FOR EVERY DOCTOR IN THE EMERGENCY DEPARTMENT

A E T C M

Emergency Doctor's Medicolegal Manual

100 essential medico-legal topics — consent, documentation, MLCs, negligence, courts and more — explained for Indian emergency practice

Updated for BNS, BNSS & BSA 2023

AETCM
Academy for Emergency, Trauma & Critical care Medicine

By

Dr. Gireesh Kumar K.P.

With section numbers of the Bharatiya Nyaya Sanhita, Bharatiya Nagarik Suraksha Sanhita and Bharatiya Sakshya Adhiniyam

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Emergency Doctor’s Medicolegal Manual

100 essential medico-legal topics for the emergency department

With section numbers of the Bharatiya Nyaya Sanhita 2023 (BNS), the Bharatiya Nagarik Suraksha Sanhita 2023 (BNSS) and the Bharatiya Sakshya Adhiniyam 2023 (BSA), and other laws relevant to emergency practice

Dr. Gireesh Kumar K.P.

AETCM · Academy for Emergency, Trauma & Critical care Medicine

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Important. This manual is an educational guide for doctors. It is not legal advice and does not replace the bare Acts, court judgments, State rules or your institution's policies. Laws, rules and judgments change; section numbers and provisions are stated as understood in October 2026 and should be verified from official sources (India Code, Gazette of India, NMC, State notifications) before being relied on in a particular case.

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Foreword

Some books are written because a subject demands them. Others are written because a teacher cannot bear to see his students struggle. This book belongs to both.

I have known Dr. Gireesh Kumar K.P., the author of this book, for over twenty years. He was my teacher in MBBS, and he has remained a colleague and a friend ever since. Few people combine his depth of knowledge with such warmth and approachability. As Principal of Amrita School of Medicine, a General Medicine physician, and one of those instrumental in establishing among the first Emergency Medicine units in Kerala, he has seen the needs of the emergency department up close. He has also seen how little help is available to the doctors who work there.

Emergency physicians make decisions in minutes, with incomplete information, often in front of anxious families. The same decision that saves a life can, if poorly documented or improperly consented, become the subject of a complaint or a legal proceeding. Yet medicolegal training is rarely given the attention it deserves. Most of us learn it the hard way, through a difficult case or a notice we never expected. Existing texts are often written for lawyers or for academic study, and are seldom of use when a doctor is standing at the bedside at 3 a.m., wondering what to do next.

Emergency Doctor's Medicolegal Manual, with its 100 essential medicolegal topics, fills this gap. It is built around everyday scenarios that emergency physicians actually face, presented in a concise and easy-to-follow format that lets the reader find what they need quickly and act with confidence. Books in this format are very rare, and this unique approach is what makes the work so valuable. It speaks to the working clinician in plain language, without assuming any legal background.

This is not Dr. Gireesh's first book. He is a prolific writer, and this manual is yet another feather in his cap. What drives him is a simple belief, one he has often shared: "No student should suffer understanding the subject like some of us did." That conviction runs through every page. He continues to give generously of his knowledge, to students and to practising doctors alike.

I am confident that this book will be a trusted companion to residents, emergency physicians, and all who work in acute care. By helping doctors document better, communicate better, and decide with greater assurance, it will protect both the physician and the patient.

I have been extremely fortunate to have a teacher, colleague, and friend like him. I wish Dr. Gireesh every success that he so richly deserves, and I look forward to his future endeavours.



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Preface

Dear colleagues,

Every doctor who works in an emergency department lives in two worlds at once. In one, a patient is bleeding, seizing or not breathing, and every minute counts. In the other, the same patient is a road traffic accident, an assault, a poisoning or a burn — a medico-legal case that will be read by the police, argued over by lawyers, and examined in court long after the patient has left our care.

Most of us were taught a great deal about the first world and very little about the second. We learn the law on the job, often after something has gone wrong: a summons we do not understand, a complaint about consent, a dying declaration that we were not sure how to record. On 1 July 2024 the Indian Penal Code, the Code of Criminal Procedure and the Indian Evidence Act were replaced by the Bharatiya Nyaya Sanhita, the Bharatiya Nagarik Suraksha Sanhita and the Bharatiya Sakshya Adhiniyam — and even experienced doctors now need to relearn the section numbers they quote every day.

This manual is written for the doctor on duty in casualty, with little formal training in law. It takes one hundred real situations — consent and refusal, documentation, MLCs and police intimation, sexual assault, dying declarations, negligence, courts and councils, end-of-life care, and the new frontiers of telemedicine, AI and cyber-security — and puts each on a single page: what the law says (with section numbers), what to do in the department, what to document, the traps to avoid, the key judgment, and one pearl to remember.

The guiding principle throughout is simple: **treat first, then document honestly and inform the right authority.** The law in India protects the doctor who acts in good faith, with reasonable care, and keeps a truthful record. It rarely forgives the doctor who delays emergency care for paperwork, alters notes, or hides what happened.

This book is not a substitute for the bare Acts, your State's rules or your hospital's medico-legal cell — but I hope it will be the first page you turn to when the next difficult case walks through the door.

With best wishes,



Dr. Gireesh Kumar K.P.
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October 2026

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How to use this manual

Each of the 100 topics occupies one page and follows the same order, so you always know where to look.

Box	What it gives you
Topic bar and title	Topic number, part of the book, the situation, and a one-line summary.
The law	The provisions that apply, with section numbers — BNS, BNSS, BSA, other Acts, regulations and Supreme Court rulings.
In the ED — what to do	Practical steps in the order you would take them.
Document this	What your notes must contain to protect the patient and you.
Legal traps	The mistakes that most often lead to complaints, prosecution or compensation.
Case law	A key judgment or legal principle.
Pearl	One line to remember on a busy night.

Abbreviations

Abbreviation	Meaning
BNS	Bharatiya Nyaya Sanhita 2023 (replaced the Indian Penal Code, IPC)
BNSS	Bharatiya Nagarik Suraksha Sanhita 2023 (replaced the Code of Criminal Procedure, CrPC)
BSA	Bharatiya Sakshya Adhiniyam 2023 (replaced the Indian Evidence Act, IEA)
CEA	Clinical Establishments (Registration and Regulation) Act 2010
CPA	Consumer Protection Act 2019
MHCA	Mental Healthcare Act 2017
MV Act	Motor Vehicles Act 1988
POCSO	Protection of Children from Sexual Offences Act 2012
THOTA	Transplantation of Human Organs and Tissues Act 1994
IMC Regulations	Indian Medical Council (Professional Conduct, Etiquette and Ethics) Regulations 2002
RMP / MLC / LAMA	Registered medical practitioner / medico-legal case / leaving against medical advice

> Section numbers are given in the form "BNS 30" or "BNSS 194(3)". Where an old IPC/CrPC/IEA number is widely known, the appendices give the new–old correspondence.

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India's new criminal laws — what changed for doctors

From **1 July 2024**, three new laws replaced the colonial-era codes: the **Bharatiya Nyaya Sanhita (BNS)** replaced the IPC, the **Bharatiya Nagarik Suraksha Sanhita (BNSS)** replaced the CrPC, and the **Bharatiya Sakshya Adhiniyam (BSA)** replaced the Indian Evidence Act. Offences committed before that date continue under the old laws.

Changes every emergency doctor should know

• **Medical negligence (BNS 106(1))** — a registered medical practitioner causing death by negligence during a medical procedure faces up to **2 years** and fine, lower than the general 5 years.
• **Grievous hurt (BNS 116)** — the duration criterion is now **15 days** (earlier 20).
• **Attempted suicide** — the old IPC 309 has not been retained; BNS 226 punishes only attempts made to compel or restrain a public servant. MHCA s.115 presumes severe stress and mandates care.
• **Zero FIR and e-FIR (BNSS 173)**, **forensic visits for serious offences (BNSS 176(3))**, and **audio-video recording** of search and seizure (BNSS 105) and of evidence (BNSS 254, 265, 308, 530).
• **Survivor examination (BNSS 184)** — within 24 hours, report to the investigating officer within 7 days, exact start/end time recorded.
• **Free treatment (BNSS 397)** — all hospitals must treat rape, acid-attack and POCSO victims free and inform police; failure is punishable under **BNS 200**.
• **Electronic records** are "documents" (BSA 2(1)(d)), admissible (BSA 61) with the BSA 63 certificate.

Quick conversion — the sections you will use most

Subject	Old	New
Causing death by negligence	IPC 304A	**BNS 106(1)**
Grievous hurt	IPC 320	**BNS 116**
Good-faith act without consent	IPC 92	**BNS 30**
Consent in good faith for benefit	IPC 88	**BNS 26**
Rape	IPC 375/376	**BNS 63/64**
Acid attack	IPC 326A/B	**BNS 124**
Dowry death	IPC 304B	**BNS 80**
Non-treatment of victim	IPC 166B	**BNS 200**
False certificate	IPC 197	**BNS 234**
Disappearance of evidence	IPC 201	**BNS 238**
FIR	CrPC 154	**BNSS 173**
Examination of rape survivor	CrPC 164A	**BNSS 184**
Treatment of victims	CrPC 357C	**BNSS 397**
Police inquest	CrPC 174	**BNSS 194**
Exam of accused at police request	CrPC 53	**BNSS 51**
Exam of arrested person	CrPC 54	**BNSS 53**
Dying declaration	IEA 32(1)	**BSA 26(a)**
Expert opinion	IEA 45	**BSA 39**
Electronic record certificate	IEA 65B	**BSA 63**
Refreshing memory	IEA 159	**BSA 162**

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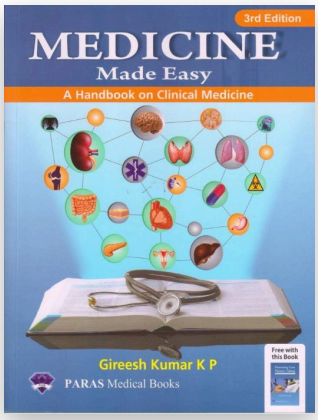
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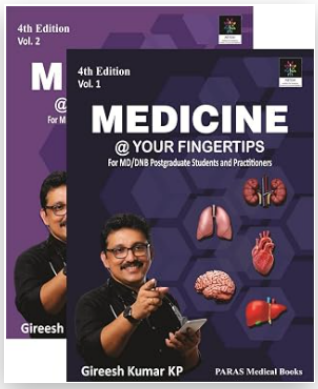
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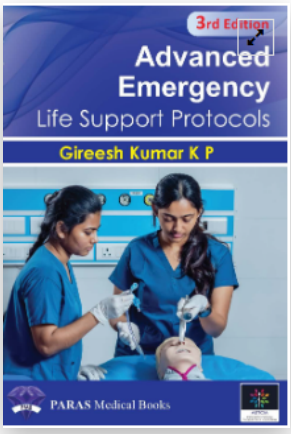
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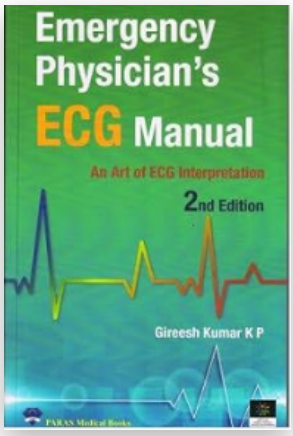
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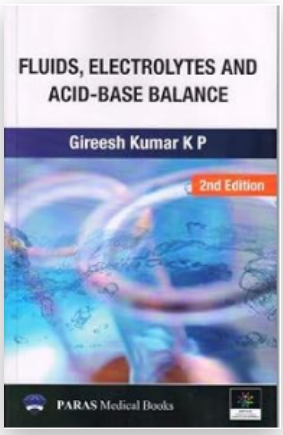
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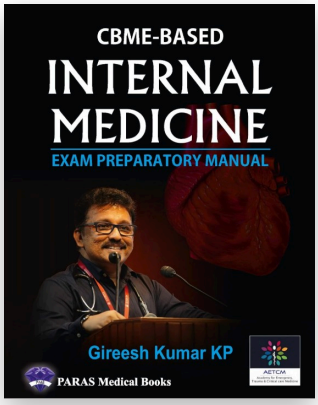
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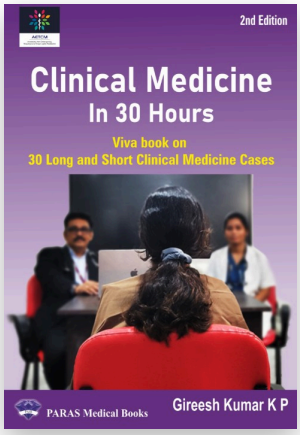
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PART 1

Consent and Autonomy

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TOPIC 1 OF 100 | CONSENT AND AUTONOMY

Implied consent in life-threatening emergencies

When the patient cannot consent and delay will cost life or limb, treat first — the law protects good-faith emergency care.

⚖ THE LAW

Constitution Art. 21 Right to life includes the right to emergency medical care; every doctor, government or private, must give immediate aid to preserve life (Parmanand Katara, 1989).

BNS 30 An act done in good faith for a person's benefit without consent is not an offence when consent cannot be obtained in time and there is no guardian available.

BNS 26 Harm caused in good faith, with consent, to benefit a person is protected — the basis of all consented emergency procedures.

CEA 2010 s.12(2) Every clinical establishment must provide examination and treatment needed to stabilise an emergency medical condition, within its staff and facilities.

BNS 2(11) "Good faith" = done with due care and attention — careless haste is not good faith.

IN THE ED — WHAT TO DO

1. Decide quickly: is there an immediate threat to life, limb or organ, and is the patient unable to consent (unconscious, shocked, hypoxic, confused)?
2. Look for a relative or legal guardian; if available within the time the emergency allows, inform and take their consent.
3. If no one is available, proceed with only the treatment needed to save life or prevent serious harm — airway, breathing, haemorrhage control, resuscitation.
4. Do not wait for police, MLC formalities, payment or identity proof before life-saving care.
5. Once the patient regains capacity, explain what was done and take consent for further treatment.

DOCUMENT THIS

☐ Clinical state showing incapacity (GCS, SpO2, BP, mental status) with time.

☐ "Emergency — consent could not be obtained because ..." and the efforts made to contact relatives (names, phone, time).

☐ Exact interventions done under implied consent and why each was immediately necessary.

☐ Names of the second doctor or nurse who witnessed the decision.

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LEGAL TRAPS

✖ Implied consent covers only what is urgently necessary — not elective extras done "while the patient is under".

✖ A clear, valid refusal given earlier by a competent patient overrides implied consent.

✖ Delaying treatment to collect advance payment or "police permission" invites liability under Art. 21 and the CEA.

CASE LAW / KEY PRINCIPLE

Pt. Parmanand Katara v. Union of India (1989) 4 SCC 286 — Preservation of life is paramount; legal formalities cannot delay emergency treatment.

Paschim Banga Khet Mazdoor Samity v. State of W.B. (1996) 4 SCC 37 — Failure to provide timely emergency care violates Art. 21.

PEARL **Write one line before you start: "Life-threatening emergency, patient incapable of consent, no relative available — treated under implied consent (BNS 30)."**

TOPIC 2 OF 100 | CONSENT AND AUTONOMY

Informed consent — the basics

Consent is valid only if it is voluntary, informed, specific and given by a competent person who understands it.

⚖ THE LAW

BNS 26	Protection for harm caused in good faith with the person's consent, for his benefit.
BNS 25	A person above 18 may consent to harm not intended or known to be likely to cause death or grievous hurt.
BNS 28	Consent is not valid if given under fear of injury or misconception of fact, or by a person who is of unsound mind, intoxicated, or a child below 12.
IMC Regulations 2002, 7.16	Before any operation, written consent of the patient (or guardian for a minor) must be obtained.

IN THE ED — WHAT TO DO

1. Explain in a language the patient understands: diagnosis, proposed procedure, material risks, benefits, alternatives (including no treatment), and likely outcome of refusal.
2. Give time for questions; check understanding by asking the patient to explain back.
3. Take written, procedure-specific consent for invasive procedures, sedation, blood transfusion, and HIV testing.
4. The doctor doing the procedure (or a competent member of the team) must take the consent — not the clerk or security.
5. Consent for one procedure does not extend to another, unless an unforeseen life-threatening condition arises during it.

DOCUMENT THIS

☐ Name of procedure, risks explained (list the major ones), alternatives discussed.

☐ Language used and interpreter's name if any.

☐ Signature of patient, doctor and an independent witness, with date and time.

☐ For a patient who cannot sign: thumb impression, witness, and reason.

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LEGAL TRAPS

✖ Blanket "consent for any procedure" forms are legally weak.

✖ A signature without explanation is not informed consent.

✖ Consent taken after sedation or opioids may be challenged.

CASE LAW / KEY PRINCIPLE

Samira Kohli v. Dr. Prabha Manchanda (2008) 2 SCC 1 — Consent for diagnostic laparoscopy did not cover hysterectomy; adequate information must be disclosed for real consent.

PEARL Informed consent is a conversation recorded on paper — the paper alone is not consent.

TOPIC 3 OF 100 | CONSENT AND AUTONOMY

Refusal of treatment and leaving against medical advice (LAMA/DAMA)

A competent adult may refuse any treatment — your job is to make the refusal informed and well documented.

⚖ THE LAW

Constitution Art. 21 Bodily autonomy and the right to refuse treatment are part of the right to life and privacy (Common Cause, 2018; Puttaswamy, 2017).

BNS 30 Lets you act without consent only when consent cannot be obtained — not when it is refused.

BNS 126 / 127 Physically stopping a competent adult from leaving can be wrongful restraint or wrongful confinement.

MHCA 2017 s.4 Capacity is decision-specific; a person is presumed to have capacity unless shown otherwise.

IN THE ED — WHAT TO DO

1. Assess capacity first (see Topic 4); refusal by an incapable patient is handled differently.
2. Explain diagnosis, the treatment advised, and the specific risks of leaving — including death or permanent disability — in plain words.
3. Explore the reason (cost, family, fear, belief) and offer alternatives: partial treatment, referral, review later.
4. Offer what the patient will accept: medicines, dressing, first dose of antibiotic, referral letter.
5. In an MLC, still inform the police that the patient left against advice.
6. Make clear the patient may come back at any time.

DOCUMENT THIS

☐ Use the LAMA/DAMA form: diagnosis, risks explained, patient's own words of refusal, capacity assessment.

☐ Signatures of patient (and relative), doctor and witness, with time; if the patient refuses to sign, record "refused to sign" with witness.

☐ Treatment and advice given at discharge, and return precautions.

LEGAL TRAPS

✖ A pre-printed LAMA form with no specific risks written is weak evidence.

✖ Do not threaten or detain the patient; call security only for violence.

✖ Do not refuse future care because the patient left earlier.

CASE LAW / KEY PRINCIPLE

Common Cause v. Union of India (2018) 5 SCC 1 — Right to refuse medical treatment is part of the right to live with dignity.

PEARL **Quote the patient: "I understand I may die if I leave, but I still want to go home."**

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TOPIC 4 OF 100 | CONSENT AND AUTONOMY

Capacity versus competence

Capacity is a clinical, decision-specific judgement you make at the bedside; competence is a legal status decided by a court.

⚖ THE LAW

MHCA 2017 s.4 A person has capacity if he can understand relevant information, appreciate foreseeable consequences, and communicate the decision.

BNS 22 Nothing is an offence if done by a person who, due to unsoundness of mind, cannot know the nature of the act.

BNS 28 Consent of a person of unsound mind or under intoxication who cannot understand its nature is not valid consent.

Indian Majority Act 1875 A person attains majority at 18 years.

IN THE ED — WHAT TO DO

1. Test four abilities for this decision: understand, retain, weigh (appreciate) and communicate.
2. Look for reversible causes of incapacity: hypoxia, hypoglycaemia, shock, head injury, sepsis, drugs, alcohol, pain.
3. Re-assess after correcting them; capacity can fluctuate.
4. Mental illness or intoxication does not automatically mean incapacity.
5. The bigger the risk of the decision, the more careful the assessment should be.

DOCUMENT THIS

☐ The decision being assessed and the information given.

☐ Findings on each of the four abilities, with the patient's own answers.

☐ GCS, orientation, glucose, SpO2, intoxication signs at the time.

☐ Your conclusion: "has / lacks capacity for this decision", with time and witness.

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LEGAL TRAPS

✖ Labelling an inconvenient refusal as "lack of capacity" is unethical and indefensible.

✖ Do not equate disagreement with incapacity.

✖ Capacity found at 2 am may be different at 6 am — document re-assessment.

CASE LAW / KEY PRINCIPLE

Common Cause v. Union of India (2018) — A person with decision-making capacity may refuse treatment, including life support.

PEARL **Ask: "What do you understand is wrong with you, and what could happen if you go home?"**

TOPIC 5 OF 100 | CONSENT AND AUTONOMY

Surrogate decision-making and next of kin

When the patient lacks capacity, decide with the person best placed to represent the patient's interests and values.

⚖ THE LAW

MHCA 2017 s.14 A person may appoint a nominated representative for mental-health decisions; the Act sets an order of others who may act if none is appointed.

BNS 27 Acts in good faith for the benefit of a child under 12 or a person of unsound mind, with the consent of the guardian or lawful carer, are protected.

Common Cause (2018, modified 2023) For incapacitated patients without an advance directive, decisions on life support involve the family/next friend and medical boards.

General practice in India No single statute fixes a hierarchy for general medical decisions; customarily spouse, adult children, parents, adult siblings, then other relatives or lawful guardian.

IN THE ED — WHAT TO DO

1. Find out if the patient has an advance directive or nominated representative.
2. Identify the closest available family member and record the relationship.
3. Ask them what the patient would have wanted, not just what they want.
4. When relatives disagree, involve a senior, the treating team, and the hospital ethics or medical board.
5. In emergencies, do not delay life-saving treatment while relatives are traced (BNS 30).

DOCUMENT THIS

☐ Name, relationship and contact of the surrogate; proof of relationship if available.

☐ Information given, questions asked, and decision taken, with time.

☐ Disagreements among relatives and how they were addressed.

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LEGAL TRAPS

✖ Friends, police or employers are not legal surrogates for treatment decisions.

✖ A relative cannot consent to a treatment the patient clearly refused while competent.

CASE LAW / KEY PRINCIPLE

Aruna Ramchandra Shanbaug v. Union of India (2011) 4 SCC 454 — Recognised the role of a "next friend" in decisions for an incapable patient.

PEARL Write who decided, why they are the right person, and what they said the patient would want.

TOPIC 6 OF 100 | CONSENT AND AUTONOMY

Advance directives, living wills and DNR orders

A valid living will must be respected; withholding or withdrawing life support follows the Supreme Court's procedure.

⚖ THE LAW

Common Cause v. UOI (2018) 5 SCC 1	Passive euthanasia and advance medical directives (living wills) are legally recognised under Art. 21.
Common Cause — 2023 modification	Living will signed before two witnesses and attested by a notary or gazetted officer; primary and secondary medical boards to decide within 48 hours each; Magistrate's prior approval no longer needed.
MHCA 2017 s.5	A person may make an advance directive about mental-health treatment.
Harish Rana v. UOI (2026)	Supreme Court allowed withdrawal of life-sustaining treatment including clinically assisted nutrition and hydration, with a palliative care plan.

IN THE ED — WHAT TO DO

1. Ask family and records whether a living will exists; check the hospital or digital record copy.
2. In a sudden cardiac arrest with no verified directive, resuscitate.
3. A verified directive that applies to the current situation should be followed after informing the treating team and seniors.
4. DNR / "do not attempt resuscitation" decisions should be made by the senior treating consultant with the patient or family and documented in writing.
5. Continue comfort care, analgesia and dignity whatever the resuscitation decision.

DOCUMENT THIS

☐ Copy of the directive, who produced it, and how it was verified.

☐ Medical board decisions with names and times.

☐ DNR order: reason, who decided, discussion with family, review date.

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LEGAL TRAPS

✖ A verbal "don't do anything" from one relative at the door is not a DNR order.

✖ DNR does not mean "do not treat" — fluids, antibiotics and pain relief continue as planned.

✖ Never write DNR without discussion with the patient or family.

CASE LAW / KEY PRINCIPLE

Common Cause v. Union of India (2018; modified 24 Jan 2023) — Framework for living wills and withdrawal of life support.

PEARL In doubt in the ED: resuscitate first, clarify later.

TOPIC 7 OF 100 | CONSENT AND AUTONOMY

Emergency treatment of minors

A child in danger is treated first; parental consent is sought, but never allowed to delay life-saving care.

⚖ THE LAW

BNS 2(3)	"Child" means a person below 18 years.
BNS 27	Good-faith acts for the benefit of a child under 12, done with the consent of the guardian, are protected.
BNS 28	Consent given by a child under 12 is not valid consent.
BNS 30	Good-faith emergency treatment without consent is protected when no guardian is available in time.
POCSO Act 2012 s.19 & POCSO Rules 2020 r.6	Suspected sexual abuse must be reported; emergency care cannot be made conditional on police requisition.

IN THE ED — WHAT TO DO

1. For any minor, try to contact parents or legal guardian; a teacher or relative accompanying may be recorded but is not a legal guardian.
2. If life or limb is at risk, treat immediately and inform the guardian as soon as possible.
3. Respect the views of older adolescents and involve them in decisions.
4. For sexual assault in a minor, follow POCSO: examine with consent of guardian/child as appropriate, inform police, and give free treatment (BNSS 397).
5. For a lost or abandoned child, report within 24 hours to Childline / police / CWC (JJ Act s.32).

DOCUMENT THIS

- ☐ Age and how it was determined; who accompanied the child.
- ☐ Efforts to reach guardian; time of contact.
- ☐ Reason treatment could not wait.

LEGAL TRAPS

✖ An adolescent's refusal of life-saving treatment does not bind you when the guardian consents — escalate to seniors.

✖ Never examine a minor's genitals without a chaperone and explanation.

✖ Do not discharge an unaccompanied child without a responsible adult or authority.

