Medico Legal Issues and Anaesthesia

Practicing medicine now is hazardous & risky. Mutual faith replaced with mutual suspicion. With the gradual increase in number of lawsuits, it seems many more physicians will have to face legal problems in future and understanding this issue has become a need of the time. Practicing defensive medicine has also become inevitabl

Physicians should be aware of their responsibilities, rights and duties including the rights of the patients. What to prioritize in emergency situations not exceed their ability or competence. Immediate aim is to save life. Errors/mistaken diagnosis / judgment does not amount to negligence. They should know when, why and where to refer. In which cases the police should be informed. All acts must be recorded or documented. All records must be clear, chronological, correct, complete and contemporary.¹

According to the GMC, Medical Council Code of Conduct Section 1.1.2 "The quality of medical records is a direct reflection of the quality of medical practice. To achieve and maintain a high standard of medical practice, proper medical documentation is essential. All doctors have a responsibility to maintain a clear, accurate, adequate and contemporaneous medical records of their patients."

Medico legal considerations are a significant part of the process of making many patient care decisions and policies for the treatment of mentally incompetent people and minors, the performance of sterilization or therapeutic abortion, and the care of terminally ill patients. Medico legal policies provide the framework for informed consent, professional liability and many other aspects of current practice in the health care field.²

The law establishes the right of the individual to make personal decisions concerning any physical act to which his body is subjected. Personal rights are absolute and the sane individual may refuse medical treatment even such refusal is associated with the hazard of death. In the event of a surgical operation the law requires that a written consent

be obtained. An unmarried patient under the age of 18 is considered to be a minor in our country. He /She is therefore not allowed to give consent for surgery on himself/herself. Written consents obtained after administration of pre-medications have on occasion been designated as null and void by the courts. In the event of an operative mishap it is the duty of the court to consider the duties of those involved, to identify their responsibilities the surgeon, the anaesthetist, and the hospital may all be named as defendants. The Penal Code in Bangladesh allows a victim of negligence to file a case if the doctor involved did not possess the educational or professional degrees he claimed he had, or if he failed to take the patient's consent before operating on him. 4 Awareness during anaesthesia are a common cause of litigation in the west. The operating room is the highest spot of litigation. Deaths due to anaesthesia are uncommon with an estimated incidence 1 in 56,000. We are all likely to be associated with an intraoperative death at some point in our careers. Most are expected or understood. When death or serious injury is unexpected, the experience can be extremely traumatic for all concerned.⁵ How we as anesthesiologists address peri-operative risk will define the future of our profession. The definitions of anesthesia's contribution to peri-operative risk have expanded from "anesthesia-only" to "anesthesia-contributory" to "anesthesia-related".

Medico-legal issues are a continuing concern for the anesthesiologists. Taken too seriously they can alter our practice so that legal concerns rather than medical principles are in control. Taken too lightly these concerns can materialize into an "adverse outcome" disaster.

The best way of averting disasters is to prevent them and the first step in this regard is proper documentation and to report anaesthetic incidents. Regular medical audit and implementing their recommendation shall also play and important role in reducing anaesthetic incidents.

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References

- 1. Waisel DB, Truog RD. An introduction to ethics. Anesthesiology 1997; 87:411-17.
- Beauchamp TL, Childress JF. Principles of Biomedical Ethics, 4th edn. New York: Oxford University Press, 1994.
- 3. Fenwick P, Beran RG. Informed consent: should Bolam be rejected? Med Law 1997; 16:

215-23.

- Michael JP, George G. Medicolegal aspects of anesthesia. In: Nunn JF, utting JE, Brown BR eds. General anesthesia 5th edn. London: Butloeworths, 1989:1370-1383
- Hawkins J: Certified Nurse, midwives, obstetric anesthesia and you, American Society of Anesthesiologists. Newsletter 1999: 63(8).
- 6. Posner K: Data reveal trends in anesthesia malpractice payments. American Society of Anesthesiologists Newsletter 2004: 68(6).