Consent -3

- **Any physical examination needs permission or consent of the patient otherwise the doctor may be guilty of assault (battery) if he touches or even attempts to touch an unwilling person.**
- **Types of consent:**

1- **Implied consent: where a person comes to visit a doctor or asks the physician to visit him, (does not extend to intimate or to invasive examinations)**

2- **Expressed consent:**

- ***Expressed written consent.(*surgical interference or complex diagnostic procedures)**
- ***Expressed verbal consent.(* witnessed by another person)**

Elements of informed consent

Most hospitals has a special format for informed consent, it entail:

1- Nature of surgical procedure in details or treatment and why it should be done.

2- The method of anesthesia.

3- Expectations of the recommended treatment and success.

- **The period of stay in hospital**

4- Alterna-tive method of treatment which are available and the probable outcome in the absence of any treatment.

5- Adverse effects and complications expected or risks involved

Informed consent

- ***All details should be explained to the patient in understandable non technical terms. This followed by patient's signature.***
- ***Consent only extends to what was explained to the patient& nothing extra should be done.***
- ***Informed consent should be taken before doing any research on patients.***
- ***Informed consent protect physician from malpractice***

Consent should be taken from the patient before examining or treating him except in :

1- **Prisoners**
2- **Pilot & airplane crew**
3- **Food dealers**
4- **To test sanity**
5- **Emergency & critical cases**

:Medical interference without consent

- In an emergency, such as an accident where the victim is in extremis على حافة الموت, unconscious or shocked.....to save life or preserve health
- Routine medical examination of new prisoner to exclude infectious diseases.

Consent is invalid in the following:

1- Unlawful act

ex: Criminal abortion.

2- Operations with no medical indication

ex: Amputation of finger to be unfit to military service.

3- Consent given by one has no right to give

ex: minors (below age) , mental patients

4- Consent obtained by fraud

ex: convincing the patient that the operation is necessary to save his life while this is not true.

1- In case of children , the responsible relatives or guardians give consent to treatment on their behalf

2- In mental disease or defect : it is impossible for the patient to understand and give consent to medical procedures . Either a relative , legal guardian , the medical institution or a legally appointed authority gives permission on behalf of that patient

Disclosure of Patient

- Information Disclosure

Patients have the right to receive accurate and easily understood information about their health plan.

- Participation in Treatment Decisions

Patients have the right

- **To know all their treatment options**
- **To participate in decisions about their care.**
- **Patient should be told the truth but if his condition was fatal and the truth will harm him physically or psychological , the physician may disclose his condition to his family unless the patient asked him not to tell them.**
- **Parents, guardians, family members, or other individuals that patients choose can represent them if they cannot make their own decisions.**

Disclosure

***- Disclosure refers to both giving the needed information by clinician and making them understandable by the patient. (*Information should be given in terms that the patient can understand.)**

- It provides continuing & trusting Dr-Pt relationship. **Informed patients are more satisfied with their care and less apt to change physicians than patients who are not well informed .**

- including nature of illness, treatment and expected effect, hospital stays duration, time for recovery, restrictions on daily activities, scars, alternative options and use of medication. + **information about relevant alternative options and their expected benefits and relevant risks , and an explanation of the consequences of declining or delaying treatment**

- ***Pt. have the right to:***

- ask questions when they do not understand information or instructions. (**the clinician must respond to questions or requests for further information).**

- tell their doctor if they believe that they cannot follow through with their treatment.

- **Patients should be told the truth . Not telling the truth can harm patients in many ways . Patients who remain uninformed about their condition may fail to obtain medical attention when they should . They may also make decisions affecting their lives if they were not aware of their condition .**

Medical reports Certificates &

Medical reports & certificates

- **Registered practitioners are in certain cases bound to give certificates, notifications, reports or other documents, signed by them, for use in courts or for administrative purposes.**

- **A complete, accurate, and authoritative report can be obtained only by careful preparation and by a thorough understanding on the part of the physician as to what should be included in the report.**
- **The criminal law is accusing any physician or surgeon who is writing a medical report or certificate, which is not true as forgery by prison or a fine.**

-

القانون المدنى مادة 221:

كل شخص صنع بنفسه أو بواسطة شخص آخر شهادة مزورة على ثبوت عاهة لنفسه أو لغيره باسم طبيب أو جراح بقصد أن يخلص نفسه أو غيره من أى خدمة عمومية يعاقب بالحبس.

مادة 222 عقوبات:

كل طبيب أو جراح أو قابلة أعطى بطريق المجاملة شهادة أو بياناً مزوراً بشأن حمل أو مرض أو عاهة أو وفاة مع علمه بتزوير ذلك يعاقب بالحبس أو بغرامة لا تجاوز خمسمائة جنيه مصرى فإذا طلب لنفسه أو لغيره أو أخذ وعداً أو عطيه القيام بشئ من ذلك أو وقع الفعل نتيجة لرجاء أو توصية أو وساطة يعاقب بالعقوبات المقررة فى باب الرشوة.

ويعاقب الراشي والوسيط بالعقوبة المقررة للمرشي أيضاً.