CASE LAW / KEY PRINCIPLE

POCSO Act s.19–21 — Non-reporting of child sexual abuse is itself an offence.

PEARL **For children: treat, protect, inform — in that order.**

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TOPIC 8 OF 100 | CONSENT AND AUTONOMY

Emergency treatment of intoxicated patients

Intoxication may remove capacity, but it does not remove the duty of care — treat the medical risk, not the smell of alcohol.

⚖ THE LAW

BNS 23	No offence by a person intoxicated against his will who cannot know the nature of his act.
BNS 24	A voluntarily intoxicated person is treated as having the knowledge he would have had if sober.
BNS 28	Consent of an intoxicated person who cannot understand its nature is not valid.
BNSS 51	A registered medical practitioner may examine an arrested person at a police officer's request; reasonable force may be used.
MV Act 1988 s.185, 203, 204	Drunk driving offence (blood alcohol above 30 mg per 100 ml), breath test and laboratory test.

IN THE ED — WHAT TO DO

1. Exclude hypoglycaemia, head injury, hypoxia, sepsis, other drugs, and withdrawal before blaming alcohol.
2. Check capacity for any refusal; if the patient lacks capacity and the condition is serious, treat under BNS 30 and observe.
3. Observe until clinically sober and safe; do not discharge to the road alone.
4. Collect blood or urine for alcohol/toxicology only with consent, on police requisition, or when clinically required.
5. Inform police if it is an RTA, assault, poisoning or other MLC.

DOCUMENT THIS

☐ Objective signs of intoxication (smell, gait, speech, nystagmus, pupils) — avoid the word "drunk" without evidence.

☐ GCS and capacity at each assessment; serial observations.

☐ Samples taken: type, time, by whom, sealed and handed to whom.

LEGAL TRAPS

✖ Never certify "under the influence of alcohol" on smell alone; record "smell of alcohol present".

✖ Missed intracranial bleed in the "drunk" patient is a classic negligence claim.

✖ Do not release an intoxicated, incapable patient against advice without a responsible adult.

CASE LAW / KEY PRINCIPLE

Jacob Mathew v. State of Punjab (2005) 6 SCC 1 — Liability arises from failure to meet the standard of a reasonable practitioner — missing a treatable condition can be negligent.

PEARL **Every intoxicated patient has a head injury and hypoglycaemia until proved otherwise.**

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TOPIC 9 OF 100 | CONSENT AND AUTONOMY

Patient abandonment and unsafe transfers

Once you accept a patient, you must not withdraw care or transfer them without stabilisation and a proper handover.

⚖ THE LAW

IMC Regulations 2002, 2.4 Once a case is undertaken, the physician should not neglect the patient or withdraw without adequate notice.

IMC Regulations 2002, 2.1.1 A physician should be ever ready to respond to the calls of the sick and injured.

CEA 2010 s.12(2) Stabilise the emergency medical condition before referral.

BNS 106(1) Death caused by a rash or negligent act of a registered medical practitioner during a medical procedure: up to 2 years and fine.

IN THE ED — WHAT TO DO

1. Stabilise airway, breathing, circulation and bleeding as far as your facility allows before any referral.
2. Call the receiving hospital and speak to a doctor; confirm a bed and the speciality are available.
3. Send a written referral with findings, treatment given, investigations and reason for transfer.
4. Transfer in an appropriate ambulance with trained staff, oxygen, monitoring and drugs.
5. Inform the patient/relatives of the reason, risks and destination.

DOCUMENT THIS

☐ Clinical condition at the time of transfer (vitals, GCS).

☐ Name of receiving doctor and hospital, time of call, acceptance.

☐ Mode of transport, escort, equipment, and handover note.

LEGAL TRAPS

✖ "Referred to higher centre" with no stabilisation, call or note is a common cause of litigation.

✖ Refusing a patient because of an MLC, non-payment or "no bed" without first aid is indefensible.

✖ Do not discharge a patient merely to avoid a difficult case.

CASE LAW / KEY PRINCIPLE

Parmanand Katara (1989) — No doctor can refuse first aid on the plea that the case is medico-legal or belongs to another hospital.

PEARL **Stabilise, speak, send — and write all three.**

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TOPIC 10 OF 100 | CONSENT AND AUTONOMY

Involuntary emergency psychiatric care

Under the MHCA, you may give emergency treatment for up to 72 hours to prevent death, serious harm or serious damage.

⚖ THE LAW

MHCA 2017 s.94 Any registered medical practitioner may give emergency treatment (including transport to a mental health establishment) for up to 72 hours, or until assessment — ECT is not allowed.

MHCA 2017 s.89 / s.90 Supported admission (up to 30 days, and beyond) for persons with high support needs, through a mental health establishment.

MHCA 2017 s.97 Physical restraint only when it is the only means to prevent imminent harm; seclusion is not permitted; record and review.

MHCA 2017 s.100 Police must take a person with mental illness who is a danger, or wandering, to a public health establishment within 24 hours.

MHCA 2017 s.115 A person who attempts suicide is presumed to be under severe stress and shall not be tried and punished; government must provide care.

IN THE ED — WHAT TO DO

1. Rule out medical causes of agitation: hypoxia, hypoglycaemia, sepsis, head injury, intoxication, withdrawal.
2. Use de-escalation first; then the least restrictive measures; rapid tranquillisation per protocol.
3. Involve the nominated representative or family; inform them of the emergency treatment.
4. Refer early to psychiatry or the nearest mental health establishment.

DOCUMENT THIS

☐ The risk (to self, others or property) and why treatment was immediately necessary.

☐ Drugs given, restraint used (type, start/stop time, monitoring every 15 minutes), and reason.

☐ Who was informed and when; time of psychiatry referral.

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LEGAL TRAPS

✖ Restraint without documentation is assault on paper.

✖ Keeping a patient beyond 72 hours under s.94 without proper admission is illegal.

✖ Do not treat suicide attempters as criminals — treat them as patients.

CASE LAW / KEY PRINCIPLE

MHCA 2017 s.115 — Decriminalised attempted suicide in practice; mandates care and rehabilitation.

PEARL **Least restrictive, shortest possible, documented every 15 minutes.**

PART 2

Documentation and Charting

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TOPIC 11 OF 100 | DOCUMENTATION AND CHARTING

Real-time versus retrospective charting

Write as you go; if you must add later, add openly — never alter, back-date or over-write.

⚖ THE LAW

BNS 238 Causing disappearance of evidence of an offence, or giving false information to screen an offender, is punishable.

BNS 241 Destroying or secreting a document or electronic record to prevent its production as evidence is an offence.

BNS 228 / 229 Fabricating false evidence (including a false entry in a record) is punishable.

BSA 63 Electronic records are admissible with a certificate; EHR audit trails will show every edit and its time.

IN THE ED — WHAT TO DO

1. Make notes at the time of the event or as soon as the emergency permits.
2. For a resuscitation, appoint a scribe and reconcile the notes immediately after.
3. If you remember something later, write a dated, timed "late entry" with the actual time of writing.
4. Correct errors with a single line, initials, date and time; the original must remain readable.
5. After an adverse event, add facts — not opinions or blame — and inform your senior.

DOCUMENT THIS

☐ Date, time (24-hour), legible name, designation and registration number with every entry.

☐ "Late entry — written at 03:40 for events at 01:15" where applicable.

☐ Corrections initialled and timed.

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LEGAL TRAPS

✖ Using correction fluid, tearing pages or re-writing a whole page is presumed tampering.

✖ Editing the EHR after receiving a complaint or legal notice is discoverable and devastating to the defence.

✖ Never add notes to a record after it has been requisitioned by police or court.

CASE LAW / KEY PRINCIPLE

Principle — Medical councils and consumer commissions treat altered records as evidence of misconduct and draw adverse inferences.

PEARL **An honest late entry protects you; a secret change destroys you.**

TOPIC 12 OF 100 | DOCUMENTATION AND CHARTING

Accurate arrival and intervention timelines

Time is the first question in every emergency case — door-to-doctor, door-to-needle, time of death.

⚖ THE LAW

BSA 39	Courts rely on expert medical opinion — which depends on documented times and findings.
BNSS 184(5)	In examination of a rape survivor, the exact time of commencement and completion of examination must be recorded.
BNSS 194	Police inquest reports must reach the Magistrate within 24 hours — they rely on hospital times.
CPA 2019	Consumer commissions examine delay as a key element of deficiency in service.

IN THE ED — WHAT TO DO

1. Record arrival time and triage time on every case sheet.
2. Record exact times of key events: first doctor contact, ECG, CT, thrombolysis, intubation, defibrillation, specialist call and arrival.
3. In a code, record time of arrest, rhythm, each shock and drug, ROSC or time of death.
4. Synchronise clocks — monitors, defibrillators and wall clocks often differ; note the source.
5. Record time of police intimation and time body handed over.

DOCUMENT THIS

☐ Arrival, triage, doctor, investigations, consultant call, decision, disposition — all with time.

☐ Delays and their cause (e.g., "CT unavailable — machine down 01:00–02:30").

☐ Times of death and declaration, with the name of the doctor.

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LEGAL TRAPS

✖ "Patient seen" without time is almost useless in court.

✖ A difference between monitor printout and notes must be explained, not ignored.

✖ Rounded times ("10:00, 10:30") look reconstructed.

CASE LAW / KEY PRINCIPLE

V. Kishan Rao v. Nikhil Super Speciality Hospital (2010) 5 SCC 513 — Records showing treatment and its timing are central to deciding negligence in consumer cases.

PEARL **If it isn't timed, it didn't happen on time.**

TOPIC 13 OF 100 | DOCUMENTATION AND CHARTING

Incomplete or missing emergency records

A missing case sheet is treated as a missing defence — complete every record before you leave the shift.

⚖ THE LAW

IMC Regulations 2002, 1.3.1	Indoor patient records must be maintained for 3 years from commencement of treatment.
IMC Regulations 2002, 1.3.2	Records requested by patient, authorised attendant or legal authority must be issued within 72 hours.
BNS 210	Intentional omission to produce a document or electronic record to a public servant legally bound to receive it is an offence.
Savita Garg v. National Heart Institute (2004) 8 SCC 56	Hospital must produce its records and doctors; adverse inference can be drawn when it does not.

IN THE ED — WHAT TO DO

1. Complete the ED record for every patient — including those who die, leave, are referred or are "only seen".
2. Use a standard ED template: history, examination, investigations, treatment, response, disposition.
3. Record vital signs on arrival and before disposition.
4. Keep MLC copies, police intimation copies and consent forms with the main record.
5. Never take original records home; give copies, not originals, to patients.

DOCUMENT THIS

☐ Disposition: admitted (where), discharged (with what advice), referred (to whom), LAMA, died.

☐ Investigations ordered and results reviewed (or pending, and who will follow up).

☐ Signature, name and registration number on every page.

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LEGAL TRAPS

✖ Courts may draw an adverse inference when records are not produced.

✖ "Notes lost" after a complaint looks like destruction of evidence (BNS 241).

✖ Incomplete records shift the burden onto you to prove good care.

CASE LAW / KEY PRINCIPLE

Savita Garg v. Director, National Heart Institute (2004) 8 SCC 56 — Burden on the hospital to explain treatment through its records and staff.

PEARL **Before you sign out: every patient you saw has a complete, signed note.**

TOPIC 14 OF 100 | DOCUMENTATION AND CHARTING

Legibility and electronic audit trails

Write so a stranger can read it in court ten years later; in the EHR, every login and keystroke is evidence.

⚖ THE LAW

BSA 2(1)(d)	"Document" includes electronic and digital records.
BSA 61	An electronic or digital record shall not be denied admissibility merely because it is electronic.
BSA 63	Electronic records are admissible with the certificate in the Schedule (Part A by the party, Part B by an expert).
IT Act 2000 s.43A & s.72A	Liability for negligent handling of sensitive personal data and for disclosure in breach of lawful contract.

IN THE ED — WHAT TO DO

1. Write in capitals or clear print for names, drugs and doses; avoid ambiguous abbreviations.
2. Use only your own login; never share passwords or work on another doctor's open session.
3. Log out when leaving a terminal.
4. Use generic drug names, units in full ("units", "micrograms").
5. Print and sign key electronic notes for MLC files if your hospital requires paper copies.

DOCUMENT THIS

☐ Name, designation, registration number, and signature or digital signature with every entry.

☐ For copied ("copy-forward") notes: update them — do not copy yesterday's examination.

☐ Drug name, dose, route, frequency, and time given.

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LEGAL TRAPS

✖ Illegible notes are interpreted against the writer.

✖ Copy-paste notes with wrong findings undermine your credibility in court.

✖ Audit trails show who looked at a VIP or colleague's record without reason (confidentiality breach).

CASE LAW / KEY PRINCIPLE

Arjun Panditrao Khotkar v. Kailash Gorantyal (2020) 7 SCC 1 — Certificate for electronic records (now BSA 63) is mandatory for admissibility of secondary electronic evidence.

PEARL **Your password is your signature — never lend it.**

TOPIC 15 OF 100 | DOCUMENTATION AND CHARTING

Documenting refusals by patients and families

Refusals are the commonest defence and the commonest gap — record them verbatim and witnessed.

⚖ THE LAW

Constitution Art. 21 Competent patients may refuse treatment.

BNS 30 Does not authorise treatment against a valid refusal.

BSA 26 Statements of a person who has since died can become relevant evidence — a recorded refusal may later be crucial.

IN THE ED — WHAT TO DO

1. Record what was advised: investigation, admission, procedure, referral.
2. Record what was refused, by whom, and the reason given.
3. Record the specific risks explained, including death or disability.
4. Offer and record the alternative accepted.
5. Get the refusing person's signature and a witness; if they refuse to sign, note "refused to sign" with witness name.

DOCUMENT THIS

☐ "Advised CT head for head injury with vomiting; patient's son refused saying 'we will go to our own hospital'. Risk of brain haemorrhage and death explained in Malayalam."

☐ Time, names, relationship, language used.

☐ Advice given and return precautions.

LEGAL TRAPS

✖ "Patient not willing" without details carries little weight.

✖ A relative's refusal cannot override a competent patient's consent.

✖ For children, a parent's refusal of life-saving care should be escalated, not simply accepted.

CASE LAW / KEY PRINCIPLE

Samira Kohli (2008) — Autonomy requires adequate information — the same applies to informed refusal.

PEARL **Quote, don't paraphrase.**

TOPIC 16 OF 100 | DOCUMENTATION AND CHARTING

Negative findings and differential diagnosis

Write what you looked for and did not find — it proves you thought of the dangerous causes.

⚖ THE LAW

Jacob Mathew v. State of Punjab (2005) — The standard is that of an ordinary competent practitioner; your notes must show reasonable thinking.

BSA 39 / 45 — Experts' opinions and their grounds are relevant — experts will judge you on your record.

CPA 2019 — Deficiency in service is judged from records of what was done and considered.

IN THE ED — WHAT TO DO

1. For each high-risk complaint, record the key negatives: chest pain (no pulse deficit, ECG findings), headache (no neck stiffness, no focal deficit), abdominal pain in women (pregnancy test result).
2. Write a short differential diagnosis and why the dangerous ones are unlikely.
3. Record investigations considered and why they were or were not done.
4. Record re-examination findings before discharge.
5. Write a clear impression and plan.

DOCUMENT THIS

☐ "No focal neurological deficit, GCS 15, no neck stiffness, fundi normal."

☐ "Differential: ACS — ECG and troponin normal ×2; aortic dissection — equal pulses, normal mediastinum."

☐ Reassessment before discharge with vitals.

LEGAL TRAPS

✖ Notes that list only positives make it impossible to prove you excluded danger.

✖ "NAD" or "WNL" for the whole system is weak.

✖ Unexplained abnormal vital signs at discharge are a major red flag in litigation.

CASE LAW / KEY PRINCIPLE

Kusum Sharma v. Batra Hospital (2010) 3 SCC 480 — A doctor is not liable if he acts per a reasonable body of opinion — documentation shows that he did.

PEARL **Write the negatives that matter for the diagnosis you fear.**

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TOPIC 17 OF 100 | DOCUMENTATION AND CHARTING

Consultation and handoff documentation

Record who you called, when, what you told them, what they advised, and when they came.

⚖ THE LAW

IMC Regulations 2002, Ch. 3 Duties in consultation — consultants should be punctual and communicate with the referring doctor.

BNS 106(1) Criminal negligence can arise from omissions in a chain of care.

Savita Garg (2004) The hospital is answerable for the team's acts and omissions.

IN THE ED — WHAT TO DO

1. Call the specialist directly; give a structured summary (e.g., SBAR).
2. Record the time of call, name of the person spoken to, advice received and expected arrival time.
3. If the specialist does not respond, escalate to a senior and the duty administrator.
4. At shift change, hand over every sick and pending patient face-to-face.
5. Record pending results and who will follow them up.

DOCUMENT THIS

☐ "02:10 — called Dr X (surgery registrar), SBAR given, advised CT abdomen and review; arrived 02:45."

☐ Repeated calls and escalation with times.

☐ Handover note with outstanding tasks.

LEGAL TRAPS

✖ "Informed surgeon" without name and time is insufficient.

✖ Following unsafe telephone advice does not transfer responsibility — you remain responsible for your patient.

✖ Unrecorded verbal handovers lead to "nobody's patient".

CASE LAW / KEY PRINCIPLE

Malay Kumar Ganguly v. Dr Sukumar Mukherjee (2009) 9 SCC 221 — Collective failures of the treating team amounted to negligence.

PEARL **Name, time, advice, arrival — four words that win cases.**

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TOPIC 18 OF 100 | DOCUMENTATION AND CHARTING

LAMA / DAMA documentation template

A good LAMA record proves the patient was warned of death or disability and chose to leave with capacity.

⚖ THE LAW

Constitution Art. 21 Right to refuse treatment.

MHCA 2017 s.4 Capacity assessment must be specific to the decision.

BNS 126 / 127 Detaining a competent adult against will may amount to wrongful restraint/confinement.

IN THE ED — WHAT TO DO

1. Use a hospital LAMA form, but write case-specific details by hand.
2. Assess and record capacity.
3. Explain risks in the patient's language with an interpreter if needed.
4. Offer alternatives, prescription, referral letter and copy of reports.
5. For MLCs, inform the police about LAMA.

DOCUMENT THIS

☐ Diagnosis and advice: "Advised admission for suspected ectopic pregnancy."

☐ Specific risks: "Internal bleeding, shock, death."

☐ Patient's words, capacity statement, signatures of patient/relative, doctor and witness, date and time.

☐ Discharge medicines, advice and invitation to return at any time.

LEGAL TRAPS

✖ Mass-printed forms with no specifics are often discounted by courts.

✖ Do not make the patient pay a "penalty" or withhold reports as punishment for leaving.

✖ Do not record LAMA for a patient who lacked capacity — that is abandonment.

CASE LAW / KEY PRINCIPLE

Common Cause (2018) — Autonomy to refuse medical treatment is constitutionally protected.

PEARL **A LAMA note should read like a story: advice, risks, refusal, capacity, alternatives, signatures.**

TOPIC 19 OF 100 | DOCUMENTATION AND CHARTING

Preserving physical evidence and chain of custody

Every bullet, garment and swab is evidence — collect, label, seal, record and hand over against signature.

⚖ THE LAW

BNS 238	Causing evidence of an offence to disappear is punishable.
BNSS 176(3)	For offences punishable with 7 years or more, a forensic expert must visit the crime scene and collect evidence.
BNSS 105	Search and seizure must be recorded by audio-video electronic means.
BNSS 184(2)	In sexual-assault examination, material taken for DNA profiling must be recorded.

IN THE ED — WHAT TO DO

1. Cut clothing around (not through) bullet holes, stab tears and stains.
2. Air-dry wet clothing; pack each item separately in paper bags — not plastic.
3. Handle bullets and fragments with gloved fingers or rubber-tipped forceps — never metal forceps.
4. Label each item: name, MLC number, item, date, time, collected by.
5. Seal with hospital seal; hand over to police against a signed receipt.

DOCUMENT THIS

☐ Chain-of-custody register: item, sealed by, time, handed to (name, rank, number), signature.
☐ Photographs of injuries with a scale (with consent).
☐ Samples sent for analysis and their seals.

LEGAL TRAPS

✖ Washing a wound before photographing or collecting trace evidence may destroy evidence.
✖ Unsealed items left in the ED lose evidentiary value.
✖ Giving bullets to relatives is a serious lapse.

CASE LAW / KEY PRINCIPLE

Principle — Courts discount physical evidence when its sealing or chain of custody cannot be proved.

PEARL **Paper bag, label, seal, sign, receipt.**

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TOPIC 20 OF 100 | DOCUMENTATION AND CHARTING

Retention of emergency and MLC records

Keep MLC records much longer than ordinary records — until the case is over, and as your State rules require.

⚖ THE LAW

IMC Regulations 2002, 1.3.1 — Minimum 3 years for indoor records.

BNS 241 — Destroying a record to prevent its production as evidence is an offence.

Limitation — Consumer complaints can be filed within 2 years of the cause of action (CPA 2019 s.69), and minors may sue later; criminal trials may take years.

State / institutional rules — Many States and hospitals retain MLC records for 10 years or permanently; follow your State health department orders.

IN THE ED — WHAT TO DO

1. Keep MLC records separately in a secure, indexed register.
2. Store MLC registers, police intimation copies, wound certificates, postmortem requisitions and chain-of-custody registers.
3. Do not destroy any record connected with a pending case, complaint or legal notice.
4. Digitise with a proper audit trail; keep originals as required.
5. Issue certified copies with a covering letter; keep the original.

DOCUMENT THIS

☐ MLC number, date, police station, FIR/crime number if known.

☐ Copies of all certificates issued.

☐ Record of whom copies were given to and when.

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LEGAL TRAPS

✖ Disposing of MLC files after 3 years like routine records can destroy your only defence.

✖ Lost MLC registers attract inquiry.

✖ Original records sent to court should be acknowledged and a copy kept.

CASE LAW / KEY PRINCIPLE

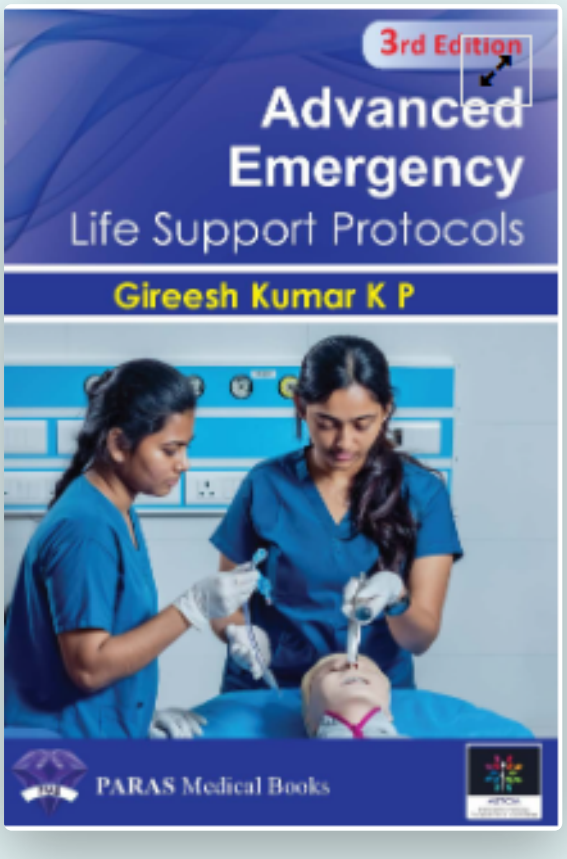
Savita Garg (2004) — The hospital bears the burden of producing records explaining care.

PEARL **For MLCs, keep until the case is closed — and then some.**

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PART 3

Medico-Legal Cases and Police Intimation

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TOPIC 21 OF 100 | MEDICO-LEGAL CASES AND POLICE INTIMATION

What is a medico-legal case (MLC)?

An MLC is any case of injury or illness where the attending doctor, after history and examination, thinks investigation by law-enforcement is needed to fix responsibility.

⚖ THE LAW

BNSS 2(1)(g) & 173 Cognizable offences are recorded by police as FIR; the hospital's intimation often starts this process.

BNSS 33 Every person aware of the commission of certain serious offences (e.g., murder, culpable homicide) must inform the police or Magistrate.

BNS 211 / 239 Omitting to give information that one is legally bound to give, or intentionally omitting to inform of an offence, is punishable.

BNSS 397 Hospitals must give free first aid/treatment to victims of rape and acid attack and inform police immediately.

IN THE ED — WHAT TO DO

1. Treat first — MLC registration never delays emergency care.
2. Register as MLC: all injuries (assault, RTA, fall from height with suspicion, industrial accidents), burns, poisoning (homicidal, suicidal, accidental or unknown), sexual assault, suspected abuse of child/elder/woman, attempted suicide, firearm and blast injuries, unconscious patient with unknown cause, brought-dead and unexplained sudden death, criminal abortion, dog and animal bite where foul play is alleged, deaths under anaesthesia/surgery where foul play is alleged, and patients brought by police.
3. Allot an MLC number; fill the MLC register.
4. Send written intimation to the jurisdictional police station (or police aid post) immediately.
5. If in doubt — register as MLC; it can be closed later, but cannot be opened backwards.

DOCUMENT THIS

☐ MLC register: number, date/time, name, age, sex, address, identification marks (two), brought by (name, address, relation), history in their words, injuries, treatment, intimation time and to whom.

☐ Thumb impression of the patient when required by your State format.

☐ Copy of police intimation with receipt.

LEGAL TRAPS

✖ Not registering an obvious MLC because "the family doesn't want police" is unlawful.

✖ Writing your opinion of who is guilty is not your job — record facts and history as given.

✖ Never write a reason for injury as fact: write "alleged assault by known person".

CASE LAW / KEY PRINCIPLE

Pt. Parmanand Katara (1989) — Medico-legal formalities can never delay treatment.

