medical Negligence charges with out taking Medical Opinion from a Medical Board and legal opinion from the Bar [7,12].

In spite of making such provisions, Medical Practitioners are unable to enjoy them, because the Investigating Officer is booking the deaths occurring in the treatment procedures under *Sec.304 of I.P.C.* as the Medical Practitioner has the knowledge about such death as a consequence to his treatment, instead of *Sec. of 304-A,* which is for rash and negligent act. Comparison of two sections of I.P.C. the basic difference is that in Sec. 304 there is intentional act of negligence while in 304-A the act is never done with the intention to cause death [7].

Sec. 304 – A of I.P.C.	Sec. 304 of I.P.C.
Cognisable	Cognisable
Bail able	Non-bail able
Compoundable	Non-compoundable
Tried in Magistrate Court	Tried in Sessions Court
2 years imprisonment	>7 years imprisonment

Conclusion

The principal that doctors, and indeed all professionals, should be accountable for their failures is entirely acceptable. It does not; however mean that criminal prosecutions should be the instrument chosen to perform that task. This paradigm shift in the perceptions of society in controlling the professional activities of Doctors has brought in defensive medicine, which in turn escalates the cost of health care. In fact making doctors criminally liable for the death of a patient means a step backwards towards the ancient feudal system.

There is a need to increase awareness on the role of Medical Practioner with respect to their ethical responsibilities as providers and also a strong need to formulate standard operating procedure (SOP) in the context of Medical Practioner, nurses and police and their respective Medico legal roles.

There is a need to emphasize the importance of proper communication skill and vigilantly dealing of the medico legal cases.. "Ideal" medical records should be kept in every case. Doctor should use the reasonable degree of skill, care, knowledge prudence in treatment of his patient. Lastly one should never forget; *"Not knowing the law is no defense and every person of a sound mind and age of discretion is bound to know the law present at that time".*

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Conflict of Interest

This study is an insight and eye opener of scenario in India and there is no conflict of interest involved so ever.

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Ethical Clearance

The articles do not violate any ethical, moral or legal guidelines pertaining to original scientific work.

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Stab Injury to Chest

Prateek Rastogi

Abstract

Fatal stab wounds to chest are common in homicides as well as suicide. The presentation and circumstantial evidence goes a long way in differentiating the manner of death. Herein, a case is presented where a young male was found dead on railway station in suspicious circumstances.

Keywords: Stab Wound; Chest Injury; Homicide.

Introduction

Stab wounds to chest are a common finding in homicides, suicides as well as accidental death. The chest is commonly chosen as a site for assault as well as suicides knowing well that heart and lungs are located here and a blow may be fatal. Commonly sharp weapons are employed and stab is preferred injury with an intention to reach the heart, uncommonly, the site may be involved in accidents during a fall on a sharp pointed object. Although, there is an element of doubt involved but a careful autopsy, crime scene investigation and account of eye witnesses if available can help in diagnosis. Here, a case is presented where a young male was found dead seeming an air of suspicion.

Case Report

As per the information furnished by police a young male aged about 27 yrs was found dead at the platform of railway station in early hours of morning. Portion of shirt on front of chest was blood stained. A small wound measuring 2.5x1 cm was seen on front of chest. There was a doubt regarding its nature being homicidal or occurring due to fall on a pointed surface in intoxicated state. Body was subjected to post mortem examination on the same day in afternoon with a request to preserve viscera.

On external examination body measured 170cms in length and weighed 54kgs. Body was cold to touch and rigor mortis was present all over the body. Post mortem lividity was present at back and fixed. A stab wound measuring 2.5x1cm was seen in right 5th inter-coastal space in midclavicular line on front of chest. The wound was directed from lateral to medial and from below upwards. IT perforated the 5th inter coastal muscle, pleurae, anterio-medial border of right lung and pericardium before penetrating the medial border of heart (right ventricle). Pericardium contained 30 ml of blood, Stomach contained whitish fluid without any abnormal odor, and right lung was pale on cut section. No other external injuries are present on the body. All other body orifices are intact. Cause of death was opined as penetrating sharp force trauma to the heart.