مادة 223:

العقوبات المبنية بالمادتين السابقتين يحكم بها أيضاً إذا كانت تلك الشهادة معدة لأن تقدم إلى المحاكم.

There are certain circumstances in which a physician is asked to issue a medical report or certificate: e.g.

1-Birth certificate: including date and place of birth, sex of the baby, name of father and mother.

2-Vaccination: including type and time.

3-It is the duty of a physician to report to the health authorities all suspected cases of contagious disease so that proper examination may be made by experts and the public health protected.

- **distnictly certificate (شهادة الأعذار الطبية)**
- **شهادة التسنين للتأكد من وصول الاسنان لمرحلة ال second molar**
- **X-Ray on the elbow & hands to detect the ossification of epiphyses and metaphyses**

4-Work accident: reporting the cause of accident, the effects, any infirmity and time

of wound, site, causative instrument, associated lesions and complications & expected time for cure.

6-Occupational disease: reports include type of disease and need for diminishing effort or change of work and time needed for rest.

7-Age determination: to evaluate criminal responsibility and for free consent in rape.

اذا كان مرتكب الجريمة عمره 18 الا يومين يُحول للأحداث ولا يسجن

8-Test for sanity. (mentality)

9-Sick - leave reports for students.

10-For insurance.

11-Death certificate: **The physician must sign a certificate giving the cause of death of a deceased person on whom he has been in professional attendance.**

It is forbidden for a physician to sign a death certificate in certain cases;

a. In any violent death, whether homicidal, suicidal or accidental.

b. In any death in which the physician has not been in attendance or in which he is unable to establish the cause of death with reasonable clinical probability.

c. In any death in which it appears that a criminal act may have been a contributing cause.

Such cases must be referred to the designated medicolegal authority.

Legal rules that should be followed on issuing a medical report or certificate:

1-It should be given to the patient himself except when he is incompetent due to underage or insanity; in these cases it is given to his guardian.

2-It should be accurate, honest and includes the correct and complete information about the condition.

3-It should not entail any personal expectation but should be based on the utmost scientific standards. It should be issued after using the best skill of knowledge of the physician.

4-It should include in details all the data that have been asked for.

5- It should not include any dictated data by any person.

6-The physician should be sure of the identity of the person he is giving the report to.

7-He should not sign the certificate if he is not the one who wrote it except after thorough revision. A physician should certify only that which he has personally verified.

Any practitioner who signs such certificate which is untrue, misleading or improper, is liable to have his name erased from the register.

Doctor is allowed to give certificate to his patient about his or her medical condition.

The certificate must include true, correct and accurate data.

In case of age-estimation certificates for marriage, certificate must show name, photo and finger print of the person and is given to the patient him self (not to relative).

Medical syndicate

- **Definition:**

  The constitution and power which exercises disciplinary control over the physician and give them license to practice medicine.

- **Role :**

Protect the public by keeping a medical register for qualified men and distinguish them from non qualified persons.

It is the authority who issues the obligations and privileges and supervise its implementation.

Medical council

If the practitioner is guilty of dishonorable or disgraceful conduct, the medical council erase or omit his name from the register.

The disciplinary committee

It is the court to convict practitioners in case of professional misconduct or any kind of offense.

Guidelines for clinicians on medical records and notes

a- **Information for planning patient care**

b- **A means of communicating information between the attending doctors and the health care workers dealing with the patient**

c- **Documentary evidence of the patient's illness, treatment and response to treatment**

d- **Information for review, study, evaluation for care given to the patients**

e- **Protection of the legal interests of the patients, hospitals and health care workers**

f- **A database for medical education and research**

I. Each hospital record should contain the following identification data:

- Number on every page
- Name in full on every page
- Address
- Telephone number
- Date of birth
- Sex
- Person to notify in an emergency
- Occupation and marital status
- The patient’s registered medical practitioner

2. The clinical record:

1- The notes should include the following details:

- Initial history (previous illness, and details of medication)

- Initial physical examination, including patient's height and weight

- A working diagnosis and medical care plan

2- Notes supplemented and updated regularly to include details and reports of all investigations, treatments and verbal advice given to the patient and his relatives

3- An entry must be made on discharge recording the clinician responsible for the decision, the status and destination of the patient, and arrangements for follow up. A copy of the preliminary discharge letter should be filled in the notes.

3. Nursing records
4. Patients undergoing surgery
5. Patients in intensive therapy units:

a- A clear statement why the patient was admitted to the ITU

b- An accurate record of monitoring of the physiological state while the patient was in the ITU

c- Details of the therapeutic maneuvers performed

d- When the patient is moved from the ITU, a description of the patient's clinical status must be written down and the reason for transfer .

6. Details on discharge:

1- All patients should take with them a brief summary note (name of the consultant in charge, operation, diagnosis, current ongoing medication and arrangements for wound management).

2- Discharge summary/letter which is completed within 14 days of the patients discharge. Includes a précis of the clinical notes, the full diagnosis and the name of the consultant in charge. This is sent to the general practitioner, hospital of institution to which the patient is discharged.

3- When a patient dies a similar documentation should be completed and sent to the patient's general practitioner.

4- Details of the death certificate entry should be written into the patient's notes.