PEARL **Doubtful? Make it an MLC.**

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TOPIC 22 OF 100 | MEDICO-LEGAL CASES AND POLICE INTIMATION

Police intimation — how and how fast

Inform the police promptly and in writing; record the time, mode and the name of the officer.

⚖ THE LAW

BNSS 173 Information in cognizable cases: police record the FIR; e-FIR and zero FIR are allowed.

BNSS 33 Public duty to inform police of specified serious offences.

BNS 211 / 239 Penalties for omission to inform when bound to do so.

BNSS 397 & BNS 200 Failure of a hospital to treat rape or acid-attack victims free and inform police — punishment up to one year, or fine, or both, for the person in charge.

IN THE ED — WHAT TO DO

1. Send intimation immediately after initial stabilisation — not hours later.
2. Use the hospital's printed intimation format; send to the jurisdictional police station through the hospital police aid post or by messenger/phone/email as per local rules.
3. For deaths, unknown bodies, and unconscious unknown patients — inform at once.
4. For a patient who dies after an MLC registration, send a second intimation about the death.
5. If the patient leaves (LAMA/absconds), inform police.

DOCUMENT THIS

☐ Time and mode of intimation; name, rank and number of the officer receiving.

☐ Copy of intimation with acknowledgement.

☐ Time police arrived and their requisitions.

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LEGAL TRAPS

✖ Waiting for the police to come before treating the patient.

✖ Informing police only by phone without written record.

✖ Sharing medical details with police beyond what is legally required (keep to the injury and requisition).

CASE LAW / KEY PRINCIPLE

Lalita Kumari v. Govt. of U.P. (2014) 2 SCC 1 — Registration of FIR is mandatory when information discloses a cognizable offence.

PEARL **Treat, then tell — in writing, with time.**

TOPIC 23 OF 100 | MEDICO-LEGAL CASES AND POLICE INTIMATION

Road traffic accidents (RTAs)

Treat the golden hour, protect the Good Samaritan, register the MLC, and use the cashless scheme.

⚖ THE LAW

MV Act 1988 s.134 — The driver must take the injured to a doctor/hospital and inform police; every doctor/hospital must attend to the injured without waiting for procedural formalities.

MV Act s.134A & Good Samaritan Rules 2020 — A Good Samaritan is not liable civil or criminally and cannot be compelled to reveal identity, pay, or stay at the hospital.

MV Act s.162 & Cashless Treatment of Road Accident Victims Scheme 2025 — Cashless treatment up to ₹1.5 lakh per victim for up to 7 days at designated hospitals (notified May 2025).

BNS 106(1), 125, 281 — Death by negligence; acts endangering life or personal safety; rash driving on a public way.

MV Act s.185 — Driving with blood alcohol over 30 mg per 100 ml is an offence.

IN THE ED — WHAT TO DO

1. Primary survey and resuscitation first; trauma team activation as needed.
2. Do not detain or question the bystander who brought the patient; thank them and let them leave.
3. Register as MLC; record who brought the patient and the vehicle details as told.
4. Note signs of alcohol use; collect blood alcohol only on police requisition/consent or for clinical need.
5. Enrol the patient in the cashless scheme/insurance as per hospital procedure — never demand advance payment.

DOCUMENT THIS

☐ History: time of accident, place, mechanism (pedestrian, two-wheeler, helmet, seat belt).

☐ Injuries in detail, with diagrams; investigations; treatment given.

☐ Police intimation; Good Samaritan's details only if he volunteers them.

LEGAL TRAPS

✖ Demanding money or police papers before treatment.

✖ Writing "drunk" on smell alone.

✖ Failing to document helmet/seat-belt status — it matters in compensation claims.

CASE LAW / KEY PRINCIPLE

Savelife Foundation v. Union of India (2016) 7 SCC 194 — Supreme Court approved Good Samaritan guidelines, later given statutory force in s.134A.

PEARL **Golden hour, no money first, no harassment of the helper.**

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TOPIC 24 OF 100 | MEDICO-LEGAL CASES AND POLICE INTIMATION

Hurt and grievous hurt — how the law classifies injuries

Your wound certificate decides the charge; know the eight kinds of grievous hurt under BNS 116.

⚖ THE LAW

BNS 114 / 115	Hurt = bodily pain, disease or infirmity; voluntarily causing hurt punishable up to 1 year.
BNS 116	Grievous hurt: (a) emasculation; (b) permanent loss of sight of either eye; (c) permanent loss of hearing of either ear; (d) loss of any member or joint; (e) destruction or permanent impairment of powers of any member or joint; (f) permanent disfiguration of head or face; (g) fracture or dislocation of bone or tooth; (h) any hurt that endangers life or causes severe bodily pain or inability to follow ordinary pursuits for 15 days.
BNS 117	Voluntarily causing grievous hurt — punishable up to 7 years.
BNS 118	Hurt or grievous hurt by dangerous weapons or means (sharp, firearm, fire, poison, corrosive, explosive, animal).
BNS 109 / 110	Attempt to murder; attempt to commit culpable homicide.

IN THE ED — WHAT TO DO

1. Examine and record every injury: type, site (with distance from landmarks), size, shape, margins, direction, colour (for bruises), age of injury.
2. Name the likely weapon category: blunt, sharp, firearm, burn, chemical.
3. Give your opinion as "simple", "grievous", or "kept under observation" pending X-ray/CT/specialist opinion.
4. Revise the opinion in writing once investigations are available.
5. Mark "dangerous to life" only when it truly was.

DOCUMENT THIS

- ☐ Injury list with numbered entries and body diagrams.
- ☐ Investigations relied on for the final opinion.
- ☐ Final opinion with date, signature and seal.

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LEGAL TRAPS

- ✖ Calling a fracture "simple" because the patient walked in — any fracture is grievous.
- ✖ Guessing the weapon precisely ("knife of 10 cm") — say "sharp-edged weapon".
- ✖ Missing old injuries or defence wounds.

CASE LAW / KEY PRINCIPLE

Principle — Courts rely heavily on the injury report made closest to the time of incident; later contradictions damage both prosecution and doctor.

PEARL **Fracture, eye, ear, face, joint, life-threat or 15 days — then it is grievous.**

TOPIC 25 OF 100 | MEDICO-LEGAL CASES AND POLICE INTIMATION

Firearm and blast injuries

Treat the wound, keep the evidence — bullets, wads, pellets and clothing belong to the investigation.

⚖ THE LAW

BNS 109 Attempt to murder (including by firearm).

BNS 118 Hurt or grievous hurt by dangerous weapons, including firearms and explosives.

Arms Act 1959 Offences relating to illegal firearms; the police will need your findings on range and direction.

BNSS 176(3) Forensic team must visit scenes of serious offences — hospital evidence complements this.

IN THE ED — WHAT TO DO

1. Resuscitate and manage per trauma protocol.
2. Do not label "entry" or "exit" definitively if unsure — describe features (size, margins, abrasion collar, tattooing, blackening, singeing).
3. Recover bullets/fragments with rubber-tipped forceps; do not scratch them.
4. Preserve clothing (cut around holes); air-dry; separate paper bags.
5. Swab hands for gunshot residue only on police request and per protocol.

DOCUMENT THIS

☐ Each wound: site, size, shape, margins, surrounding signs, probable direction.

☐ X-ray findings of retained projectiles.

☐ Items handed to police with seal and receipt.

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LEGAL TRAPS

✖ Washing away blackening/tattooing before documentation.

✖ Handing bullets to relatives or discarding them in the OT.

✖ Writing "self-inflicted" or "accidental" as fact.

CASE LAW / KEY PRINCIPLE

Principle — Range and direction of fire are often decided on the hospital's first description — be descriptive, not conclusive.

PEARL **Describe, don't decide; preserve, don't polish.**

TOPIC 26 OF 100 | MEDICO-LEGAL CASES AND POLICE INTIMATION

Burns — thermal, chemical and electrical

Every burn is potentially medico-legal; dowry deaths and acid attacks carry special legal duties.

⚖ THE LAW

BNS 124(1) / 124(2) Grievous hurt by acid; throwing or attempting to throw acid.

BNSS 397 Free first aid and treatment to acid-attack victims by all hospitals; inform police immediately.

BNS 80 / 85 / 86 Dowry death (death by burns or bodily injury within 7 years of marriage with cruelty/harassment for dowry); cruelty by husband or relatives.

BNSS 194(3) Death of a woman within 7 years of marriage by suicide or in suspicious circumstances: body must be sent for post-mortem.

BSA 118 Presumption of dowry death when cruelty for dowry is shown soon before death.

IN THE ED — WHAT TO DO

1. Resuscitate; estimate TBSA and depth; manage airway early in inhalation injury.
2. Irrigate chemical burns copiously; identify the agent if possible.
3. Look for entry/exit marks in electrical burns; ECG.
4. For a married woman with burns, ask about the circumstances privately and gently.
5. Arrange a dying declaration early if life is in danger (Topic 29).

DOCUMENT THIS

☐ Agent, time, place, history as told by the patient (in her words) and by bystanders, separately.

☐ Distribution and pattern: splash, pour, kerosene smell, clothing burnt, defence pattern.

☐ TBSA and depth; fitness for statement.

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LEGAL TRAPS

✖ Accepting "stove burst" without recording inconsistencies.

✖ Delaying a dying declaration until the patient is in shock or intubated.

✖ Billing acid-attack victims.

CASE LAW / KEY PRINCIPLE

Laxmi v. Union of India (2014) 4 SCC 427 — Directed free treatment for acid-attack victims in private hospitals too, and regulation of acid sale.

PEARL **In every burnt woman, think dowry death and record her words early.**

TOPIC 27 OF 100 | MEDICO-LEGAL CASES AND POLICE INTIMATION

Sexual assault — examination and care

Consent, care, evidence, confidentiality — and never the "two-finger test".

⚖ THE LAW

BNS 63–70 Rape (definition, punishment, survivor below 16/12 years, causing death/vegetative state, gang rape).

BNSS 184 Examination by an RMP (preferably in a government hospital) with consent, within 24 hours of the police receiving information; report with reasons, consent and exact times; forwarded to IO within 7 days.

BNSS 397 & BNS 200 Free treatment by every hospital, and police intimation; failure is punishable.

BNS 72 Disclosing the identity of a rape survivor is an offence.

POCSO Act s.19 & s.27 Mandatory reporting for children; medical examination of a girl by a woman doctor, in the presence of a parent or trusted person.

BSA 120 Presumption of absence of consent in certain rape prosecutions where the woman says she did not consent.

IN THE ED — WHAT TO DO

1. Treat injuries first; offer emergency contraception, STI prophylaxis and HIV PEP.
2. Take informed written consent separately for examination, evidence collection, and police intimation; an adult survivor may refuse any part — treatment still continues.
3. Follow the MoHFW Guidelines & Protocols for medico-legal care of survivors (2014) and use a sexual-assault evidence kit.
4. Examine in privacy with a female attendant; record the history in the survivor's words.
5. Collect, label, dry, seal and hand over samples with chain of custody.

DOCUMENT THIS

☐ Consent forms, history, examination findings, samples collected, treatment and counselling.

☐ Exact start and end time of examination (BNSS 184(5)).

☐ Opinion: "findings consistent/not consistent with recent sexual activity; absence of injuries does not rule out sexual assault".

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LEGAL TRAPS

✖ The two-finger (per-vaginal "virginity") test is unscientific and has been held to be misconduct.

✖ Comments on "habituation", hymen or character are prohibited.

✖ Writing "no rape" — rape is a legal conclusion, not a medical diagnosis.

CASE LAW / KEY PRINCIPLE

State of Jharkhand v. Shailendra Kumar Rai (2022) — Supreme Court held that anyone conducting the two-finger test is guilty of misconduct (following Lillu v. State of Haryana, 2013).

PEARL **Treat, protect, preserve, and never judge.**

TOPIC 28 OF 100 | MEDICO-LEGAL CASES AND POLICE INTIMATION

Attempted suicide

Treat as a patient in distress, not a criminal — register the MLC and arrange mental-health care.

⚖ THE LAW

MHCA 2017 s.115 A person who attempts suicide is presumed to be under severe stress and shall not be tried and punished; the government must provide care, treatment and rehabilitation.

BNS 226 Attempt to commit suicide to compel or restrain a public servant from lawful duty — punishable (up to 1 year, fine, or community service).

BNS 107 / 108 Abetment of suicide (of a child or person of unsound mind; and in general) remains an offence.

BNS 123 / 286 Harm by poison with intent; negligent conduct with poisonous substances.

IN THE ED — WHAT TO DO

1. Resuscitate and treat poisoning, hanging, or self-injury per protocol.
2. Register as MLC and inform police — abetment, homicide disguised as suicide, or dowry cruelty must be excluded by investigation.
3. Assess suicide risk; keep the patient safe from further harm (remove ligatures, sharps, medicines).
4. Refer to psychiatry; involve family supportively.
5. Preserve suicide notes, containers and ligature material for police.

DOCUMENT THIS

☐ Method, substance, time, circumstances, who found the patient.

☐ Risk assessment (intent, plan, previous attempts, mental illness, substance use).

☐ Safety measures and psychiatric referral.

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LEGAL TRAPS

✖ Discharging a high-risk patient without psychiatric assessment.

✖ Moral lectures or threats of prosecution.

✖ Assuming "accidental" poisoning in an adult without enquiry.

CASE LAW / KEY PRINCIPLE

Gian Kaur v. State of Punjab (1996) 2 SCC 648 — Upheld the old offence of attempted suicide; MHCA s.115 now removes punishment by presuming severe stress.

PEARL **Every attempt is an MLC and a psychiatric emergency.**

TOPIC 29 OF 100 | MEDICO-LEGAL CASES AND POLICE INTIMATION

Dying declarations

A statement by a dying person about the cause of his death is admissible evidence — record it early, accurately and in his own words.

⚖ THE LAW

BSA 26(a)	A statement by a person who has died, about the cause of his death or the circumstances of the transaction resulting in his death, is relevant evidence.
BNSS 183	A Judicial Magistrate may record statements; ideally a Magistrate records the dying declaration.
Laxman v. State of Maharashtra (2002) 6 SCC 710	Doctor's certification of fitness is a rule of caution; what is essential is that the person was in a fit state of mind.

IN THE ED — WHAT TO DO

1. If death is imminent, inform police to arrange a Magistrate; if there is no time, the doctor should record it.
2. Certify fitness: conscious, oriented, able to understand and answer — before and after the statement.
3. Record in the declarant's own words and language; use question-and-answer form; avoid leading questions.
4. Read it back; take signature or thumb impression; sign with a witness who is not a relative or interested person.
5. Record even if partial; record gestures if the patient cannot speak.

DOCUMENT THIS

☐ Date, time of start and end, persons present.

☐ Fitness certificate with clinical basis (GCS, orientation).

☐ Exact words, questions asked, answers.

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LEGAL TRAPS

✖ Relatives or police prompting answers.

✖ Recording after heavy sedation without noting it.

✖ Waiting for the Magistrate while the patient deteriorates.

CASE LAW / KEY PRINCIPLE

Laxman v. State of Maharashtra (2002) 6 SCC 710 — A dying declaration can be relied on without a doctor's certificate if the recorder is satisfied about fitness — but the certificate strengthens it.

PEARL **Fit, free, in own words, read back, signed, witnessed.**

TOPIC 30 OF 100 | MEDICO-LEGAL CASES AND POLICE INTIMATION

Brought-in-dead and suspicious early deaths

Confirm death carefully, inform police, do not issue a death certificate, and preserve the body and evidence.

⚖ THE LAW

BNSS 194	Police inquest into suicide, homicide, death by animal/machinery/accident, or suspicious death; report to Magistrate within 24 hours; body sent for post-mortem in specified situations.
BNSS 196	Magistrate's inquiry into cause of death, including deaths in police custody and of women within 7 years of marriage.
Registration of Births and Deaths Act 1969 s.10(3)	Medical certificate of cause of death (MCCD) is issued only for deaths attended by the RMP, where the cause is known and natural.
BNS 238	Concealing evidence of an offence is punishable.

IN THE ED — WHAT TO DO

1. Confirm death clinically (absent pulse, breathing, heart sounds, pupillary reflexes; ECG asystole) and record the time.
2. Note the circumstances: who brought the body, when, from where, history.
3. Do a brief external examination; note injuries, ligature marks, rigor, lividity, temperature.
4. Inform police in writing; keep the body in the mortuary until inquest.
5. Communicate compassionately with relatives; explain why a post-mortem may be required.

DOCUMENT THIS

☐ Time of arrival, time death declared, examination findings.

☐ Name of the person who brought the body, police intimation details.

☐ Items with the body (clothes, valuables, notes) handed over against signature.

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LEGAL TRAPS

✖ Issuing an MCCD for a brought-dead or unnatural death.

✖ Handing over a suspicious death body to relatives without police clearance.

✖ Writing "cardiac arrest" as the cause of death — it is a mode, not a cause.

CASE LAW / KEY PRINCIPLE

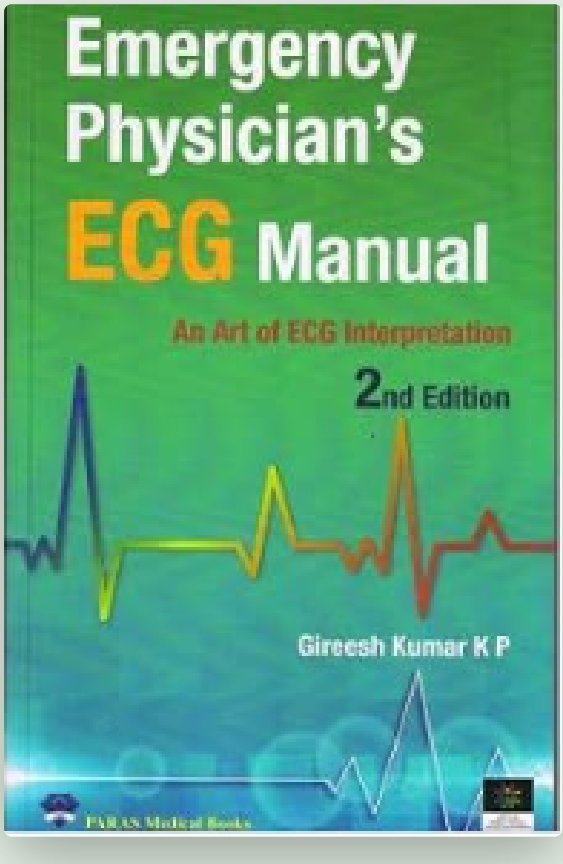
Principle — The emergency physician confirms death and preserves evidence; the cause in unnatural deaths is decided by post-mortem and inquest.

PEARL **Brought dead + any doubt = police inquest, no certificate.**

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PART 4

Negligence and Malpractice

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TOPIC 31 OF 100 | NEGLIGENCE AND MALPRACTICE

The four pillars of negligence

A claim succeeds only if the patient proves duty, breach, causation and damage — understand each to protect yourself.

⚖ THE LAW

Law of torts / CPA 2019 — Civil negligence: duty of care owed, breach of the standard of care, damage, and causal link — compensation awarded by civil courts or consumer commissions.

BNS 106(1) — Criminal negligence: death by rash or negligent act; for a registered medical practitioner during a medical procedure, up to 2 years and fine.

Jacob Mathew v. State of Punjab (2005) 6 SCC 1 — For criminal liability, negligence must be gross — of a very high degree; mere error of judgement or accident is not criminal.

Dr. Laxmanbalkrishna Joshi v. Dr. Trimbak Bapu Godbole (1969) — A doctor owes a duty of care in deciding to treat, in deciding what treatment, and in administering it.

IN THE ED — WHAT TO DO

1. Duty: arises the moment you accept or start assessing a patient in the ED.
2. Breach: judged against a reasonably competent doctor of your level in similar circumstances — not against a super-specialist.
3. Causation: the breach must have caused or materially contributed to the harm.
4. Damage: physical, psychological or financial loss must be proved.
5. Your record is the main evidence on all four pillars.

DOCUMENT THIS

☐ Time you assumed care; your assessment and plan.

☐ Reasons for each decision, especially when you deviate from a guideline.

☐ Patient's condition at handover/discharge.

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LEGAL TRAPS

✖ Saying "I was not on duty for him" when you assessed him is no defence — duty already exists.

✖ An honest error of judgement after reasonable assessment is not negligence; failure to assess is.

✖ Criminal complaints against doctors need a credible independent medical opinion before police act (Jacob Mathew).

CASE LAW / KEY PRINCIPLE

Jacob Mathew v. State of Punjab (2005) 6 SCC 1 — Bolam test adopted; guidelines to protect doctors from frivolous criminal prosecution.

PEARL **Duty + breach + causation + damage — all four, or no negligence.**

TOPIC 32 OF 100 | NEGLIGENCE AND MALPRACTICE

Standard of care in the emergency department

You are judged as a reasonably competent emergency doctor at your level, with the resources available at that time.

⚖ THE LAW

Bolam test (adopted in Jacob Mathew, 2005)	Not negligent if acting in accordance with a practice accepted as proper by a responsible body of medical opinion.
Kusum Sharma v. Batra Hospital (2010) 3 SCC 480	A doctor is not negligent merely because a better alternative existed; reasonable skill and care is the test.
Arun Kumar Manglik v. Chirayu Health (2019) 7 SCC 401	Standard of care must be judged by the standard expected of a reasonable practitioner, considering advances in the field.
CEA 2010 s.12(2)	Stabilisation within the staff and facilities available.

IN THE ED — WHAT TO DO

1. Follow recognised protocols (triage, ACLS/ATLS, sepsis bundles, stroke and STEMI pathways) and document deviations with reasons.
2. Work within your training and seek senior help early.
3. Use the facilities available, and arrange referral for those not available.
4. Re-assess and re-triage patients whose condition changes.
5. Keep your knowledge current — outdated practice may fall below standard.

DOCUMENT THIS

☐ Protocol followed or reason for not following it.

☐ Resources unavailable and steps taken (referral, calls).

☐ Senior consultation and advice.

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LEGAL TRAPS

✖ "Everyone does it this way" is not a defence if it is clearly unsafe.

✖ Equally, you are not negligent for choosing one of two accepted approaches.

✖ Lack of resources must be recorded at the time — not claimed later.

CASE LAW / KEY PRINCIPLE

Kusum Sharma v. Batra Hospital (2010) 3 SCC 480 — Principles for deciding medical negligence, including error of judgement and choice of treatment.

PEARL **Reasonable doctor, reasonable care, recorded reasons.**

TOPIC 33 OF 100 | NEGLIGENCE AND MALPRACTICE

Missed high-risk diagnoses

Aortic dissection, ACS, ectopic pregnancy, SAH, meningitis, testicular torsion and sepsis drive most ED claims — build safety nets.

⚖ THE LAW

CPA 2019 & law of torts Failure to diagnose a condition that a reasonable doctor would have diagnosed is a deficiency in service.

BNS 106(1) A missed diagnosis leading to death may attract criminal complaint — protected unless the negligence is gross.

V. Kishan Rao (2010) In obvious cases, negligence can be found even without an expert, on the records.

IN THE ED — WHAT TO DO

1. Chest pain: ECG within 10 minutes, repeat ECG/troponin as per pathway; consider dissection (pulse deficit, pain character).
2. Woman of reproductive age with abdominal pain or syncope: urine pregnancy test always.
3. Thunderclap headache: CT and, if needed, LP or specialist referral.
4. Fever with altered sensorium or rash: think meningitis/sepsis; early antibiotics.
5. Young male with scrotal pain: urgent urology review — do not wait for ultrasound if delay.

DOCUMENT THIS

☐ Red-flag questions asked and negatives found.
☐ Risk scores used (HEART, Wells, qSOFA).
☐ Safety-netting advice in discharge notes.

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LEGAL TRAPS

✖ Anchoring on a "gastritis" or "anxiety" label.
✖ Discharging with unexplained tachycardia, hypotension or hypoxia.
✖ Not reviewing abnormal results that arrive after discharge.

CASE LAW / KEY PRINCIPLE

Principle — Courts look at whether the dangerous alternatives were considered and excluded — your notes must show it.

PEARL Before discharge, ask: "What is the worst thing this could be, and have I excluded it?"

TOPIC 34 OF 100 | NEGLIGENCE AND MALPRACTICE

Delayed diagnosis and treatment — re-triage failures

Patients deteriorate while waiting; a waiting-room death is a system and individual liability.

⚖ THE LAW

Paschim Banga Khet Mazdoor Samity (1996) Failure to provide timely medical treatment violates Art. 21; the State must ensure adequate facilities.

CPA 2019 Unreasonable delay is a deficiency in service.

Savita Garg (2004) Hospitals are vicariously liable for systemic failures of their staff.

IN THE ED — WHAT TO DO

1. Use a validated triage system (e.g., colour-coded/ESI/MTS) at the door.
2. Re-triage waiting patients at fixed intervals and whenever they complain.
3. Display "tell us if you feel worse" signage; empower nurses to escalate.
4. Prioritise time-critical conditions (stroke, STEMI, sepsis, trauma) with pathways.
5. Escalate overcrowding to administrators in writing.

DOCUMENT THIS

☐ Triage category and time; re-triage times and vitals.

☐ Reasons for delay (CT queue, no bed, specialist delay).

☐ Escalation messages to administration.

LEGAL TRAPS

✖ Undocumented waiting times leave you unable to show reasonable effort.

✖ Ignoring a relative's complaint that the patient "looks worse".

✖ Leaving abnormal vitals unacted on in the waiting area.

CASE LAW / KEY PRINCIPLE

Paschim Banga Khet Mazdoor Samity v. State of W.B. (1996) 4 SCC 37 — Denial of timely emergency treatment due to lack of beds/facilities violates Art. 21.

PEARL **The waiting room is part of the ED — monitor it.**

TOPIC 35 OF 100 | NEGLIGENCE AND MALPRACTICE

Acting beyond your competence

Do what you are trained to do; for everything else, call for help — attempting the unfamiliar without need is negligence.