Discussion

Injuries to the chest can be fatal in majority of situations. Cause of death may vary from trauma to heart, lungs, ribs, major blood vessels or even diaphragm resulting in hemorrhage, air embolism, tamponade, respiratory failure [1-3]. The injuries may range from blunt force impact as in road traffic accidents; stampede etc., to sharp force trauma as in stab wounds [4-5]. In present case, the deceased was found dead on a railway platform in early hours of morning raising suspicion. A single wound was seen

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on front of chest and there were no eye witnesses to the event. Post mortem examination showed the single stab wound which penetrated the heart after perforating the intervening structures in a straight line. Intoxication was ruled out by viscera examination. The cause of death was clear and further investigations were done to conclude the manner of death. Presence of body on platform with no sharp structures nearby ruled out accident. Absence of any knife or other sharp object, absence of motive ruled out suicide and pointed towards a possible homicide.

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Unplanned Complex Suicide

Manohar Shelake*, Nitin Ninal, Rajesh Bardale***, Yogita Kurhe******

Abstract

Suicide is an act of self-inflicted, self-intentioned taking of one's life. The term "complex suicide" refers to suicides in which more than one method is employed to commit suicide. A dead body of a 34 year old female was brought to mortuary of Government Medical College Hospital Miraj for postmortem examination. She was married since 10 yrs. Ligature mark was present around neck with knot impression at left sub-mandibular area. Presence of multiple injuries raises suspicion of foul play. Therefore, differentiation has to be made whether the given case is suicide or homicide. Careful postmortem examination and thorough investigation of scene of crime is necessary to arrive at a proper conclusion.

Keywords: Death; Suicide; Self-harm; Forensic; Ligature.

Introduction

Suicide is an act of self-inflicted, self-intentioned taking of one's life [1]. The term "complex suicide" refers to suicides in which more than one method is employed to commit suicide [2]. A distinction can be made between planned and unplanned complex suicides i.e., primary and/or secondary combinations. In planned complex suicides one or more methods are applied simultaneously in order to make sure that death will occur even if other method fails. In unplanned complex suicides, the mode of performance is changed after the first chosen method fails or working too slow or appears to be too painful [3]. As per National Crime Record Bureau the reported rate of suicides is consistently higher among men as compared to women irrespective of age group [4]. Hanging is a common mode of suicide [5]. However, precise rate of complex suicide is not available but are rare in occurrence. Herewith we are reporting one of such unplanned complex suicidal death.

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Case Report

A dead body of a 34 year old female was brought to mortuary of Government Medical College Hospital Miraj for postmortem examination. She was married since 10 yrs. History and police inquest revealed hanging in the kitchen which was locked from inside. The suspension point was ceiling fan. Parent alleged foul play and complaint was lodged at local police station. History of marital disharmony with frequent quarrels was present. There was previous suicidal attempt six months back and she was admitted in same hospital and treated for poisoning. No documentation is available whether psychiatric counseling was done or not. Postmortem examination was done on the same day. Police brought the odhni by which body was found suspended separately after removing from neck. One intact glass and one broken glass pieces were also brought by police along with dead body. At autopsy she was averagely built, Ligature mark was present around neck with knot impression at left submandibular area (Fig.1). Ligature mark was broad, prominent over anterior and right lateral part of neck. It was directed upwards on right lateral side and downwards on left lateral side. It was faint on posterior aspect merging in hairs. Color

of ligature mark was reddish brown with parchmentized skin. Ligature mark was compatible with soft, broad material like odhni (Fig. 2). On both forearms and wrists, multiple parallel incised wounds were present. On right side, parallel superficial injuries were present over distal third of forearm and wrist on flexor aspect (Fig 3). On left side, multiple parallel superficial incised wounds were found distal half of forearm and wrist on flexor aspect. The injuries were fresh and possible with the broken glass pieces. Sharp edges of glass pieces showed dried blood stains (Fig 2). Injuries over left side were more in number than right side injuries. The directions of injuries over left side were lateral to medial and obliquely going proximally on medial side. On right side injuries were more transverse than oblique. This indicates right handedness of deceased with self inflicted injuries.