⚖ THE LAW

IMC Regulations 2002, 1.1.3	Only a doctor with a recognised qualification and registration may practise modern medicine; practising beyond one's system of medicine is misconduct.
Martin F. D'Souza v. Mohd. Ishfaq (2009) 3 SCC 1	Doctors must exercise the skill they profess; reasonable skill, not the highest skill.
BNS 106(1)	Death resulting from a procedure undertaken negligently.

IN THE ED — WHAT TO DO

1. Know your limits; ask for senior or specialist help early.
2. In a true emergency where no one else is available, a life-saving procedure within your general training is justified (e.g., needle decompression, cricothyroidotomy) — record why.
3. Maintain and document your training (ACLS/ATLS, airway courses, ultrasound credentialing).
4. Hospitals should have a privileging/credentialing policy for ED procedures.

DOCUMENT THIS

☐ Indication, urgency, and why no more experienced person was available.
☐ Consent or emergency justification.
☐ Procedure note and complications.

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LEGAL TRAPS

✖ Attempting elective or semi-urgent procedures you are not trained in "to help".
✖ Signing reports (e.g., radiology, ECHO) you are not qualified to interpret as final.
✖ Prescribing beyond your system of medicine (e.g., cross-pathy) is misconduct.

CASE LAW / KEY PRINCIPLE

Poonam Verma v. Ashwin Patel (1996) 4 SCC 332 — A homoeopath prescribing allopathic drugs was negligent per se.

PEARL **Brave is good; trained is better; documented is essential.**

TOPIC 36 OF 100 | NEGLIGENCE AND MALPRACTICE

Communication failures with patients and families

Most complaints begin with poor communication, not poor medicine.

⚖ THE LAW

Samira Kohli (2008) Adequate disclosure of information is a legal requirement for consent.

IMC Regulations 2002, 2.3 Physicians should neither exaggerate nor minimise the gravity of a patient's condition and should inform the patient/relatives appropriately.

CPA 2019 Non-disclosure and poor information can amount to deficiency in service.

IN THE ED — WHAT TO DO

1. Introduce yourself; explain who you are and your role.
2. Update families regularly, especially during long resuscitations and waits.
3. Use simple language and a professional interpreter where needed.
4. Break bad news in a private space, with a nurse present, and allow questions.
5. Acknowledge emotions; never argue or blame colleagues in front of families.

DOCUMENT THIS

☐ Who was informed, what was said, by whom, and when.
☐ Questions asked and answers given.
☐ Family's understanding and decisions.

LEGAL TRAPS

✖ Contradictory messages from different team members.
✖ Off-hand remarks ("this should have come earlier", "the other hospital spoiled it").
✖ Silence after an adverse event — it breeds suspicion.

CASE LAW / KEY PRINCIPLE

Principle — Consumer commissions often find deficiency where information was not given, even when the clinical care was reasonable.

PEARL **Explain early, explain often, explain the same thing.**

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TOPIC 37 OF 100 | NEGLIGENCE AND MALPRACTICE

Teamwork and handoff failures

Shift changes and nurse–doctor gaps lose patients; use structured handovers and close the loop.

⚖ THE LAW

Malay Kumar Ganguly (2009) Team failures in a hospital can add up to negligence; responsibility is shared.

Savita Garg (2004) The hospital is answerable for its staff's collective acts.

Jacob Mathew (2005) Criminal liability remains individual and requires gross negligence.

IN THE ED — WHAT TO DO

1. Use a structured handover tool (SBAR/I-PASS) at every shift change.
2. Hand over face-to-face at the bedside for critically ill patients.
3. List pending tasks, results and responsible person.
4. Read back verbal orders and critical results; record them.
5. Encourage nurses and juniors to speak up ("stop the line").

DOCUMENT THIS

☐ Handover note signed by both outgoing and incoming doctors.

☐ Verbal orders documented and countersigned.

☐ Critical result communication with time and recipient.

LEGAL TRAPS

✖ "Corridor handovers" with no record.

✖ Assuming someone else followed up a result.

✖ Hostile team culture that suppresses concerns.

CASE LAW / KEY PRINCIPLE

Malay Kumar Ganguly v. Dr Sukumar Mukherjee (2009) 9 SCC 221 — Collective negligence of doctors and hospital established.

PEARL **Every patient must always have one named doctor.**

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TOPIC 38 OF 100 | NEGLIGENCE AND MALPRACTICE

Supervising residents, interns and juniors

The consultant or senior on duty remains responsible for supervision; trainees remain responsible for their own acts.

⚖ THE LAW

Principle of vicarious liability	The hospital and supervising doctor are liable for negligent acts of juniors acting under them.
NMC Compulsory Rotating Medical Internship Regulations 2021	Interns work under supervision; they are not independent practitioners.
BNS 106(1)	Applies to registered medical practitioners; individual gross negligence is required for criminal liability.

IN THE ED — WHAT TO DO

1. Define clearly what juniors may do alone and when they must call.
2. Be physically or readily available; respond promptly to calls.
3. Review all patients admitted or discharged by juniors within a defined time.
4. Countersign notes and prescriptions as required by hospital policy.
5. Juniors must escalate when uncertain and document the call.

DOCUMENT THIS

☐ Name of supervising doctor for each patient.
☐ Calls from juniors, advice given, and when the senior reviewed.
☐ Countersignatures.

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LEGAL TRAPS

✖ Leaving interns alone in the ED at night.
✖ Signing blank forms or prescriptions in advance.
✖ Juniors hiding mistakes for fear of seniors.

CASE LAW / KEY PRINCIPLE

Achutrao Haribhau Khodwa v. State of Maharashtra (1996) 2 SCC 634 — The State/hospital is vicariously liable for negligence of its doctors.

PEARL **Supervise as if your name is on every note — because it is.**

TOPIC 39 OF 100 | NEGLIGENCE AND MALPRACTICE

Vicarious liability of the hospital

The hospital is responsible for the negligence of its doctors, nurses and staff, and for its own system failures.

⚖ THE LAW

Spring Meadows Hospital v. Harjol Ahluwalia (1998) 4 SCC 39	Hospital liable for negligence of its nurse and doctor; patients are "consumers" of hospital services.
Achutrao Haribhau Khodwa (1996)	Government hospitals are vicariously liable for doctors' negligence.
IMA v. V.P. Shantha (1995) 6 SCC 651	Medical services (except those entirely free) are "services" under consumer law.
CPA 2019 s.2(42)	"Service" includes medical services provided for consideration.

IN THE ED — WHAT TO DO

1. Follow hospital protocols — they show the system expects safe care.
2. Report unsafe staffing, equipment failure and drug shortages in writing.
3. Report adverse events through the incident reporting system.
4. Keep your own professional indemnity insurance even if the hospital has cover.
5. Inform hospital management/medico-legal cell early when a complaint is likely.

DOCUMENT THIS

☐ Incident reports.
☐ Written requests for staff, equipment or beds.
☐ Communication with administration.

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LEGAL TRAPS

✖ Assuming the hospital's insurance will always defend you — individual doctors are also named.
✖ Silently working with broken equipment.
✖ Contract doctors may still be treated as the hospital's agents.

CASE LAW / KEY PRINCIPLE

Spring Meadows Hospital v. Harjol Ahluwalia (1998) 4 SCC 39 — Hospital and staff jointly liable; compensation awarded to parents as well.

PEARL **Report system failures in writing — it protects patients and you.**

TOPIC 40 OF 100 | NEGLIGENCE AND MALPRACTICE

Disclosing adverse events

Be open, honest and timely when something goes wrong — India has no "apology law", so apologise for the outcome, not with admissions of liability.

⚖ THE LAW

IMC Regulations 2002, 2.3 Physicians must neither exaggerate nor minimise the gravity of the patient's condition and must keep the patient or relatives appropriately informed.

BNS 238 / 241 Concealing or destroying evidence of what happened is an offence.

CPA 2019 Concealment and lack of transparency strengthen a deficiency claim.

IN THE ED — WHAT TO DO

1. Stabilise the patient and prevent further harm first.
2. Inform your senior and the hospital's risk/medico-legal team.
3. With a senior, meet the patient/family soon; explain what happened in facts, what is being done, and what happens next.
4. Express regret ("I am sorry this happened") without speculating or blaming others.
5. Offer follow-up and a named contact.

DOCUMENT THIS

☐ Factual account of the event in the record (not opinions).

☐ Disclosure meeting: who attended, what was said, questions, plan.

☐ Incident report reference.

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LEGAL TRAPS

✖ Altering records after an adverse event.

✖ Blaming colleagues or the system in front of the family.

✖ Promising compensation on the spot.

CASE LAW / KEY PRINCIPLE

Principle — Transparency reduces litigation and is ethically required; concealment converts errors into misconduct.

PEARL **Facts, regret, plan, follow-up — and no cover-ups.**

PART 5

Statutory and Regulatory Compliance

41. The duty to treat and stabilise — India's "anti-dumping" law p. 56
42. Confidentiality and patient privacy p. 57
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TOPIC 41 OF 100 | STATUTORY AND REGULATORY COMPLIANCE

The duty to treat and stabilise — India's "anti-dumping" law

India has no EMTALA, but the Constitution, the Supreme Court, the CEA and the BNSS together impose a clear duty to give emergency care.

⚖ THE LAW

Constitution Art. 21 & Parmanand Katara (1989)	Every doctor must give emergency aid to preserve life; no legal formality can delay it.
CEA 2010 s.12(2)	Every registered clinical establishment must examine and treat to stabilise any emergency medical condition, within its staff and facilities.
BNSS 397 & BNS 200	All hospitals must give immediate free treatment to rape and acid-attack victims; the person in charge who fails faces up to 1 year, or fine, or both.
MV Act s.134 & s.162	Duty to attend accident victims without waiting for formalities; Cashless Treatment Scheme 2025 (up to ₹1.5 lakh for 7 days).
State Clinical Establishment Acts / Rules	Many States require display of charges, emergency care without advance deposit, and referral only after stabilisation.

IN THE ED — WHAT TO DO

1. Never turn away an emergency patient for lack of money, ID, police papers, beds or speciality.
2. Assess, resuscitate and stabilise within your facilities.
3. If transfer is needed, follow safe-transfer practice (Topic 77).
4. Use government schemes (PM-JAY, State schemes, cashless RTA scheme) to fund care.
5. Report deliberate "dumping" by other hospitals through proper channels.

DOCUMENT THIS

- ☐ Time of arrival and first treatment.
- ☐ Stabilisation done and why transfer was needed.
- ☐ Financial counselling notes — after, never before, life-saving care.

LEGAL TRAPS

- ✖ "No bed" written on the triage slip with no treatment given.
- ✖ Demanding deposit before emergency treatment.
- ✖ Refusing MLC cases.

CASE LAW / KEY PRINCIPLE

Paschim Banga Khet Mazdoor Samity v. State of W.B. (1996) 4 SCC 37 — Compensation awarded when a patient was refused by several government hospitals.

PEARL **First aid, first — paperwork, later.**

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TOPIC 42 OF 100 | STATUTORY AND REGULATORY COMPLIANCE

Confidentiality and patient privacy

What you learn as a doctor is confidential — disclose only with consent, by law, by court order, or to prevent serious harm.

⚖ THE LAW

K.S. Puttaswamy v. Union of India (2017) 10 SCC 1	Privacy, including health information, is a fundamental right under Art. 21.
IMC Regulations 2002, 2.2 & 7.14	Do not reveal patient confidences, except as required by law, by court order, for a serious and identified risk to a specific person/community, or for notifiable diseases.
BNS 72	Disclosing the identity of a victim of rape and certain sexual offences is punishable.
HIV & AIDS (Prevention and Control) Act 2017	HIV status may be disclosed only with informed consent or as permitted by the Act (s.8 — court order or specified circumstances).
DPDP Act 2023 & DPDP Rules 2025; IT Act s.43A, s.72A	Duties on hospitals as data fiduciaries; penalties for negligent handling and unlawful disclosure of personal data.

IN THE ED — WHAT TO DO

1. Discuss patients in private; draw curtains; lower your voice.
2. Share information with relatives only with the patient's permission (or when the patient lacks capacity).
3. Give police only what is legally needed for the MLC/requisition.
4. Never photograph patients on personal phones or share images in groups.
5. Access only records of patients you are treating.

DOCUMENT THIS

- ☐ Consent for disclosure (to whom, what).
- ☐ Legal basis for disclosure (requisition number, court order).
- ☐ Requests for records and copies issued.

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LEGAL TRAPS

- ✖ Discussing VIP or celebrity patients with media or friends.
- ✖ WhatsApp forwarding of patient images or reports.
- ✖ Disclosing HIV status to family without consent.

CASE LAW / KEY PRINCIPLE

Mr. X v. Hospital Z (1998) 8 SCC 296 — Disclosure of HIV status to the fiancée was justified to protect her health — a narrow exception to confidentiality.

PEARL **Need to know, not nice to know.**

TOPIC 43 OF 100 | STATUTORY AND REGULATORY COMPLIANCE

Mandatory reporting of child abuse and neglect

If you suspect sexual abuse of a child, you must report — failure is an offence.

⚖ THE LAW

POCSO Act 2012 s.19 — Any person (including doctors and hospital staff) who knows or apprehends a sexual offence against a child must inform the Special Juvenile Police Unit or local police.

POCSO Act s.21 — Failure to report or record: imprisonment up to 6 months, or fine, or both (higher for persons in charge of institutions regarding subordinates).

POCSO Act s.27 & POCSO Rules 2020 r.6 — Medical examination as per BNSS 184; girl child examined by a woman doctor in presence of parent/trusted person; emergency care without demanding legal requisition.

JJ Act 2015 s.75 — Cruelty to a child by a person having charge of the child is punishable; s.32 — abandoned/lost child to be reported within 24 hours.

BNS 93 — Exposure and abandonment of a child under 12 years.

IN THE ED — WHAT TO DO

1. Suspect abuse when the history does not fit the injury, there is delay in seeking care, patterned injuries, multiple injuries of different ages, genital injury or STI in a child.
2. Treat first; keep the child safe (admit if needed).
3. Inform police/SJPU and Childline (1098) and record the intimation.
4. Inform the Child Welfare Committee when care and protection are needed.
5. Avoid repeated interviews; record the child's words exactly.

DOCUMENT THIS

☐ History from each carer separately; inconsistencies.
☐ Injuries with body maps and photographs (with consent).
☐ Reporting details: to whom, when, reference number.

LEGAL TRAPS

✖ "Waiting to be sure" — reasonable suspicion is enough to report.
✖ Confronting the suspected abuser in front of the child.
✖ Discharging the child back to an unsafe home.

CASE LAW / KEY PRINCIPLE

State of Maharashtra v. Dr. Maroti Kashinath Pimpalkar (2022) — Supreme Court held that non-reporting of child sexual abuse is a serious offence that shields offenders.

PEARL **Suspect, protect, report.**

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TOPIC 44 OF 100 | STATUTORY AND REGULATORY COMPLIANCE

Elder abuse and vulnerable adults

India has no mandatory elder-abuse reporting law, but abandonment and assault are offences — document, protect and inform.

⚖ THE LAW

Maintenance and Welfare of Parents and Senior Citizens Act 2007 s.24 — Abandoning a senior citizen by a person having care: up to 3 months, or fine up to ₹5,000, or both.

BNS 115 / 117 / 118 — Hurt and grievous hurt, whether by family or carers.

BNS 126 / 127 — Wrongful restraint/confinement (e.g., locking up an elderly person).

Rights of Persons with Disabilities Act 2016 — Protects persons with disabilities from abuse, violence and exploitation.

IN THE ED — WHAT TO DO

1. Suspect abuse with unexplained bruises, pressure sores, malnutrition, dehydration, poor hygiene, fear of carers, or delayed presentation.
2. Interview the elderly patient alone where possible.
3. Treat and admit if unsafe at home.
4. Register an MLC for injuries suggesting assault; inform police.
5. Involve the social worker and, where available, the Maintenance Tribunal/district authorities.

DOCUMENT THIS

☐ Patient's own account, recorded verbatim.
☐ Injuries, nutrition, hydration, pressure sores with photographs.
☐ Carer's account and inconsistencies.

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LEGAL TRAPS

✖ Attributing all injuries to "falls" without enquiry.
✖ Discharging to the same carer when abuse is suspected.
✖ Ignoring cognitive impairment when taking history.

CASE LAW / KEY PRINCIPLE

Principle — Courts and tribunals rely on hospital records to establish neglect and abandonment.

PEARL **Ask the patient, alone, "Do you feel safe at home?"**

TOPIC 45 OF 100 | STATUTORY AND REGULATORY COMPLIANCE

Domestic and intimate-partner violence

Ask, document, treat and connect to help; register an MLC for injuries and respect the survivor's choices.

⚖ THE LAW

BNS 85 / 86	Cruelty by husband or his relatives (physical or mental), punishable up to 3 years.
BNS 80	Dowry death within 7 years of marriage.
Protection of Women from Domestic Violence Act 2005	Medical facilities must provide medical aid to an aggrieved person on request; Protection Officers and service providers can help with protection and shelter.
BNS 115 / 117 / 118	Hurt and grievous hurt.

IN THE ED — WHAT TO DO

1. Screen privately for violence when injuries are unexplained, repeated, or in pregnancy.
2. Treat injuries; register an MLC for assault injuries and inform police as required.
3. Respect the adult survivor's decisions on complaint; give information about the Protection Officer, helplines (181 Women Helpline, 112) and shelter.
4. Assess risk to children in the home.
5. Arrange a safe discharge plan.

DOCUMENT THIS

☐ History in her own words, including who caused the injury (as alleged).
☐ Detailed injury documentation with body maps/photographs (with consent).
☐ Information given and referrals made.

LEGAL TRAPS

✖ Interviewing the woman in front of the husband or in-laws.
✖ Writing judgemental comments.
✖ Missing burns or head injuries in a "fall" story.

CASE LAW / KEY PRINCIPLE

Principle — Hospital records are often the only contemporaneous evidence in later domestic violence and dowry cases.

PEARL **Ask alone, believe, document, refer.**

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TOPIC 46 OF 100 | STATUTORY AND REGULATORY COMPLIANCE

Controlled drugs — prescribing and diversion

Morphine and other narcotics are essential medicines — prescribe them, but keep impeccable records.

⚖ THE LAW

NDPS Act 1985 (amended 2014)	"Essential narcotic drugs" (morphine, fentanyl, methadone, etc.) are regulated uniformly; recognised medical institutions may stock and dispense them under the NDPS Rules.
Drugs Rules 1945 — Schedules H, H1 and X	Prescription-only drugs; Schedule H1 and X drugs require special records and warnings.
IMC Regulations 2002, 7.8	Prescribing steroids/psychotropics without absolute medical indication is misconduct.
BNS 276–278 & 286	Adulterated drugs; negligent conduct with poisonous substances.

IN THE ED — WHAT TO DO

1. Prescribe opioids for genuine indications (acute pain, MI, palliation) at appropriate doses.
2. Write generic name, strength, dose, route, frequency, quantity, and your registration number.
3. Maintain a narcotic stock and dispensing register with double signature for administration and wastage.
4. Report missing stock immediately to the in-charge.
5. Be alert to drug-seeking behaviour; check previous records.

DOCUMENT THIS

- ☐ Indication, dose, time given and by whom.
- ☐ Wastage witnessed and signed.
- ☐ Discharge prescriptions with limited quantity.

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LEGAL TRAPS

✖ Pre-signed prescriptions or sharing narcotic cupboard keys.

✖ Undertreating pain out of fear of the law — this is also substandard care.

✖ Unrecorded "verbal" opioid orders.

CASE LAW / KEY PRINCIPLE

Principle — The 2014 NDPS amendment was intended to improve access to pain relief; documentation, not avoidance, is the safeguard.

PEARL **Prescribe confidently, record meticulously.**

TOPIC 47 OF 100 | STATUTORY AND REGULATORY COMPLIANCE

Drunk-driving and toxicology testing

Test for alcohol or drugs with consent, on lawful police requisition, or for clinical need — and keep the chain of custody.

⚖ THE LAW

MV Act s.185 Driving with blood alcohol exceeding 30 mg per 100 ml (by breath analyser) or under the influence of drugs is an offence.

MV Act s.203 / s.204 Breath tests and laboratory tests of blood/urine at a hospital at police request.

BNSS 51 Examination of an arrested accused by a registered medical practitioner at police request, including blood, urine, and other samples; reasonable force may be used.

Selvi v. State of Karnataka (2010) 7 SCC 263 Involuntary narco-analysis, polygraph and brain mapping violate Art. 20(3) and 21.

IN THE ED — WHAT TO DO

1. Accept a written requisition from police stating the legal provision.
2. Explain the test to the person; record consent or refusal (refusal itself may have legal consequences under the MV Act).
3. Use non-alcoholic skin swabs for blood alcohol samples.
4. Collect into labelled, sealed containers with preservative as per lab protocol; hand to police with receipt.
5. Never compromise clinical care for evidence collection.

DOCUMENT THIS

- ☐ Requisition number, officer, time.
- ☐ Clinical signs of intoxication observed.
- ☐ Sample details: type, volume, time, seal, receiver.

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LEGAL TRAPS

- ✖ Using alcohol swabs for blood alcohol samples.
- ✖ Giving an opinion on "drunkenness" from smell alone.
- ✖ Performing invasive collection on a resisting person beyond what BNSS 51 permits.

CASE LAW / KEY PRINCIPLE

Selvi v. State of Karnataka (2010) 7 SCC 263 — Limits on compelled testing; ordinary medical examination under procedure law remains permitted.

PEARL **Requisition, consent/refusal noted, sealed sample, signed receipt.**

TOPIC 48 OF 100 | STATUTORY AND REGULATORY COMPLIANCE

Occupational exposure and safety of ED staff

Needlestick injuries and workplace violence are occupational hazards — report, treat, and document.

⚖ THE LAW

NACO National Guidelines on Post-Exposure Prophylaxis	Start HIV PEP as early as possible (ideally within 2 hours, not later than 72 hours) after significant exposure.
Bio-Medical Waste Management Rules 2016	Segregation, sharps disposal, and recording/reporting of accidents.
Epidemic Diseases Act 1897 (as amended 2020)	Violence against healthcare personnel during an epidemic: 3 months–5 years (6 months–7 years for grievous hurt), cognizable and non-bailable.
State healthcare-violence laws & BNS 115, 117, 121, 132	State Acts protecting healthcare workers (e.g., Kerala 2012, amended 2023) and general offences of hurt and assault on public servants.

IN THE ED — WHAT TO DO

1. After needlestick: wash with soap and water, do not squeeze or scrub; report to the PEP officer; assess source risk; start PEP if indicated; test baseline.
2. Use standard precautions; never recap needles; dispose of sharps immediately.
3. For violence: ensure safety, call security/police, register a complaint; do not retaliate.
4. Document incidents in the hospital incident register.
5. Ensure hepatitis B vaccination of all staff.

DOCUMENT THIS

☐ Exposure details: time, device, depth, source status.
☐ PEP started (time, regimen), follow-up tests.
☐ Violence incident: persons, injuries, damage, police complaint number.

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LEGAL TRAPS

✖ Not reporting a needlestick "because it was small".
✖ Delaying PEP beyond 72 hours.
✖ Accepting violence as "part of the job".

CASE LAW / KEY PRINCIPLE

Principle — Prompt reporting protects workers' compensation and legal rights.

PEARL **Wash, report, assess, PEP — within hours.**

TOPIC 49 OF 100 | STATUTORY AND REGULATORY COMPLIANCE

Notifiable diseases and public-health reporting

Some diseases must be notified — confidentiality yields to public-health law.

⚖ THE LAW

Epidemic Diseases Act 1897	Government may make regulations for dangerous epidemic diseases; doctors must comply.
BNS 271 / 272 / 273	Negligent or malignant acts likely to spread dangerous disease; disobedience of quarantine rules.
TB notification (MoHFW, 2012; 2018 Gazette)	Notification of every TB case is mandatory for all providers; non-compliance can attract BNS 271/272.
IMC Regulations 2002, 7.14	Confidentiality does not apply to notifiable diseases; inform health authorities immediately.
IDSP / IHIP	Integrated Disease Surveillance Programme reporting of outbreak-prone diseases (S, P and L forms).

IN THE ED — WHAT TO DO

1. Know your State's notifiable disease list (e.g., cholera, plague, diphtheria, measles, AFP, dengue, malaria, Japanese encephalitis, leptospirosis, scrub typhus, rabies in many States).
2. Notify TB through Ni-kshay.
3. Report clusters of unusual illness to the district surveillance unit.
4. Inform the patient that notification is a legal requirement.
5. Isolate infectious patients as per protocol.

DOCUMENT THIS

- ☐ Date and mode of notification; reference/ID.
- ☐ Isolation measures and advice given.
- ☐ Contact tracing information shared with authorities.

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LEGAL TRAPS

- ✖ Not notifying "because the patient asked us not to".
- ✖ Delaying notification until laboratory confirmation when clinical notification is required.
- ✖ Discharging an infectious patient without public-health advice.

CASE LAW / KEY PRINCIPLE

Principle — Public-health law prevails over individual confidentiality for notifiable diseases.

PEARL **If the law lists it, you report it.**

TOPIC 50 OF 100 | STATUTORY AND REGULATORY COMPLIANCE

Inquest and referral of deaths for post-mortem

India uses a police (and Magistrate) inquest system — know which deaths you must refer.

⚖ THE LAW

BNSS 194	Police inquest for suicide, homicide, deaths by animals/machinery/accident, or deaths with reasonable suspicion of an offence; body sent for post-mortem when required.
BNSS 196	Magistrate's inquiry for deaths/disappearance/rape in police custody and specified deaths of women within 7 years of marriage.
Registration of Births and Deaths Act 1969 s.10(3)	MCCD only for natural deaths with known cause attended by the doctor.
BNS 211	Omission to give information to a public servant when legally bound.

IN THE ED — WHAT TO DO

1. Refer to police (inquest) all unnatural deaths: trauma, burns, poisoning, hanging, drowning, electrocution, RTAs, assault, criminal abortion, deaths in custody.
2. Also refer sudden unexpected deaths where the cause is unknown, deaths of brought-dead patients, and deaths where relatives allege negligence or foul play.
3. Refer deaths of women within 7 years of marriage in suspicious circumstances.
4. Do not issue MCCD in these cases; write "body handed over to police for inquest".
5. Preserve tubes and lines in place for post-mortem when foul play or procedure-related death is suspected (follow hospital policy).

DOCUMENT THIS

- ☐ Reason for police referral.
- ☐ Time of intimation and body handover.
- ☐ Lines, tubes and devices left in situ.

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LEGAL TRAPS

✖ Writing a natural cause on the MCCD to "help the family" avoid post-mortem.

✖ Removing tubes/lines in a death under investigation.

✖ Releasing a body without police clearance.

CASE LAW / KEY PRINCIPLE

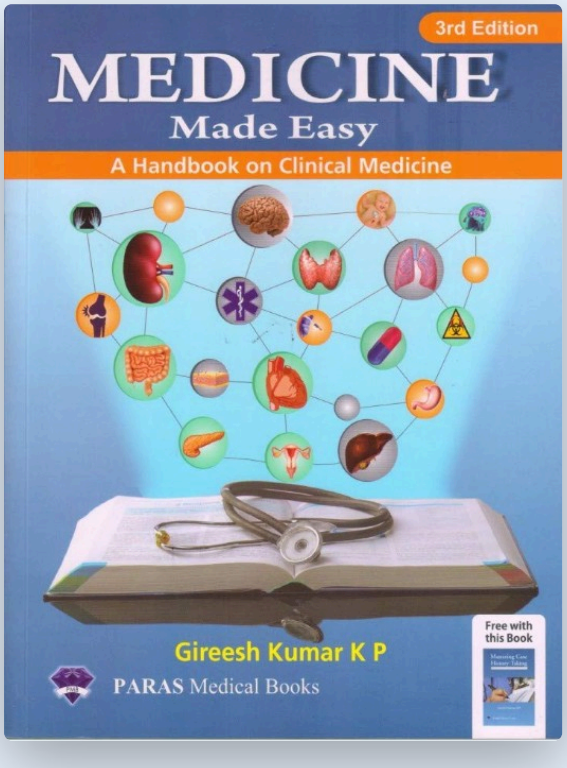
Principle — A death certificate wrongly issued for an unnatural death may amount to a false certificate (BNS 234) and misconduct.

PEARL **Unnatural or unknown = police inquest.**

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PART 6

Critical Care and End-of-Life Issues

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TOPIC 51 OF 100 | CRITICAL CARE AND END-OF-LIFE ISSUES

Brain-stem death certification

Brain-stem death is legal death in India under THOTA — certified only by the prescribed board, with two sets of tests.

⚖ THE LAW

THOTA 1994 s.2 & s.3(6) "Brain-stem death" is recognised; certification by a Board of medical experts (RMP in charge of the hospital, an independent specialist, a neurologist/neurosurgeon, and the treating RMP).

THOTA Rules 2014, Form 10 Brain-stem death certificate; two sets of tests with an interval of at least 6 hours.

THOTA s.3(1A) Duty of the ICU/treating doctor to ask relatives of brain-stem dead patients about organ donation and inform the authorised transplant centre.

Supreme Court (2026) Expert review of brain-death protocols has been sought; follow the latest NOTTO/MoHFW guidance.

IN THE ED — WHAT TO DO

1. Identify suspected brain-stem death: irreversible coma of known cause, apnoeic on ventilator.
2. Exclude reversible causes: sedatives, hypothermia, metabolic/endocrine disturbance, neuromuscular blockade, shock.
3. Inform the hospital's authorised brain-death board; the ED doctor usually does not certify alone.
4. Continue full support until the board's decision.
5. Communicate honestly and compassionately with the family.

DOCUMENT THIS

☐ Cause of coma, prerequisites satisfied.
☐ Times and results of each set of tests (including apnoea test) by board members.
☐ Form 10 completed and signed.

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LEGAL TRAPS

✖ Declaring "brain dead" in the ED without the board.
✖ Discussing organ donation before the family has understood the death.
✖ Stopping support before certification.

CASE LAW / KEY PRINCIPLE

Principle — Only the board's certification under THOTA establishes brain-stem death for legal purposes.

PEARL **Brain-stem death is a board decision, not a bedside impression.**

TOPIC 52 OF 100 | CRITICAL CARE AND END-OF-LIFE ISSUES

Withholding versus withdrawing life-sustaining treatment

In law and ethics they are equivalent — decisions must follow the Supreme Court's process and be well documented.

⚖ THE LAW

Common Cause v. UOI (2018; modified 2023)	Passive euthanasia (withholding/withdrawing life support) is lawful under the procedure laid down; primary and secondary medical boards decide within 48 hours each.
Aruna Shanbaug v. UOI (2011) 4 SCC 454	Recognised passive euthanasia for patients in a permanent vegetative state.
Harish Rana v. UOI (2026)	Clinically assisted nutrition and hydration is medical treatment and may be withdrawn in a patient with no prospect of recovery, with a palliative care plan.
BNS 100–106	Active euthanasia (deliberately causing death) remains culpable homicide.

IN THE ED — WHAT TO DO

1. In the ED, start resuscitation when wishes and prognosis are unknown.
2. When further treatment is clearly futile, involve the senior consultant and family; consider a time-limited trial.
3. Follow the hospital's end-of-life policy and medical board process before withdrawing life support.
4. Never give drugs with intent to hasten death; give drugs to relieve symptoms.
5. Shift the focus to comfort, dignity and family presence.

DOCUMENT THIS

- ☐ Prognosis and reasons for futility.
- ☐ Discussion with family: who, when, what was agreed.
- ☐ Medical board decisions and orders.

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LEGAL TRAPS

- ✖ Unilateral withdrawal by a junior doctor.
- ✖ Calling withdrawal "discharge against medical advice" to avoid the process.
- ✖ Using sedatives in doses intended to end life.

CASE LAW / KEY PRINCIPLE

Common Cause v. Union of India (2018) 5 SCC 1 — Right to die with dignity; detailed procedure for withdrawal of life support.

PEARL **Withholding and withdrawing are the same decision — make it properly, together, on paper.**

TOPIC 53 OF 100 | CRITICAL CARE AND END-OF-LIFE ISSUES

Organ and tissue donation

Identify potential donors early, request donation respectfully, and follow THOTA strictly.

⚖ THE LAW

THOTA 1994 s.3 Authority for removal of organs from a deceased donor — by the donor's prior authorisation or by the person lawfully in possession of the body, if no objection.

THOTA s.3(1A) Mandatory request: the treating doctor must ask the relatives of a brain-stem dead patient about donation and inform the transplant centre.

THOTA s.18–20 Offences: removal without authority, commercial dealings in organs.

THOTA & BNSS 194 In MLC deaths, organs may be retrieved with police/forensic coordination so as not to prejudice post-mortem.

IN THE ED — WHAT TO DO

1. Notify the transplant coordinator/NOTTO-ROTTO-SOTTO network when brain-stem death is suspected.
2. Keep the donor physiologically stable.
3. Let trained coordinators make the request with the family.
4. For MLC cases, inform police and arrange forensic presence/consent per State protocol.
5. Tissue (cornea, skin) can be donated after cardiac death within hours — inform the eye bank.

DOCUMENT THIS

☐ Family consent in the prescribed THOTA form, with witnesses.

☐ Police/forensic clearance for MLC cases.

☐ Timeline of retrieval.

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LEGAL TRAPS

✖ Pressuring families or linking donation to waiving bills.

✖ Retrieval in an MLC without police clearance.

✖ Missing the mandatory request.

CASE LAW / KEY PRINCIPLE

Principle — Proper documentation protects both the donor family and the team from allegations of organ trading.

PEARL **Ask every family — respectfully, through the coordinator.**

TOPIC 54 OF 100 | CRITICAL CARE AND END-OF-LIFE ISSUES

CPR futility and family disputes

You are not obliged to give treatment that cannot work — but decide carefully, explain clearly and involve seniors.

⚖ THE LAW

Common Cause (2018/2023)	Decisions on life support follow a structured process with family involvement and medical boards.
IMC Regulations 2002, 2.3	Do not exaggerate or minimise the patient's condition; keep family informed.
CPA 2019	Poor communication about prognosis frequently leads to deficiency claims.

IN THE ED — WHAT TO DO

1. Start CPR when there is no valid decision not to; stop when ACLS criteria and clinical judgement show futility.
2. Allow family presence during resuscitation if they wish and it is safe.
3. Explain what was done, for how long, and why it was stopped.
4. When families demand continuation of clearly futile CPR, involve a senior; consider a short continuation while explaining, but do not prolong indefinitely.
5. Offer bereavement support.

DOCUMENT THIS

- ☐ Arrest time, rhythms, interventions, duration, reasons for stopping.
- ☐ Names of team leader and members.
- ☐ Family discussions and their responses.

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LEGAL TRAPS

- ✖ "Slow codes" (pretending to resuscitate) are dishonest.
- ✖ Stopping CPR without documenting rationale.
- ✖ Making futility decisions alone as a junior.

CASE LAW / KEY PRINCIPLE

Principle — Futility decisions are medical, but they must be explained and documented transparently.

PEARL **Lead the code, then lead the conversation.**

TOPIC 55 OF 100 | CRITICAL CARE AND END-OF-LIFE ISSUES

Palliative and end-of-life care in the ED

Dying patients deserve symptom relief, dignity and family time — this is good medicine and good law.

⚖ THE LAW

Common Cause (2018) Right to die with dignity is part of Art. 21.

NDPS Act (as amended 2014) Morphine and other essential narcotic drugs are available for pain relief through recognised medical institutions.

Harish Rana (2026) Withdrawal of treatment must be supported by a robust palliative care plan.

National Programme for Palliative Care (NPPC) Government programme to integrate palliative care into health services.

IN THE ED — WHAT TO DO

1. Recognise dying; review the goals of care with family.
2. Treat pain, breathlessness, secretions, agitation and nausea with appropriate drugs.
3. Avoid unnecessary investigations and procedures.
4. Provide a quiet space and allow family presence.
5. Refer to the palliative care team or home care services.

DOCUMENT THIS

- ☐ Goals of care agreed and with whom.
- ☐ Symptom control drugs, doses and effects.
- ☐ DNR/limitation decisions.

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LEGAL TRAPS

✖ Withholding opioids out of fear of "causing death".

✖ Aggressive interventions against agreed goals.

✖ Moving the dying patient repeatedly for bed management.

CASE LAW / KEY PRINCIPLE

Principle — Relieving suffering with appropriate doses is lawful, even if life may be shortened incidentally; intent to kill is not.

PEARL **Comfort is a treatment.**

TOPIC 56 OF 100 | CRITICAL CARE AND END-OF-LIFE ISSUES

Catastrophic procedural complications

A failed airway or a torn vessel is not automatically negligence — poor preparation, poor response and poor documentation are.

⚖ THE LAW

Jacob Mathew (2005) An accident during treatment is not negligence if the doctor used reasonable skill and care.

BNS 106(1) Death by gross negligence during a medical procedure.

Martin F. D'Souza (2009) Doctors are not liable for every mishap; only for failure to act with reasonable care.

Samira Kohli (2008) Material risks should be disclosed beforehand where time permits.

IN THE ED — WHAT TO DO

1. Prepare: checklists, equipment checks, back-up plans (e.g., difficult airway algorithm and surgical airway kit).
2. Call for help early when the procedure is going wrong.
3. Follow recognised rescue algorithms.
4. Disclose the complication honestly to the patient/family.
5. Report through the incident system.

DOCUMENT THIS

☐ Indication, consent/emergency justification, pre-procedure checks.
☐ Step-by-step events with times, rescue actions, people called.
☐ Outcome and disclosure.

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LEGAL TRAPS

✖ Omitting complications from the record.
✖ Persisting with failed attempts without escalation.
✖ No back-up equipment available — a system failure that becomes your failure.

CASE LAW / KEY PRINCIPLE

Kusum Sharma v. Batra Hospital (2010) — Complications that occur despite reasonable care do not by themselves prove negligence.

PEARL **Prepare, escalate, disclose.**

TOPIC 57 OF 100 | CRITICAL CARE AND END-OF-LIFE ISSUES

Intra-arrest and post-arrest transport risks

Moving unstable patients is dangerous — transport only when the benefit outweighs the risk and with the right team.

⚖ THE LAW

CEA 2010 s.12(2) Stabilise before transfer within available facilities.

IMC Regulations 2002, 2.4 Do not abandon a patient you have undertaken to treat.

CPA 2019 Unsafe transfer can be a deficiency in service by both sending and receiving hospitals.

IN THE ED — WHAT TO DO

1. Achieve the best possible stability (airway secured, IV access, vasopressors ready) before moving.
2. Use a transport checklist: monitor, defibrillator, oxygen, suction, drugs, ventilator settings.
3. Send a doctor/trained nurse capable of resuscitation.
4. Call ahead; confirm the receiving team is ready.
5. Continue documentation during transport.

DOCUMENT THIS

☐ Condition before, during and after transport.
☐ Escort, equipment, communication with receiving team.
☐ Events during transport.

LEGAL TRAPS

✖ Sending a ventilated patient with an untrained attendant.
✖ Transfers made for non-clinical reasons (bed pressure, finance) without stabilisation.
✖ No handover note.

CASE LAW / KEY PRINCIPLE

Principle — Responsibility continues until a competent team receives the patient.

PEARL **Stable enough, staffed enough, equipped enough — or don't move.**

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TOPIC 58 OF 100 | CRITICAL CARE AND END-OF-LIFE ISSUES

Equipment failure and adverse events during resuscitation

Check your equipment daily; when it fails, rescue the patient and report the device.

⚖ THE LAW

Medical Devices Rules 2017 & Materiovigilance Programme of India (MvPI)	Adverse events related to medical devices should be reported.
CPA 2019	Hospitals are responsible for providing functioning equipment.
Savita Garg (2004)	Hospital accountable for systemic deficiencies.

IN THE ED — WHAT TO DO

1. Check defibrillators, suction, oxygen, laryngoscopes and ventilators every shift; record in a checklist.
2. Keep backup equipment and know where it is.
3. When equipment fails: switch to backup, continue resuscitation, call for help.
4. Remove the faulty device from use, label it, and preserve it for inspection.
5. Report through the hospital incident system and MvPI.

DOCUMENT THIS

- ☐ Daily equipment check logs.
- ☐ Details of failure: device, serial number, time, effect.
- ☐ Report numbers.

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LEGAL TRAPS

- ✖ Discarding the failed device or disposables.
- ✖ Not documenting the failure.
- ✖ Using equipment known to be faulty.

CASE LAW / KEY PRINCIPLE

Principle — Undocumented equipment checks are presumed not done.

PEARL **Check it before you need it.**

TOPIC 59 OF 100 | CRITICAL CARE AND END-OF-LIFE ISSUES

Patients in police custody and prisoners

Treat the prisoner as a patient — clinical need first, security second, dignity always.

⚖ THE LAW

BNSS 53 An arrested person must be examined by a medical officer soon after arrest; injuries and marks of violence must be recorded and a copy given to the arrested person.

BNSS 46 & 43(3) No unnecessary restraint; handcuffs only in specified circumstances.

D.K. Basu v. State of W.B. (1997) 1 SCC 416 Medical examination of arrestees every 48 hours during detention; injury memos.

MHCA 2017 s.103 / s.104 Mentally ill prisoners and persons in custodial institutions.

IN THE ED — WHAT TO DO

1. Examine with privacy as far as security allows; request police to stay outside the curtain if safe.
2. Record all injuries carefully with their probable age — custodial violence may be alleged later.
3. Ask whether the person has any complaint of ill-treatment and record the answer.
4. Remove restraints if they interfere with treatment, in consultation with police.
5. Discharge or return to custody only when medically fit; write "fit to be kept in custody" honestly.

DOCUMENT THIS

☐ Name of escorting police, requisition, time.

☐ Injuries with age estimation; complaints of assault.

☐ Treatment and fitness opinion.

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LEGAL TRAPS

✖ Writing "no injuries" without full examination.

✖ Issuing a "fitness certificate" under pressure.

✖ Discussing the case with police beyond medical findings.

CASE LAW / KEY PRINCIPLE

D.K. Basu v. State of W.B. (1997) 1 SCC 416 — Guidelines against custodial violence including medical examination.

PEARL Your examination may be the only protection against custodial torture — do it fully.

TOPIC 60 OF 100 | CRITICAL CARE AND END-OF-LIFE ISSUES

VIP and high-profile patients

Treat VIPs like every patient — same protocols, same confidentiality, extra care with information.

⚖ THE LAW

Puttaswamy (2017)	Privacy of health information is a fundamental right.
IMC Regulations 2002, 2.2 & 7.14	No disclosure without consent or legal basis.
DPDP Act 2023; IT Act s.72A	Unauthorised disclosure of personal data is punishable.
BNS 356	Defamation by careless statements about a patient.

IN THE ED — WHAT TO DO

1. Follow standard clinical pathways — avoid "VIP syndrome" (deviating from protocol due to status).
2. Restrict record access to the treating team.
3. Route all media communication through the designated spokesperson with written consent.
4. Keep security and political visitors out of the clinical area.
5. Do not let other patients be neglected because of VIP presence.

DOCUMENT THIS

- ☐ Clinical notes as usual.
- ☐ Consent for any public statements.
- ☐ Access log reviews if breaches are suspected.

LEGAL TRAPS

- ✖ Staff taking selfies or sharing updates on social media.
- ✖ Junior staff speaking to the press.
- ✖ Skipping necessary tests "to avoid inconvenience".

CASE LAW / KEY PRINCIPLE

Principle — Breach of a VIP's confidentiality attracts disciplinary, civil and criminal action.

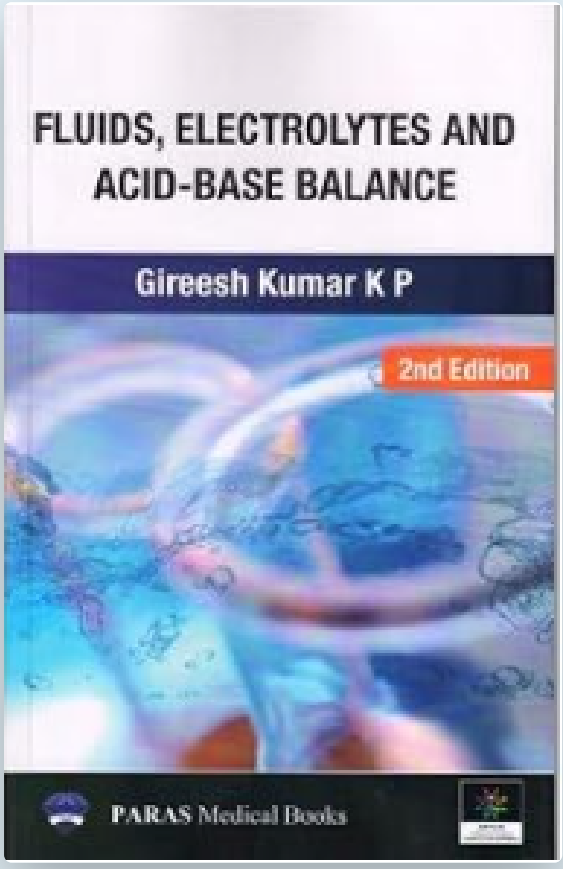
PEARL **Same care, fewer words.**

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PART 7

High-Risk Clinical Traps

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TOPIC 61 OF 100 | HIGH-RISK CLINICAL TRAPS

Fever in infants and young children

Sick children deteriorate fast — missed sepsis and meningitis in children are among the costliest claims.

⚖ THE LAW

CPA 2019 & law of torts Failure to recognise and treat serious bacterial infection can amount to deficiency in service.

BNS 106(1) Death from grossly negligent failure to treat.

IMNCI / national guidelines Danger signs in children must trigger urgent referral or treatment.

IN THE ED — WHAT TO DO

1. Triage with paediatric vitals and danger signs (lethargy, poor feeding, convulsions, grunting, mottling, bulging fontanelle).
2. Infants under 3 months with fever need full evaluation; low threshold for blood culture, urine, and LP.
3. Give early antibiotics when sepsis or meningitis is suspected — do not delay for tests.
4. Re-examine after antipyretics; a child who stays unwell needs admission.
5. Give clear written return advice (red flags) when discharging.

DOCUMENT THIS

☐ Age-specific vitals, CRT, danger signs present/absent.

☐ Investigations, antibiotics and timing.

☐ Reassessment before discharge; advice given and understood by parents.

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LEGAL TRAPS

✖ Attributing fever to "viral" without examination.

✖ Discharging infants with fever and no source without senior review.

✖ Not documenting the child's appearance ("playful, feeding well").

CASE LAW / KEY PRINCIPLE

Principle — In paediatric claims, documented reassessment and clear return advice are often decisive.

PEARL **Well-looking, feeding, active, normal vitals — or admit.**

TOPIC 62 OF 100 | HIGH-RISK CLINICAL TRAPS

Non-accidental injury in children

Think abuse whenever the story does not fit the injury — you are the child's protector and a mandatory reporter.

⚖ THE LAW

POCSO Act s.19 / s.21 Mandatory reporting of sexual offences against children; failure is punishable.

JJ Act 2015 s.75 Cruelty to a child by a person having charge of the child.

BNS 115 / 117 / 118 Hurt and grievous hurt; BNS 93 abandonment of a child under 12.

BNSS 397 Free treatment and police intimation for child sexual-assault victims (POCSO ss.4, 6, 8, 10).

IN THE ED — WHAT TO DO

1. Red flags: delay in seeking care, changing history, injuries in non-mobile infants, patterned bruises, burns in stocking/glove distribution, multiple fractures of different ages, retinal haemorrhages, subdural bleeds.
2. Do a skeletal survey and fundus examination when indicated.
3. Admit for safety when in doubt.
4. Inform police and the Child Welfare Committee; call Childline 1098.
5. Involve paediatrics and social work.

DOCUMENT THIS

☐ History from each carer separately (verbatim).
☐ Injury map, photographs, investigations.
☐ Notifications made.

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LEGAL TRAPS

✖ Accusing parents directly in the ED.
✖ Discharging before safety is ensured.
✖ Missing "sentinel" small bruises in infants.

CASE LAW / KEY PRINCIPLE

State of Maharashtra v. Dr. Maroti Kashinath Pimpalkar (2022) — Non-reporting of abuse is a serious offence.

PEARL **A bruise in a baby who cannot cruise is abuse until proved otherwise.**

TOPIC 63 OF 100 | HIGH-RISK CLINICAL TRAPS

High-risk obstetric emergencies in the ED

Ectopic pregnancy, eclampsia, abruption and PPH kill quickly — and generate litigation when missed or delayed.

⚖ THE LAW

MTP Act 1971 (amended 2021) s.5 Termination by a single RMP at any gestation when immediately necessary to save the woman's life.

BNS 88–92 Causing miscarriage, death of quick unborn child — good-faith medical treatment to save the mother's life is excepted.

CEA 2010 s.12(2) Stabilise before referral.

BNSS 194(3) Deaths of women within 7 years of marriage may need inquest/post-mortem.

IN THE ED — WHAT TO DO

1. Urine pregnancy test in every woman of reproductive age with abdominal pain, bleeding or syncope.
2. Treat eclampsia with magnesium sulphate and BP control; plan delivery with obstetrics.
3. Recognise abruption and PPH early; activate massive transfusion; call obstetrics/anaesthesia.
4. Refer early with stabilisation if your ED lacks obstetric facilities.
5. Report maternal deaths through Maternal Death Surveillance and Response (MDSR).

DOCUMENT THIS

☐ LMP, UPT result, vitals, bleeding estimate.
☐ Drugs (MgSO4 dose, uterotonics), blood products, times.
☐ Obstetric consult time and arrival.

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LEGAL TRAPS

✖ Missing ectopic pregnancy as "gastritis".
✖ Delaying MgSO4 for specialist arrival.
✖ Transferring a bleeding woman without IV access, blood and escort.

CASE LAW / KEY PRINCIPLE

Principle — Maternal deaths are reviewed systematically; your notes will be part of the review.

PEARL **Every woman of reproductive age is pregnant until the test says otherwise.**

TOPIC 64 OF 100 | HIGH-RISK CLINICAL TRAPS

Perimortem caesarean delivery

In maternal cardiac arrest beyond about 20 weeks, perform resuscitative hysterotomy by 4–5 minutes — delay kills mother and baby.

⚖ THE LAW

BNS 30	Good-faith act without consent when consent cannot be obtained in time — applies to the arrested mother.
BNS 26	Harm caused in good faith for a person's benefit.
MTP Act s.5	Lawful termination to save the woman's life at any gestation.

IN THE ED — WHAT TO DO

1. Start CPR with left uterine displacement; call obstetrics, neonatology and anaesthesia immediately.
2. If there is no ROSC by 4 minutes and the uterus is at or above the umbilicus, begin perimortem caesarean so as to deliver by 5 minutes.
3. Do it in the ED — do not move the patient to the theatre.
4. Continue CPR throughout.
5. Inform the family as soon as possible.

DOCUMENT THIS

- ☐ Time of arrest, gestational age/fundal height, time of incision, time of delivery.
- ☐ Team members and roles.
- ☐ Outcome of mother and baby.

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LEGAL TRAPS

- ✖ Waiting for consent from relatives.
- ✖ Delaying for transfer to OT.
- ✖ Not documenting the timeline.

CASE LAW / KEY PRINCIPLE

Principle — A perimortem caesarean is a resuscitation procedure for the mother — the emergency exception to consent applies.