Fig .1: Ligature mark over neck

Fig. 2: Ligature material odhani and broken piece of glass

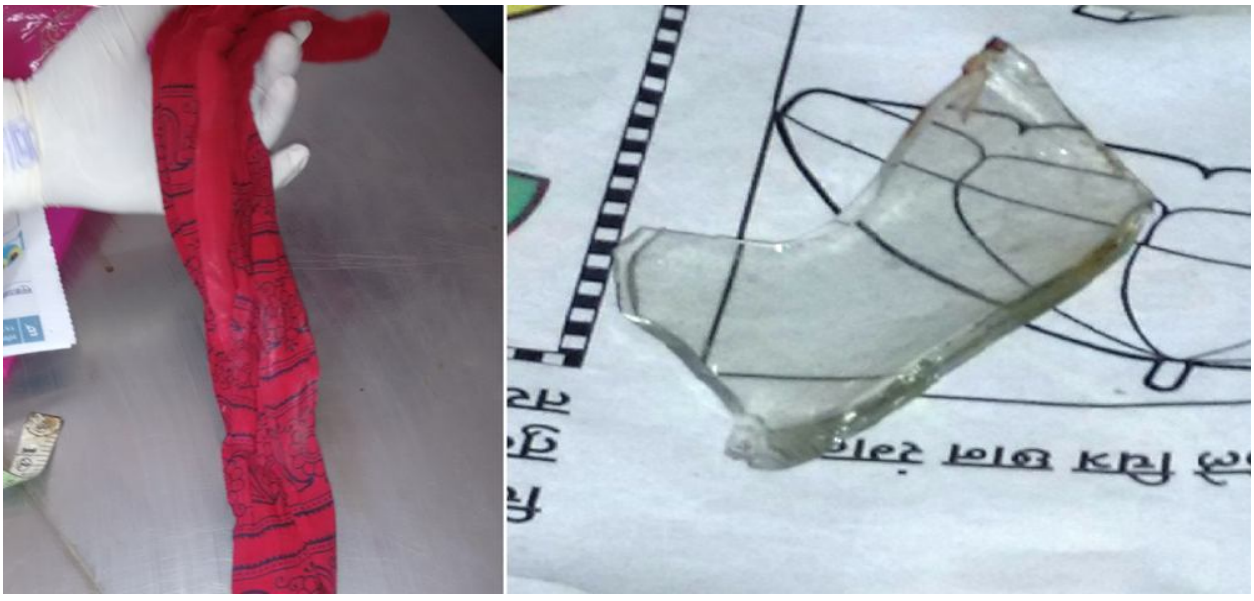
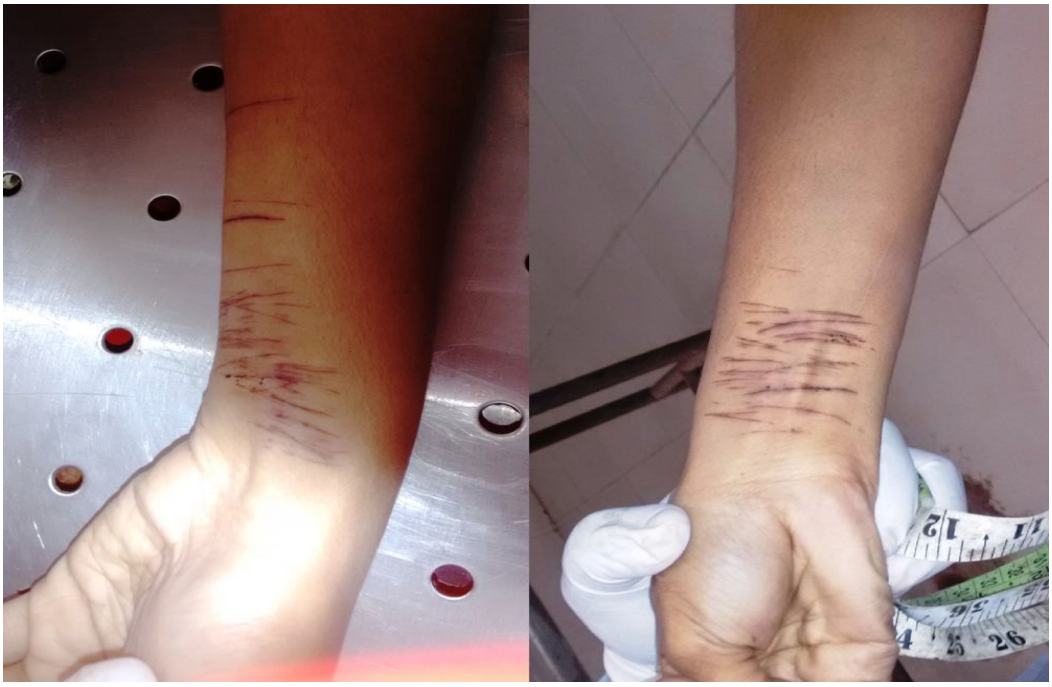