PEARL **Four minutes to decide, five to deliver.**

TOPIC 65 OF 100 | HIGH-RISK CLINICAL TRAPS

Poisoning and overdose — disposition

Every poisoning is an MLC; observe long enough, assess intent, and preserve evidence.

⚖ THE LAW

- **BNS 123** — Causing hurt by poison with intent to commit an offence.
- **BNS 286** — Negligent conduct with poisonous substances.
- **MHCA 2017 s.115** — Attempted suicide — care, not punishment.
- **Insecticides Act 1968 / State rules** — Agrochemical poisonings may need reporting to agriculture/health authorities.

IN THE ED — WHAT TO DO

1. Resuscitate; identify the agent (containers, tablets, history); contact a poison centre.
2. Register an MLC; inform police.
3. Preserve gastric aspirate, vomit, blood and urine, and containers — seal and hand over to police.
4. Observe for the required period based on the agent (e.g., paracetamol levels, sustained-release drugs, delayed toxicity).
5. Psychiatric assessment before discharge in intentional overdose.

DOCUMENT THIS

☐ Agent, amount, time, route, intent (as stated).

☐ Samples preserved and handed over.

☐ Observation period and reason for discharge.

LEGAL TRAPS

✖ Discharging too early for drugs with delayed toxicity.

✖ Not preserving samples in suspected homicidal poisoning.

✖ Writing "accidental" without enquiry.

CASE LAW / KEY PRINCIPLE

Principle — Viscera and samples taken in life are often the only toxicological evidence if the patient later dies.

PEARL **Treat, preserve, observe, assess intent.**

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TOPIC 66 OF 100 | HIGH-RISK CLINICAL TRAPS

Restraint and seclusion

Restraint is a last resort — unlawful or poorly documented restraint is assault and wrongful confinement.

⚖ THE LAW

MHCA 2017 s.97 Physical restraint only when it is the only means to prevent imminent and immediate harm; seclusion/solitary confinement not permitted; restraint to be recorded and reviewed, nominated representative informed.

BNS 126 / 127 Wrongful restraint and wrongful confinement.

BNS 115 Voluntarily causing hurt (injuries from improper restraint).

BNS 30 Good-faith acts without consent to prevent harm when consent cannot be obtained.

IN THE ED — WHAT TO DO

1. Try verbal de-escalation and environmental measures first.
2. If necessary, use the least restrictive method for the shortest time; trained staff only.
3. Consider medical causes and chemical sedation per protocol.
4. Monitor the restrained patient continuously (airway, circulation, limbs) and reassess every 15 minutes.
5. Remove restraints as soon as the risk passes.

DOCUMENT THIS

☐ Reason for restraint (specific behaviour and risk).

☐ Type, start and end time, observations every 15 minutes.

☐ Who authorised, who applied, who was informed.

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LEGAL TRAPS

✖ Prone restraint and positional asphyxia.

✖ Restraint for staff convenience or as punishment.

✖ No record of monitoring.

CASE LAW / KEY PRINCIPLE

Principle — Every restraint must be justifiable to a court as necessary, proportionate and monitored.

PEARL **Least, shortest, watched, written.**

TOPIC 67 OF 100 | HIGH-RISK CLINICAL TRAPS

Eye emergencies

Missed acute angle-closure glaucoma, retrobulbar haemorrhage or penetrating injury can cost an eye — and an eye is "grievous hurt" territory in law.

⚖ THE LAW

BNS 116(b) Permanent privation of sight of either eye is grievous hurt (relevant to assault cases you certify).

CPA 2019 & law of torts Missed or delayed diagnosis leading to loss of vision is a common negligence claim.

IN THE ED — WHAT TO DO

1. Check visual acuity in every eye complaint — it is the "vital sign" of the eye.
2. Red eye with pain, haloes, vomiting and mid-dilated pupil: think angle-closure; start treatment and refer urgently.
3. Proptosis, pain and reduced vision after trauma: think retrobulbar haemorrhage; lateral canthotomy if trained and indicated.
4. Suspected penetrating injury: shield, no pressure, CT, urgent ophthalmology.
5. Chemical injury: irrigate immediately and copiously.

DOCUMENT THIS

☐ Visual acuity both eyes, pupils, IOP if measured.

☐ Time of ophthalmology referral and arrival.

☐ Injury description in assault cases.

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LEGAL TRAPS

✖ Treating angle-closure as migraine or gastritis.

✖ Not recording visual acuity.

✖ Delaying irrigation for history-taking.

CASE LAW / KEY PRINCIPLE

Principle — A documented visual acuity on arrival is often the decisive record in eye injury litigation.

PEARL **No eye examination is complete without visual acuity.**

TOPIC 68 OF 100 | HIGH-RISK CLINICAL TRAPS

Compartment syndrome

Pain out of proportion is the alarm — missed compartment syndrome leads to amputation and large compensation.

⚖ THE LAW

BNS 116(d)/(e) Loss or permanent impairment of a limb is grievous hurt — relevant when injuries are certified.

CPA 2019 & law of torts Delay in diagnosis or fasciotomy is a recognised deficiency.

IN THE ED — WHAT TO DO

1. Suspect in tibial and forearm fractures, crush injuries, tight casts, reperfusion, and prolonged immobilisation.
2. Watch for pain out of proportion, pain on passive stretch, tense compartments; pallor and pulselessness are late signs.
3. Loosen casts and dressings immediately; elevate to heart level, not above.
4. Call orthopaedics urgently; measure compartment pressure if available.
5. Document serial neurovascular examinations.

DOCUMENT THIS

☐ Time of injury, serial examinations with times.

☐ Analgesic requirement trend.

☐ Time of orthopaedic call and decision.

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LEGAL TRAPS

✖ Masking pain with escalating opioids without re-examination.

✖ Waiting for loss of pulses.

✖ Discharging with a tight cast without advice.

CASE LAW / KEY PRINCIPLE

Principle — Documented serial neurovascular checks are the best defence.

PEARL **Escalating pain needs escalating attention, not just escalating morphine.**

TOPIC 69 OF 100 | HIGH-RISK CLINICAL TRAPS

Missed foreign bodies in wounds

Glass, wood and metal fragments left in wounds lead to infection, disability and claims.

⚖ THE LAW

CPA 2019 & law of torts Failure to explore or image a wound appropriately can be a deficiency in service.

BNS 238 In assault cases, retrieved foreign bodies may be evidence — preserve them.

IN THE ED — WHAT TO DO

1. Ask about the mechanism (glass, wood, metal, high-pressure injection).
2. Explore wounds adequately under good light and anaesthesia.
3. X-ray for glass and metal; ultrasound for wood and plastic.
4. Remove or refer; tell the patient if a foreign body may remain.
5. Give tetanus prophylaxis and antibiotics when indicated.

DOCUMENT THIS

☐ Mechanism, exploration findings, imaging done.

☐ Foreign bodies removed (and handed to police in MLCs).

☐ Advice about possible retained fragments and follow-up.

LEGAL TRAPS

✖ Suturing a glass wound without exploration or imaging.

✖ Not telling the patient a fragment may remain.

✖ Missing tendon or nerve injury in hand wounds.

CASE LAW / KEY PRINCIPLE

Principle — A note stating "wound explored to base, no foreign body seen, X-ray negative" defends you.

PEARL **Glass in the history = X-ray before suture.**

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TOPIC 70 OF 100 | HIGH-RISK CLINICAL TRAPS

Cervical spine clearance after trauma

A missed cervical spine injury can mean quadriplegia — use validated rules and document them.

⚖ THE LAW

CPA 2019 & law of torts Failure to immobilise or image appropriately can be negligence.

BNS 116(e) Permanent impairment of a member or joint is grievous hurt — relevant in RTAs and assaults.

IN THE ED — WHAT TO DO

1. Use spinal motion restriction in suspected injury; avoid unnecessary prolonged collar use.
2. Apply validated clinical rules (Canadian C-Spine Rule or NEXUS) in alert, stable patients.
3. Image (CT preferred in adults) when rules indicate or the patient cannot be assessed clinically.
4. Do not clear the spine clinically in intoxicated, distracted or obtunded patients.
5. Refer to spine surgery for any injury or neurological deficit.

DOCUMENT THIS

☐ Rule used and criteria met.

☐ Neurological examination before and after imaging.

☐ Imaging results and who reviewed them.

LEGAL TRAPS

✖ Removing the collar because the patient "seems fine" without assessment.

✖ Missing injuries in elderly patients after minor falls.

✖ Not documenting neurological status.

CASE LAW / KEY PRINCIPLE

Principle — Documented use of a validated decision rule is strong evidence of reasonable care.

PEARL **Rule, image, or keep immobilised — never guess.**

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PART 8

Operational and System Pressures

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TOPIC 71 OF 100 | OPERATIONAL AND SYSTEM PRESSURES

Overcrowding and boarding

Patients waiting in corridors are still your patients — keep them monitored, treated and documented.

⚖ THE LAW

Paschim Banga Khet Mazdoor Samity (1996) The State must provide adequate facilities; lack of beds is no excuse to deny emergency care.

CEA 2010 s.12(2) Stabilise within available staff and facilities.

Savita Garg (2004) Hospitals answer for systemic failures.

IN THE ED — WHAT TO DO

1. Continue observations and treatment for admitted patients waiting in the ED ("boarders").
2. Clarify who is responsible: the ED team or the admitting team — write it.
3. Escalate overcrowding to the administrator in writing using the hospital surge plan.
4. Prioritise by acuity, not by arrival order.
5. Communicate delays to patients and families.

DOCUMENT THIS

☐ Responsible team for each boarder.

☐ Observation charts and medication administration.

☐ Escalation messages with times.

LEGAL TRAPS

✖ "Admitted — waiting for bed" with no further notes for hours.

✖ Unmonitored patients on trolleys.

✖ Missed medication doses because "ward will give".

CASE LAW / KEY PRINCIPLE

Principle — Courts look at what was done for the patient during the delay, not just the delay itself.

PEARL **A boarder needs a named doctor and a chart.**

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TOPIC 72 OF 100 | OPERATIONAL AND SYSTEM PRESSURES

Triage errors

Triage decides who waits — under-triage of sick patients is a major source of harm and claims.

⚖ THE LAW

CPA 2019 Delay due to wrong triage can be a deficiency in service.

Paschim Banga (1996) Timely emergency care is part of Art. 21.

IN THE ED — WHAT TO DO

1. Use a validated, structured triage tool (e.g., colour-coded triage, ESI, MTS) with trained nurses/doctors.
2. Include vital signs in triage; use red-flag lists (chest pain, stroke signs, sepsis, pregnancy bleeding, children with danger signs).
3. Re-triage on change or at fixed intervals.
4. Audit triage accuracy regularly.
5. Allow anyone to upgrade a patient's priority.

DOCUMENT THIS

☐ Triage category, vital signs, time, triage officer.

☐ Re-triage times and changes.

☐ Reasons for over-riding triage.

LEGAL TRAPS

✖ Triage based on appearance alone ("walking, talking").

✖ Not repeating vitals in waiting patients.

✖ Elderly and children under-triaged due to atypical presentations.

CASE LAW / KEY PRINCIPLE

Principle — Documented, protocol-based triage demonstrates a reasonable system of care.

PEARL **Triage is a process, not a single moment.**

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TOPIC 73 OF 100 | OPERATIONAL AND SYSTEM PRESSURES

Telephone advice

Advice without examination is risky — give it only within clear limits, document it, and advise attendance when in doubt.

⚖ THE LAW

Telemedicine Practice Guidelines 2020 (MoHFW/NMC Board of Governors) Telephone/audio is a recognised mode; the RMP must use professional judgement, maintain records, and advise in-person care when needed; emergencies must be directed to the nearest facility.

IMC Regulations 2002 The same professional and ethical standards apply to remote advice.

CPA 2019 Negligent advice by phone can be a deficiency in service.

IN THE ED — WHAT TO DO

1. Identify the caller and patient; confirm the relationship.
2. Use a structured triage script; ask about red flags.
3. If any danger sign: advise immediate attendance or call 108/112.
4. Do not prescribe Schedule X drugs or start complex treatment by phone.
5. Document the call immediately.

DOCUMENT THIS

☐ Date, time, caller, patient, complaint, advice given.
☐ Red flags asked about.
☐ Advice to attend/emergency number given.

LEGAL TRAPS

✖ "Give him Gelusil and see" for chest pain.
✖ Undocumented calls.
✖ Advising staff to give drugs without seeing the patient when you could come.

CASE LAW / KEY PRINCIPLE

Principle — A short, timed note of telephone advice is the only proof of what you said.

PEARL When in doubt, bring them in.

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TOPIC 74 OF 100 | OPERATIONAL AND SYSTEM PRESSURES

Locum and contract doctors

Your contract may vary; your professional duty does not — be registered, credentialed, oriented and insured.

⚖ THE LAW

NMC Act 2019 & State Medical Council Acts	Practising requires valid registration with the NMC/State Medical Council.
IMC Regulations 2002, 1.4	Registration number must be displayed on prescriptions and certificates.
Vicarious liability	Hospitals are usually liable for locum doctors working within their system; the doctor is also personally liable.

IN THE ED — WHAT TO DO

1. Ensure your registration is valid and recorded with the hospital.
2. Get orientation: protocols, escalation contacts, equipment location, MLC procedures.
3. Clarify your role and the consultant on call.
4. Maintain personal indemnity insurance.
5. Hand over properly at the end of each shift.

DOCUMENT THIS

☐ Name, designation, registration number on every note.
☐ Who you escalated to.
☐ Handover notes.

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LEGAL TRAPS

✖ Working without orientation to MLC and transfer procedures.
✖ Leaving before your relief arrives.
✖ Assuming the hospital's cover will protect you personally.

CASE LAW / KEY PRINCIPLE

Principle — Courts apply the same standard of care to locums as to permanent staff.

PEARL **Same patient, same standard — whoever pays you.**

TOPIC 75 OF 100 | OPERATIONAL AND SYSTEM PRESSURES

Short staffing and documenting reasonable efforts

When staffing is unsafe, care for the sickest, escalate in writing, and record the conditions.

⚖ THE LAW

Savita Garg (2004) & Spring Meadows (1998) Hospitals are liable for inadequate staffing and systemic failures.

Jacob Mathew (2005) The standard of care considers the circumstances in which the doctor worked.

CPA 2019 Deficiency in service may lie with the institution rather than the individual.

IN THE ED — WHAT TO DO

1. Prioritise by clinical need; delegate safely.
2. Inform the senior and administrator in writing (email/register) when staffing is unsafe.
3. Call in backup staff per hospital policy.
4. Record delays and their cause in patient notes factually.
5. Fill incident reports for harm or near-misses due to staffing.

DOCUMENT THIS

☐ Staff on duty, patient numbers, critical cases.
☐ Escalation messages with time.
☐ Factual notes of delay reasons.

LEGAL TRAPS

✖ Silently accepting unsafe staffing.
✖ Writing angry comments about management in patient notes.
✖ Leaving patients unseen without telling anyone.

CASE LAW / KEY PRINCIPLE

Principle — Written escalation shifts accountability to the system where it belongs.

PEARL **If it's unsafe, write it — to the right person, not in the case sheet.**

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TOPIC 76 OF 100 | OPERATIONAL AND SYSTEM PRESSURES

On-call specialist non-response

You remain responsible until the specialist arrives — escalate persistently and document each attempt.

⚖ THE LAW

IMC Regulations 2002, Ch. 3	Consultants must be punctual and cooperate in consultation.
Malay Kumar Ganguly (2009)	Specialists and hospitals share liability for delays in team care.
CPA 2019	Specialist delay can be a hospital deficiency.

IN THE ED — WHAT TO DO

1. Call the specialist directly; clearly state urgency.
2. If no response within the defined time, call again, then escalate to the specialist's senior and the medical superintendent.
3. Meanwhile, continue resuscitation and investigations; consider transfer if the speciality is unavailable.
4. Use the hospital's on-call escalation policy.
5. Debrief and file an incident report.

DOCUMENT THIS

☐ Time and number of each call, person contacted, response.
☐ Escalation steps and responses.
☐ Patient condition during the wait.

LEGAL TRAPS

✖ Simply writing "surgeon informed" once and waiting.
✖ Abusive conversations recorded on phones.
✖ Delaying transfer while waiting for an unavailable specialist.

CASE LAW / KEY PRINCIPLE

Principle — Documented, timed escalation protects both patient and ED doctor.

PEARL **Call, re-call, escalate, record.**

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TOPIC 77 OF 100 | OPERATIONAL AND SYSTEM PRESSURES

Inter-facility transfers

A safe transfer is planned, agreed, stabilised, escorted and documented — sending is not the same as dumping.

⚖ THE LAW

CEA 2010 s.12(2) Stabilise emergency conditions before referral.

Parmanand Katara (1989) First aid cannot be refused; referral cannot replace initial care.

MV Act s.162 & Cashless Scheme 2025 Cashless care for RTA victims may avoid unnecessary financial transfers.

CPA 2019 Both sending and receiving hospitals may be liable for unsafe transfer or refusal.

IN THE ED — WHAT TO DO

1. Decide on transfer for clinical need (speciality, ICU, procedure) — not for finance alone.
2. Contact the receiving doctor; confirm acceptance and bed.
3. Stabilise; secure airway, IV access, immobilise fractures, control bleeding.
4. Choose appropriate ambulance and escort; send referral letter, images and reports.
5. Explain to the patient/family and take consent.

DOCUMENT THIS

☐ Indication, receiving doctor/hospital, time of acceptance.

☐ Condition before transfer; escort; equipment.

☐ Consent for transfer and copies sent.

LEGAL TRAPS

✖ "Refer to Medical College" written on a slip with no call or stabilisation.

✖ Transfers at night without escort.

✖ Refusing to accept a referred patient without assessing them.

CASE LAW / KEY PRINCIPLE

Principle — Responsibility continues until handover to a competent receiving team.

PEARL **Call, stabilise, escort, send papers.**

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TOPIC 78 OF 100 | OPERATIONAL AND SYSTEM PRESSURES

Discharge instructions

Clear, written, understood instructions with return precautions are the strongest defence after discharge.

⚖ THE LAW

CPA 2019 Failure to give adequate discharge advice may amount to deficiency in service.

IMC Regulations 2002, 1.3.2 Patients are entitled to copies of their records.

State CEA Rules Many States require discharge summaries for all admitted patients.

IN THE ED — WHAT TO DO

1. Give a written summary: diagnosis, treatment given, medicines (name, dose, duration), follow-up.
2. List specific return warning signs ("come back immediately if...").
3. Explain in the patient's language; use teach-back.
4. Ensure pending results will be followed up and how the patient will be contacted.
5. Provide copies of investigations.

DOCUMENT THIS

☐ Copy of discharge advice in the record.
☐ Who received the advice and their understanding.
☐ Pending tests and follow-up plan.

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LEGAL TRAPS

✖ "Review SOS" without specifics.
✖ Discharging with unexplained abnormal vitals.
✖ Prescriptions without duration.

CASE LAW / KEY PRINCIPLE

Principle — Written safety-netting shifts some responsibility to the informed patient.

PEARL **Diagnosis, drugs, danger signs, follow-up — in writing.**

TOPIC 79 OF 100 | OPERATIONAL AND SYSTEM PRESSURES

Language barriers and interpreters

Consent and history taken in a language the patient does not understand are invalid and unsafe.

⚖ THE LAW

Samira Kohli (2008) Consent requires adequate information understood by the patient.

BNS 28 Consent under misconception is not valid.

BNSS 184 Survivor examination requires informed consent — language matters.

IN THE ED — WHAT TO DO

1. Ask the patient's preferred language.
2. Use trained interpreters or bilingual staff where possible; telephone interpreting if available.
3. Avoid children as interpreters, and be careful with family interpreters in abuse cases.
4. Use simple words, diagrams and teach-back.
5. Provide consent forms in the local language.

DOCUMENT THIS

☐ Language used; interpreter's name and relationship.

☐ How understanding was confirmed.

☐ Translated documents provided.

LEGAL TRAPS

✖ English-only consent forms signed by patients who cannot read English.

✖ Using the alleged abuser as interpreter.

✖ Assuming nodding means understanding.

CASE LAW / KEY PRINCIPLE

Principle — Courts examine whether the patient actually understood — the form's language is often questioned.

PEARL **If they can't understand you, they haven't consented.**

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TOPIC 80 OF 100 | OPERATIONAL AND SYSTEM PRESSURES

Clinical decision support and EHR alerts

Overriding an electronic safety alert is sometimes right — but record why.

⚖ THE LAW

BSA 63	EHR logs, alerts and overrides are admissible electronic evidence.
CPA 2019	Ignoring a system warning that would have prevented harm can be a deficiency.
ICMR Ethical Guidelines for AI in Healthcare (2023)	Clinicians remain accountable for decisions supported by digital tools.

IN THE ED — WHAT TO DO

1. Read alerts (allergy, interaction, dose) before overriding.
2. Override only for a clear clinical reason; enter the reason in the override field.
3. Report faulty or excessive alerts to the IT/clinical safety team.
4. Double-check high-risk drugs (insulin, potassium, heparin, opioids).
5. Never use another person's login to bypass restrictions.

DOCUMENT THIS

- ☐ Override reason.
- ☐ Discussion with pharmacist or senior where relevant.
- ☐ Monitoring plan when giving a flagged drug.

LEGAL TRAPS

- ✖ Habitual "click-through" of every alert.
- ✖ Overriding allergy alerts without checking the reaction history.
- ✖ Disabling alerts without governance approval.

CASE LAW / KEY PRINCIPLE

Principle — Audit trails show every override — an unexplained override after harm looks indefensible.

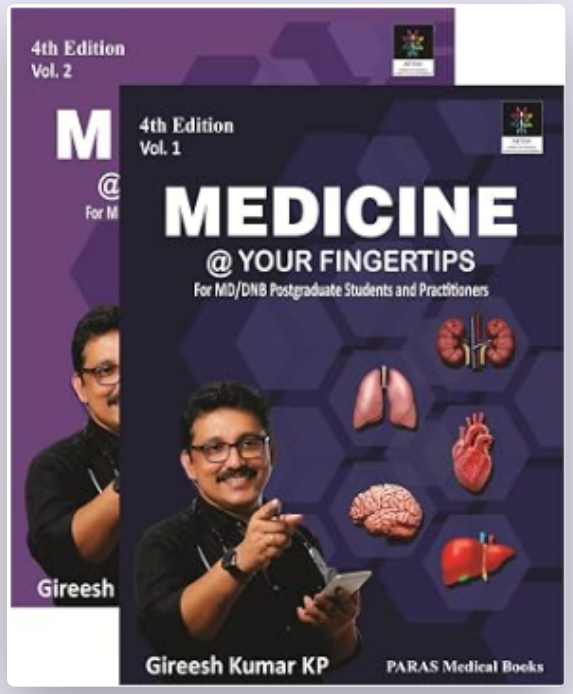
PEARL **Override with a reason, or don't override.**

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PART 9

Ethics, Professionalism and the Courtroom

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TOPIC 81 OF 100 | ETHICS, PROFESSIONALISM AND THE COURTROOM

Court summons — what to do

A summons is a legal order; obey it, prepare from your records, and inform your institution.

⚖ THE LAW

BNSS 63–71	Form and service of summons (including on government servants through the head of office, and by post/electronic means).
BNSS 94	Summons to produce a document or other thing (e.g., medical records).
BNS 208	Intentional non-attendance in obedience to a lawful summons is punishable.
BNSS 530 & BNSS 254/265/308	Proceedings may be held in electronic mode; evidence can be recorded by audio-video means.

IN THE ED — WHAT TO DO

1. Acknowledge receipt; note the court, case number, date and time.
2. Inform your head of department/medical superintendent and the medico-legal cell.
3. Retrieve and study the original records; prepare a copy.
4. If you genuinely cannot attend, inform the court in writing in advance with reasons, or request video-conference evidence.
5. Claim travel allowance/witness fees as per rules.

DOCUMENT THIS

☐ Summons register entry: date received, date of appearance.
☐ Records taken to court and returned.
☐ Communication with the court.

LEGAL TRAPS

✖ Ignoring summons — courts can issue bailable or non-bailable warrants.
✖ Sending a junior who did not examine the patient.
✖ Taking original records without permission and losing them.

CASE LAW / KEY PRINCIPLE

Principle — Doctors' timely evidence is essential to justice; courts increasingly allow video evidence to reduce disruption.

PEARL **Never ignore a summons — attend, request VC, or explain in advance.**

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TOPIC 82 OF 100 | ETHICS, PROFESSIONALISM AND THE COURTROOM

Fact witness versus expert witness

As the treating doctor you testify to facts you recorded; as an expert you give opinions — know which role you are in.

⚖ THE LAW

BSA 39(1) Opinions of experts in science (including medicine) are relevant facts.

BSA 45 The grounds on which an expert's opinion is based are also relevant.

BNSS 326 Deposition of a medical witness taken before a Magistrate may be given in evidence in the Sessions trial.

BNSS 329 / 330 Reports of certain government scientific experts and certain documents may be used without formal proof (unless the court requires).

IN THE ED — WHAT TO DO

1. Fact witness: describe what you saw, did and recorded; avoid opinions outside your field.
2. Expert witness: state your qualifications, the material you relied on, your reasoning, and its limits.
3. Distinguish clearly between what you observed and what you infer.
4. Remain impartial — your duty is to the court, not to either side.
5. Refuse to give opinions outside your expertise.

DOCUMENT THIS

☐ Your original notes and certificates, read before deposition.
☐ Literature you rely on (for expert opinion).
☐ Copy of your deposition if provided.

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LEGAL TRAPS

✖ Becoming an advocate for one side.
✖ Guessing beyond the evidence.
✖ Contradicting your own records without explanation.

CASE LAW / KEY PRINCIPLE

State of H.P. v. Jai Lal (1999) 7 SCC 280 — An expert must be skilled, and the court must be satisfied about the grounds of opinion; the opinion is advisory.

PEARL **Facts from memory and records; opinions only with reasons.**

TOPIC 83 OF 100 | ETHICS, PROFESSIONALISM AND THE COURTROOM

Giving evidence in criminal courts for MLC injuries

Your wound certificate becomes evidence — prepare, be precise, and be fair.

⚖ THE LAW

BSA 162–164	A witness may refresh memory from notes made at the time; the adverse party may inspect them.
BSA 142 / 143	Examination-in-chief, cross-examination and re-examination.
BSA 146	Leading questions are generally not permitted in examination-in-chief but are allowed in cross-examination.
BNS 229	Giving false evidence is punishable.

IN THE ED — WHAT TO DO

1. Read the MLC record, wound certificate and any additional reports before the hearing.
2. Bring the original register or certified copy as directed.
3. Answer the question asked; keep answers short and factual.
4. Explain medical terms simply for the court.
5. If you do not know or cannot remember, say so.

DOCUMENT THIS

- ☐ Your copy of the certificate and notes.
- ☐ Any revised opinion (e.g., after X-ray) and its date.
- ☐ Court attendance record.

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LEGAL TRAPS

- ✖ Changing your opinion in court without a medical reason.
- ✖ Using jargon the judge cannot follow.
- ✖ Volunteering speculation about the accused.

CASE LAW / KEY PRINCIPLE

Principle — Contemporaneous notes used to refresh memory carry great weight; inconsistent testimony damages credibility.

PEARL Your best preparation is a good record made years earlier.

TOPIC 84 OF 100 | ETHICS, PROFESSIONALISM AND THE COURTROOM

Handling cross-examination

Stay calm, courteous and factual — the lawyer tests your evidence, not your worth.

⚖ THE LAW

BSA 146 & 149 Leading questions and questions to test veracity are allowed in cross-examination.

BSA 148 Cross-examination on previous written statements (your earlier certificate or notes).

BSA 137 A witness is not excused from answering on the ground that the answer may incriminate — but such answers cannot be used against him except for perjury.

IN THE ED — WHAT TO DO

1. Listen to the full question; pause before answering.
2. Ask for the question to be repeated or clarified if needed.
3. Answer "yes", "no", or "I don't know" when that is the truth; explain if needed.
4. Concede reasonable points (e.g., possible alternative mechanisms).
5. Address the judge; remain respectful even when provoked.

DOCUMENT THIS

☐ Know your record — dates, times, findings.
☐ Know textbook basics of your findings (age of bruise, weapon class).
☐ Notes on cases you have deposed in.

LEGAL TRAPS

✖ Arguing with the lawyer.
✖ Giving absolute answers ("impossible") where medicine allows doubt.
✖ Being drawn into areas outside your expertise.

CASE LAW / KEY PRINCIPLE

Principle — Calm concession of uncertainty increases credibility; dogmatism reduces it.

PEARL **Short answers, true answers, polite answers.**

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TOPIC 85 OF 100 | ETHICS, PROFESSIONALISM AND THE COURTROOM

Working early with hospital risk management and legal counsel

When a complaint, notice or adverse event arises, involve the medico-legal team early — and say nothing you would not say in court.

⚖ THE LAW

CPA 2019 s.69 Consumer complaints within 2 years of the cause of action; notices often come later.

BSA 132 Professional communications with legal advisers are privileged.

BNS 238 / 241 Never destroy or alter records in anticipation of litigation.

IN THE ED — WHAT TO DO

1. Inform your head of department and the hospital's medico-legal cell as soon as you receive a complaint or legal notice.
2. Secure the original records; make a copy for your reference.
3. Write a factual personal account (for counsel, not in the case sheet).
4. Inform your indemnity insurer promptly as required by the policy.
5. Do not contact the complainant or discuss the case on social media.

DOCUMENT THIS

☐ Date of receipt of notice; to whom it was forwarded.

☐ Your factual statement (kept with counsel).

☐ Insurer notification.

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LEGAL TRAPS

✖ Replying to legal notices yourself without advice.

✖ Late intimation to the insurer (may void cover).

✖ Discussing the case with colleagues in a way that can be quoted.

CASE LAW / KEY PRINCIPLE

Principle — Early, organised defence with intact records is the most effective protection.

PEARL **Notify early, preserve records, speak through counsel.**

TOPIC 86 OF 100 | ETHICS, PROFESSIONALISM AND THE COURTROOM

Peer review, audits and confidentiality

Peer review improves care, but India has no specific statutory privilege for it — write review documents carefully.

⚖ THE LAW

BSA (no doctor–patient or peer-review privilege)	Only certain communications (e.g., with legal advisers, BSA 132) are privileged; courts may summon other documents (BNSS 94).
IMC Regulations 2002	Professional courtesy and the duty to expose unethical conduct by colleagues.
Clinical Establishments and NABH standards	Require morbidity–mortality reviews and incident reporting.

IN THE ED — WHAT TO DO

1. Participate in morbidity and mortality meetings and audits.
2. Keep review discussions focused on systems and learning.
3. Separate quality documents from the patient's medical record.
4. Write factual, non-judgemental review notes.
5. Follow hospital policy on confidentiality of audit documents.

DOCUMENT THIS

- ☐ Minutes stating facts and system lessons.
- ☐ Action plans with responsibility.
- ☐ Anonymised data where possible.

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LEGAL TRAPS

✖ Writing "this was negligence" in an audit note.

✖ Copying audit conclusions into the patient's record.

✖ Using peer review for personal rivalries.

CASE LAW / KEY PRINCIPLE

Principle — Audit documents may be summoned; write them as if the judge will read them.

PEARL **Learn openly, write carefully.**

TOPIC 87 OF 100 | ETHICS, PROFESSIONALISM AND THE COURTROOM

Complaints to medical councils

Respond promptly, professionally and with facts — a well-prepared reply often ends the matter.

⚖ THE LAW

NMC Act 2019 s.30	State Medical Councils receive and decide complaints of professional or ethical misconduct; appeals lie to the NMC's Ethics and Medical Registration Board (EMRB).
IMC (Professional Conduct, Etiquette and Ethics) Regulations 2002	Continue to define misconduct while the NMC's 2023 conduct regulations remain in abeyance — check the current NMC notification.
IMC Regulations 2002, Ch. 8	Punishment ranges from warning to removal of name from the register.

IN THE ED — WHAT TO DO

1. Read the complaint carefully and note the deadline.
2. Seek advice from the medico-legal cell, senior colleagues and your insurer.
3. Reply in a factual, chronological manner with copies of records.
4. Be respectful; avoid attacking the complainant.
5. Attend hearings with your counsel if permitted.

DOCUMENT THIS

- ☐ Copy of complaint and your reply with enclosures.
- ☐ Dates of hearings and outcomes.
- ☐ Any appeal timelines.

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LEGAL TRAPS

- ✖ Ignoring council notices.
- ✖ Emotional or defensive replies.
- ✖ Altering records before producing them.

CASE LAW / KEY PRINCIPLE

Principle — Councils judge professional conduct — honest records and a respectful reply carry great weight.

PEARL **Facts, records, respect, deadlines.**

TOPIC 88 OF 100 | ETHICS, PROFESSIONALISM AND THE COURTROOM

Dual loyalty — patients in police custody

Your primary duty is to the patient's health; cooperate with lawful police requests without becoming an instrument of coercion.

⚖ THE LAW

BNSS 51 / 52 / 53	Lawful medical examination of accused and arrested persons at police request.
D.K. Basu (1997)	Medical examination to protect arrestees from custodial violence.
Selvi v. State of Karnataka (2010)	Involuntary narco-analysis and similar techniques are unconstitutional.
IMC Regulations 2002, 2.2 & 7.14	Confidentiality; disclosure only as required by law.

IN THE ED — WHAT TO DO

1. Treat medical needs first, irrespective of the alleged crime.
2. Perform only examinations and sample collections that are lawful and requisitioned.
3. Record any allegation of torture and injuries consistent with it.
4. Refuse to participate in torture, forced testing outside the law, or falsified certificates.
5. Seek advice from seniors/medico-legal cell when pressured.

DOCUMENT THIS

☐ Requisition, examination done, consent/refusal.
☐ Injuries and allegations.
☐ Pressure or threats received (factually).

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LEGAL TRAPS

✖ Certifying "fit for custody" without examination.
✖ Collecting samples beyond the requisition.
✖ Sharing medical information unrelated to the investigation.

CASE LAW / KEY PRINCIPLE

D.K. Basu v. State of W.B. (1997) 1 SCC 416 — Doctors are a safeguard against custodial abuse.

PEARL **Doctor first, witness second, never an interrogator.**

TOPIC 89 OF 100 | ETHICS, PROFESSIONALISM AND THE COURTROOM

Social media and your digital footprint

Never post identifiable patient information or rant online — it can breach confidentiality, defame and end careers.

⚖ THE LAW

IMC Regulations 2002, 2.2 & 7.14	Disclosure of patient secrets is misconduct.
IMC Regulations 2002, 6.1	Doctors must not advertise or solicit patients.
BNS 72	Disclosure of identity of sexual-offence victims.
BNS 356	Defamation; IT Act s.72A and DPDP Act 2023 — unlawful disclosure of personal data.

IN THE ED — WHAT TO DO

1. Do not post patient photos, X-rays or stories that could identify the patient — even without names.
2. Take explicit consent for any educational use and de-identify thoroughly.
3. Keep professional and personal accounts separate.
4. Do not comment on colleagues' or hospitals' cases publicly.
5. Think before posting about workplace violence or disputes — use official channels.

DOCUMENT THIS

☐ Written consent for any image used in teaching or publication.
☐ De-identification steps.
☐ Institutional approval where required.

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LEGAL TRAPS

✖ "Interesting case" posts from the ED in WhatsApp groups.
✖ Venting about a patient or family.
✖ Selfies in the resuscitation room.

CASE LAW / KEY PRINCIPLE

Principle — Screenshots are permanent evidence; deletion does not erase liability.

PEARL **If you wouldn't say it in court, don't post it online.**

TOPIC 90 OF 100 | ETHICS, PROFESSIONALISM AND THE COURTROOM

Conscientious objection and declining procedures

You may decline non-emergency acts against your conscience — never an emergency or life-saving duty.

⚖ THE LAW

Constitution Art. 21 & Parmanand Katara (1989) Emergency care cannot be refused.

MTP Act 1971 s.5 Termination by a single RMP is lawful at any gestation when immediately necessary to save the woman's life — personal objection cannot justify refusal then.

IMC Regulations 2002, 2.4 A doctor may choose whom to serve, but must respond in an emergency and must not abandon a patient.

BNSS 184(7) Nothing permits examination of a survivor without her consent — her refusal is respected.

IN THE ED — WHAT TO DO

1. Declare foreseeable objections to your department in advance.
2. In a non-emergency, refer promptly to a willing colleague without delay or judgement.
3. In an emergency, act to save life regardless of personal views.
4. Never impose your beliefs on the patient.
5. Follow lawful police/court directions for examinations within consent rules.

DOCUMENT THIS

- ☐ The request, your objection, and the referral made (time, to whom).
- ☐ Emergency care given.
- ☐ Patient informed of alternatives.

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LEGAL TRAPS

- ✖ Delaying a referral to frustrate a lawful choice.
- ✖ Refusing emergency management because it involves a contested procedure.
- ✖ Moral comments recorded in notes.

CASE LAW / KEY PRINCIPLE

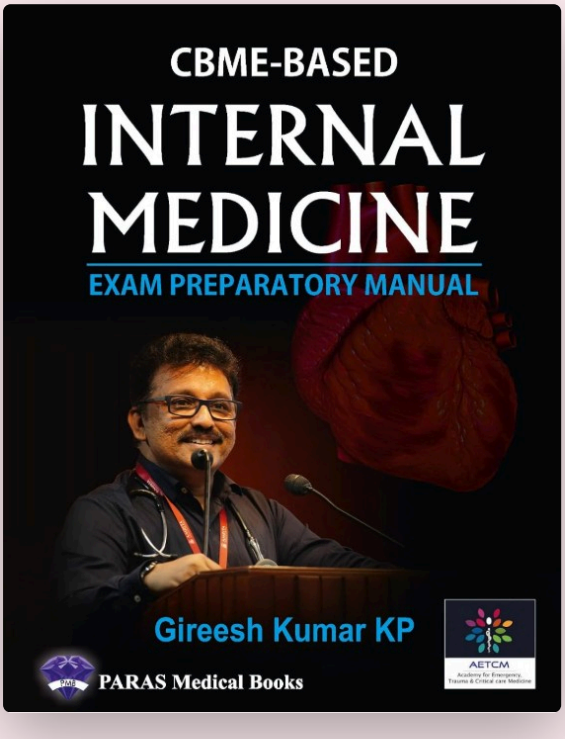
Principle — Conscience is a personal right that never overrides a patient's right to emergency care.

PEARL **Object if you must, refer at once, and never in an emergency.**

ALSO BY THE AUTHOR

Dr. Gireesh Kumar K.P.

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PART 10

Special Populations and Emerging Frontiers

91. Poor and uninsured patients p. 115
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93. Refugees and asylum seekers p. 117
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TOPIC 91 OF 100 | SPECIAL POPULATIONS AND EMERGING FRONTIERS

Poor and uninsured patients

Inability to pay is never a reason to refuse or delay emergency care — use the schemes that exist.

⚖ THE LAW

Constitution Art. 21; Parmanand Katara (1989); Paschim Banga (1996)	Right to emergency care irrespective of means.
CEA 2010 s.12(2)	Stabilisation duty of every registered clinical establishment.
AB PM-JAY & State health schemes	Cashless secondary/tertiary care for eligible families at empanelled hospitals.
MV Act s.162 & Cashless Scheme 2025; BNSS 397	Cashless care for RTA victims; free care for rape and acid-attack survivors.

IN THE ED — WHAT TO DO

1. Treat first; discuss finances only after stabilisation.
2. Check eligibility for PM-JAY or State schemes; involve the scheme desk/social worker.
3. For RTAs, enrol under the cashless scheme.
4. For rape and acid-attack survivors, treat completely free.
5. If transfer to a government hospital is needed, transfer safely (Topic 77).

DOCUMENT THIS

☐ Time of treatment vs time of financial counselling.
☐ Scheme enrolment details.
☐ Reasons for any transfer.

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LEGAL TRAPS

✖ Holding patients or bodies for unpaid bills.
✖ Discharging unstable poor patients to "manage at home".
✖ Asking for deposits at triage.

CASE LAW / KEY PRINCIPLE

Paschim Banga Khet Mazdoor Samity v. State of W.B. (1996) 4 SCC 37 — The State must ensure emergency care is available to all.

PEARL The emergency is the same whatever the wallet.

TOPIC 92 OF 100 | SPECIAL POPULATIONS AND EMERGING FRONTIERS

Foreign nationals and non-citizens

Art. 21 protects every person in India — treat non-citizens fully, and comply with reporting duties for foreigners.

⚖ THE LAW

Constitution Art. 21	The right to life applies to "every person", not only citizens.
Immigration and Foreigners Act 2025 s.10 (in force 1 Sept 2025)	Hospitals and nursing homes that provide indoor treatment/lodging must report foreigners admitted (and attendants given beds) to the Registration Officer as prescribed.
MLC duties (BNSS 173, 194)	Apply equally to foreign nationals.

IN THE ED — WHAT TO DO

1. Provide emergency care without regard to nationality, visa or documentation.
2. Inform the hospital's foreigner-registration desk to file the prescribed report with the Registration Officer, in the form and manner notified.
3. Use interpreters; inform the embassy/consulate when the patient wishes or in death, through police/administration.
4. Keep copies of passport/visa when available — but never delay treatment for them.

DOCUMENT THIS

- ☐ Nationality and documents seen.
- ☐ Reports filed and their reference numbers.
- ☐ Consent in an understood language.

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LEGAL TRAPS

- ✖ Refusing treatment for lack of a passport.
- ✖ Not reporting foreign in-patients as required.
- ✖ Sharing patient details with authorities beyond legal requirements.

CASE LAW / KEY PRINCIPLE

Principle — Constitutional protection of life extends to foreigners; administrative reporting does not reduce clinical duty.

PEARL **Treat first, then report as the law requires.**

TOPIC 93 OF 100 | SPECIAL POPULATIONS AND EMERGING FRONTIERS

Refugees and asylum seekers

Treat with the same standard; document injuries and trauma carefully — your records may support legal protection.

⚖ THE LAW

Constitution Art. 21	Right to life and dignity for all persons.
NHRC v. State of Arunachal Pradesh (1996) 1 SCC 742	The State must protect the life and liberty of refugees (Chakmas) in India.
Immigration and Foreigners Act 2025	Reporting of foreigners admitted to hospitals applies.
MHCA 2017	Mental health care for trauma, including for non-citizens.

IN THE ED — WHAT TO DO

1. Provide emergency care without discrimination.
2. Use interpreters; be trauma-informed.
3. Document injuries, scars and psychological symptoms objectively when requested.
4. Link with UNHCR partner agencies/NGOs where available.
5. Maintain confidentiality — disclose only as required by law.

DOCUMENT THIS

☐ Identity documents shown (e.g., UNHCR card).
☐ Injuries/scars with descriptions and photographs (with consent).
☐ Referrals made.

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LEGAL TRAPS

✖ Speculating on immigration status in clinical notes.
✖ Denying care due to fear of authorities.
✖ Disclosing location or details to unauthorised persons.

CASE LAW / KEY PRINCIPLE

National Human Rights Commission v. State of Arunachal Pradesh (1996) 1 SCC 742 — Protection of life and liberty of non-citizens.

PEARL **Document what you see, not what you assume.**

TOPIC 94 OF 100 | SPECIAL POPULATIONS AND EMERGING FRONTIERS

Falls in the elderly and suspected neglect

Investigate the cause of the fall, look for injury and neglect, and plan a safe discharge.

⚖ THE LAW

MWPSC Act 2007 s.24 Abandonment of a senior citizen by a person having care — punishable.

BNS 115 / 117 Hurt and grievous hurt, including by carers.

CPA 2019 Missed fractures/intracranial bleeds in elderly fallers are common claims.

IN THE ED — WHAT TO DO

1. Ask why the patient fell (syncope, stroke, drugs, hypoglycaemia, arrhythmia).
2. Have a low threshold for CT head in anticoagulated elderly patients and for hip/spine imaging.
3. Look for signs of neglect: pressure sores, dehydration, malnutrition, poor hygiene.
4. Assess home safety and support before discharge.
5. Involve geriatrics/social work; inform police if assault or wilful neglect is suspected.

DOCUMENT THIS

☐ Mechanism, preceding symptoms, medications (anticoagulants).

☐ Injuries and neglect signs with photographs.

☐ Discharge plan and carer.

LEGAL TRAPS

✖ Missing hip fractures in "unable to walk" elderly.

✖ Discharging confused patients alone.

✖ Ignoring repeated "falls" histories.

CASE LAW / KEY PRINCIPLE

Principle — Repeat falls with injuries of varying ages warrant safeguarding enquiry.

PEARL **Ask why they fell and whether they are safe to go home.**

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TOPIC 95 OF 100 | SPECIAL POPULATIONS AND EMERGING FRONTIERS

Telemedicine and remote consultations

Teleconsultation follows the Telemedicine Practice Guidelines 2020 — same standards, clear limits, full records.

⚖ THE LAW

Telemedicine Practice Guidelines 2020 (MoHFW / NMC)	RMPs may consult by video, audio or text; must verify identity, obtain consent, maintain records and refer to in-person care when needed; prescribing restrictions apply (e.g., Schedule X/NDPS drugs not permitted).
IT Act 2000 & DPDP Act 2023	Secure handling of patient data.
CPA 2019	Deficiency in teleconsultation services is actionable.

IN THE ED — WHAT TO DO

1. Verify patient identity and the RMP's registration is visible.
2. Obtain consent (implied when patient initiates; explicit otherwise).
3. Use teleconsultation for triage/advice; direct emergencies to the nearest ED/108.
4. Prescribe only as permitted for the mode of consultation.
5. Keep records of the consultation and prescriptions.

DOCUMENT THIS

- ☐ Mode, time, patient identity verification, consent.
- ☐ History, advice, prescription.
- ☐ Referral advice.

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LEGAL TRAPS

- ✖ Prescribing narcotics or Schedule X drugs remotely.
- ✖ Managing obvious emergencies remotely.
- ✖ Using insecure personal chat apps without safeguards.

CASE LAW / KEY PRINCIPLE

Principle — The same duty of care applies whether the patient is in front of you or on a screen.

PEARL **Telemedicine extends care — it doesn't lower the standard.**

TOPIC 96 OF 100 | SPECIAL POPULATIONS AND EMERGING FRONTIERS

Artificial intelligence in triage and diagnosis

AI tools assist — the doctor decides, and the doctor is accountable.

⚖ THE LAW

ICMR Ethical Guidelines for Application of AI in Biomedical Research and Healthcare (2023)	Human oversight, accountability, transparency and data protection are required.
Medical Devices Rules 2017	Software that functions as a medical device may need regulatory approval.
DPDP Act 2023	Personal data used by AI tools must be processed lawfully.
Jacob Mathew / Kusum Sharma standard	Liability is judged by the conduct of a reasonable doctor — reliance on a tool does not remove it.

IN THE ED — WHAT TO DO

1. Use only approved, validated tools within their intended use.
2. Treat AI output as one input; verify against clinical findings.
3. Document your own reasoning, especially when you disagree with the AI.
4. Inform patients when AI is materially involved, per hospital policy.
5. Report errors and biases to the governance team.

DOCUMENT THIS

- ☐ Tool name/version and output used.
- ☐ Your independent assessment.
- ☐ Reason for agreeing/disagreeing.

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LEGAL TRAPS

- ✖ Copy-pasting AI-generated notes without verification.
- ✖ Uploading identifiable patient data to public chatbots.
- ✖ Deferring to the algorithm when the patient looks sick.

CASE LAW / KEY PRINCIPLE

Principle — The clinician remains the legally responsible decision-maker.

PEARL **AI suggests; you decide; you document.**

TOPIC 97 OF 100 | SPECIAL POPULATIONS AND EMERGING FRONTIERS

Wearable and consumer health data

Smartwatch ECGs and home readings can help — interpret them critically and record them properly.

⚖ THE LAW

BSA 61 / 63	Electronic and digital records are admissible with the required certificate.
DPDP Act 2023 & IT Act 2000	Handle personal health data lawfully and securely.
Medical Devices Rules 2017	Consumer devices may not be validated medical devices.

IN THE ED — WHAT TO DO

1. Ask about data from wearables (heart rhythm alerts, glucose monitors, BP records).
2. Interpret with caution; confirm with standard tests (12-lead ECG, lab glucose).
3. Record relevant data in the notes with device type and time.
4. Do not ignore significant alerts; do not over-rely on normal readings.
5. Save images or exports only through secure hospital systems.

DOCUMENT THIS

- ☐ Device, data shown, time stamp.
- ☐ Your confirmatory tests.
- ☐ How the data influenced decisions.

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LEGAL TRAPS

- ✖ Dismissing a smartwatch AF alert without ECG.
- ✖ Storing patient screenshots on personal phones.
- ✖ Treating consumer data as definitive.

CASE LAW / KEY PRINCIPLE

Principle — If you rely on patient-provided digital data, record what you saw and how you verified it.

PEARL **Use it, verify it, record it.**

TOPIC 98 OF 100 | SPECIAL POPULATIONS AND EMERGING FRONTIERS

Pandemics and mass-casualty incidents

In disasters, triage and resource allocation follow declared plans — document the crisis standard you worked under.

⚖ THE LAW

Disaster Management Act 2005	National/State/District plans; obligations to follow directions of disaster authorities.
Epidemic Diseases Act 1897 (as amended 2020)	Powers to regulate during epidemics; protection of healthcare workers from violence.
BNS 271–273	Spreading infection negligently/malignantly; disobeying quarantine rules.
Paschim Banga (1996)	The State must plan for emergency care capacity.

IN THE ED — WHAT TO DO

1. Activate the hospital disaster plan; know your role.
2. Use a standard mass-casualty triage system (e.g., START/SALT).
3. Allocate scarce resources according to the declared protocol, not personal preference.
4. Keep minimum dataset records (triage tag, injuries, treatment, disposition).
5. Protect staff with PPE and rest rotations.

DOCUMENT THIS

☐ Triage tag numbers and categories.
☐ Time of declaration of disaster and protocol used.
☐ Deviations from usual standards and reasons.

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LEGAL TRAPS

✖ Abandoning documentation entirely.
✖ Ad-hoc allocation of ventilators/ICU beds without criteria.
✖ Speaking to the media without authorisation.

CASE LAW / KEY PRINCIPLE

Principle — Courts consider the extraordinary circumstances of a disaster when judging standard of care — if it is documented.

PEARL **Plan, triage, record, rotate.**

TOPIC 99 OF 100 | SPECIAL POPULATIONS AND EMERGING FRONTIERS

Cyber-security and ransomware

When systems go down, patient care continues on paper — and incidents must be reported promptly.

⚖ THE LAW

IT Act 2000 s.70B & CERT-In Directions (April 2022)	Cyber-security incidents must be reported to CERT-In within 6 hours of noticing them.
DPDP Act 2023 & DPDP Rules 2025	Personal data breaches must be intimated to the Data Protection Board and affected persons as prescribed.
IT Act s.43A / s.72A	Liability for negligent data security and unlawful disclosure.

IN THE ED — WHAT TO DO

1. Have downtime procedures: paper case sheets, lab request forms, manual drug charts.
2. On suspected attack, inform IT security immediately; do not pay or negotiate yourself.
3. Continue clinical care; prioritise critical patients' information (allergies, medications).
4. After recovery, enter paper notes into the system as "downtime entries" with original times.
5. Use strong passwords, multi-factor login, and never open suspicious attachments.

DOCUMENT THIS

- ☐ Downtime start/end times.
- ☐ Paper records scanned and linked.
- ☐ Incident report reference.