Fig. 3: Injuries over forearms and wrists



Discussion

Suicide is preventable form of death. The causes of suicide are multi-factorial including social, economic, psychological, work pressure etc [6]. Suicide in married females is sensitive issue and many times husband and in-laws faces wrath from relatives and society. Many times such deaths are labeled as dowry deaths. Analysis of cause or provocative reason is seldom done. When marriage is solemnized it is expected that the couple should live life happily. After marriage when the female enters her new house, she has to make considerable adjustments. She has to adjust with husband, in-laws and other family members. The adjustments include physical, emotional, mental, and psychological. The problem gets complicated if there is marital discord or poor relationship. In the present case there was marital disharmony and because of this a six months before she had attempted suicide by consuming the poison.

In current case the postmortem findings and ligature material along with broken glass pieces correlate with pattern of injuries found over body. While cut marks over forearms and wrists were superficial and nonlethal; the cause of death is given as asphyxia due to hanging. Previous suicide attempt and marital disharmony are important factors behind current attempt. The present case emphasizes the need of psychiatric counseling in a patient with suicide attempt and taking extra care of such individuals.

Presence of multiple injuries raises suspicion of foul play. Therefore, differentiation has to be made whether the given case is suicide or homicide. Careful postmortem examination and thorough investigation of scene of crime is necessary to arrive at a proper conclusion.

In planned complex suicides the obvious reasons to use more than one method simultaneously is to ensure death, accelerate the process or cause less pain to the individual by a planned combination of methods [2]. In unplanned complex suicides individual do not use combined method or planned combination of more than one method. Here the victim switch to another suicide method after the first method chosen failed [7]. In unplanned complex suicides, as in present case, self-inflicted injuries by sharp force, especially cuts on the forearm and wrists, are often found as the primary act of suicide [5]. In the present case hanging was used as terminal method after the first phase of self-inflicted injuries was over. In the literature the use of up to 5 suicidal methods applied one after the other have been described [3].

In conclusion complex suicides represent a situation where the wish to die is so irresistible that for ensuring death the victim employs more than one method. Careful autopsy and investigation at the scene of crime is essential to allow a precise reconstruction of events that occurred prior to death.

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1) Type of manuscript (e.g. Original article, Review article, Case Report)
2) The title of the article, which should be concise, but informative;
3) Running title or short title not more than 50 characters;
4) The name by which each contributor is known (Last name, First name and initials of middle name), with his or her highest academic degree(s) and institutional affiliation;
5) The name of the department(s) and institution(s) to which the work should be attributed;
6) The name, address, phone numbers, facsimile numbers and e-mail address of the contributor responsible for correspondence about the manuscript;
7) The total number of pages, total number of photographs and word counts separately for abstract and for the text (excluding the references and abstract);
8) Source(s) of support in the form of grants, equipment, drugs, or all of these;
9) Acknowledgement, if any; and
I0) If the manuscript was presented as part at a meeting, the organization, place, and exact date on which it was read.

Abstract Page

The second page should carry the full title of the manuscript and an abstract (of no more than 150 words for case reports, brief reports and 250 words for original articles). The abstract should be structured and state the Context (Background), Aims, Settings and Design, Methods and Material, Statistical analysis used, Results and Conclusions. Below the abstract should provide 3 to 10 keywords.

Introduction

State the background of the study and purpose of the study and summarize the rationale for the study or observation.

Methods

The methods section should include only information that was available at the time the plan or protocol for the study was written such as study approach, design, type of sample, sample size, sampling technique, setting of the study, description of data collection tools and methods; all information obtained during the conduct of the study belongs in the Results section.