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LEGAL TRAPS

✖ Clinical paralysis because "the system is down".

✖ Using personal email/WhatsApp to transfer patient data during outages.

✖ Delayed reporting beyond statutory timelines.

CASE LAW / KEY PRINCIPLE

Principle — Patient safety during downtime depends on rehearsed paper processes.

PEARL **Practise downtime before it happens.**

TOPIC 100 OF 100 | SPECIAL POPULATIONS AND EMERGING FRONTIERS

Professional indemnity insurance

Every emergency doctor needs personal indemnity cover — understand limits, exclusions, and claim notification.

⚖ THE LAW

CPA 2019	Consumer commissions can award large compensation; pecuniary jurisdiction: District up to ₹50 lakh, State ₹50 lakh–₹2 crore, National above ₹2 crore (2021 Rules).
IMA v. V.P. Shantha (1995) 6 SCC 651	Medical services are covered by consumer law.
Dr. Balram Prasad v. Dr. Kunal Saha (2014) 1 SCC 384	Very high compensation awarded for medical negligence.
BNS 106(1)	Criminal proceedings are not covered by civil indemnity in the same way — legal defence cover terms vary.

IN THE ED — WHAT TO DO

1. Buy personal professional indemnity cover adequate for emergency practice; renew on time.
2. Check whether cover is "claims-made" or "occurrence-based"; buy retroactive/tail cover when changing jobs or retiring.
3. Check whether legal defence costs for criminal and council proceedings are included.
4. Notify the insurer promptly of any notice, complaint or incident likely to lead to a claim.
5. Keep policy documents accessible.

DOCUMENT THIS

- ☐ Policy number, insurer, limits, period.
- ☐ Notifications made with dates.
- ☐ Correspondence with insurer's counsel.

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LEGAL TRAPS

- ✖ Relying only on the hospital's policy.
- ✖ Late notification that voids cover.
- ✖ Admitting liability or settling without the insurer's consent.

CASE LAW / KEY PRINCIPLE

Dr. Balram Prasad v. Dr. Kunal Saha (2014) 1 SCC 384 — Illustrates the scale of potential liability.

PEARL **Insure, read the policy, notify early.**

Appendix A — Bharatiya Nyaya Sanhita 2023 (BNS)

Section	Subject	Old IPC	Topics
BNS 2(3)	"Child" — a person below 18 years	New	7
BNS 2(11)	"Good faith" — done with due care and attention	52	1
BNS 3(5)	Acts done by several persons in furtherance of common intention	34	—
BNS 18	Accident in doing a lawful act	80	—
BNS 19	Act likely to cause harm, done without criminal intent, to prevent other harm	81	—
BNS 20–22	Child under 7; child 7–12 of immature understanding; person of unsound mind	82–84	4
BNS 23–24	Intoxication — involuntary; voluntary (knowledge presumed)	85–86	8
BNS 25	Consent (person above 18) to harm not intended or known likely to cause death/grievous hurt	87	2
BNS 26	Act not intended to cause death, done by consent in good faith for the person's benefit	88	1, 2, 64
BNS 27	Act in good faith for benefit of child under 12 / person of unsound mind, with guardian's consent	89	5, 7
BNS 28	Consent known to be given under fear or misconception; consent of child, insane or intoxicated person	90	2, 4, 7, 8, 79
BNS 30	Act done in good faith for benefit of a person without consent	92	1, 3, 7, 15, 64, 66
BNS 31	Communication made in good faith	93	—
BNS 63–64	Rape — definition (medical procedure is not rape) and punishment	375–376	27
BNS 65	Rape of a woman under 16 / under 12 years	376(3), 376AB	27
BNS 66	Rape causing death or persistent vegetative state	376A	27
BNS 70	Gang rape	376D	27
BNS 72	Disclosure of identity of victim of certain offences	228A	27, 42, 89
BNS 74–79	Outraging modesty, sexual harassment, disrobing, voyeurism, stalking, insulting modesty	354, 354A–D, 509	—
BNS 80	Dowry death	304B	26, 45
BNS 85–86	Cruelty by husband or relatives; definition of cruelty	498A	26, 45
BNS 88–92	Causing miscarriage; without consent; death of quick unborn child	312–316	63
BNS 93	Exposure and abandonment of child under 12	317	43
BNS 94	Concealment of birth by secret disposal of dead body	318	—
BNS 100–101	Culpable homicide; murder	299–300	52
BNS 103	Punishment for murder (103(2): murder by group on specified grounds)	302	52
BNS 105	Punishment for culpable homicide not amounting to murder	304	52
BNS 106(1)	Death by negligence — RMP during medical procedure: up to 2 years and fine	304A	9, 17, 23, 31, 33, 35, 38, 52, 56, 61, 100
BNS 106(2)	Rash/negligent driving causing death and escaping without reporting (kept in abeyance)	New	52

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Appendix A — Bharatiya Nyaya Sanhita 2023 (BNS) (continued)

Section	Subject	Old IPC	Topics
BNS 107–108	Abetment of suicide (child / unsound mind; general)	305–306	28
BNS 109–110	Attempt to murder; attempt to commit culpable homicide	307–308	24, 25
BNS 114–115	Hurt; voluntarily causing hurt and punishment	319, 321, 323	24, 44, 45, 48, 62, 66, 94
BNS 116	Grievous hurt — eight kinds (now 15 days' severe pain/incapacity)	320	24, 67, 68, 70
BNS 117	Voluntarily causing grievous hurt	322, 325	24, 44, 45, 48, 62, 94
BNS 118	Hurt / grievous hurt by dangerous weapons or means	324, 326	24, 25, 44, 45, 62
BNS 121(1)	Voluntarily causing hurt to deter public servant from duty	332	48
BNS 123	Causing hurt by poison with intent to commit an offence	328	28, 65
BNS 124	Grievous hurt by acid; throwing or attempting to throw acid	326A, 326B	26
BNS 125	Act endangering life or personal safety of others	336–338	23
BNS 126–127	Wrongful restraint; wrongful confinement	339–342	3, 18, 44, 66
BNS 132	Assault or criminal force to deter public servant	353	48
BNS 200	Punishment for non-treatment of victim (hospital in charge)	166B	22, 27, 41
BNS 208	Non-attendance in obedience to an order (summons) from public servant	174	81
BNS 210	Omission to produce document or electronic record to public servant	175	13
BNS 211	Omission to give notice or information to public servant	176	21, 22, 50
BNS 226	Attempt to commit suicide to compel or restrain public servant	New (309 not retained)	28
BNS 227–229	Giving and fabricating false evidence; punishment	191–193	11, 83
BNS 234–235	Issuing/signing a false certificate; using it as true	197–198	—
BNS 238	Causing disappearance of evidence / giving false information to screen offender	201	11, 19, 30, 40, 69, 85
BNS 239	Intentional omission to give information of offence by person bound to inform	202	21, 22
BNS 241	Destruction of document or electronic record to prevent its production as evidence	204	11, 20, 40, 85
BNS 271–273	Negligent / malignant act likely to spread infection; disobedience to quarantine	269–271	49, 98
BNS 276–278	Adulteration and sale of adulterated drugs	274–276	46
BNS 281	Rash driving or riding on a public way	279	23
BNS 286	Negligent conduct with respect to poisonous substance	284	28, 46, 65
BNS 351	Criminal intimidation	503, 506	—
BNS 356	Defamation	499–500	60, 89

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Appendix B — Bharatiya Nagarik Suraksha Sanhita 2023 (BNSS)

Section	Subject	Old CrPC	Topics
BNSS 2(1)(g)	Cognizable offence	2(c)	21
BNSS 33	Public to give information of certain offences	39	21, 22
BNSS 43(3)	Arrest how made — use of handcuffs in specified cases	46	59
BNSS 46	No unnecessary restraint	49	59
BNSS 51	Examination of accused by medical practitioner at request of police	53	8, 47, 88
BNSS 52	Examination of person accused of rape by medical practitioner	53A	88
BNSS 53	Examination of arrested person by medical officer	54	59, 88
BNSS 63–71	Summons — form, service, service on government servants, by post	61–69	81
BNSS 94	Summons to produce document or other thing	91	81
BNSS 105	Recording of search and seizure through audio-video electronic means	New	19
BNSS 173	Information in cognizable cases (FIR; zero FIR and e-FIR)	154	21, 22, 92
BNSS 176(3)	Forensic expert to visit crime scene (offences punishable with 7+ years)	157 (new sub-section)	19, 25
BNSS 179–180	Police power to require attendance and examine witnesses	160–161	—
BNSS 183	Recording of confessions and statements by Magistrate	164	29
BNSS 184	Medical examination of the victim of rape (24 hours; report in 7 days)	164A	12, 19, 27, 79, 90
BNSS 193	Police report on completion of investigation	173	—
BNSS 194	Police inquest — suicide, homicide, accident, suspicious death	174	12, 26, 30, 50, 53, 63, 92
BNSS 196	Inquiry by Magistrate into cause of death	176	30, 50
BNSS 254, 265, 308	Recording of evidence by audio-video means	231, 242, 273	81
BNSS 326	Deposition of medical witness	291	82
BNSS 329	Reports of certain Government scientific experts	293	82
BNSS 330	No formal proof of certain documents	294	82
BNSS 336	Evidence of public servants, experts, police officers in certain cases	New	—
BNSS 396	Victim compensation scheme	357A	—
BNSS 397	Treatment of victims — free first aid/treatment and police intimation	357C	21, 22, 26, 27, 41, 62, 91
BNSS 530	Trials and proceedings in electronic mode	New	81

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Appendix C — Bharatiya Sakshya Adhiniyam 2023 (BSA)

Section	Subject	Old IEA	Topics
BSA 2(1)(d)	"Document" includes electronic and digital records	3	14
BSA 22–23	Confessions caused by inducement; confession to police	24–26	—
BSA 26	Statements of persons who are dead — (a) dying declaration	32	15, 29
BSA 29	Entries in public / electronic records made in performance of duty	35	—
BSA 39	Opinions of experts; (2) Examiner of Electronic Evidence	45, 45A	12, 16, 82
BSA 45	Grounds of opinion, when relevant	51	16, 82
BSA 57–58	Primary and secondary evidence	62–63	—
BSA 61	Electronic or digital record not to be denied admissibility	New	14, 97
BSA 63	Admissibility of electronic records — certificate (Schedule)	65B	11, 14, 80, 97
BSA 117–118	Presumption: abetment of suicide by married woman; dowry death	113A–113B	26
BSA 120	Presumption as to absence of consent in certain rape prosecutions	114A	27
BSA 124	Who may testify	118	—
BSA 132	Professional communications (legal advisers) — privileged	126	85
BSA 137	Witness not excused from answering on ground of self-incrimination	132	84
BSA 142–143	Examination of witnesses; order of examinations	137–138	83
BSA 146	Leading questions	141–143	83, 84
BSA 148–149	Cross-examination on previous statements; lawful questions	145–146	84
BSA 162–164	Refreshing memory; adverse party's right to see the writing	159–161	83
BSA 168	Judge's power to put questions or order production	165	—

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Appendix D — Other Acts, rules and guidelines

Law / guideline	Why it matters in the ED
Constitution of India, Art. 21	Right to life — includes emergency medical care, privacy, dignity
Clinical Establishments (Registration & Regulation) Act 2010, s.12(2)	Duty to stabilise emergency medical conditions
Motor Vehicles Act 1988 — s.134, 134A, 162, 185, 203, 204	Duty to aid accident victims; Good Samaritan; cashless scheme; drunk driving and testing
Cashless Treatment of Road Accident Victims Scheme 2025	Up to ₹1.5 lakh per victim for 7 days at designated hospitals
Mental Healthcare Act 2017 — s.4, 5, 14, 89–90, 94, 97, 100, 103–104, 115	Capacity, advance directives, nominated representative, admission, emergency treatment, restraint, police duties, attempted suicide
POCSO Act 2012 — s.19, 21, 27; POCSO Rules 2020 r.6	Mandatory reporting, penalty, medical examination, emergency care
Juvenile Justice Act 2015 — s.32, 33, 75	Reporting of found children; cruelty to child
Transplantation of Human Organs and Tissues Act 1994 & Rules 2014	Brain-stem death board, Form 10, mandatory request, offences
MTP Act 1971 (amended 2021), s.5	Emergency termination to save life by a single RMP
HIV & AIDS (Prevention and Control) Act 2017	Consent for testing, confidentiality (s.8), non-discrimination
Maintenance and Welfare of Parents and Senior Citizens Act 2007, s.24	Abandonment of senior citizens
Protection of Women from Domestic Violence Act 2005	Medical aid to aggrieved persons; Protection Officers
NDPS Act 1985 (amended 2014); Drugs Rules 1945 Sch. H, H1, X	Essential narcotic drugs; prescription-only and controlled drugs
Registration of Births and Deaths Act 1969, s.10(3)	Medical certificate of cause of death
Epidemic Diseases Act 1897 (amended 2020)	Epidemic powers; violence against healthcare personnel
Disaster Management Act 2005	Disaster plans and authorities
Consumer Protection Act 2019 (+ 2021 jurisdiction Rules)	Medical negligence claims; 2-year limitation (s.69)
NMC Act 2019; IMC (Professional Conduct, Etiquette & Ethics) Regulations 2002	Registration, complaints, ethics, records (1.3), confidentiality (2.2, 7.14)
IT Act 2000 (s.43A, 70B, 72A); CERT-In Directions 2022	Data security, cyber incident reporting within 6 hours
Digital Personal Data Protection Act 2023 & Rules 2025	Personal data duties, breach intimation
Telemedicine Practice Guidelines 2020	Standards and prescribing limits for teleconsultation
Immigration and Foreigners Act 2025, s.10	Hospitals to report foreigners admitted as in-patients
Bio-Medical Waste Management Rules 2016; NACO PEP guidelines	Sharps safety, exposure management
Medical Devices Rules 2017; Materiovigilance Programme of India	Device adverse-event reporting
ICMR Ethical Guidelines for AI in Healthcare 2023	Accountability and oversight of AI tools

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Appendix E — Landmark judgments

Case	Principle	Topics
Achutrao Haribhau Khodwa v. State of Maharashtra (1996) 2 SCC 634	The State/hospital is vicariously liable for negligence of its doctors.	38
Arjun Panditrao Khotkar v. Kailash Gorantyal (2020) 7 SCC 1	Certificate for electronic records (now BSA 63) is mandatory for admissibility of secondary electronic evidence.	14
Aruna Ramchandra Shanbaug v. Union of India (2011) 4 SCC 454	Recognised the role of a "next friend" in decisions for an incapable patient.	5
Common Cause v. Union of India (2018) 5 SCC 1	Right to refuse medical treatment is part of the right to live with dignity.	3, 4, 6, 18, 52
D.K. Basu v. State of W.B. (1997) 1 SCC 416	Guidelines against custodial violence including medical examination.	59, 88
Dr. Balram Prasad v. Dr. Kunal Saha (2014) 1 SCC 384	Illustrates the scale of potential liability.	100
Gian Kaur v. State of Punjab (1996) 2 SCC 648	Upheld the old offence of attempted suicide; MHCA s.115 now removes punishment by presuming severe stress.	28
Jacob Mathew v. State of Punjab (2005) 6 SCC 1	Liability arises from failure to meet the standard of a reasonable practitioner — missing a treatable condition can be negligent.	8, 31
Kusum Sharma v. Batra Hospital (2010) 3 SCC 480	A doctor is not liable if he acts per a reasonable body of opinion — documentation shows that he did.	16, 32, 56
Lalita Kumari v. Govt. of U.P. (2014) 2 SCC 1	Registration of FIR is mandatory when information discloses a cognizable offence.	22
Laxman v. State of Maharashtra (2002) 6 SCC 710	A dying declaration can be relied on without a doctor's certificate if the recorder is satisfied about fitness — but the certificate strengthens it.	29
Laxmi v. Union of India (2014) 4 SCC 427	Directed free treatment for acid-attack victims in private hospitals too, and regulation of acid sale.	26
Malay Kumar Ganguly v. Dr Sukumar Mukherjee (2009) 9 SCC 221	Collective failures of the treating team amounted to negligence.	17, 37
MHCA 2017 s.115	Decriminalised attempted suicide in practice; mandates care and rehabilitation.	10
Mr. X v. Hospital Z (1998) 8 SCC 296	Disclosure of HIV status to the fiancée was justified to protect her health — a narrow exception to confidentiality.	42

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Appendix E — Landmark judgments (continued)

Case	Principle	Topics
National Human Rights Commission v. State of Arunachal Pradesh (1996) 1 SCC 742	Protection of life and liberty of non-citizens.	93
Parmanand Katara (1989)	No doctor can refuse first aid on the plea that the case is medico-legal or belongs to another hospital.	9
Paschim Banga Khet Mazdoor Samity v. State of W.B. (1996) 4 SCC 37	Failure to provide timely emergency care violates Art. 21.	1, 34, 41, 91
POCSO Act s.19–21	Non-reporting of child sexual abuse is itself an offence.	7
Poonam Verma v. Ashwin Patel (1996) 4 SCC 332	A homoeopath prescribing allopathic drugs was negligent per se.	35
Pt. Parmanand Katara v. Union of India (1989) 4 SCC 286	Preservation of life is paramount; legal formalities cannot delay emergency treatment.	1, 21
Samira Kohli v. Dr. Prabha Manchanda (2008) 2 SCC 1	Consent for diagnostic laparoscopy did not cover hysterectomy; adequate information must be disclosed for real consent.	2, 15
Savelife Foundation v. Union of India (2016) 7 SCC 194	Supreme Court approved Good Samaritan guidelines, later given statutory force in s.134A.	23
Savita Garg v. Director, National Heart Institute (2004) 8 SCC 56	Burden on the hospital to explain treatment through its records and staff.	13, 20
Selvi v. State of Karnataka (2010) 7 SCC 263	Limits on compelled testing; ordinary medical examination under procedure law remains permitted.	47
Spring Meadows Hospital v. Harjol Ahluwalia (1998) 4 SCC 39	Hospital and staff jointly liable; compensation awarded to parents as well.	39
State of H.P. v. Jai Lal (1999) 7 SCC 280	An expert must be skilled, and the court must be satisfied about the grounds of opinion; the opinion is advisory.	82
State of Jharkhand v. Shailendra Kumar Rai (2022)	Supreme Court held that anyone conducting the two-finger test is guilty of misconduct (following Lillu v. State of Haryana, 2013).	27
State of Maharashtra v. Dr. Maroti Kashinath Pimpalkar (2022)	Supreme Court held that non-reporting of child sexual abuse is a serious offence that shields offenders.	43, 62
V. Kishan Rao v. Nikhil Super Speciality Hospital (2010) 5 SCC 513	Records showing treatment and its timing are central to deciding negligence in consumer cases.	12

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Appendix F — Model formats

F1. Intimation to police — medico-legal case

To: The Station House Officer, _____ Police Station

Sir/Madam, This is to inform you that _____ (name), aged _____, sex _____, residing at _____, was brought to the Emergency Department of _____ Hospital on _____ (date) at _____ (time) by _____ (name, relation/address) with alleged history of _____ (assault / RTA / burns / poisoning / fall / other).

The patient has been registered as MLC No. _____ and is receiving treatment. Present condition: _____. Kindly take necessary action.

Signature, name, designation and registration number of doctor: _____ Date/time: _____

Received by (name, rank, number): _____ Date/time: _____

F2. Evidence label and chain-of-custody record

MLC No. _____ Patient: _____ Item: _____

Collected by: _____ on _____ at _____ Sealed with: _____

Handed over to (name, rank, number, police station): _____ on _____ at _____

Signature of doctor: _____ Signature of receiving officer: _____

Use your State/hospital's official formats where prescribed; these models show the minimum details that must appear.

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Appendix F — Model formats (continued)

F3. Leaving against medical advice (LAMA / DAMA)

I, _____, aged _____, (patient / relationship to patient _____) have been informed by Dr _____ in _____ (language) that the diagnosis is _____ and that the advised treatment is _____.

I have been told that leaving the hospital now may result in: _____ _____ including the risk of permanent disability or death.

I have been offered alternatives: _____. Despite this, I am leaving against medical advice of my own free will. I know I may return at any time.

Patient's own words: _____

Doctor's capacity assessment: The patient understands, retains and weighs the information and communicates a decision — **has / lacks** capacity for this decision.

Signature/thumb impression of patient: _____ Relative: _____ Witness: _____

Doctor (name, registration no.): _____ Date/time: _____ Police informed (MLC): Yes / No / NA

F4. Emergency treatment without consent (implied consent note)

Date/time _____. The patient is _____ (unconscious / GCS __ / in shock / hypoxic) and is unable to give consent. The condition _____ is an immediate threat to life/limb. Efforts to contact relatives: _____. Treatment given in good faith for the patient's benefit under the emergency exception (BNS 30): _____.

Doctor: _____ Witness: _____

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Appendix F — Model formats (continued)

F5. Dying declaration (when recorded by a doctor)

Hospital _____ Ward/ED _____ Date _____

Time started _____ Time ended _____

Certificate of fitness (before): I have examined _____ and found him/her conscious, oriented and mentally fit to make a statement. Clinical basis (GCS, orientation): _____

Persons present: _____ (no relative or interested person to prompt).

Q1. What is your name and address? A: _____

Q2. How did you get these injuries/burns? A: _____

Q3. Who caused them? A: _____

Q4. Where and when did it happen? A: _____

(Record questions and answers verbatim, in the declarant's language; do not ask leading questions.)

Statement read over and admitted correct. Signature/thumb impression of declarant: _____

Certificate of fitness (after): The declarant remained fit throughout. Doctor (name, reg. no.): _____ Witness: _____

Whenever possible, request the police to arrange a Magistrate to record the dying declaration (BNSS 183); record it yourself only when death is imminent and there is no time (BSA 26(a)).

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Appendix F — Model formats (continued)

F6. Injury (wound) certificate — essential contents

MLC No. _____ Name/age/sex _____ Address _____

Brought by _____ on _____ at _____

Identification marks: (1) _____ (2) _____

Alleged history (in the person's words): _____

Consent for examination: _____ Signs of alcohol/drugs: _____

Injuries — for each: number, type (abrasion/contusion/laceration/incised/stab/burn/firearm), site with measurements from landmarks, size, shape, margins, direction, colour/age: _____

Investigations advised: _____

Opinion: Injury No. __ is **simple / grievous / kept under observation**; probable weapon class **blunt / sharp / firearm / burn / chemical**; age of injuries consistent with _____.

Final opinion after investigations (date): _____

Doctor's signature, name, designation, registration number, seal: _____

F7. Brought-in-dead record

Time of arrival _____ Brought by _____ Death confirmed at _____ by _____

Findings: pulse/respiration/heart sounds absent; pupils _____; ECG _____; rigor _____; lividity _____; external injuries _____

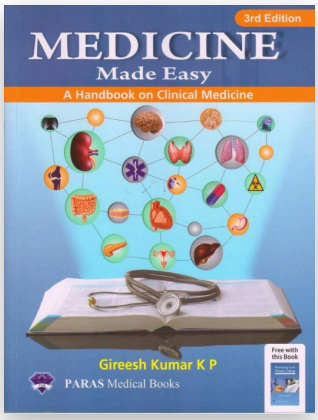
Police intimated at _____ to _____ Body shifted to mortuary at _____ Belongings handed over to _____

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ALSO BY

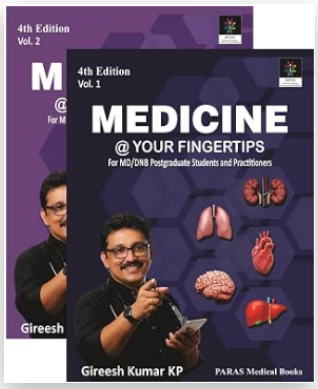
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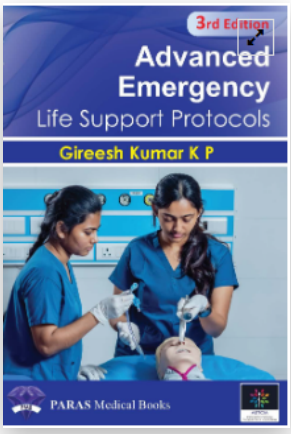
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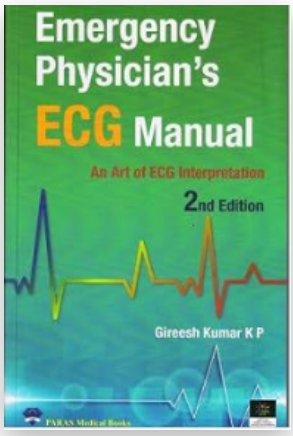
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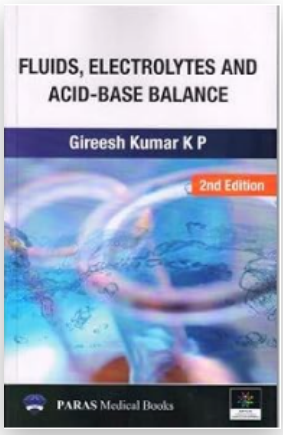
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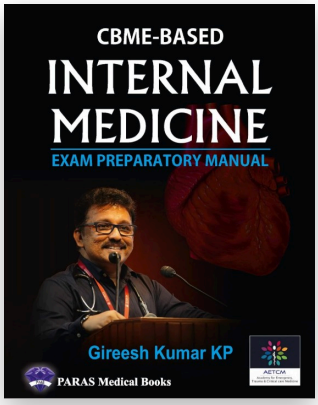
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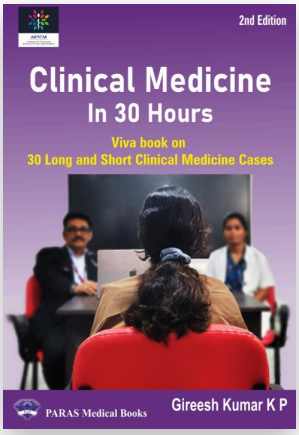
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