Reports of randomized clinical trials should be based on the CONSORT Statement (http://www.consort-statement.org). When reporting experiments on human subjects, indicate whether the procedures followed were in accordance with the ethical standards of the responsible committee on human experimentation (institutional or regional) and with the Helsinki Declaration of 1975, as revised in 2000 (available at http://www.wma.net/e/policy/l7-c_e.html).

Results

Present your results in logical sequence in the text, tables, and illustrations, giving the main or most important findings first. Do not repeat in the text all the data in the tables or illustrations; emphasize or summarize only important observations. Extra or supplementary materials and technical details can be placed in an appendix where it will be accessible but will not interrupt the flow of the text; alternatively, it can be published only in the electronic version of the journal.

Discussion

Include summary of key findings (primary outcome measures, secondary outcome measures, results as they relate to a prior hypothesis); Strengths and limitations of the study (study question, study design, data collection, analysis and interpretation); Interpretation and implications in the context of the totality of evidence (is there a systematic review to refer to, if not, could one be reasonably done here and now?, What this study adds to the available evidence, effects on patient care and health policy, possible mechanisms)? Controversies raised by this study; and Future research directions (for this particular research collaboration, underlying mechanisms, clinical research). Do not repeat in detail data or other material given in the Introduction or the Results section.

References

List references in alphabetical order. Each listed reference should be cited in text (not in alphabetic order), and each text citation should be listed in the References section. Identify references in text, tables, and legends by Arabic numerals in square bracket (e.g. [10]). Please refer to ICMJE Guidelines (http://www.nlm.nih.gov/bsd/uniform_requirements.html) for more examples.

Standard journal article

[1] Flink H, Tegelberg Å, Thörn M, Lagerlöf F. Effect of oral iron supplementation on unstimulated salivary flow rate: A randomized, double-blind, placebo-controlled trial. J Oral Pathol Med 2006;35:540-7.

[2] Twetman S, Axelsson S, Dahlgren H, Holm AK, Källeståll C, Lagerlöf F, et al. Caries-preventive effect of fluoride toothpaste: A systematic review. Acta Odontol Scand 2003;61:347-55.

Article in supplement or special issue

[3] Fleischer W, Reimer K. Povidone iodine antisepsis. State of the art. Dermatology 1997;195 Suppl 2:3-9.

Corporate (collective) author

[4] American Academy of Periodontology. Sonic and ultrasonic scalers in periodontics. J Periodontol 2000;71:1792-801.

Unpublished article

[5] Garoushi S, Lassila LV, Tezvergil A, Vallittu PK. Static and fatigue compression test for particulate filler composite resin with fiber-reinforced composite substructure. Dent Mater 2006.

Personal author(s)

[6] Hosmer D, Lemeshow S. Applied logistic regression, 2nd edn. New York: Wiley-Interscience; 2000.

Chapter in book

[7] Nauntofte B, Tenovuo J, Lagerlöf F. Secretion and composition of saliva. In: Fejerskov O, Kidd EAM,

editors. Dental caries: The disease and its clinical management. Oxford: Blackwell Munksgaard; 2003. p. 7-27.

No author given

[8] World Health Organization. Oral health surveys - basic methods, 4th edn. Geneva: World Health Organization; 1997.

Reference from electronic media

[9] National Statistics Online—Trends in suicide by method in England and Wales, 1979-2001. www.statistics.gov.uk/downloads/theme_health/HSQ 20.pdf (accessed Jan 24, 2005): 7-18. Only verified references against the original documents should be cited. Authors are responsible for the accuracy and completeness of their references and for correct text citation. The number of reference should be kept limited to 20 in case of major communications and 10 for short communications.

More information about other reference types is available at www.nlm.nih.gov/bsd/uniform_requirements.html, but observes some minor deviations (no full stop after journal title, no issue or date after volume, etc).

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Number tables, in Arabic numerals, consecutively in the order of their first citation in the text and supply a brief title for each.

Explain in footnotes all non-standard abbreviations that are used in each table.

For footnotes use the following symbols, in this sequence: *, ¶, †, ‡‡,

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Type or print out legends (maximum 40 words, excluding the credit line) for illustrations using double spacing, with Arabic numerals corresponding to the illustrations.

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